May 2023

KW4 OHT REFUGEE HEALTH INTEGRATED CARE TEAM

FINAL EVALUATION REPORT

PREPARED FOR

KW4 Ontario Health Team

PREPARED BY

Alexandra Whate
Catherine Tong
Lama Abdallah
Jacobi Elliott
Paul Stolee

ghs Geriatric Health Systems Research Group

UNIVERSITY OF WATERLOO

Contents

Funding for this evaluation was provided by the KW4 OHT and the University of Waterloo

EXECUTIVE SUMMARY

Purpose

This final report was developed to capture key lessons learned as they relate to processes, implementation and outcomes of the KW4 Ontario Health Team (OHT) Refugee Health Integrated Care Team (hereafter ICT) program. The lessons and recommendations reported here can be used to help guide and plan future iterations of the ICT program or similar refugee health initiatives implemented by the KW4 OHT and beyond.

Background

The KW4 OHT Refugee Health ICT program was approved in October 2021 and formally launched in January 2022. The aim of the ICT was to provide support to Primary Care Providers (hereafter PCPs) participating in the program by directly delivering, and linking refugee patients to, additional care and services, including mental health and community-based services. The ICT is made up of staff from several organizations [Carizon, Centre for Family Medicine (CFFM), Reception House, Sanctuary Refugee Health Clinic (SRHC), Home and Community Care Support Services Waterloo Wellington (HCCSS WW)] and includes: Discharge and Intake Coordinators (one at SRHC and a team at CFFM provided in kind), a Case Manager and a Pharmacist (funded by the KW4OHT), a HCCSS WW Care Coordinator (in-kind), and three Newcomer System Navigators from Carizon (in-kind); plus a collaborator from Reception House (in-kind). In addition, Directors from Carizon and CFFM provided leadership and oversight for the team (in-kind).

The objectives of the ICT program are:

1. To successfully transition 300 medically stable refugees, who have been in Canada for more than a year, to non-team-based PCP by June 2022.
2. To provide refugees with easier access to community resources by providing a team-based approach
3. To support refugees to become more independent in navigating the health and social system to access the supports they need.
4. To increase the knowledge of refugee patients such that they know with whom to connect and where to go when they need help.
5. To support PCPs to enable them to take on more refugees as patients.
6. To support PCP by having them access a team of inter-disciplinary professionals and interpretation services to better provide care.

Evaluation Aims and Approach

We have used a process evaluation approach as this method allowed us to monitor and document the process of the program's implementation which will result in a better understanding of the relationship between specific program elements and program outcomes. The aims of this evaluation are:

1. To understand the types of complexities experienced by patients who have been served by the ICT program and what their experience has been.
2. To track and describe the implementation and evolution of the ICT program.
3. To demonstrate and describe the activities of the ICT.
4. To understand how the various components of the ICT program (staff roles, interpretation, etc.) are used.
5. To identify barriers and facilitators to implementation of ICT activities.
6. To determine the characteristics needed for PCP clinics, staff, and patients to implement successful ICT programs.

Data for this evaluation was drawn from three sources:

1. Evaluation team notes that were made through observation at 32 ICT and ICT leadership meetings between May 30th, 2022 and March 31 2023
2. Interviews with ICT staff, clinicians and patients
3. ICT Patient database (Penelope) and virtual interpretation service app usage data

Evaluation Findings

Process and Implementation

The ICT program developed and evolved over time and included two important pivots that took place in response to the needs of the physicians and patients involved in the ICT. Pivot 1 allowed the ICT to more quickly refer and stream refugee patients, who were transitioning from a refugee health clinic to a permanent primary care practice, through the ICT program. Pivot 2 was made to ensure that outgoing patients were successful in making it to their first intake appointment and become rostered patients at their new clinic. As the model was refined, staff and leadership developed new protocols and adjusted the roles of the team members as required.

The delivery of this model leaned on the unique skills of several staff members who were able to meet the diverse needs of ICT patients. The integrated approach was intended to support the receiving physicians, so that their clinic team could principally focus on patients' primary care needs.

Patients Served

A total of 664 patients were transitioned from CFFM and Sanctuary to PCPs between September 2021 and March 2023. Of these patients, 621 received level 1 support, that is, they were provided with assistance in

booking their first intake appointment and transitioning to their new clinic; 43 of these patients (24 families) required level 2 support from the ICT, which includes more intensive support and referral to additional team members. Hours spent with ICT patients was only captured for the 43 level 2 patients. ICT staff spent a total of 565 hours serving these level 2 patients. Those who did require ICT supports had high and diverse needs.

Staff & Clinician Interviews

We conducted 13 in-depth interviews with ICT staff members and clinicians involved it the ICT program; the findings of these interviews are summarized beginning on page 20. We also drew on these interviews, in addition to other data sources (observations, documentation, meeting notes), to compose the lessons learned and recommendations, which are summarized below.

Patient Interviews

We interviewed eight ICT patients (four female, four male) who represent a total of 50 family members; the findings of these interviews are summarized beginning on page 30. Patients experienced barriers (e.g., long wait times, transportation, difficulty accessing specialist services) and facilitators (e.g., interpretation, care provided in the language of the patient, access to walk-in appointments) to care. All patients experienced very positive interactions with ICT staff and the services that they provided and described feelings of relief, improved health and wellbeing, and gratitude in response to the ICT's efforts. Patients received a variety of services from the ICT members, including medical support (e.g., helping with appointment booking, paperwork, medication, referrals to allied health and specialist services, and provision of medical devices) and non-medical support (e.g., accessing food, housing, and other necessities, connecting patients to community services, including programs for children). Patients described that the ICT members went far beyond medical services to provide vital social supports that improved the quality of life and wellbeing of their families. While some patients preferred in-person interpretation and others did not have a preference, all patients agreed that interpretation services are essential to their care.

Lessons Learned

- A new refugee health integrated care team can have substantial impact in its first year but **several pivots and modifications** to the model or processes may be required.

- It can take time for a multidisciplinary team to "hit their stride", and to be refined and implemented to its fullest potential. Starting "small" is prudent as this allows for more timely and responsive pivots.

- Implementing a one-year pilot program may mean that core staff members will begin to look for future employment before the program concludes, resulting in program disruptions.

- Transitions from the refugee health clinic to the new PCP requires a "warm hand off", and **patients may require substantial support**, particularly in getting to the first few appointments. Patients require in-depth orientations about their upcoming transitions, what to expect, and how to prepare for their new clinic.

- It is very challenging to identify and recruit clinics willing to take on refugee patients, and **relationship building with physicians willing to take on refugee patients takes time** and is best done in person.

- Physicians and their staff may not adopt "easy to adopt" technologies and integrate these into their practices without **regular and sustained support**, reminders, and encouragement.

- **When introducing a new technology/product/service/process to a clinic, it must be available to all the patients on their roster**. Clinics will be hesitant to integrate something new if it requires the extra task of distinguishing who is/who is not "part of the program". This also creates inequities in their practice, with some but not all having access to the new technology/product/service/process. This was the most notable barrier to clinicians who were asked to use the virtual interpretation service but did not integrate it into their practice.

- Practices, protocols, and expectations vary across clinics and physicians. **Different recruitment approaches will work with different clinics**; efforts must be made to understand how each partnering clinic operates.

- Even if a physician speaks the same language as the patient, there may be **barriers to communication with office staff**, which may limit the patient's ability to book an appointment, etc. Translation for "front of house" staff is just as important as translation for direct care.

- ICT members need to understand their role and set firm boundaries regarding what ICT can and cannot provide. This can be emotionally demanding work for the staff.

- Each family/patient is different (e.g., education level, literacy, language skills, socio-economic status, personal networks), and as such requires **an individualized approach**. Some patients will move through the transition well, while others will require much more intensive supports and will take more time. ICT may be required for less or more than one year, depending on the patient's needs.

- Refugee and newcomer service agencies in the region were previously working in silos, and many ICT partners had not directly collaborated. **When working together, organizations could more effectively meet the unique and wide-ranging needs of refugee patients** (social and health sector services collaborating in new ways).

- While it is necessary in the delicate first years in Canada, the care provided by many refugee health clinics is much more comprehensive, accessible, and flexible than the average family practice. **It can therefore be jarring when patients move to the traditional system**. This can lead patients to expect a level or type of care that is not reflective of how the broader health care system operates in Ontario (e.g., single patient, single issue appointments)

Recommendations & Insights for Future Iterations of ICT

- When implementing a new program or model it is important to understand the unique needs and characteristics of each clinic. Clinics require personalized and ongoing support, training and communication to ensure success.

- Training and support at the clinics must include reception and other patient-facing staff. When working with refugees and newcomers, all staff should have access to interpretation services; this is an accessibility issue that has been largely overlooked and underfunded.

- ICT and similar initiatives would benefit from a strong marketing strategy, so that physicians, patients and community providers/partners know about the model, the supports available, and how to access them. Clinicians would also like stronger feedback loops, so they better understand what types of health and social services their patients are receiving via the ICT team. This would also improve the health community's understanding of the program and potentially promote further uptake.

- ICT teams may wish to work with refugee health clinic partners to better prepare and ease their patients into the broader system. This should be done with patients incrementally, so patients in the refugee health clinics gradually become more accustomed to the way in which health care is typically provided to the general public.

- Consider the inclusion of Settlement Workers within the ICT program as settlement issues (e.g., housing, employment) were often raised by ICT patients.

- The ICT coordination role does not necessarily require a specific clinical or professional designation as many of that role's core functions are administrative. This may be cost saving.

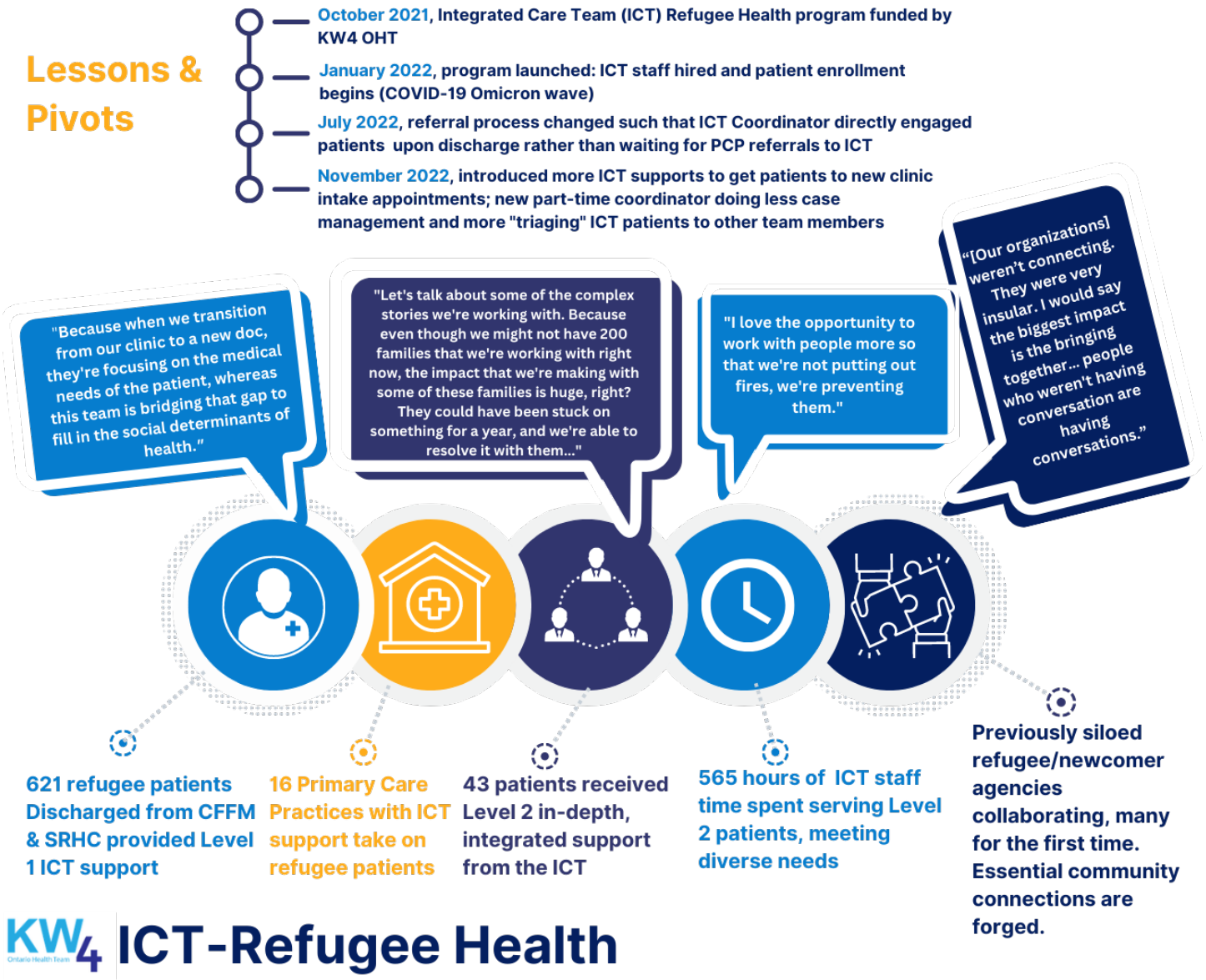
- Continue to develop a discharge protocol, with clear indicators for readiness.

- Consider more team building at the outset of the program. Initial team building sessions could also be the opportunity to learn about each person's role, scope of work, and unique skill sets.

- All future ICT programs should include a virtual interpretation service or a similar interpretation service, not only to support health care, but also to help these programs communicate and support patients outside of the health care system. These types of supports should be accessible to all participating clinics, for all their patients.

- Future iterations of the ICT and or similar models should dedicate time to finding/procuring a single EMR (electronic medical record) that all team members can access and use, irrespective of their location, organizational affiliation, or professional status. It can be traumatizing for refugees to re-tell their stories, often to relative strangers/new agencies, thus identifying a mechanism to avoid this trauma, while also supporting the consolidated records-keeping for the ICT should be a priority but may be technically difficult to achieve.

Executive Summary Infographic



BACKGROUND

The KW4 Ontario Health Team (OHT) received its formal approval from the Ontario Ministry of Health on October 23, 2020. KW4 represents Kitchener, Waterloo, and the Townships of Wellesley, Wilmot and Woolwich. KW4 identified the following priority populations for their initial areas of focus: refugees, persons who are frail, and persons experiencing homelessness. In June 2022, year two of the KW4 OHT, it was decided that priority would be placed on the refugee/newcomer population. The region is identified as a designated resettlement area for Government Assisted Refugees (GARs) and other newcomers.

Since 2008, The Centre for Family Medicine Refugee Health Clinic (hereafter CFFM) has worked closely with Reception House, to provide primary care to GARs in the region. Additionally, in 2013, the Sanctuary Refugee Health Clinic (hereafter SRHC) opened to support Privately Sponsored Refugees in the region and refugee claimants, along with supporting some GARs through the partnership with CFFM. CFFM currently has greater numbers of active patients compared to its human health resource ratio, however CFFM does not operate with a waitlist. SRHC currently has an extensive waitlist of newcomers applying to become rostered patients.

To maintain capacity to continue to serve GARs and newcomers, the KW4 OHT and its partners determined that the health care of refugees should be transitioned, in a timely way, from these clinics to other team and non-team based Primary Care Providers (PCPs) throughout the region especially since CFFM is a short-term transitional clinic designed to only support patients temporarily upon arrival, and SRHC has a 3000+ waitlist. Work to transition refugee patients to permanent PCPs has been an ongoing process. However, for the timeframe and purposes of this evaluation, patient transition counts began in August 2021 with the recruitment of mostly non-team-based PCPs and the transition of patients to willing PCPs.

To support this work, the KW4 OHT Refugee Health Integrated Care Team (hereafter ICT) program was approved in early Fall 2021 and formally launched in November of 2021. The ICT program aimed to provide support to PCPs participating in the program by directly delivering, and linking refugee patients to additional care and services, including mental health and community-based services, and through supporting the PCP in their delivery of care by providing access to an on-demand app-based virtual interpretation service, which links to real-time professional medical interpreters working in 250+ languages within 20-30 seconds.

The ICT is made up of staff from several organizations: Carizon[1], CFFM, SRHC, Home and Community Care Support Services Waterloo Wellington (HCCSS WW), and Reception House. The team includes: Discharge and Intake Coordinators (one at SRHC and a team at CFFM provided in kind), a Case Manager (which transitioned to an ICT Coordinator role) and a Pharmacist (funded by the KW4OHT), a HCCSS WW Care

[1] On March 31, 2023 Carizon merged with KW Counselling Services and Monica place to become Camino Wellbeing + Mental Health.

Coordinator (in-kind), and three Newcomer System Navigators from Carizon (in-kind); plus a collaborator from Reception House (in-kind). In addition, Directors from Carizon and CFFM provided leadership and oversight for the team (in-kind). Funding from the KW4OHT ended in November 2023, however due to the Case Manager leaving their role earlier than expected, an ICT Coordinator was hired and funded for an additional few months with leftover salary from the Case Manager. Funding was secured through a grant from Immigration Partnership to continue to fund the role of ICT coordinator until December 2023. Note that while we use the term "patients" throughout this document for consistency, some organizations (e.g. Carizon) refer to these same individuals as "clients".

The service provided by the ICT can be broken down into two levels. Level 1 includes assistance from the Case Manager/ICT Coordinator who booked the intake appointment and ensured the patients medical chart was transferred to the new PCP. Level 2 patients received more intensive support that includes Case Manager/ICT Coordinator follow-up and possible connection to additional ICT services (e.g. Care Navigators, Pharmacist support, home and community care), either before after the transition is made to PCP.

Program Goals and Objectives

The goal of the Refugee Health ICT project was to provide a robust and sustainable program that would increase overall access to primary care for refugees in the region and support PCPs that are providing care to refugees. In transitioning medically stable refugees to PCPs, this will allow the Centre for Family Medicine Refugee Health Clinic and the Sanctuary Refugee Health Clinic to continue to serve incoming refugee families.

The objectives of the ICT program were to:

1. Successfully transition 300 medically stable refugees to non-team-based PCP who have been in Canada for more than a year by June 2022.
2. Provide refugees with easier access to community resources by providing a team-based approach.
3. Support refugees to become more independent in navigating the health and social system to access the supports they need.
4. Increase the knowledge of refugee patients such that they know with whom to connect and where to go when they need help.
5. Support PCPs to enable them to take on more refugees as patients.
6. Support PCP by having them access a team of inter-disciplinary professionals and interpretation services to better provide care.

EVALUATION APPROACH

Evaluation Method & Aims

The focus of this evaluation in on the level 2 ICT patients. We have used a process evaluation approach as this method allows us to monitor and document the processes of the program's implementation. The focus of a process evaluation is on the types and quantities of services delivered, the beneficiaries of those services, the resources used to deliver the services, the practical problems encountered, and the ways such problems were resolved. In addition, we used the Consolidated Framework for Implementation Research (CFIR) to guide data collection, coding, analysis, and reporting of findings, which allows for a systematic, comprehensive, and timely understanding of barriers and facilitators of the ICT.

We consulted with the ICT leadership team to identify the following Evaluation Aims:

1. Understand who has been served by the ICT and what their experience has been.
2. Demonstrate and describe the activities of the ICT to understand the implementation of the program
3. Understand how the various components of the ICT program (staff roles, interpretation services, etc.) are used and distributed.
4. Understand the barriers/facilitators to implementation of ICT activities.
5. Determine the characteristics needed for PCP clinics, staff, and patients to implement successful ICT programs.

Data Sources

Data for this evaluation was gathered from several sources:

ICT Observations: The evaluation team has been observing and keeping implementation notes at the weekly ICT and ICT leadership meetings since May 30th, 2022 (a total of 32 meetings attended). We have drawn on those notes to inform this report.

ICT Staff and Clinician Interviews: This report draws on interviews with thirteen staff members and leaders from the ICT project as well as clinicians from the primary care clinics to which the refugees were transferred. Interviews were conducted online (via MS Teams) and were recorded and transcribed. Interviews lasted an average of 66 mins (min: 35, max: 98).

ICT Patient Interviews: The research team interviewed 8 ICT patients representing 50 family members (mean age of participants=48 years, age range 32-75 years, female=4, male=4). Participants had been in Canada from 15-51 months (average= 34 months). All interviews were conducted by telephone with seven using a virtual interpretation service (Arabic=5, Somali=1, Tigrinya=1), and one conducted in English without interpretation. Interviews lasted an average of 39 minutes (range =35-45 minutes)

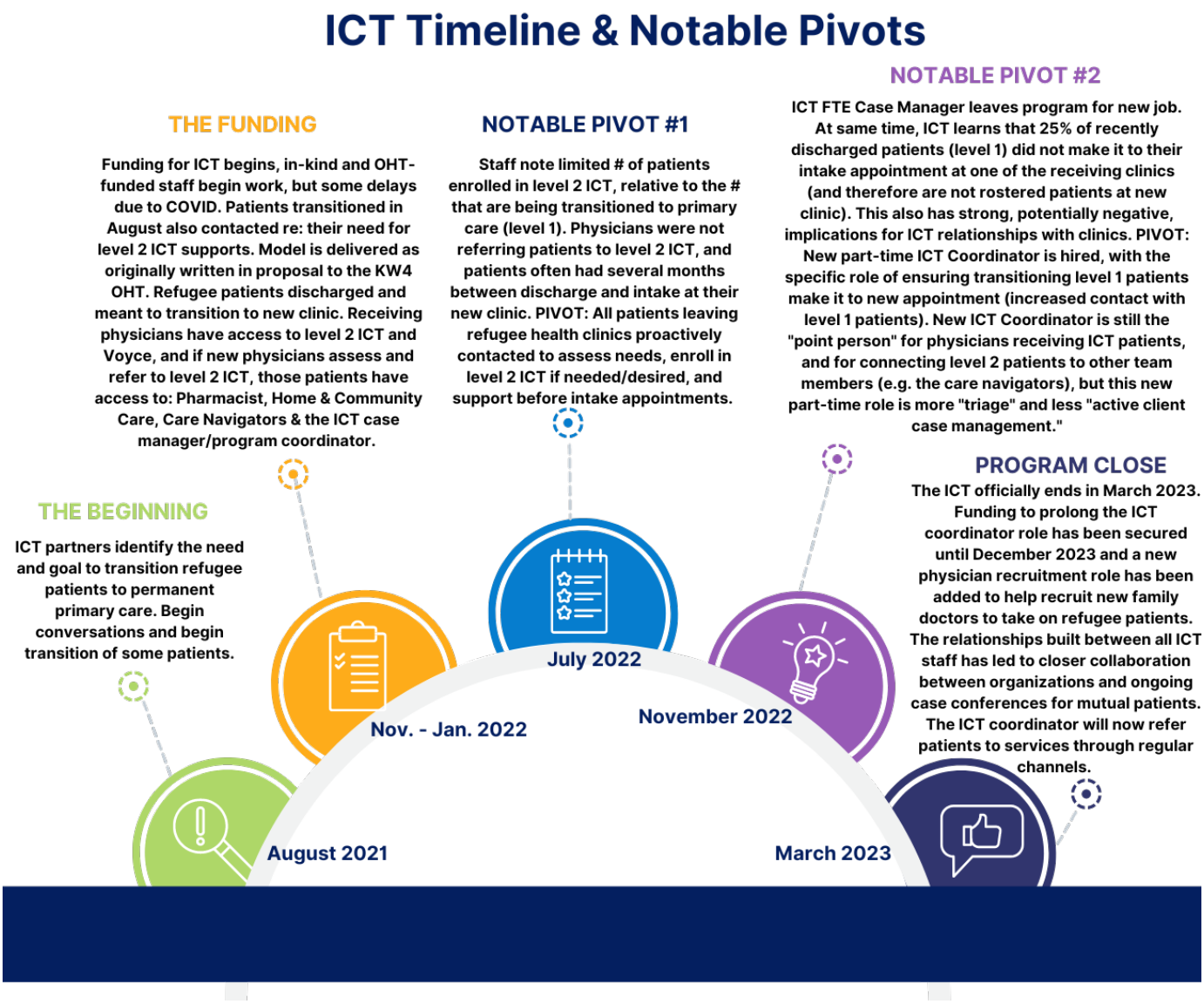
ICT Patient Database and Interpretation Records: ICT leadership provided the research team with reports and statistics from the Penelope database that is used as a patient database by ICT staff. They also provided the research team with reports and statistics for the virtual interpretation service usage throughout the program.

EVALUATION FINDINGS

Implementation & Process Findings

The ICT program developed and evolved over time and included a few important pivots that took place in response to the needs of the physicians and patients involved in ICT and lessons learned. As the model was refined, staff and leadership developed new protocols and adjusted the roles of the team members as required. The timeline and pivots of the ICT program are presented in Figure 2.

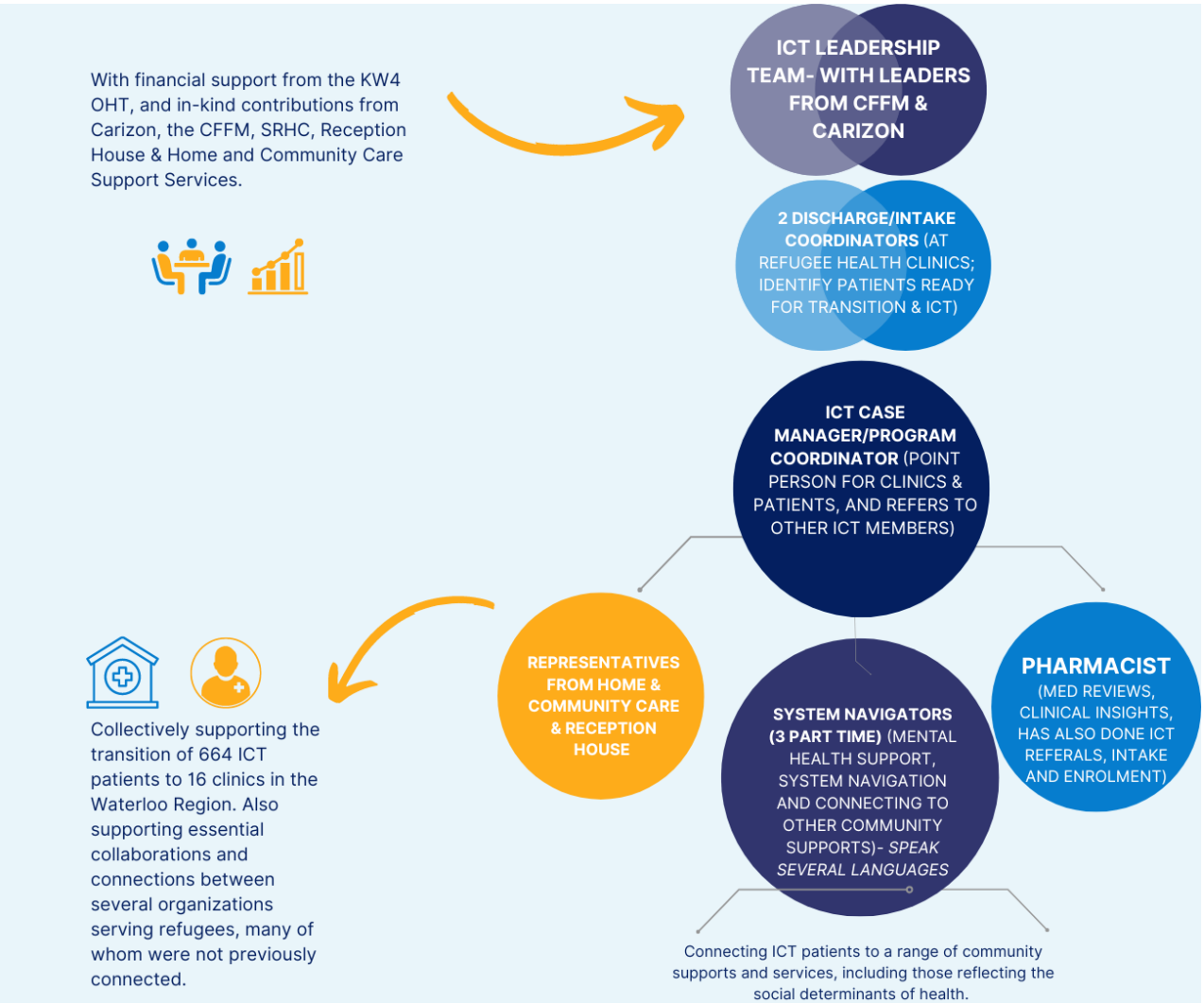
Figure 2. ICT Timeline & Notable Pivots



All patients from CFFM and SRHC that transitioned to a new PCP were provided with level 1 support. This means that the ICT Coordinator booked the intake appointment and ensured the patients' medical files were transferred to the new PCP. Prior to the hiring of the ICT Coordinator, this role was often fulfilled by a Case Manager from Reception House with support from the Discharge & Intake Coordinators or their staff at CFFM and SRHC. Once hired, the ICT Case Manager along with the ICT Pharmacist called all level 1 patients that were previously transitioned to their new PCP to determine whether they needed level 2 support. Patients requiring level 2 support maintained contact with the Case Manager (this could occur before or after intake to their new PCP) and were able to receive additional ICT services. Physicians who observed unmet needs could also refer ICT level 1 patients for ICT level 2 supports.

Given that the ICT is an integrated care team, the delivery of this model leans on the unique skills of several staff members. This integrated approach helped to meet the diverse needs of ICT patients (including physical, emotional, mental health, settlement, food security, housing, system navigation, interpretation, and others). The integrated approach was intended to support the receiving physicians, so that their clinic team could principally focus on patients' primary care needs. This team approach is summarized in Figure 3 below.

Figure 3 The ICT Members



ICT Roles

The roles on the ICT are summarized in Table 1 below. It is important to note that the personal background and skills of many of the ICT members played a significant role in the success of the program. Many ICT members spoke at least one language commonly spoken by the refugee population they served, and some had shared cultural backgrounds that allowed for increased understanding and trust between the ICT members and their patients. Almost all staff members had experience working with refugee populations in the past. The individual in the Pharmacist role had extensive prior experience on integrated care and community care teams and had strong rapport building and interviewing skills, which allowed her to work well outside the scope of a traditional Pharmacist. Only 13% of the Pharmacist's time was spent completing medication-related tasks or consultations. Given her access to the EMR (electronic medical record), she also spent a significant amount of time assisting with recruiting and enrolling patients to the ICT program and was

responsible for calling those patients that were discharged prior to the more inclusive process (key pivot #1) being implemented to see if they would like to enroll in the ICT program.

In addition to the formal ICT staff, there was one additional person from Reception House that took part in many of the ICT meetings. This person made significant contributions to the team by using their existing relationships with PCPs and reaching out to new PCP in the region to take on refugee patients. This person's exceptional social and communication skills, relationship building efforts and persistence were vital for recruiting PCPs for this program. Despite the efforts of the Reception House staff member, the program experienced significant issues recruiting new clinicians. For this reason, and in light of recommendations made in the interim report of this evaluation, the CFFM and KDCHC hired a part-time position whose role it is to connect with and recruit family practices to take on new patients. This new role is funded until December 2023.

Patients Served

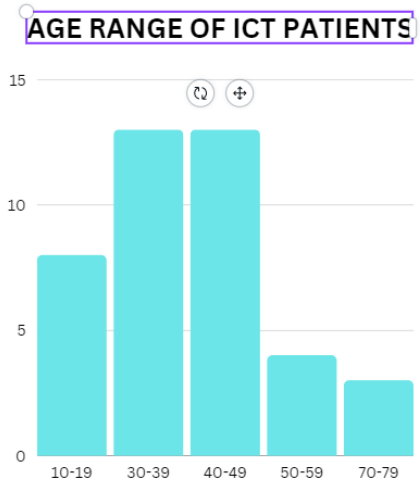
A total of 664 medically stable patients were transitioned from CFFM (442) and SRHC (222) to 16 PCPs since September 2021. In the beginning months of the program, one clinic with Arabic speaking Physicians took the majority of patients (336), another clinic that opened during the program took on 95 patients, while the remaining clinics ranged from 1-52 patients each, with 8 clinics taking 5 or fewer patients.

Of these 664 patients, only 43 individuals from 24 families (~6%) required level 2 support from the ICT (Figure 4). ICT staff spent a total of 565 hours serving these 43 patients. These patients had high and diverse needs, and although were medically stable at the time of discharge, many had complex social and medical needs. Staff documented the time spent with patients in the EMR, Penelope. They documented the general type of service they provided for patients, and the number of hours spent (Table 1). In addition, for some categories, staff were able to check off topics related to any additional support that they provided. The additional support provided was wide-ranging and included support for: education, employment, English language learning, finances, home and community care, identification card services, interpretation, isolation, mental health, settlement, appointment attendance, and transportation. The hours provided by the Discharge and Intake Coordinator and the Case Manager for level 1 patients is not captured, nor is time spent in team meetings or on program administrative tasks.

Table 1: ICT roles, organizational affiliation, and description

Role/Title	Time Allocated to ICT & Funding	Role Description
Case Manager/ ICT Coordinator	Full Time, CFFM Funded by KW4 OHT	The Case Manager (and after pivot #2 the ICT Coordinator) is the primary contact for the ICT team and acts as the main support when a patient transitions from CFFM or SRHC to their new PCP. The Case Manager/Coordinator contacts patients to prepare them for the move by providing education around expectations, and also facilitates the scheduling of an intake appointment. The Case Manager/Coordinator identifies the needs of the patients and refers the patient to the other team members for service as needed. The Case Manager/Coordinator acts as the point of contact for PCPs that feel their patients require service.
Pharmacist	Part-time, CFFM Funded by KW4 OHT	Involved as a pharmacist after patients transition to new PCP. Conducts patient interviews to determine needs, identifies medication issues, and discusses treatment options with PCP as needed. (EMR Note: Because this individual has access to the patients' clinical records in the CFFM EMR, this staff member was often contacting potential ICT patients to enroll them in ICT and complete the initial intake assessment.
Discharge and Intake Coordinators	Part-time, CFFM & SRHC in-kind	The discharge coordinator at SRHC and the discharge team at CFFM work to identify patients that are ready to be discharged to PCPs. They, along with members of their healthcare team, review records to determine which patients may be in need of ICT support and obtain patient permission to enroll the patient in the ICT program.
Home and Community Care Coordinator	Part-time, HCCS in-kind.	Coordinates home and community care services for ICT patients identified by the Case Manager or PCP as needing homecare services.
Newcomer System Navigators	3 Part-time Positions, Carizon in-kind funded through ICRC	The System Navigators provide navigational support to patients that may need additional mental health or social services. They identify the needs of the patient and provide referrals or information about the supports that are available in the community.
Case Manager Reception House	Casual Position, Reception House in-kind	Approaches and recruits PCPs in the region to take on refugee patients. Develops relationships with PCPs and clinic staff, and provides education and support to ensure that PCPs and staff are prepared to take on patients.

Figure 4. Level 2 patient demographics and the time spent by ICT staff types of services provided to level 2 patients (n=43)



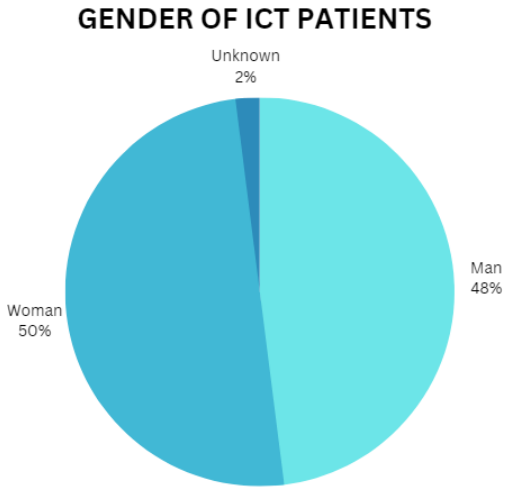
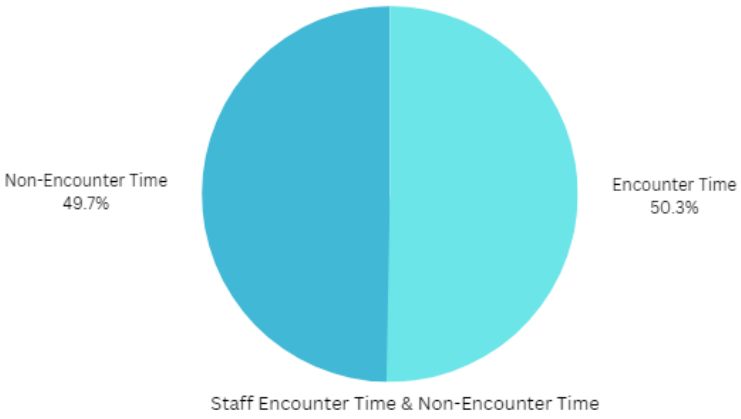


Table 3: ICT Staff hours[2]



Staff Role	Hours Spent
Case Manager/Coordinator	233.8
Pharmacist	137.9
System Navigators (3 Positions)	193.3
TOTAL HOURS SPENT	565

[2] The staff hours include only those hours that are logged in the Penelope EMR (hours spent on individual patients) and do not include any hours spent in team meetings or other program administration tasks.

Virtual Interpretation Service Usage

The ICT uses an application-based virtual interpretation service that offers access to real-time medical interpretation in 240+ languages. All ICT team members were able to access the service at any time to interact with ICT patients. In addition, upon signing on to take on ICT patients, clinics were offered an account that allowed them access to the virtual interpretation service. Clinicians were instructed to only use the service with patients that were registered with the ICT, however clinicians reported this to be problematic, as it was hard for them to know, of their 1000s of rostered patients, which few were part of ICT. Only half of clinics used the virtual interpretation service provided. The table below summarizes the app usage among ICT staff and clinics.

ICT Role	Virtual Interpretation App Usage
Case Manager/Coordinator	**2276 minutes**
Care Navigators (3 positions)	**686 minutes**
Pharmacist	**210 minutes**
Primary Care Provider Clinics (8 clinics)	**969 minutes**

Qualitative Staff and Clinician Interview Finding

Discharge & intake processes

Overall, CFFM and SRHC use similar indicators to signal that a patient in ready for discharge. These are:

1. The patient is deemed medically stable by the healthcare team without any major complexities or issues; and/or if many complexities it is ensured they are stabilized managing their complex health care needs
2. The patient is able to book an appointment relatively independently (may include an assessment of language skills or ability to access interpretation);
3. The patient has a demonstrated ability to attend appointments (e.g. patient shows up to current appointments and has access to transportation); and
4. There is an appropriate doctor willing to take on the patient (may include language and cultural considerations). Staff noted that finding a 'good match' between patient and physician is important for success.

The intake process varies depending on the clinic to which the patient is being discharged. Staff reported that different clinics have different protocols and intake procedures, including differences in the ways that medical records are transferred and the ways in which intake appointments are run (one family member vs. all family members present), and also differences in the follow-up processes (e.g. some clinics accept email appointment requests) and language capabilities of staff. Staff noted quite a few issues that arose during this process, including files not being transferred successfully, patients missing intake appointments, patients inappropriately using intake appointments for medical issues, and patients missing out on needed services between discharge and intake. This latter issue was the precipitating factor for key Pivot #1 (referring all outgoing refugee patients to ICT, to ensure that if they needed/wanted ICT supports, those were in place well before their intake appointment). Staff also noted that the care model used at the CFFM is much different to that of Primary Care Clinics, which has sometimes resulted in patients having unrealistic expectations of their Family Health experience:

> "*We haven't properly prepared patients for the move, we've provided them with this awesome service, yeah, we love everybody that comes here, we'll see your family for three hours. But we're not like titrating that we're not- we're not slowly reducing how well we see folks, we're not getting them ready for what's coming. And so yeah, I think that that's something that may need to be built in at some point into how they work towards discharge.*"

Team composition & roles

Establishing the roles on the ICT took some time and planning and ensuring that ICT team members understood each others' roles and boundaries was important in the development of the program:

> *"As we onboard more team members […] we started more team meetings to know each other, define our roles, that was a big piece of it, make sure that we all knew kind of the boundaries of each other's roles, but also what each other's roles could offer, seeing those not everyone had worked in kind of this capacity before. And then we just started to define kind of the program […] And we develop throughout this whole time in the process map to see okay, what- what's similar between the agencies what's a bit different[…] We also made sure that each team member had a say so that nothing that we planned was set in stone because we were very understanding of the fact that the program and our kind of criteria for it was going to have to be adaptable and flexible."*

Notably, many staff members mentioned the importance of flexibility in the roles of the team members, as several roles were working beyond the usual scope of their profession:

> *"So definitely flexible. Being able to go into the different environments and maybe do things that you wouldn't normally do in [my usual] role [...] outreach would be one of the skills or duties on that I guess because you're doing a lot of outreach work [...] just being very open. Like I said, be adaptable to different environments, and flexible to do things that maybe aren't part of your role."*

Having ICT members with a variety of backgrounds was seen as a strength of the program as it allowed patients to receive more holistic care:

> *"[One team member] is looking at this situation from this angle. [Another team member] may look at it from this angle, and say, forget about this angle. Yeah. So I think it is great [...] I see like how each one of us is critical."*

Staff members had difficulty in identifying any roles that were unnecessary, however some did feel that the main ICT staff role, the Case Manager, could have been more of an administration role and that the Care Navigators could have been utilized as needed for the social work or system navigation work. Most staff felt that additional roles, specifically an administrative support person, and a settlement worker would be an asset to the team:

> *"Who's going to be receiving faxes, sending faxes, or connecting with patients, making sure all the administrative work? So, [having] a team assistant, I think it would very useful, if the team becomes like more fluid and our processes are, run more smoothly."*

And,

> *"If you have one person who's able, maybe that administrative person to just work on those surveys and keep getting patients and receiving information, then the pharmacist and social worker and everyone else can keep doing their role."*

And,

> *"Because it's [...] a specific niche, right? In terms of the work that it is. And it requires a specific knowledge base. That and, connections that settlement workers have, and that we don't necessarily have [...] we'd be starting from scratch trying to figure it out. And they would know exactly what the issue is, right? [...] we could very much use the settlement worker, because we're- through tracking the themes of what we're working on, we've identified settlement work comes up in almost every case."*

Team building & new collaborations

The ICT received funding in October 2021, and launched the team in January 2022, which coincided with one of the worst waves of the COVID-19 pandemic. This was a challenging time to launch and form a new, interdisciplinary team in the health and social care sector, as many staff were redeployed and/or assisting with the pandemic response. In observing the ICT meetings, we noted increased comfort and collaboration between ICT staff members over time. For many members of the ICT, this was their first time meeting and working with staff from the other organizations. One staff member remarked:

> *"Up until ICT happened, Center for Family Medicine, Sanctuary weren't connecting. And they weren't connecting with mental health services or those community supports. They were very insular. [...]I would say the biggest impact is the bringing together of home care, and the medical models and our organization and Reception House to really clearly understand how our work can work together to help support, that's been the biggest impact. So, people who weren't having conversation are having conversations."*

The collaboration between the organizations involved was seen by staff as one of the most important aspects of this work; the staff emphasized that the value of the ICT lies in the collaboration and shared vision among the organizations:

> *"I don't think it's one organization, I think it's multi organizations that have to have the same mind the same mission, vision, values and the same purpose. I don't think it's one organization, this is a larger effort."*

Staff noted that in working together, they were learning from one another, for example, ICT members noted early on that their notetaking techniques were very different across professions, and through negotiation and kind criticism, one ICT member was able to teach the others the most effective method for notetaking in this type of work.

Data collection & staff communication

As the ICT program developed, communication between ICT members from the various organizations was a challenge. Staff contact information was not shared immediately upon the creation of the team, and therefore it was observed that at the ICT meetings staff would share their contact information with one another after the need arose. Several meetings were spent discussing the introduction of a secure chat program, Hypercare, however ultimately, it was decided that the addition of a new program would be too complex for the team since most staff were already using a different program in their regular work, in addition to Penelope for the ICT work.

Staff noted that there is difficulty in the transfer of patient files and information through the system. For example, patient records are passed from CFFM or SRHC to the new doctor, however this data is not passed to the ICT. Additionally, there is data collected by Reception House by caseworkers that may be relevant to the ICT but is not accessible.

Staff developed their own data collection tools to facilitate their meetings with the patients. One staff member noted that she used pen and paper to take notes when having discussion with patients and would then have to relay the information to another staff member who would enter the information into Penelope. Staff noted that a shared database would be beneficial both for the ICT and beyond.

> *"So like having some sort of connection between the agencies will be really helpful. Because like you said, information is stored that the patient has to continually repeat their story, everywhere they go. And it does not become any easier. And they're quite exhausted at this point, […]I'll only get more of the story, if they consent to me talking to the Reception House case manager. […] Having some sort of either shared database, whether it's even just demographic information, right? Like that could do wonders. And so, you don't have to start from scratch for everything."*

Staff also noted issues with the capabilities of Penelope to capture multiple staff attending appointments together, or the ability of staff to make entries for patients at the same time.

> *"It's just how our database works. But it's not ideal. Because there's a case note that [one staff member] starts […] And then my team will go in and add their comments from that meeting. And then [another ICT staff] will go in and add into the same note. And just from like, a patient's story tracking stuff, it doesn't feel accurate. And so when you're pulling your data, like you're seeing [the same ICT staff name over and over], but it's not just [that ICT staff member], there's like all these people that are here, but you can't really get a good picture of how much effort how much time was [Care Navigator], and how much time was [homecare], and how much time was [pharmacy], if they're all documenting under the same note".*

In working from different databases and records, clinicians also noted that communication was challenging, and that they did not have a strong sense of what types of supports their patients were receiving via ICT. Speaking about referring patients for social care supports, a clinician explained:

"I don't even know if the ICT team was supporting my people… Yeah, I never got feedback, so I never knew if they saw somebody from there because of those things. That would be great to know, because that absolutely is part of their healthcare, right. And their, and their overall health. But if they helped them access, you know, food programs or housing or anything like that, I never know."

Sustainability & funding

The need to move patients out of CFFM and SRHC to regular family doctors is critical, as both clinics are currently beyond capacity and refugees are being forced to seek healthcare in less appropriate settings (e.g. emergency rooms). Staff identified that the most critical factor affecting sustainability of the program is the willingness of clinics to accept patients, and therefore the ICT need to work diligently to continue to build and maintain relationships with family doctors in the region:

"It's sustainable, if there's doctors, it's sustainable if there's clinics. If no one is accepting… So, right now, much of the work of ICT has been from a handful of doctors who are willing to accept one family each. As new clinics come on, if new clinics come on, ICT's efforts are going to be critical in…building that capacity"

Many staff noted that the effort involved in successfully transitioning and caring for this patient population is much more complex, and more time consuming, than average, noting specifically that the numbers in the program may not be a true reflection of the amount of work that has happened, nor of the true impact of the work:

"And the numbers, tell one story, even if it's little. But the actual effort required to do this is- it's massive. So, I just don't want the committee to say, oh, you only supported 20 patients, or whatever patients"

And,

"The qualitative is just as important as the quantitative and that that really needs to be equally valued. It's not only the number of impacts being made, but the quality of those impacts being made. Because you can make like 100 contacts, but you can transition them and they could be in a really precarious situation, with no help, right. Or you can have, like 40 patients and be able to like really spend more time listening to their stories and creating sustainable care plans […]I love the opportunity to work with people more so that we're not putting out fires, but we're preventing them from relapsing into the program again."

Timelines & flexibility

New teams and new models take time to establish and refine. The ICT has made a few notable pivots, or shifts, to their model, and these are outlined in the timeline in Figure 1, on page 14. Below, the staff reflect on the importance of being able to pivot and refine a model during the development phase, and how long these processes may take. Several team members noted that one year is not enough time to "hit their stride." One team member who had previously worked on a similar integrated care team felt that her prior team took several years to hit their stride, gel as a team, firm up their model, and start to demonstrate strong impact.

> *"I feel like we've started to hit a stride. I don't think we necessarily hit it. Because I think that we're still learning because there's so much to learn. I think we'd be a bit naive to jump into it and say that we've learned everything we can in a year. Which is the limit. I think it's an unfortunate limitation, right? Of- of when it comes to funding being like, okay, well prove to us in a year because there's so much need in the community. If you can't identify in a year that there's a need here then we need to put the funding elsewhere or something like that, right? It is unfortunate in terms of being on that time crunch, but I also get it."*

Another ICT member explained the importance of starting small, allowing time for important lessons and modifications before launching a larger program.

> *"... working with a smaller pool initially, it provides us with so much value and so much ability to adapt the program to their needs, right? And identify those themes. Whereas if we went on quantity, we'd get a lot of patients through, but we really wouldn't know the impact, right?*

Physician recruitment, physician relationships & use of the ICT program

ICT members repeatedly discussed the importance of physician involvement in ICT. It is fundamentally impossible to move patients out of refugee clinics (e.g., SRHC and the Centre for Family Medicine) and into a more permanent medical home, without practices *willing and able* to take them on.

> *"The number one issue is a lack of family doctors, or practitioners just generally being able to attach folks...So, the lack of doctors just means that you sort of end up having really no need to take on more patients... If you have a handful of doctors who are willing to take on one family a year, and then a few clinics who can take on the bulk of that, that's not a system that's going to be sustainable in the long run."*

Several ICT members have worked to establish relationships with physicians, to facilitate the transition of patients. These can be complex relationships that need to be nurtured. ICT had a

limited number of instances in which refugee patients and new physicians did not interact well, and the ICT was very conscious about tracking and addressing issues as they arose. For example, at one point approximately 25% of patients who were meant to transition to a new clinic were "no shows" and missed their initial appointment with the physician was meant to be their new doctor. In this instance, in Pivot #2, ICT introduced a part time staff member who was specifically tasked with supporting transitions, as ICT recognized that this pattern of "no shows" could compromise the relationship with the clinic, and their willingness to receive refugee patients in the future.

The ICT model was meant as "the carrot" to entice and support physicians who were willing to take on new refugee patients.

> *"…that's the whole point of this team, to eliminate that gap. Because when we transition from our clinic to a new doc, they're focusing on the medical needs of the patient, whereas this team is bridging that gap to fill in the social determinants of health…it makes it easier for the doctors and the patients themselves. That warm connection."*

Most physicians, however, who have participated in ICT have not necessarily used or maximized the supports available to their new refugee patients through the program. This is not to suggest that patients haven't been supported by ICT, but rather than the initiative/referrals to use ICT services have rarely come from physicians. ICT supports have often been offered to transitioning patients before they even meet with their new physician, as there is often a long wait for patients to attend their intake appointment at the receiving clinic.

> *"I think it was challenging because, like what we see now is the family doctor, they don't have time, they don't really care about taking this extra step to do it [refer patients to ICT]. So, when they shifted referrals to the [refugee health] clinics themselves, identify and say okay, this family needs ICT support. It can be faster."*

Insights on working with refugee patients

Staff discussed the joy and satisfaction of working with refugee patients and being given the opportunity to provide meaningful support, and clinicians recognized that the ICT team was engaged in complex work.

One team member described her admiration, and empathy, for refugee patients, and noted that most people fail to understand the profound and sometimes complex needs of these patients:

> *"Like you feel for them for the fear that they have for the anxiety that they sort of have around doing things. I find them to be somewhat brave. And they're pretty resilient. And despite all these, these setbacks or barriers, they're still able to make ends, and get through the day. But it's a lot harder for them. And unless you speak with them and see how they're living. I think everyone else just has no clue."*

While some refugee patients will be relatively independent and are able to navigate our complex health, social, financial and educational systems, others will struggle. All ICT staff noted that some refugee patients, particularly those in the ICT program, have complex needs that are often intersecting and all-encompassing. As one staff member noted we can't "*talk to them about mental health needs while they don't have food, and they don't have secured housing.*" Referring to the complex patient profile, another ICT member noted:

> *"And with the OHT, I was like, share the qualitative piece, like, let's talk about some of the complex stories we're working with. Because even though we might not have 200 families that we're working with right now, the impact that we're making with some of these families is huge, right? …we're able to resolve it with them and community partners."*

Insights working in a complex & resource scarce health and social care system

Many ICT members discussed the emotional toll of working in a broader health and social care system that is not sufficiently supporting refugees. For example:

> *You have to learn boundaries, right? You have to learn okay, this is this my job? Is this not my job? Because if you try to take on everything, you're gonna burn out, right? Especially when it comes to really tough things such as housing, like that is a situation where often you have to say to patients, this is the best option we have and it's still not ideal, right?*

And,

> *"Sometimes it's very hard to, you know, to, to keep your anger. I am angry of the system, because it like, it's not [refugees'] fault that they are not well supported."*

Staff members discussed the emotional toll, but also noted that they are well-supported by the ICT leadership in navigating their own emotions, and challenging situations.

> *"You want to do better, you know, and meet patients with a very high need… sometimes you struggle to- to deal with these cases…But the support is always there. They also provide training- we have a lot of training… the team is always there for us, the supervisor is always there for us."*

Despite the difficulties faced by the ICT team and their patients in working in a resource-scarce system, ICT team members find ways to ensure that they are doing their best to find ways to support their patients.

Finally, clinicians discussed the resource scarce landscape and pressing demands on their practices, which has implications for their participation in programs like the ICT. For example, one clinician explained:

> *" Yeah, 1800 patients is a lot. A colleague of mine in the States has 1000 patient's max, and makes the same amount of money I do. Just the reality of the system of how many patients do we need and how this works. Yeah."*

An additional complication, shared by both ICT leadership and participating clinic staff, was that refugee clinics provide a very comprehensive and flexible model of health care, in which entire families can attend an appointment, several issues can be discussed in one appointment, and arriving late or missing appointments is generally accommodated. While this level of flexibility and compassion is warranted for newly arrived refugees, it becomes difficult for refugee patients to move to new clinics, which are not nearly as flexible. As refugee patients become more aware of the shortcoming of the broader health care system for the general public, there is little incentive to leave for a new practice. One clinician explained:

> *" That's the other thing that I would love…education around the different parts of the Ontario healthcare system…some education around, you know, family doctors want everyone who's going to be seen to have an appointment, don't bring all four children in a 10 minute spot. Except - that's where the exhaustion comes in. Right? And that's really hard to educate around. Because of the refugee clinic, they do it like that, and probably book accordingly. I don't do that."*

Another clinician similarly noted:

> "*The person who is in, in first 30 days, yeah, by all means, I will see you every day, if that's what it takes, right… but, hey, as you get more and more stable, we will start to make you more independent. And then that - if that mimics what, you know, a physician in our community can do, then that transition, it just becomes less painful… if your end goal is to get patients to move out of your clinic, what's the incentive of somebody getting great service to leave your system?"*

Qualitative Patient Interview Findings

Barriers to accessing care

Many participants described the barriers they experienced accessing healthcare in Canada beyond the ICT, which provided important context to this evaluation.

Wait times

As is commonly experienced by many patients in Ontario, several participants indicated that despite having a new family doctor and a referral made, they had trouble accessing the specialist care they needed in a timely manner:

> *"So, I was able to see [family doctor], but when it came to the part of actually being referred to a specialist or to get into the specialist, I've been waiting for a year or maybe 10 months now, so I'm on this waiting list to be referred to a specialist to check my - check on my condition"* Male, age 45

And likewise:

> *"So, after the imaging, they told us that he had some blocked arteries, and he needs to he needs to go to the specialist. And we're still now waiting for, for you know for the doctor to call us back. Until now, we didn't get any response, even that his situation is dangerous and he's not walking. We even mentioned that to the family doctor, but he didn't get a response back either. And we've been waiting for that for seven months now." Female, age 46*

For one participant, the wait time for a specialist was made even longer due to lack of interpretation services, leading the participant to suggest that the ICT might be better able to help them by providing interpretation services for this type of appointment:

> *"So, when the appointment came and we had someone that speaks only a little bit of English, they cancelled the appointment because they told us that we have to bring an interpreter with us there to the appointment because he has to do like a couple of movements with his nose at the appointment. So, we couldn't get a hold of one. So, I'd really like to have someone in the team, like an interpreter that can go with us to the appointments, because we're - until now we're still waiting for this appointment. It's been a year and until now we didn't get one."* -Female age 46

It is not uncommon to wait for long periods of time for specialist services in Ontario, however refugee patients may wait longer if interpretation services are not available when needed.

Transportation:

A few participants noted that transportation is a barrier to them accessing timely health services. One participant noted the difference between their ability to access the CFFM and the transportation issues they face when trying to access their new family doctor:

> *"Previously our doctor was near our home near downtown so it was not too far, it's like 15 to 20 minutes, so it was easy for us to go to our doctor. But now, she's too far, even, we cannot travel by bus. It's very far we cannot reach after one hour, so it would be good if It's near our accommodation, because now she's really too far."* Male, age 32.

One participant described their challenge with booking appointments as they are reliant on others for transportation to their new doctor:

> *"I'm not able to schedule an appointment by myself and also I do not have a transport, I rely on people or friends to take me to my appointments so even the two appointment that I attended at the new doctor's office - these are times that I cancelled because I could not get transportation."* -Female, age 48

Location of the clinic and access to transportation should be considered when patients are transitioned to their new family doctor.

Facilitators to accessing care:

Participants described several factors which made accessing healthcare easier. Interpretation was the number one facilitator, and is described in greater detail below, however several participants noted that the fact that their physician spoke their language was of great benefit:

> *"Because of the fact that the physician speaks our language, so, the communication was very excellent. We were able to explain to him any new pain that comes up, any new symptom, and any modification in the medication or change in the dosage. We were able to understand him when he talks, when he talked about that. So, the treatment we received were very excellent in terms of the communication and the care itself."* -Male, age 75

And likewise:

> *"I was really happy because and the new doctor speaks Arabic and that's a language - one of the language that I speak, so, I will be able to explain myself."* -Female, age 48

In addition to speaking the same language, participants who were rostered at clinics that provided walk-in appointments found accessing care easier than it was at clinics that required appointments. When asked if she has had issues accessing her new clinic, one participant replied:

> *"No, not at all, actually, sometimes we go there without any appointments. We would wait for like five or ten minutes to go in."* -Female, age 46

Providing care in the language of the patient, and providing flexible, on-demand appointment times were both facilitators to accessing care.

Perceptions of the ICT

Participants were overwhelmingly positive when describing their interactions with ICT staff, and the services provided:

Relief:

Several participants indicated that the ICT gave them feelings of relief, and felt that their lives were made easier by their connection with the ICT :

> *"To be honest, this experience has been really beneficial and really mind easing. It makes everything easier for the newcomers in general, it really helps through the services and the facilitations provided"- Male, age 35*

Some participants described that their situation prior to their connection with the ICT team was quite dire, with one participant explaining:

> *"Our situation was really bad when we met [name of ICT staff member] and her team and - I don't know - I cannot even imagine how we would have survived without their help and their services or their systems. So, we did not even have food, we did not even have anything to eat or anything to support ourselves. So, I think we really needed their help and without them we could not have survived."* -Female, age 48

Improved wellbeing:

Several participants expressed that they had improved health and wellbeing since being connected with the ICT team:

> *"Yes, they really helped a lot, they impacted a lot positively [...] it really helped me or affected me positively in my health and my well being."* -Female, age 48

And likewise:

> *"So actually, it's very excellent. When they come and help me, I feel very optimistic and hopeful that they're providing me with so many services, so I was really happy."* Female, age 57

Not a single participant reported any negative experiences or outcomes due to their interactions with the ICT.

Gratitude:

Many participants expressed gratitude for the ICT services:

> *"I would love to extend gratitude to, well [...] they have been a really great team. They have been have really great assistance and help to us, and I would like to thank them very much"* Male, age 45

And likewise:

> *"Frankly, I'm very thankful for them. They were very understanding, helpful, thoughtful, and very good[...] they're all very helpful and cooperative, and I really thank them a lot. Thank God."*

Several participants asked the interviewers to pass on their thanks to the ICT members, and many gave 'shout outs' to ICT members by name, indicating that they were incredibly grateful for the kindness and compassion that were provided by the individuals on the ICT.

Services provided by ICT:

Participants described a variety of services and help provided by ICT members, including medical and non-medical services.

Allied health and medical devices:

Participants described the assistance that the ICT provided in helping them access medical services such as physiotherapy and optometry services. One participant described how an ICT member who spoke their language accompanied them to the optometrist:

> *"[ICT team member] also comes four times to our home, and he also helped my father to go to the eye doctor, and he helped him to talk with the eye doctor."* -Male, age 32

Several participants were provided with connections to psychological services through the ICT, with one participant sharing that the ICT was able to connect her daughter with a counsellor when her daughter was experiencing life threatening mental health issues:

"They [the ICT members] know my daughter is suicidal. They got [daughter] like, a counselor for me. I-I feel better now that [my daughter] has somebody like a counselor.

Another participant described the help that the ICT member provided in accessing assistive devices:

> "*They helped me by contacting the wheelchair service center and they were able to get me a wheelchair and they are still following up, like if there were any malfunction or if the wheelchair required any maintenance, they would be able to help you with that as well."* Male, age 37

Notably, participants were pleased with the level of follow-up and ongoing support that was provided in accessing medical services.

Medication supports

Over half of participants indicated that the ICT helped them with their medications, including providing medication consultations in home:

> "*They helped us with getting the medications. They asked us about the medications that we've been using. And they, especially me, because I've been using an iron pill that used to hurt me, but now they brought me another iron pill that is lighter.*" -Female, age 46

One participant described how the ICT pharmacist was able to communicate with their physician to straighten out some mix ups with medications:

> *"They also helped me with my medications. I had a problem pertaining one of the medications wasn't possibly taking correct, correctly. And there was a mix up of medications, so [the ICT pharmacist] helped me […] They also organized the process of how the medications are going and also getting information with the doctor"* -Male, age 45

Participants were overall very satisfied with the help they received from the ICT pharmacist.

Help with appointments:

Many participants reported that the ICT helped them to book, and keep, appointments with their new family doctor, some describing that the ICT member is the person they call to book the appointment on their behalf:

> *"I call [ICT member] if I need to schedule an appointment with the doctor […], I'm not able to schedule an appointment by myself"* -Female, age 48

Other participants noted that the ICT members helped them to learn to book appointments on their own:

> *"[The ICT members] are the ones who set the appointments for me. So, they taught me how - it's either sending a text message or going to the doctor's office."* Male, age 37

One participant explained that before they were in contact with the ICT, they missed multiple appointments with their new family doctor, and that the ICT was now intervening to help them reschedule their appointment.

> *'We actually were very late for the appointments. So, they [the ICT] try to communicate with the doctors [...] they came, they asked us questions about our health, about the problems we're facing with the appointments, and they really tried their best to help us [...] she [the ICT member] tried a lot. She told us that she would call the clinic and try to book an appointment for us. But, they told her that we're on the waiting list and she's waiting for the clinic to call her back."* - Female, age 46

Booking appointments, appointment reminders and education about how to independently book an appointment was a common service provided by the ICT, and was appreciated by most participants.

Connections and referrals to additional services:

Many participants described the ways in which the ICT was able to connect them to services in the region, including such things as passports and identification services, by helping with paperwork and applications, and by connecting patients to the YMCA:

> *"[The ICT members] helped me, and also they helped with multiple meetings. They also helped me with getting my paperwork sorted with YMCA, so they have been in, well a great deal of help to me."* Male, age 45

Others reported help with accessing food and other necessities:

> *"I cannot even imagine how we would have survived without their help and their services or their systems. So, we did not even have food, we did not even have anything to eat or anything to support ourselves. So, I think we really needed their help and without them we could not have survived."* Female, age 48

Participants also reported that the ICT was able to help them connect with housing services:

> *"They tried their best to help. Like, for example, when we complained that our rent is very expensive, they tried to refer us to an organization."* -Female, age 46

Additionally, several participants reported that the ICT helped them to access programs for their children, with one participant even noting that an ICT member provided a bicycle for his son:

> *"They also helped with activities for the kids. So they did everything, to be honest [...] Even one time I told them that my son wants, wanted a bicycle. They tried to get him one. So, I want to thank them very much. They're a good team."* Male, age 37

Overall, participants were very happy with all of the connections made by the ICT members:

> *"They were so helpful, and they spared no effort. And they connect us to whichever services we needed or required."* -Male, age 74

The services and connections provided by the ICT went above and beyond medical services and included many social services that improved the quality of life of all participants.

Interpretation Needs

Access to interpretation was found by many participants to be critical to their ability to access services. Most participants did not speak enough English to be able to book an appointment with a clinic, and as described above, relied on the ICT to help them to book appointments. Many participants expressed frustration with not being able to understand office staff that were tasked with booking appointments or following up with results for patients on behalf of the doctor:

> *"Because every time we go to the doctors, they would tell us that the clinic called and, yes, they called, but we need someone speaks in Arabic to call us and tell us what is the required, because we know that when they're speaking, they're saying one of our names, but we don't know what they're saying [...] The doctor is, he speaks Arabic, but none of the staff speaks in Arabic. And when they call us from the clinic trying to inform of something, they speak in English. And we know that they're mentioning one of our names, but we don't know what they're saying."* -Female, age 46

Several participants reported that they used family members, often their children, to help them with interpretation during appointments. When asked how she manages to speak with her doctor, one participant replied:

> *"Either my son or my daughter sometimes - they go with me to the appointment, and they speak English with them."* -Female, age 57

Another participant described that he has to act as the interpreter for his older family members, despite his own difficulty with the language:

> *"Yeah, if I don't go to the doctor with my father or my mother, my father or my mother cannot communicate with the doctor [...] Yeah, I always have to be by their side wherever they are going to, anywhere, because I try to communicate with the little language that I do have, with my broken English."* -Male, age 32

Many participants expressed a need for interpretation services outside of their medical appointments:

> *"I'd like to be there an interpreter the whole time, to call the interpreter, and to help us anytime we want. Because, you know, we're still here new in Canada. You know? Like language barrier, it's very hard for us"* -Female, age 46

And likewise:

> *"It is really important because there's so many people who are coming into the country with their families and their children, and they do not speak the language. It would be really hard for them to be able to access medical services and even other services - and if they do not speak - if they do not get interpretation of people who can speak their language and explain to them, it will be really difficult for them to be able to access those services and to be able to adjust to the country."* -Female, age 48

Accessible interpretation was among the most important services to the interview participants. While several participants expressed that the mode of interpretation (in-person or virtual) was not important:

> *"It wouldn't make any difference if they are in person or they are with me on the phone. The most important thing is that we are understanding one another."* -Male, age 45

And

> *"if it's in person or over the phone, both are fine."* -Female, age 57

Other participants felt that in-person interpretation was preferable:

> *"If the interpreter is in-person, then my father and my mother, because they're old age, so they can easily understand and they can easily hear the interpreter. And the thing is, they can also talk directly to the, to the interpreter, so that he can help him to convey the information to the doctor or to the responsible person." -Male, age 32*

And likewise:

"It's better to have an in person interpreter [...] because they are clearer when it comes to delivering ideas." -Male, age 37

Regardless of the interpretation being in-person or virtual, participants were clear that interpretation is critical for their ability to access the services they need.

Summary of Program Objective Achievements

In light of the evaluation findings presented throughout this report, the table below assesses the achievement of program objectives as set out by the ICT leadership team. A green checkmark indicates that the objective was met, a yellow line indicates that the objective was partially met, and the red x indicates that the objective was not met.

Program Objective	*Achievement Status*	*Outcome*
Successfully transition 300 medically stable refugees to non-team-based PCP who have been in Canada for more than a year by June 2022.		The ICT program transitioned 664 refugees to PCPs in the region. To continue to transition patients at this rate, additional family practices will need to be recruited.
Provide refugees with easier access to community resources by providing a team-based approach		Patients in ICT overwhelmingly endorsed the program and shared the many ways in which the team helped them access both health and social care services, in a way that was more proactive and preventative, rather than reactive.
Support refugees to become more independent in navigating the health and social system to access the supports they need.		While some patients were able to become more independent in accessing services, others would benefit from more comprehensive education to support their ability to independently navigate the health and social service systems.

Increase the knowledge of refugee patients such that they know with whom to connect and where to go when they need help.		ICT patients felt confident that they could access ICT staff when needed. The ICT ensured patients felt confident and knowledgeable about the services to which they were referred.
Support PCPs to enable them to take on more refugees as patients.		The supports offered to PCPs were not enough to enable them to take on additional patients and the ICT program struggled to find PCPs who were agreeable to taking on new patients even after they had experience with patients in the ICT.
Support PCP by having them access a team of inter-disciplinary professionals and interpretation services to better provide care.		PCPs did not access the team as expected and were often unaware of which patients were part of the ICT program. Only half of clinics took advantage of the virtual interpretation service app.

LESSONS LEARNED

Drawing on observations, interviews, meeting notes and program data, we have identified a number of "lessons learned" throughout the implementation of the ICT. Some of the lessons learned have already resulted in changes to the program model and/or delivery.

- A new refugee health integrated care team can have substantial impact in its first year but expect several pivots and modifications to the model. As outlined in the timeline in Figure 1 (page 14), this ICT made two notable shifts to its model:
    - *Key pivot #1: physicians noted that care should/could have been provided in the time between when an ICT patient was discharged from the refugee health clinic and when the new clinic was ready to offer an intake appointment. The original model had expected the new physicians to refer patients to ICT, but upon learning this, the ICT shifted its model to referring all outgoing patients to ICT Level 1.*
    - *Key pivot #2: a clinic reported that approximately ~25% of new incoming Level 1 ICT patients did not attend their intake appointment, and/or had not followed intake instructions. Noting the importance of these relationships with clinics, the ICT has developed a procedure to more directly support patients in attending their first appointments at a new clinic (e.g., going with them, ensuring paperwork and all required family members are present, and communicating with the clinic in event of needing to reschedule). This is new part-time role on the team, introduced close to the end of year 1.*

- It can take time for a multidisciplinary team to "hit their stride", and to be refined and implemented to its fullest potential. Starting "small" is prudent as this allows for more timely and responsive pivots.

- Implementing a one-year pilot program may mean that core staff members will begin to look for future employment before the program concludes, resulting in program disruptions.

- Refugee and newcomer service agencies in the region were previously working in silos, and many ICT partners had not directly collaborated. Working together meant that the organizations could more effectively meet the unique and wide-ranging needs of refugee patients.

- While it is necessary in the delicate first years in Canada, the care provided by many refugee health clinics is much more comprehensive, accessible, and flexible than the average family practice. It can therefore be jarring when patients move to the traditional system. This can lead patients to expect a level or type of care that is not reflective of how the broader health care system operates in Ontario (e.g., single patient, single issue appointments)

- When transitioning refugee patients to a new clinic, those patients will require in-depth, clear training about the transition, what to expect, and how to prepare for what care will look like (and what patients are expected to do) in their new clinic. Even with this training, many patients will require a "warm hand off", and more physical/in-person support, particularly in getting to the first few appointments.

- While the ICT was successful in transitioning 654 patients from refugee health clinics to permanent primary care doctors, it was more challenging than anticipated to identify and recruit clinics willing to take on new refugee patients. This is occurring in a context in which clinics are overstretched, underfunded, and recovering from the COVID-19 pandemic, and limited capacity to engage in new programs/additions to their workload.

- Relationship building with physicians willing to take on refugee patients takes time and is best done in person; "it's harder to ignore us when we're there".

- Physicians and their staff may not adopt "easy to adopt" technologies and integrate these into their practices without regular/sustained support, reminders, and encouragement. This was observed with the on-demand virtual interpretation service app that was available, through the ICT program, for both ICT staff and participating clinics to communicate with ICT patients (all 654 patients that we transitioned via ICT, not just those 43 in need of more intensive interdisciplinary care from the ICT). The service was used more by the ICT than the participating clinics (although some clinics offer services in the languages of ICT patients, namely Arabic).

- When introducing a new technology/product/service/process to a clinic, it must be theoretically available to all the patients in their roster. Clinics will be hesitant to integrate something new if it requires the extra task of distinguishing who is/who is not "part of the program" and therefore eligible. This also creates inequities in their practice, with some but not all having access to the new technology or service. This was the most notable barrier to clinicians who were asked to use the virtual interpretation service but did not integrate it into their practice.

- Practices, protocols, and expectations of patients vary across clinics and physicians. Different approaches will work with different clinics (e.g., some will accept emails from patients; some will not see a patient prior to reviewing their files from the refugee health clinic; some will want to re-do tests and bloodwork, etc.). Thus, efforts must be made to understand how each partnering clinic operates, and to clearly communicate this to the new patients.

- Even if a physician speaks the same language as the patient, there may be barriers to communication with office staff, which may limit the patient's ability to book an appointment, etc. Translation for "front of house" staff is just as important as translation for direct care.

- ICT members need to understand their role and set firm boundaries regarding what ICT can and cannot provide. This can be emotionally demanding work for the staff.

- Each family/patient is different (e.g., different education levels, literacy, language skills, socio-economic, personal networks), and as such has required an individualized approach. Some patients will move through the transition well, while others will require much more intensive supports and will take more time. ICT may be required for less or more than one year, depending on the patient's needs.

- Patients who speak Arabic were easier to place in new clinics and tend to have an easier time accessing a range of community supports. It is more challenging to support those who speak other languages (e.g. Somali, Rohingya, Tigrinya, etc.), as there are no providers or clinics that speak these languages.

- The virtual interpretation service app was vital in helping the ICT staff communicate with patients. A separate report on the findings related to the virtual interpretation service app will be made available.

RECOMMENDATIONS FOR FUTURE ITERATIONS OF ICT

Drawing on observations, staff interviews, meeting notes and program data, we have also identified a number of recommendations, many of which came directly from the ICT via team meetings and/or their interviews. These recommendations are meant to inform both future iterations of this ICT program, and/or other iterations of an ICT model, both locally and elsewhere.

- When implementing a new program or model that is affiliated with multiple clinics, it is important to have a flexible approach. Each clinic is unique and will require personalized and ongoing support/training/encouragement and communication.

- Training and supporting the clinics must also include reception and other patient-facing staff. When working with refugees and newcomers, front-facing staff should always have access to interpretation services; this is an accessibility issue that has been largely overlooked and underfunded.

- ICT and/or similar initiatives would benefit from a strong marketing strategy, so that physicians, patients, and community partners know about the model, the supports available, and how to access them. Clinicians would also like stronger feedback loops, so they better understand what types of health and social services their patients are receiving via the ICT team. This would also improve the health community's understanding of the program and potentially promote further uptake.

- ICT models may wish to work with refugee health clinic partners to better prepare and/or ease their patients into the broader system, which is more restrictive, once they are medically stable. This should be done with patients incrementally, so patients in the refugee health clinics gradually become more accustomed to the way in which health care is typically provided to the general public.

- Consider the inclusion of settlement workers into ICTs, as settlement issues (e.g., housing, employment) were often raised by ICT patients.

- The ICT Case Manager role does not necessarily require a specific clinical or professional designation for many of that role's core functions. This role, if offered as an administrative position, may also be potentially cost saving.

- Continue to work on a crisis response protocol, which can be triggered as needed.

- Continue to develop a discharge protocol, with clear markers on when a patient is ready for discharge (e.g., a commonly cited marker of readiness has been "can a patient make and attend an appointment with their new physician independently").

- Consider more team building at the outset to develop rapport, respect and understanding of roles among team members. Initial team building sessions could also be the opportunity to share and consolidate the team's "best way to get a hold of me" information.

- All future ICT programs should include a virtual interpretation service app or a similar interpretation service, not only to support health care, but also to help these programs communicate and support patients outside of the health care system. Future iterations should also provide interpretation services for all patients who require it, rather than limit the use of these services to specific patients.

- Future iterations of the ICT and or similar models should dedicate time to finding/procuring a single EMR that all team members can access and use, irrespective of their location, organizational affiliation, or professional status. Staff noted that it can be traumatizing for refugees to re-tell their stories, often to relative strangers/new agencies, thus consolidated record-keeping for the ICT should be a priority but may be technically difficult to achieve.