Healthy at Home: an integrated health and social care initiative for vulnerable and marginalized older adults in Toronto

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Received 16 July 2023
Revised 5 February 2024
Accepted 5 February 2024

Abstract

Purpose – The Healthy at Home (H@H) is an older adult day program that is in Toronto in Ontario, Canada. This is an integrated health and social care (IHSC) program that seeks to address the social isolation and health needs of a highly vulnerable older adult population living in the north Toronto communities. These are Russian-speaking Jewish older adult immigrants. The case provides a detailed description of the factors that enabled a diverse group of health and social care organizations to integrate their respective services to address the health and social care needs of their clients using a culturally appropriate and trauma-informed lens.

Design/methodology/approach – A case description comprised of key informant interviews, and a focus group was undertaken of representatives from health and social care organizations serving clients in the north Toronto area.

Findings – This case description identified eleven integration factors that enabled organizations to provide integrated care using a culturally appropriate and trauma-informed lens, and they include developing an aligned vision and goals, communications, an inter-organization culture of inter-dependence, champions, pre-existing relationships, and champions. In addition, operating in the not-for-profit sector, sector differences, enabling public policies and a strong sense of community have influenced integration of services across the organizational partners to serve its high-risk client group.

Originality/value – This case description lends insights into how IHSC can be leveraged to provide culturally appropriate and trauma-informed care for highly vulnerable client/patient populations. A lesson learnt is that social care partners can engage in successful integration leadership in joint health and social care integration efforts.

Keywords Seniors, Vulnerable population, Integrated care, Toronto, Canada, Health care, Social care

Paper type Research paper

Introduction

Integrated health and social care (IHSC) is a phenomenon which has been shown to produce positive health and social care outcomes for older adults and can support healthy ageing and ageing in place (AIP) in communities and out of institutions (Kodner, 2009; Hirth *et al.*, 2009). The definition offered by Cheng and Catallo (2020) denotes the need for healthcare organizations working with social services organizations to achieve seamless services coordination and care continuity for patients/clients to achieve desired health outcomes holistically. It can result in improved health outcomes, minimizes acute care utilization, supports AIP and enhances access to services and identifying unmet needs (Suter *et al.*, 2007). However, IHSC is not well understood in Canada and is an evolving phenomenon in Canada (Cheng and Catallo, 2023). Care for immigrant older adult populations can be complex given their increased risk to poor health, and IHSC can be leveraged to support enhanced care from

This work draws on research supported by the Social Sciences and Humanities Research Council in Canada.

Journal of Integrated Care
Vol. 32 No. 2, 2024
pp. 155-166

1476-9018
DOI 10.1108/JICA-07-2023-0049

a more culturally responsive perspective (Cordes, 2021; Lewis and Myhra, 2018; Lu *et al.*, 2020). This is important in a culturally diverse city like the Greater Toronto Area which attracts many immigrant older adults who do not speak English or French (Toronto Public Health, 2019). Moreover, Toronto attracts more than half of all Jewish immigrants coming to Canada, with the majority coming from the former Soviet Union countries, many of whom speak Russian as their language (UJA Federation of Greater Toronto, n.d.; Brym *et al.*, 2018). These older adults are at significant risk of marginalization.

A case description of an IHSC initiative, Healthy At Home (H@H), was undertaken for exploratory purposes to understand how a diverse group of health and social care organizations engaged in IHSC from a culturally appropriate stance for Jewish Russian-speaking older adult immigrants. This case was one of three cases that comprised the collective case by Cheng and Catallo (2023) that sought to explore integrated care within a Canadian context. The Cheng and Catallo (2023) study sought to answer the research question: what are the unique inter-organizational and contextual factors that enabled culturally appropriate IHSC?

Methodology

The case approach was followed to collect data to develop the case description. The case description was based on eleven key informant interviews (denoted by ONK#) with representatives from nine health and social services organizations and a virtual focus group composed of a subset of five healthcare and social care key informants were undertaken between October 2019 and July 30, 2020. Choosing the subset allowed the researcher to further explore topics raised in the interviews. Snowball sampling was used to recruit study participants that included frontline staff, supervisors and executive directors. Bernard Betel Centre (BB), a community services agency serving Jewish and other older adults, was a lead agency that acted as a liaison for the researchers and provided recommendations on agency partners to consider for study recruitment. Study questions were based on the IHSC conceptual framework (CF) by Cheng and Catallo (2020) that identified nine integration factors that support services integration among different health and social care partners: communication and information sharing, shared values and goals, leadership, dedicated resources for integration, team-based care approaches, inter-organizational culture, performance measurement, and accountability structures and agreements. In addition, external influencing factors compose the framework: public policies, funding models, governance authorities, geography, and client/patient characteristics. Pattern matching was undertaken to determine common themes across all interviews and the focus group using inductive and deductive analysis and involved synthesizing themes and determining frequency of themes across interviews and the focus group.

Context

System transformation

Ontario moved towards regionalization in 2008 where fourteen Local Health Integration Networks (LHINs) were established. These LHINS were responsible for planning and funding the delivery of healthcare services through accountability agreements with individual services providers by geographic regions including Toronto Central: hospitals, community health, mental health, long-term care homes, and community-based volunteer health organizations (Barker, 2007). The health-related organizations remained self-governing with their own boards. With the elected Progressive Conservative government in 2018, a new healthcare transformation agenda was advanced, that saw the province move towards a single health authority, Ontario Health, replacing the LHINs. In addition, the government is advancing an alternative integration agenda which involves the establishment of Ontario

Health Teams (OHTs) that will provide IHSC at the local level through service partnerships at the service delivery level with healthcare partners and other non-healthcare partners (Government of Ontario, 2019; Government of Ontario, 2023).

H@H description and partners

H@H is an integrated program that is composed of different health and social care organizations that have partnered to coordinate at the services and care level that was launched in July 2010 and established by BB, the United Jewish Association Federation of Greater Toronto (UJA), Jewish Russian Community Centre of Ontario, Jewish Immigration Aid Services Toronto, and Baycrest Health Sciences. Today, the program is composed of over twenty health and social services and academic agencies across Toronto with twenty locations across Toronto (Figure 1). This program supports the psychological, social, spiritual, and physical aspects of healthy ageing using a client-centred and culturally sensitive approach. H@H provides free social, recreational, educational, cultural services, health promotion and other programs to low-income and isolated older adults over 55 years of age including newcomers living within the community in the north Toronto area. The services and resources include recreational space, at least one meal, social activities, physical fitness activities, including falls prevention, and educational workshops on a variety of health (dental, nutrition) and social issues, healthcare and social care literacy sessions, and English-as-a-second language sessions. There is an emphasis on supporting Russian-speaking older adults in the Jewish community, and programming are conducted either in English and Russian, or entirely in Russian.

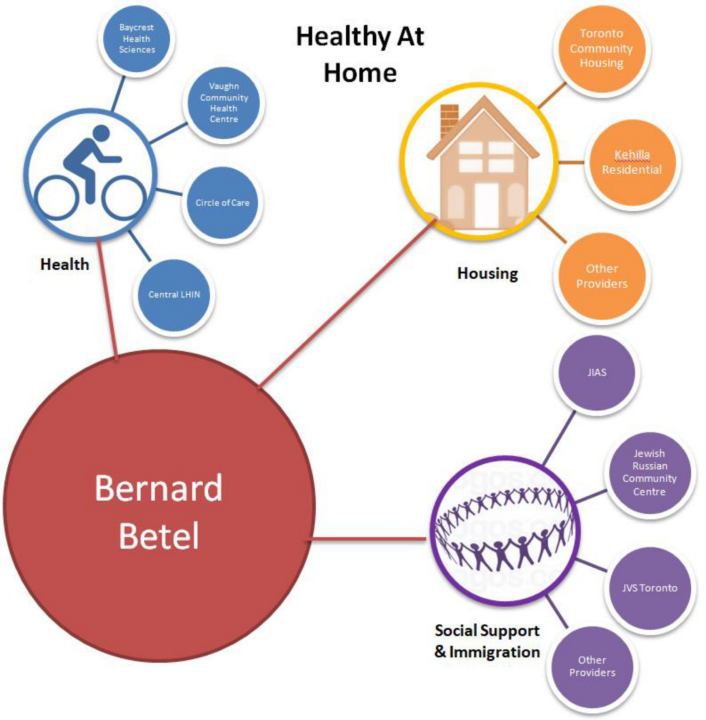

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Figure 1.
Healthy at Home program partners

The program is led and coordinated by BB. Integration among the different partners takes several forms including service referrals from individual agencies into H@H programming, shared human resources and facilities to operate specific activities, and care planning between H@H and healthcare partners. Some critical aspects that ensure cultural appropriateness include providing services in Russian, using a trauma-informed lens that are associated with the experiences of the clients, involving volunteers and staff who share similar or shared experiences and ethno-cultural backgrounds as those of the clients. In addition, the activities are heavily informed by the ethnocultural needs of the clients including ethno-culturally appropriate meals, cultural celebrations, and religious observances, to name a few.

This program has the potential to benefit clients in several ways: clients are being provided more appropriate care and are better able to navigate the different health and social care services; they are receiving accurate information about health and social services and more appropriate referrals to other service providers; there is high client satisfaction; sense of overall health and wellbeing; greater level of client engagement in their communities, which is critical in addressing social isolation; and the program offers up opportunities for clients to dialogue and engage with each other and with the program facilitators and providers.

Client description

This program serves approximately 1,000 older adults annually, and 250 are served weekly. Since its inception, 6,000 clients have participated in the program. Most clients are Russian-speaking Jewish older adults, with more than a third of all H@H program clients having survived the Holocaust at the time of the study. These clients experience complex healthcare issues including dementia, declining cognitive function, frailty, depression, and poor social care conditions including social isolation (ONKii1). For Holocaust survivors, trauma resurfaces partly due to cognitive decline. This level of complexity makes it difficult for services integration because it becomes increasingly difficult to respond in a coordinated and collaborative way for various healthcare and social care partners. Many of the H@H clients live in deep poverty which has been defined as 75% below the poverty line (Government of Canada, 2022). Many are immigrants and live in the suburban areas. These clients are marginalized and disengaged from the communities they live in. The absence of personal local networks and relationships with neighbours contributed towards social isolation among the H@H client base. This had become so pervasive among clients that it motivated the community of providers towards establishing H@H. The suburbanization of older adult Jewish immigrants in Toronto and their subsequent isolation were critical drivers towards IHSC.

Findings

Critical integration factors

The key informant interviews and focus group identified eleven integration factors that enabled the organizational partners towards providing culturally appropriate and IHSC for their clients (Table 1). These factors include eleven critical integration factors included strong communications, shared vision and goals, team-based care, dedicated resources, inter-organizational culture and pre-existing relationships were overwhelmingly regarded as being key to the success of H@H partnerships. Leadership and accountability agreements were also regarded as being important factors. The H@H case also identified three new integration factors not identified in the CF Cheng and Catallo (2020), pre-existing relationships, role clarity and champions that contributed towards its integration success.

	ONKii 1	ONKii 2	ONKii 3	ONKii 4	ONKii 5	ONKii 6	ONKii 7^	ONKii 8^	ONKii 9^	Total counts	Focus group
Communications	Y	Y		Y	Y	Y	Y	Y	Y	8	Y
Information Sharing	Y	Y		N	Y	Y	Y	Y	Y	7	
Dedicated Resources	Y	Y	Y			Y	Y	Y	Y	7	Y
Shared Vision and Goals		Y	Y	Y	Y	Y	Y	Y		7	Y
Team-Based Care	Y	Y			Y	Y	Y	Y	Y	7	Y
Culture	Y	Y	Y		Y		Y	N	Y	6	
Pre-existing Relationship	Y		Y	Y	Y	Y			Y	6	
Leadership		Y	Y		Y		Y	Y		5	
Accountability agreements		N	N	Y		Y	Y	Y	Y	5	
Role Clarity	Y		Y			Y				3	
Champions		Y				Y				2	

Note(s): ^Healthcare organizations
Source(s): Authors' own creation

Table 1.
H@H summary of critical integration factors by key informants

There were three factors that key informants identified as being the most important in allowing organizational partners to come together to serve isolated and impoverished older adult Jewish clients. **Communications and information sharing** were regarded as one of the most important factors that contributed towards the success of the different organizational partners' efforts in services integration (ONKii1-2, 4–9; Focus group, ONKii1), "*but what keeps and sustains I think a partnership is information sharing and communication*" (Focus group, ONKii1). Communication was regarded as important because it allows partners to move towards a shared vision (ONKii1); it allows partners to discuss and resolve services coordination challenges (ONKii2 and 8); and it can result in reduced programming costs because it allows for better services integration and efficiencies in delivery, by reducing duplication, better referrals and service improvements (ONKii2 and 5). **Dedicated human resources** were also regarded as key to integration. It ensures that there are staff who are solely responsible for program planning, coordinating services across a diverse group of partners, and handling critical administrative and operational details (ONKii1, 2 and 9). It has allowed the different partners to focus on relationship building: "you need to create conditions so that they can spend time getting to know the H@H program and getting to know their partners" (ONKii8). **Shared and aligned vision and goals** on the success and aim for the program were also regarded as being among the most important of the factors. One of the aligned visions shared by the providers was to provide culturally appropriate services for the clients. They help to create a common connection among a diverse group of service partners (ONKii2 and 3). It ensures that there is commitment among the partners and minimizes the perceived barriers towards partnership (ONKii8). It was viewed as a necessary building block for building trust (ONKii1 and 5): "due to a trusted relationship between the agencies . . . There's a level of confidence in our shared or aligned mission" (ONKii5).

An inter-**organizational culture** of reliance, shared sense of responsibility and collaboration exists among the different providers that helped with IHSC (ONkii1-3,4-7): "no one organization really is going to be able to move the needle on that issue (complex issues in older adults), unless there's a greater level of coordination and collaboration" (ONKii6).

When H@H was first established, there was a collective governance structure in place that was composed of leaders from each of the original cohort partnering organizations. They met regularly to discuss issues associated with the program. This structure ceased to exist after the first year, and H@H became a BB-led program. Both the collaborative and single leadership structure have been perceived to have played a critical role in making the program and collaborative service delivery successful (ONKii2-3, 5, 7–8; Focus group, ONKii2-3). Both leadership structures are regarded to have been beneficial to the collaboration in service delivery at different points in the program's history. The collaborative structure that existed in the first year, advanced partnership because it allowed them to engage in collective decision-making that would allow the program to continue to gain momentum and be successfully implemented: "People could discuss . . . and learn about the issues and they can make decisions on a high level" (ONKii2). The BB-led structure is successful because BB is regarded as being highly collaborative (ONKii5, 7–8).

Accountability agreements were viewed by some of the partners as contributing to the success of the H@H partnership, but there is no formal overarching accountability structure that exists for the H@H, nor an overarching accountability agreement that covers all organizational partners (ONKii4, 6–9). There are individual accountability agreements between BB and CoC and UJA to deliver specific aspects of the program at specific sites within the H@H program and UJA for the overall H@H program delivery. They create consistency and predictability on the components being integrated into H@H by various service partners (ONKii2). They set out clear expectations for the partners in the agreements

(ONKii9). As a result, agreements help to encourage service partners to rely on each other (ONKii 4). Agreements were also perceived as easing information sharing (ONKii2).

Pre-existing relationships were identified as contributing towards services integration among organizational partners (ONKii1, 3–6, 9). The partners entered into the H@H partnership with an elevated understanding of each other, in terms of their services, their mandate, and their reputation in supporting the shared client base and their communities (ONKii3, 5). This made collaborating much easier (ONKii3, 5): "We already trust one another as agencies because we've historically had a relationship for so many years . . . There's a level of confidence in our shared or aligned mission . . . there's a level of confidence that appropriate information is being shared" (ONKii6). These relationships gave the partners the jump-start to gain the initial services integration momentum.

A related integration factor to pre-existing relationships is **role clarity**. The pre-existing relationships among the H@H integration partners ensured that there was greater awareness of each other's services and strengths. This was associated with the awareness that partners had about each other's unique contribution. Because each organization had a unique contribution to make that was not duplicated by others, this made partnership desirable. The partners were able to identify synergies among their different contributions (ONKii1, 3, 6). This has resulted in a much more comprehensive program, in which the partners perceive that the collective contribution towards H@H has been significantly beneficial for their shared client base "that the whole is greater than the sum of its parts" (ONKii1).

Lastly, H@H **champions** have been central to the success of the H@H program, and have included organizations and individuals (ONKii2, 6). Their efforts have included engaging in advocacy, and nurturing creative partnerships helped to grow H@H in order to serve a larger client base (ONKii2, 6). Champions cut across sectoral differences to develop relationships among the diverse group of partners. They have helped to ensure that the momentum created in the early years is sustained over time.

External factors

The H@H case identified contextual factors that create enabling conditions for diverse groups of services providers to engage in culturally appropriate IHSC and that may be unique to operating in Toronto. They include operating in the not-for-profit sector, sense of community among the providers, public policies, working across different sectors and client characteristics (Table 2).

Services integration is more likely to occur among **not-for-profit organizations** for two reasons. First, because the H@H not-for-profit organizations have mandates that are aimed at supporting the public good; this aligned value encourages partners to collaborate around H@H (ONKii5). This aligned value includes the mutual appreciation that the partners know that they are engaged in H@H for motives associated with public good, and not for profit. Because these not-for-profit organizations are publicly funded and are not motivated by profit, it made it easier for partners to engage in negotiations with each other. This helps to create a less competitive environment to engage in partnership. "It aligns our motives at the beginning, and it means that I don't need to negotiate my profit margin versus Bernard Betel's profit margin . . . It takes away half of the complexity of the negotiation, because you're not trying to protect your profit margin" (ONKii8).

Policies at all levels of government intersect at the service delivery level and influence integration among different types of service delivery organizations. The City of Toronto's commitment to poverty reduction fostered partnerships among several social services support organizations and Toronto Community Housing to address poverty among older adult clients (ONKii2). The latter was particularly important given the city's concern over the growing ageing population (City of Toronto, 2018). The Wynne Liberal provincial

Table 2.
H@H summary of external influencing factors by key informant

External factors	ONKii 1	ONKii 2	ONKii 3	ONKii 4	ONKii 5	ONKii 6	ONKii 7^	ONKii 8^	ONKii 9^	Total counts
Publicly Funded	Y	Y	Y	Y	Y	Y		Y	Y	8
Not-for-profit		Y		Y	Y	Y	Y	Y	Y	7
Governance Authorities and Agreements	Y	Y			Y	Y		Y	Y	6
Policy		Y	Y	Y	Y	Y		Y	Y	7
Sense of Community	Y		Y	Y		Y				4
Geography – Urban Setting					Y	Y	Y	Y		4
Sector differences	Y	Y				Y				3
Ageing						Y			Y	2
Immigration						Y				1
Transportation					Y					1

Note(s): ^Healthcare organizations
Source(s): Authors' own creation

government policies to reduce wait times in emergency rooms and free up hospital beds exerted an influence on services integration and included disease prevention and health promotion and its association to seniors care and systems integration, specifically the implementation of the LHINs (ONKii2, 8). The government's seniors strategy supported H@H, specifically the focus on community-based exercise programs which incented partnership to access funding (Government of Ontario, 2017): "When the LHINs, eight years ago (2012–13), came up with community exercise programs that actually benefited us. That's why we are doing exercise programs. We applied for the funding, but we didn't get it, other agencies did, so we had a chance to collaborate" (ONKii2).

An environment of austerity that exists for publicly funded health and social services organizations was identified as an influencing factor (ONKii 2, 4, 6, 9; Focus group). This has created a scarce resource environment and a desire for potential service collaborators to engage in services integration because they did not have enough resources to meet their existing client demand: ". . . because the resources are very scarce, there is not enough money, not enough finances and the funders demands are much more complex, so sometimes agencies have no choice but work together to be able to receive some sort of funding" (ONKii2).

Sector differences between the health and social care sector partners were perceived as influencing H@H programming (ONKii1, 2, 6, 8; Focus group). The healthcare sector is seen as having more structure and "rigidity", compared to the social services sector which was perceived as being more "flexible", specifically as it relates to performance reporting to their respective governing authorities (ONKii2; Focus group). From a positive influence lens, the tension between the healthcare sector operating within a biomedical model and the social care sector that operates more strongly within a social determinants of health framework created a natural integration synergy among the organizational partners (ONKii8). IHSC has enabled healthcare organizations to meet needs associated with the social determinants of health through partnership with the social care sector (ONKii8). A key challenge for different sector partners was how the sectors are planned and organized. The healthcare system in Ontario is very complex and difficult to navigate for clients/patients and it was commented that the system needs to be simplified including how programs are funded (ONKii9). In contrast, the social care sector is viewed as being fragmented and piecemeal (ONKii6).

A strong **sense of community** exists among the Jewish community services agencies in the Toronto region and was identified as influencing services integration (ONKii1, 3, 4, 6, 8). This sense of community is a result of a common desire to service the older Jewish population (ONKii1). This sense of community has had an impact on integration in several ways. It has made negotiating partnerships easier because the agencies have a shared client base (ONKii3, 6). The partners feel a collective sense of responsibility for the communities they serve: "As a collective I think they take a lot of ownership of issues in the community" (ONKii6). This strong sense of community has been regarded as "one big Jewish family" in which "as family members often are, people in the organizations feel very connected to each other" (ONKii6), which helped to create pre-existing relationships that made the H@H partnership much easier: "certainly many of the leaders and staff in the organization have a history of working together" (ONKii6).

There are several distinguishing MDP **client characteristics** that play an important role in influencing collaboratively based services integration. The MDP clients are immigrants and from the former Soviet Union and only speak Russian (ONKii1-3, 5–9). This makes service delivery challenging because agencies need to find Russian-speaking volunteers and professionals (ONKii6, 8–9). Because most H@H clients are Jewish, partners designed services to be culturally appropriate and responsive (ONKii1-3, and 6). Many of the clients are Holocaust survivors (ONKii1, 2, 6). This shared experience requires greater

culturally sensitive and trauma-informed coordination to address the complexity of care resulting from trauma that resurfaces as clients age or their cognitive function declines as a result of disease (ONKii2):

> 99% are living with depression and many of them survived a lot of traumatic events, a lot are Holocaust survivors. You (service partners) need to know the clients, you need to make sure that the program is very sensitive to their needs, (so all of our partners) are working together sharing cultural sensitivity (ONKii2).

Other characteristics that were identified included age (ONKii3), complexity of healthcare and social care issues (ONKii1-2, 6). The complexity of needs make it challenging to engage in services coordination and collaboration for care partners (ONKii2).

Discussion

In summary, the H@H case has revealed that communications, shared and aligned vision and goals, inter-organizational culture, dedicated resources, agreement, pre-existing relationships and champions were regarded as inter-organizational factors to support culturally appropriate IHSC among different organizational partners. The case also shows that operating in a not-for-profit environment, government policies and a strong sense of community can foster integration among different organizations to serve vulnerable individuals.

There are three noteworthy lessons arising from the case. First, H@H is a unique case demonstrating complex voluntary-based collaboration across different sectoral organizations that have created a strong sense of community through a shared and long history of serving the same communities. H@H shows that IHSC can adopt a strong cultural competence and awareness lens. This feature is in keeping with the experiences observed in other successful initiatives including medical service providers and the accountable care organizations (ACOs) in the United States of America, LHINs in Ontario, the pre-existing relationship between the regional health authority and the local municipal council that resulted in the creation of the Tiohundra AB in Norrtaelje Sweden, and among the various organizational partners that made TWO in New Zealand a success in meeting the needs of high-risk Indigenous and non-Indigenous populations in the early years of the program (Carswell, 2015; Grudniewicz *et al.*, 2018; Murray *et al.*, 2020; Øvretveit *et al.*, 2010). The observations arising from the H@H case suggests that government policies and agendas on health and social services integration could be undertaken in concert with investments in community development to better serve hard-to-reach vulnerable population groups.

Second, the notable differences between the healthcare and social sector partners created an influencing contextual factor on integration efforts. These sectoral differences have been noted in literature as a barrier to integration (Huby *et al.*, 2010; National Academies of Sciences, Engineering and Medicine, 2019). Despite the sectoral differences, H@H partners were able to engage in services coordination efforts, and with leadership shown by the social care partners.

Third, the sense of community and pre-existing relationships among the H@H partners have a nexus with geography. Like that seen by Thiam *et al.* (2021) in their study of integrated community care where geography was identified as being critical to supporting notions of integration aimed at addressing the social determinants of health, H@H's operation in north Toronto is an aspect of its success. This region has a large concentration of health and social care providers serving the dense population of older adult Jewish populations. Moreover, the negative impact of suburbanization of the Jewish older adult population in Toronto reflects literature on the isolation of older adults who move to different geographic regions (Miller, 2017; Social Isolation Among Seniors: An Emerging Issue, 2004). H@H provides a portrait of

an IHSC situated in a Canadian urban/suburban context and may have implications from a healthy built environment policy and planning agenda, and age-friendly communities.

To conclude, H@H case is fascinating because it lends insights into how IHSC can be leveraged to provide culturally appropriate care that is trauma-informed for highly vulnerable client/patient populations with leadership from social care agencies. The Cheng and Catallo (2023) conceptual model used to frame the case description was helpful in highlighting the importance of context in shaping integration at the local level and can be considered a valuable analysis tool.

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