Appendix 1. Policy efforts in two Canadian provinces that inform Table 1 classification		
CHALLENGE	**QUEBEC**	**ONTARIO**
	Policy efforts identified on timeline and in case narratives	
Address chronic diseases		
support community-based CDSM	Some ASSS offered chronic disease self-management workshops (Stanford); Provide online Carnet Santé to enable people to view some of their health information (tests, scans, prescriptions) (2018)	Chronic disease self-management workshops (Stanford) offered through (some) LHINs
enable patient access to personal health records	The Carnet Santé is being introduced progressively to enable people to view some of their health information (tests, scans, prescriptions) (began roll out in 2018)	
engage communities in health promotion and disease prevention	Creation of CLSCs (1972). Gradual erosion of community participation in orienting CLSC services. Support IPCDC to increase population health capacity in system (2005); Public health units are embedded in CISSS/CIUSSS (2015) with uncertain impact on capacity (budget cuts; competition with acute services within a single budget envelope)	LHINs promote Advanced Health Links to serve all Ontarians with complex needs (2015); Ontario Health Teams (2019) include collaboration with community organizations and municipalities to work towards health and well-being of the community.
provide physician incentives for prevention/CDM	Fund social work and other health professionals to work within GMFs (2016)	Incentives provided to FHTs for specific monitoring/management of chronic diseases with funding for allied health professionals (2005) ; acute and primary care physicians encouraged to collaborate with other organizations on CDM in Health Teams (2019)
Consolidate governance to align with provincial objectves		
abolish governing boards of most hospitals	Governance of some hospitals and other providers transferred to CSSS in 2003 reforms; 2015 reforms consolidate governance of hospitals and other providers under large territorial establishments with CEOs and Board Chairs named by the Minister.	Only province to maintain community-based hospital governance (increasing obligations agreed with Ministry and requirement from LHINs to collaborate with other providers (Patients First, 2016)

consolidate/eliminate regional authorities	12 Regional Councils created (1970s); change to RHAs with elected boards (1990s); Agences with Ministry-appointed boards replace RHAs (2003); CISSS/CIUSSS with Boards and CEOs vetted by Minister replace Agences/CSSS (2014)	14 LHINs created, responsible for coordinating hospital and community services (2006); Patients First Act abolishes CCACs and transfers responsibility for home care to LHINs (2016); LHINs abolished (2019)
transfer some RHA functions/services to province level		
abolish community health boards –	Early CLSCs had elected community boards; CLSCs brought under CSSS governance (2003) CLSCs brought under CISSS/CIUSSS governance (2015)	
impose accountability agreements on HAs and hospitals	Impose 9 programs that all CSSS must provide (2003); Impose common programs, monitoring and reporting obligations and management structure on all establishments (CISSS/CIUSSS/AHC) (2015)	Commitment to the Future of Medicare Act imposes accountability agreements on hospitals (2004); Wait Times Information Strategy imposes accountability on hospital Boards (2004); Cascading Multi Service Accountability Agreements imposed from MOHLTC to LHIN to hospitals and other establishments (2007); Excellent Care for All Act makes hospitals and other establishments accountable for quality and mandates QI plans (2010); impose quality-based procedures for some hospital payments (2012); ECFAA amendments link executive pay to QIPs (2015)
implement performance monitoring and reporting	Create CSBE (2005) annual reports on system performance and participate in Commonwealth Fund comparisons; Lean measurement, monitoring and targets imposed in home care (2010) but successfully contested; Ministry mandatse each CISSS/CIUSSS to report on performance (2016); GP wait list (GACO/GAMF) reporting (2016)	Ontario Hospital Association manages hospital report cards (1998); Ministry mandates CCO to monitor cancer care quality and wait times (2000); Monitor hospital wait times under Wait Times Information Strategy (2003); FHTs implement assessment system of quality and safety managed by the Ontario Health Quality Council (2005); ECFAA makes hospitals and other establishments accountable for quality, mandates QI plans and reporting on quality and incidents through amendment to the Ontario Hospital Act (2010); Bill 160 increases govt oversight and inspection of community (including private) health facilities and mandates reporting on quality and safety (2017)
Shift care from institutions to community		
Develop new community delivery mechanisms	Info-santé (1995)provided by CLSCs originally, common 811 number adopted province-wide 2009, Info-sociale line added (2016) to guide people to social services	Develop and fund Ontario Telemedicine Network to serve Northern Ontario residents (well-implanted by 2014); Telehealth Ontario (2001) for teletriage; Telephone Health Advisory Service (2003) for patients of FHTs;
increase control over long-term care (LTC) and home care (HC) services	Bring LTC and HC under CSSS governance (2003), Bring LTC and HC under CISSS/CIUSSS governance (2015)	Create CCACs as single access points for community care (1998); transfer community care to LHINs (2016); HealthLinks, sub-LHINs (2016), HealthTeams (2019) promote links between hospitals, primary care and LTC-HC.

expand scope of practice and role of non-physician providers	NPs can work in GMFs under physician supervision (2010); Pharmacists allowed to switch/modify dosage of some meds; NPs granted right to initiate treatment following physician diagnosis (2018)	Funding for non-physician providers in FHTs (2005); increase pharmacist scope of practice (2012); Fund autonomous NP-run clinics (2012); RN scope of practice increased (2016)
Integrate physicians into the system		
promote standardized model of primary care (PC)	Promote GMF model of independent FFS group practice (2003); Funding support for GMF model including adoption of EMRs (2003); incentives for GMFs to extend clinic hours and become Network Clinics (2007); increase public funds for admin and transfer of non-medical providers into GMFs/Network Clinics (2015)	Promote Family Health Teams (FHT) as multidisciplinary, rostered model with blended FFS and capitation and incentives for physicians to extend clinic hours (2005); ECFAA extends mandatory QI plans to PC (2011)
promote public model of team-based PC	CLSCs (1972) were community-governed; progressive loss of community autonomy; personnel transferred into GMFs (2014-15 reforms)	Community-governed Community Health Centres with multidisciplinary teams, focus on prevention, promotion created in 1970s, steady increase over the deacades.
promote collaboration between specialists and primary care providers (PCPs)	4 RUIS created responsible for super-specialized care across each of 4 territories across province (2005); RUIS develops telehealth specialist consultation to support regional providers (2006); Bill 20 facilitates and speeds specialist referral by pooling requests (CRDS) (2015)	Ministry promotes implementation, in collaboration with Ontario Telemedicine Network and OntarioMD, of BASEe-consult service to facilitate PCP consultation with specialiss (pilot 2010, broaden 2017)
Centralize wait lists for GPs	GACO created for orphan patients (2008) with financial incentives for physicians; GACO supplemented with GAMF with financial incentives (2016)	Health Care Connect (2009)
impose obligations on physicians	Impose criteria for GMF-Network Clinics accompanied by funding (2015); Impose co-management model with physicia/-manager leads in CLSCs (2015); impose enrolment and fidelity targets on GPs (Bill 20, 2015 - penalty clause not implemented) along with minimum opening hours per week; imposes targets on specialists for referrals from GPs and prioritizing patients waiting over 6 months for elective surgeries (Bill 20, 2015 -penalty clause not implemented); increase AHC/CISSS/CIUSSS board power over medical staff, imposes performance obligations for specialists to see ER patients quickly (Bill 130, 2016)	

assign HAs some responsibility for primary care	CISSS/CIUSSS responsible for managing GACO and GAMF wait lists (2016); CISSS/CIUSSS non-physician providers seconded to GMFs/Network Clinics (2016)	Patients First Act gives LHINs responsibility to connect patients with primary care (2016)
Develop capacities		
create arm's length organizations to measure/support quality	AQESSS merges associations of establishments and provides support for improvement (2005); CSBE (2006); INESSS created (2011); INESSS given responsibility for social services as well as health (2015); INESSS given greater role in QI and spread of best practices and access to clinico-administrative data (2017)	ICES given full access to provincial data to track variations and use (1992); CCO established to oversee cancer care services and advise govt (2000); ICES develops quality and performance indicators (2004); Comitment to the Future of Medicare Act establishes the Ontario Health Quality Council (2004); ECFAA consolidates several agencies into HQO, mandated to accelerate spread of best practices (2011)
support professional communities of practice	RUIS specialists provide support to regional providers (2005)	HQO supports communities of practice for QI (2013)
support quality improvement skill development	AQESSS mandated to support QI initiatives; INESSS given improvement role (2016); Salles de pilotage (Lean model) mandated in all CISSS/CIUSSS/AHCs (2016; require QIP when measurement shows need for improvement on an indicator	CCO creates Cancer Quality Council to promote improvement (2000); HQO embeds clinical champions in LHINs (2013); support QI development in primary care (2013)
include patient advisors in QI	Mandate User Committees in all establishments (2006); fund implementation of patient partnership model (2018); create provincial citizen advisory committee (2018)	ECFAA amendment mandates that patient advisors be included on quality improvement plans (2015)
conduct patient experience surveys		ECFAA mandates hospitals to conduct annual patient experience surveys (2011)
mechanism for community input		LHINs implement community engagement strategies (2007); Health Teams must show mechanism for input from community (2019)