Creating a renewed patient-focused system of care in the Cochrane Hub

A Realignment Plan for the Cochrane Hub

Access / Quality / Value

... health care goals informing realignment decisions

June 2012

CONTENTS

Community Engagement Sessions Facilitated by: Eileen Mahood

EXECUTIVE SUMMARY

On January 25, 2012, the NE LHIN Board of Directors passed a motion which directed the NE LHIN staff to:

"Further engage with stakeholders in the Cochrane District and prepare a proposed health services realignment plan for discussion at the June 2012 meeting of the NE LHIN Board of Directors."

The passing of the above motion followed the Cochrane Hub community engagement sessions of 2011. At that time, residents in Cochrane Hub communities voiced concerns about their ongoing lack of access to local health care services. They emphasized a need for a system of care that is easier to navigate and less fragmented. The passing of the NE LHIN Board motion seven months later is in keeping with the need to create a more client-centred and community-based system of care for residents of the North East LHIN's Cochrane Hub.

Built on feedback from engagement sessions with approximately 650 participants in thirteen community engagement sessions held in February and March of 2012, this report provides a recommendation and accompanying milestones for the realignment of health care services in the area. The recommendation and milestones focus on the needs of people, not providers.

- Every year, the NE LHIN flows $128 million to the eight hospitals in the Cochrane Hub.
- Weekly reports submitted to the NE LHIN from these hospitals show that on any given day an average of 100 of the 426 hospital beds have no patients in them – they are vacant.
- In addition, about 109 people in these beds are inappropriately placed -- alternate level of care patients who could be cared for in community with the proper home care supports.
- Built decades ago, these same hospitals are also now victim to crumbling infrastructure and many of them are using their reserved funds to finance their debt. With a combined deficit of $5 million, this has decreased the working capital reserves to $12 million.
- About 24% of the area's hospital budgets go towards administration and support services.

We also know that the seven small hospitals in the Hub have an 85% rate of low acuity visitors to their ER – patients who can typically be cared for outside of hospital for non urgent needs such as removal of stitches or ear aches. These same seven small hospitals also have very low numbers of people using their ER – about 145 people between the seven sites each day.

All across Northeastern Ontario, there is a decline in population and the Cochrane Hub is no exception. It has sustained close to a 13% decline since 1996, compared to a near 20% increase in population across the province. And of the people who continue to call this great part of the province home, there are more of them who are over the age of 65.

Another startling fact is that of the 622 beds in the area's eight long-term care homes, it is estimated some 17% of residents in long-term care homes could be cared for in community with proper support.

This stark reality, coupled with the comments heard from approximately 650 people in recent months tells us that health system realignment in the Cochrane Hub is timely and the need to re-define the role of small hospitals is equally so.

Despite these changes over the years, one constant has remained -- the health care needs of people living in the Cochrane Hub communities.

In the past century, technological advancements have made health care more accessible. Telemedicine, for example, uses two-way videoconferencing to care for patients. The North East is the highest user of the technology among Ontario's 14 LHINs.

A key ingredient for any system change is leadership – it is pivotal to help everyone move toward a "new normal." In order to succeed in creating a renewed patient-focused system of care in Cochrane Hub, leaders will need to be steadfast in reaching the goal of realigning local health care to ensure a more integrated and culturally sensitive local health care system.

The recommendation and milestones have been made in accordance with the NE LHIN's Decision-Making Framework. The framework provides values, criteria and measures to evaluate new programs and initiatives, changes to existing programs, and integration proposals.[1] The criteria within the framework are aligned with indicators found in the Quality Improvement Guide of the Ontario Health Quality Council.

The communities within the Cochrane Hub are keenly interested in engaging and participating in positive changes to their local health care system. Next steps will include a communication and action plan to support implementation of this report's recommendation and milestones.

Recommendation: To create a less fragmented and more patient-focused continuum of care and realign the current 45 NE LHIN-funded health service providers in the Cochrane Hub into clusters or regional provider networks, as appropriate.

[1] Decision-Making Framework: included in Appendix.

METHODOLOGY

Community engagement is a key element in the work of LHINs; in fact, it is legislated as part of the LHINs' mandate. The North East LHIN has actively sought out the opinions and needs of those in the Cochrane Hub. Residents and health service providers living in the Cochrane Hub have participated in many NE LHIN forums and initiatives held over the past five years.

In partnership with the people of Hearst, Kapuskasing, Smooth Rock Falls, Cochrane, Iroquois Falls, Matheson, Timmins and Chapleau, and surrounding areas, the NE LHIN funds the delivery of a wide variety of health care services. In doing so, the NE LHIN continues to engage with all members of the community and work with health care providers to ensure local health care programs and services are focused on the needs and priorities of local citizens.

General awareness-building around the need for realignment -- based on challenges in the area's health care structure and service gaps -- has been part of the NE LHIN's community engagement work. Data and feedback has come largely from communities and health service providers within the Hub.

In June 2011, the NE LHIN held 13 community engagements in the Cochrane Hub. Residents of the area said that they needed ways to ensure better access to health care, more care in the community, and less competition by providers. They also expressed the need for an integrated approach to delivering health care services, and more financially stable small hospitals.

In February/March 2012, realignment-focused engagement sessions were held in:

Chapleau -- one session with board members, community and health service providers

Hearst -- one session with board members, community and health service providers

Iroquois Falls -- three sessions: one with board members, one with community and health service providers, and one with physicians

Kapuskasing -- three sessions: one with board members, one with community and health service providers, and one with physicians

Smooth Rock Falls -- one session with board members, community and health service providers

Timmins -- four sessions: one with board members, one with health service providers, one with community members, and one with physicians

Approximately 650 residents attended the engagement sessions. People participated and engaged in discussion in both English and in French. The engagements were conducted by an independent facilitator, Eileen Mahood, alongside NE LHIN senior staff. Additional sessions were held with physicians and were facilitated by the NE LHIN's Primary Care Lead, Dr. Tim Zmijowskyj, who accompanied the engagement team. Each group was presented with statistical data and key information pertaining to the Cochrane Hub. Presentations were provided either in English or in French, with narration and the opportunity for discussion in both languages.

Following the presentations, participants engaged in an open forum discussion structured around key questions to assist in generating ideas for the realignment of health services in the area. Sessions were facilitated to capture as much feedback as possible. Representatives from the French Language Health Planning Entity assisted with Francophone facilitation.

THE NEED FOR CHANGE

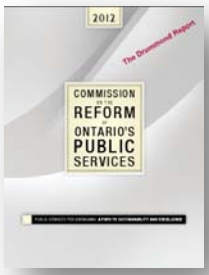
A Provincial Perspective

Currently, the Province of Ontario spends about 42 cents of every provincial program dollar on health care – 61% more than in 2003.

Participants in the engagement sessions learned about recent provincial health care directions that are pivotal to understanding the need for realignment, including:

Commission on the Reform of Ontario's Public Services ("Drummond Report")

The release of the Commission on the Reform of Ontario's Public Services includes 105 recommendations on health care reform, including the following:



Recommendation 5-5: To improve the co-ordination of patient care, all health services in a region must be integrated. This includes primary care physicians, acute care hospitals, long-term care, CCACs, home care, public health, walk-in clinics, FHTs (which for the purposes of this chapter includes Family Health Organizations [FHOs], groups and networks), community health centres and Nurse Practitioner-Led Clinics (NPLCs).[2]

Ontario Action Plan for Health Care

In January 2012, the Ministry of Health and Long-Term Care released Ontario's Action Plan for Health Care. The Plan calls for better patient care through better value for health care dollars.

Ontario's Budget, 2012

On the heels of the Drummond Report and the Action Plan, the Ontario budget was announced, giving the health sector a concrete foundation for budgeting moving forward. It also supports, in principle, the positive changes the NE LHIN is leading. Some examples include:

- Transforming health care to reduce the rate of growth of spending to an average of 2.1 per cent annually over the next three years;
- Enhancing community-based care to treat patients in alternative settings such as non-profit clinics and at home instead of in hospitals, where appropriate;
- Moving to patient-centred funding models to improve the value and quality of care. [3]

[2] Commission on the Reform of Ontario's Public Services http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf

The North East Perspective

Over the past five years, the NE LHIN has been asking Northerners – both health service providers and residents – for their ideas on how to increase access to care in their home communities. The input collected, documented and brought to the NE LHIN decision-making table has found its way into this year's priorities and are being managed under one goal – **To Realign Health Care Providers in an Effort to Increase Access to Quality Care for Northerners and Ensure a More Patient-Centred and Community-Based System.**

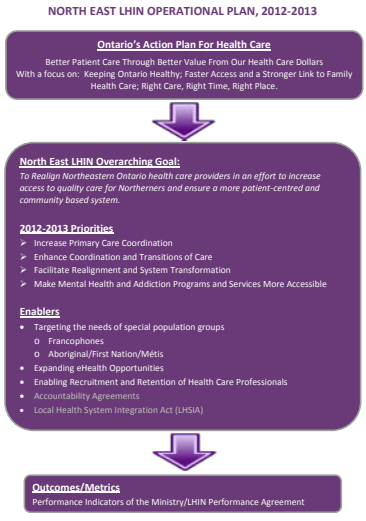
Residents of Northeastern Ontario receive a variety of front line health care services, many of which are funded by the NE LHIN within its $1.4 billion budget envelope (2012-13). The following service providers share this funding envelope:

- Community Health Centres (1%)
- Community Support Services and Assisted Living (3%)
- Community Mental Health and Addiction (5%)
- Community Care Access Centre (8%)
- Long-Term Care (15%)
- Hospitals (68%)

Currently, close to 70% of the NE LHIN's annual budget flows to 25 hospitals, based on decades-old funding practices.

The NE LHIN's regional investment in community support services totals 3% of the North East funding envelope to support people living in various home settings, with varying degrees of health challenges. (Community Support Services can include home care support, adult day care programs, transportation services, falls prevention programs, meals on wheels, etc.).

Depending on where people receive care, there are varying levels and costs. The cost of caring for a person is approximately $300,000/year in a hospital bed, approximately $46,000/year in a long-term care bed, and approximately $30,000/year to receive assisted living services.



The NE LHIN's 2011 engagement sessions within the Cochrane Hub found the need to improve access to health care and realign funding to support people to stay in community or in their homes. Meeting these needs requires finding the dollars needed for more: assisted living, transportation for medical appointments, Home First expansion, community-based mental health counseling services and crisis interventions, and other program enhancements to divert people from hospital emergency rooms and admissions.

The Cochrane Hub service realignment meets one of the four priorities of the NE LHIN 2012-13 Operational Plan – "facilitating realignment and system transformation (see plan in Appendix D).

[3] Strong Action for Ontario. 2012 Ontario Budget. Queen's Printer for Ontario. Release date: 28/03/2012

The Local Perspective

The Cochrane Hub is home to about 80,000 people. Almost 50% are Francophone and close to 12% are Aboriginal. The population of the Cochrane Hub has declined by almost 13% since the 1996 census. The population of the Northeast has declined by more than 5%, while the population of the province has grown by almost 20% during this same time frame.

Currently, the Cochrane Hub receives $192 million per year from the NE LHIN. This funding is provided to 45 health care service providers:

- 8 hospitals ($128 million). About half of the hospital funding goes to the Timmins and District Hospital (TADH) and the remainder goes to the other 7 hospitals.
- 13 Community Support Service Providers ($2 million)
- 13 Mental Health and Addictions Providers ($16 million)
- 2 Community Health Centres ($4 million)
- 8 Long-Term Care Homes ($26 million)

There are also regional providers that offer services in the Cochrane Hub area, including:

- Canadian National Institute for the Blind ($130,741)
- Canadian Red Cross ($1 million)
- Ontario March of Dimes ($105,627)

The North East LHIN also funds the North East Community Care Access Centre with about $115 million each year, of which approximately $13 million goes towards caring for people in the Cochrane Hub through personal support workers, case managers, nurses, physiotherapists, and other health care professionals in community.

Some primary care providers in the Cochrane Hub are funded directly by the Ministry of Health and Long-Term Care, including:

- 2 nursing stations (Mattice Community Clinic, Fauquier Health Centre)
- 1 public health unit (Porcupine Health Unit, Timmins)
- 6 Family Health Teams (Anson General, Iroquois Falls; Chapleau and District; Cochrane; East End, South Porcupine; Nord-Aski Regional, Hearst; and Timmins)

In addition to the $192 million the NE LHIN invests in local health service providers and the Ministry of Health and Long-Term Care's local investment in primary care, there are also costs associated with people who travel outside the region to get specialized care, for example to Health Sciences North or the Regional Cancer Centre in Sudbury, or at specialized care centres in Southern Ontario. The costs associated with this outflow for care have not been quantified.

Every year, the NE LHIN flows $128 million to the eight hospitals in the Cochrane Hub. Weekly reports submitted to the NE LHIN from these hospitals show that on any given day an average of 100 of the 426 hospital beds have no patients in them – they are vacant. In addition, about 109 people in these beds are inappropriately placed -- alternate level of care patients who could be cared for in community with the proper home care supports.

Built decades ago, these same hospitals are also now victim to crumbling infrastructure and many of them are using their reserved funds to finance their debt. With a combined deficit of $5 million, this has increased the working capital reserves deficit to $12 million.

The seven small hospitals in the Hub have an 85% rate of low acuity visitors to their ER – patients who can typically be cared for outside of hospital for non urgent needs such as removal

of stitches or ear aches. These same seven small hospitals also have very low numbers of people using their ER – about 145 people per day (combined).

All across Northeastern Ontario, there is a decline in population and the Cochrane Hub is no exception, having witnessed close to a 3% decline since 1996 compared to a near 20% increase in population across the province. And of the people who continue to call this great part of the province home, there are more of them who are over the age of 65.

This stark reality, coupled with the comments heard from approximately 650 people in recent month tells us that health system realignment in the Cochrane Hub is timely and the need to redefine the role of small hospitals is equally so.

Another startling fact is that of the 622 beds in the area's eight long-term care homes, it is estimated some 17% of the residents could be cared for in community with proper support.

Essentially, the Cochrane Hub system is unbalanced (due to high reliance on hospitals and not enough community-based care) and there is a lack of coordination among health service provider programs and services (currently 45 NE LHIN funded providers and nine provincially funded primary care providers). According to Statistics Canada data, it is also affected by a local population that is both declining and getting older. A system realignment is timely.

Although some coordination efforts have been attempted over the years, such as the 2010 Cochrane, Temiskaming and Chapleau strategic planning report, Network 13, the general surgery project, there is little evidence of voluntary patient-focused realignments occurring. These realignments are needed to produce savings which can be redirected back to community- and home-based care.

THE SEVEN PRINCIPLES FOR REALIGNMENT

1. This plan is the beginning of an ongoing process, not the end of a change initiative.

2. This plan reflects comments and suggestions from the people who live in the Cochrane Hub.

3. The realignment must not have a negative impact on the quality or safety of current services.

4. Along with the NE LHIN's Decision-Making Framework as the foundation for integration and realignment, the model must be culturally and linguistically sensitive, particularly:
   - Protecting French language services and continued delivery of quality health care services to this population group.
   - Improving the health status of Aboriginal, First Nations and Métis people and ensuring continued delivery of quality health care services to this population group.

5. The realignment process will respect the need for a more patient-centred continuum of care.

6. Technology is a key enabler that must be explored to its full capacity.

7. Ongoing communication is essential as the Recommendation and Milestones are implemented.

REALIGNMENT RECOMMENDATION AND MILESTONES

Recommendation: To create a less fragmented and more patient-focused continuum of care and realign the current 45 NE LHIN-funded health service providers in the Cochrane Hub into clusters or regional provider networks, as appropriate.

Realignment in the Cochrane Hub requires organizational integration both at the governance level and the service delivery level. The necessary cultural shift in the system, the organizations, and the individuals providing services, must be addressed with education, communication and continual monitoring, and performance measurement.

The needs of the patients and the people must continue to be at the centre of all milestones and ongoing changes required.

The clustering and regional provider network approach is proposed in support of what has been heard in the engagement sessions. There was strong opposition to centralizing all services, while clusters and regional agreements (where appropriate) were noted as allowing for more system planning and sharing of resources between neighbouring communities. The goal is to create a fully integrated system of care which will be defined through ongoing collaborative work between both the NE LHIN and health service providers, and health service providers themselves.

In order to implement the recommendation, a series of realignment milestones have been identified to move forward.

Areas of the Cochrane Hub that have a high Francophone population are concerned about integration with non-Francophone agencies. Participants expressed concern that French language services and the cultural environment of an agency would be lost if the governance of that organization was not Francophone.

The NE LHIN's principle of inclusivity includes the protection of French language health care services in the Cochrane Hub. The NE LHIN's French Language Health Planning Entity has the mandate to develop community engagement plans, in collaboration with the NE LHIN, for consultation with Francophone communities. In fact, the Entity accompanied the NE LHIN realignment team and participated in engagement sessions as facilitators for Francophone round tables.

First Nations, Aboriginal and Métis people comprise just over 10% of the Cochrane Hub's population. The NE LHIN has a Local Aboriginal Health Committee (LAHC) to ensure a collaborative, consultative model of engagement is used to improve the health status of First Nation, Aboriginal and Métis residing in the Cochrane Hub. Further engagement with this population group will need to take place by the fall of 2012.

Clusters: The creation of clusters that respect both the patient flow and organizational relationships currently within the Cochrane Hub will be at the forefront of the Cochrane Hub realignment process.

Clusters will:

- Be comprised of a number of health service providers that will work together towards common goals and develop a single accountability agreement with the NE LHIN for fiscal 2013/14.
- Plan for formalized service delivery models that include setting targets to improve integration of front-line services, clinical services and back office functions.
- Work collaboratively to improve the patient/client flow in the overall Cochrane Hub health care system.
- Create an improved experience for patients, clients and caregivers, along with the optimization of available resources.
- Respect the need for linguistic and cultural inclusivity and maintain and/or enhance existing service levels to Francophone, Aboriginal/First Nation/Métis population groups.

The following table identifies the five proposed Cochrane Hub Clusters:

Cluster		Organizations
1	**Timmins/Chapleau Hospital Cluster**	• Timmins and District Hospital • Service de santé de Chapleau Health Services (includes Bignucolo Residence and CCS seniors program) • Timmins Extendicare[a] • Golden Manor Long-term Care Home[b]
2	**Timmins/Chapleau Mental Health and Addictions Cluster**	• Timmins and District Hospital (outpatient mental health programs) • Canadian Mental Health Association Cochrane/Timiskaming Branch - Timmins • Jubilee Centre - Timmins • Timmins Consumer Survivor Network • Timmins Family Counselling Centre (sexual assault program) • Turning Point/Point Décisif - Chapleau • South Cochrane Addiction Services – Timmins
3	**MICs Group of Health Services Hospitals and Long-term Care Cluster (Matheson, Iroquois Falls, Cochrane)**	• Bingham Memorial Hospital - Matheson • Anson General Hospital - Iroquois Falls • South Centennial Manor - Iroquois Falls • Lady Minto Hospital - Cochrane • Villa Minto – Cochrane

4	**North Cochrane Hospitals and Long-Term Care Cluster (Hearst, Kapuskasing, Smooth Rock Falls)**	• Hôpital Notre Dame Hospital - Hearst • Foyer des Pionniers - Hearst • Smooth Rock Falls Hospital • Sensenbrenner Hospital - Kapuskasing • North Centennial Manor – Kapuskasing • Kapuskasing Extendicare[a] • Centre de santé communautaire de Kapuskasing et region[c]
5	**North Cochrane Mental Health and Addictions Cluster (Hearst, Smooth Rock Falls, Kapuskasing, Cochrane)**	• Maison Renaissance - Hearst • Maison Arc-en-ciel - Opasatika • Services de counselling Hearst, Kapuskasing, Smooth Rock Falls - Kapuskasing • North Cochrane Addiction Services - Kapuskasing • Cochrane District Detox - Smooth Rock Falls • Minto Counselling Services - Cochrane

Notes:

a. As long-term care homes, these homes would be part of the Extendicare Accountability Agreement noted in Milestone 19.

b. Golden Manor is municipally run by the city of Timmins and will continue to have a different accountability agreement.

c. Centre de santé communautaire de Kapuskasing et région also includes seniors' programs in Hearst, Kapuskasing and Smooth Rock Falls. It will be involved in the primary care system realignment that will be unfolding in the coming months.

Regional Providers

The NE LHIN currently has a series of regional providers that have, in the past two years, each pooled their district offices under one agreement.

The regional providers have each identified a point person for their organization, but have maintained offices in several communities. A district perspective is maintained, while combining efforts to share resources to deliver common functions. This approach supports efficiency, less duplication, and benefits from economies of scale, and assists organizations where certain skills or resources are scarce.

As a significant regional provider, the NE CCAC will work with the five clusters. The Canadian Institute for the Blind, the Ontario March of Dimes, and the Canadian Red Cross are three other examples of regional providers.

The Canadian Red Cross will take on an expanded role with the addition of the two community support services programs presently operated by the Corporation of the City of Timmins, and the Timmins Senior Citizens Recreation Centre.

As part of the Cochrane realignment process, two new regional networks/providers would be created across the North East. The Extendicare agreement would bring together the Extendicare long-term care homes in the NE LHIN under one agreement; and the Alzheimer agreement would bring together the four Alzheimer Societies from across the North East (Timmins-Porcupine, Sault Ste. Marie, Sudbury and North Bay) to develop one formalized agreement with the NE LHIN.

As the sole provider of assisted living services for the physically challenged, Access Better Living in Timmins should, in the future, partner with the Canadian Red Cross and the NE CCAC for service coordination and planning.

First Nation/Aboriginal/Métis

As previously mentioned, additional engagement activity is required with the First Nation/Aboriginal/Métis health service providers and as such, they have not been included in the clusters or the regional networks/providers.

Only a few First Nation/Aboriginal/Métis health service providers participated in the February/March 2012 engagement process, allowing for little information to proceed with a clear direction on next steps. Engagement activities for this group are expected to take place in the early fall of 2012. The goal of these sessions will be to determine the most viable option for enhancement for these providers.

The following Aboriginal/First Nation/Aboriginal/Métis health service providers will be involved in the fall 2012 engagement process
• Misiway Milopemahtesewin Community Health Centre - Cochrane • Aboriginal Peoples Alliance of Northern Ontario (APANO) - Cochrane • Constance Lake First Nation - Constance Lake • Taykwa Tagamou First Nation - Cochrane • Wabun Tribal Council -Timmins • Chapleau Cree First Nation

MILESTONES

The following milestones support the implementation of the recommendation. They also capture integration activities currently underway in the Cochrane Hub.

All health service providers within the Cochrane Hub will need to work together under *"one"* system (a Cluster Entity) for the provision of services to patients, clients and caregivers. This entails the coordination of the clusters, regional providers and others to develop a system that is patient-focused, transparent and flexible. A strong leadership, in particular a clear vision and direction, will be required to move forward with the required changes. In order to move the system forward, the following milestones are proposed:

Milestone 1: The establishment of a *Realignment Team* within each cluster comprised of both management or designates with program planning authority and board representatives.

Milestone 2: A hiring freeze on all executive and management positions until the roles have been reviewed by the Realignment Team and the NE LHIN.

Milestone 3: Individual health service provider boards to transfer into their assigned Cluster which will be responsible to negotiate an accountability agreement with the NE LHIN by fiscal 2013/14.

Milestone 4: The Realignment Team to review the administrative structure of the Cluster by fiscal 2013/14.

It is important that HSPs within each community build on existing initiatives, given that they hold the expertise, resources, volunteers and leadership to further realign the health care system. The following milestones are to be achieved in parallel with the work of designing and developing a more patient-focused continuum of care:

Milestone 5: As outlined in the Hospital Accountability Agreement, Cochrane Hub hospitals must present a balanced budget at the end of each fiscal year. Hospitals presenting a deficit position must provide the NE LHIN with a Hospital Improvement Plan (HIP) demonstrating the strategies that will be implemented by the hospital to be in a balanced position. The Cochrane Hub hospitals are to work collectively as a group and with the health service providers to address any deficit in the system. For the hospitals already engaged in a Hospital Improvement Plan (HIP) process, the following must be acted upon:

(1) Smooth Rock Falls Hospital:

a. Provide recommendations to the NE LHIN on the number of acute care beds that can converted to complex continuing care beds to meet the increasing demand for long-term care. Examine the current hospital's role and potential realignment within the existing resources and within the Cochrane Hub hospitals.
b. Identification of additional strategies for further savings in order to reduce and eliminate the current deficit.
c. The above noted options are to be included in the HIP and submitted to the NE LHIN by February 28, 2013. The HIP must include an

implementation plan, outlining clear strategies, timelines and savings that will outline how the hospital will implement the identified strategies and be in a balanced position by March 31, 2013.

(2) Services de santé Chapleau Health Services:

a. Provide recommendations to the NE LHIN on the number of acute care beds that can converted to complex continuing care beds to meet the increasing demand for long-term care. Examine the current hospital's role and potential realignment within the existing resources and within the Cochrane Hub hospitals.
b. Identification of additional strategies for further savings in order to reduce and eliminate the current deficit.
c. The above noted options are to be included in the HIP and submitted to the NE LHIN by February 28, 2013. The HIP must include an implementation plan, outlining clear strategies, timelines and savings that will outline how the hospital will implement the identified strategies and be in a balanced position by March 31, 2013.

(3) Timmins and District Hospital:

a. The hospital must continue with the implementation of the strategies identified in the HIP to be in a balanced position by September 30, 2012.
b. The NE LHIN will meet with the hospital on a regular basis to review the status of each strategy.
c. If a balanced budget is not achieved by September 30, 2012, further discussion will take place with the hospital to determine the next course of action.

Milestone 6: By October 2012, engage the NE LHIN Community Support Service funded First Nations and Aboriginal organizations: Constance Lake First Nations, Taykwa Tagamou First Nation, Chapleau Cree First Nation, Wabun Tribal Council and Aboriginal Peoples Alliance of Northern Ontario (APANO), and the Misiway Milopemahtesewin CHC on the most appropriate way to integrate services.

Milestone 7: Hôpital Notre Dame Hospital to continue to develop a model for the delivery of general surgery which will streamline general surgery in hospitals in the Cochrane Hub by December 2012.

Milestone 8: Cochrane Hub hospitals will complete a shared back office service plan by March 31, 2013 which will include information technology, help desk and common purchasing practices in fiscal 2013/14. Once established, the hospitals will work closely with their cluster groups to expand the shared service plan.

Milestone 9: Cochrane Hub NE LHIN-funded transportation service providers will streamline the current transportation structure under one service provider by March 31, 2013.

Milestone 10: The MICs Group of hospitals will explore and develop viable solutions, within their existing funding, to ensure South Centennial Manor remains open in Iroquois Falls.

Milestone 11: Transition out-patient mental health programs and funding from the Timmins and District Hospital to a community-based mental health and/or addictions organization(s) by March 31, 2013.

Milestone 12: Continue the work currently underway to develop and implement a contingency plan to address the ongoing planned closures of the residential treatment facilities in the Cochrane Hub by September 30, 2012.

Milestone 13: Bring the two LHIN-funded community senior programs in Timmins together under the Canadian Red Cross Society by March 31, 2013.

Milestone 14: As outlined in the *Cochrane and Temiskaming District, including Chapleau, Strategic Planning Project, March 2010*, establish a working group, focused on the frail elderly, to address the following tasks:

- Develop an inventory of services, by sector and geography, for frail elderly clients;
- Review current points of entry to the health system and current impediments to navigation of the health system for the frail elderly; and
- Develop and implement an integrated care pathway for this defined population.

Completion of inventory of services and system gaps will be done by December 2012 with implementation in fiscal 2013/14.

Milestone 15: Develop a model for the expansion of the system navigator, presently located in Timmins, to provide services to smaller communities. The proposed model will be presented to the NE LHIN by December 2012.

Milestone 16: Implement the recommendations in the Cochrane District Human Services and Justice Coordinating Committee Crisis Report as soon as it is released. This report must be produced and shared with the NE LHIN by December 31, 2012. Recommendations pertaining to the mental health and addiction sector will be acted upon and implemented.

Milestone 17: Implement the recommendation as outlined in the *Cochrane and Temiskaming District, including Chapleau, Strategic Planning Project, March 2010* which addresses the health human resource issues.

Milestone 18: The newly formed Kapuskasing Health Integration Council will work in collaboration with the NE LHIN on the implementation of the strategies outlined in this report. The Council will also determine the appropriateness of its current membership given the cluster recommendation of this report.

Milestone 19: Establish one Long-Term Care Service Accountability Agreement (L-SAA) for the Extendicare long-term care homes in the NE LHIN by April 1, 2013.

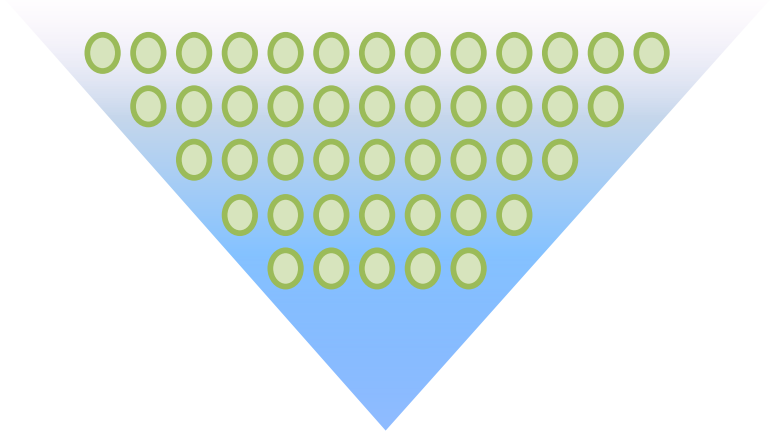
Milestone 20: Engage the four North East Alzheimer Societies to establish a Multi-Sector Service Accountability Agreement (M-SAA) for fiscal year 2013/14.

Cochrane Hub Health Services Realignment

A framework to move towards a more patient-focused and integrated system of care.

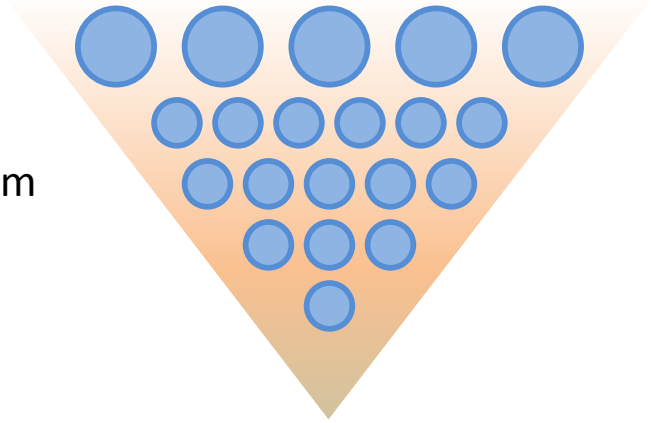
45 NE LHIN Funded Health Service Providers

Today
2012



20 NE LHIN Funded Health Service Providers

Change & Reform
2012 – 2014



A Newly Defined Cochrane Hub Health Care System

Change & Reform
2014 – 2015

ENGAGEMENT: COMMON THEMES (AND SAMPLE COMMENTS)

The focus group sessions were animated, well attended by approximately 650 people, and produced many suggestions and solutions on ways to improve access to health care. Participants were innovative, and focused on reducing duplication, streamlining administration, filling gaps by redirecting health care dollars, sensitive to linguistic needs and most importantly directed care to the patient, in his or her home, or community, as much as possible.

The importance of the current NE LHIN priorities was evidenced in the feedback received through the Cochrane Hub engagement sessions. Many communities had similar needs and priorities. Comments, ideas and feedback have been grouped under the following themes in order to guide realignment planning in a direction where it will have the most impact.

Leadership

- LHIN leadership is required to make realignment happen. Local leadership needs to be directed, supported, monitored and held accountable for making positive health care changes.
- Health service providers have to lead integration efforts – they know where the opportunities are. They have to step up to the plate and lead the change – for the patient.

Technology

- Electronic Health Records that follow the patient to all service providers would assist in the common thread of one-stop shopping/no-wrong door that was expressed in many communities.
- Increase the use of telemedicine/OTN to reduce travel for patients and bring more specialty services to the community.

Back-office Integration

- Backroom processes should be consolidated/integrated and would provide efficiencies and savings.
- Integrate back-office processes and reduction in senior administration, particularly in the hospital and mental health and addictions sector.

Patient-focused Integration

- Clients should only have to go through “one door” for all services whenever possible.
- Service provider boards need to meet and determine ways to improve system efficiency.
- The MICs Group model should be enhanced (one Board) and used in other communities.
- “One stop shopping” could be provided by small hospitals with all services under one roof.

Primary Care

- Additional Nurse Practitioners are needed across the Cochrane Hub to accept “orphan patients,” reduce the ER visits and provide enhanced access to family health care services.
- Expansion of primary care providers is needed since a high percentage of ER visits are from people with no family doctor.
- Geriatric services are very fragmented. They need to be coordinated into a single program.

- Enhanced access to primary care clinics with same day service for urgent but non-emergent care would greatly reduce low acuity ER visits across the District. Many smaller communities have no access to any services after 5 pm or on weekends.
- Family Health Teams need to provide extended hours so ER visits can be avoided.
- More after hours/walk-in clinics are needed to avoid using the local ER.
- Family Health Teams should have physicians living in the community instead of having to rely on locums.

Special Population Groups

- Francophone services need to be protected.
- Francophones need to receive health care services in French.
- More engagement with Aboriginal people is needed to help determine the opportunities for change and better services. There is a definite need to have more fulsome discussions with this population group.

Increased Access to Mental Health and Addictions

- Mental health counselling should be in community programs and not in the hospital to reduce duplication of services.
- Family Health Teams should also provide MH counselling, not hospitals.
- Mental Health and Addiction services should be merged or Detox should become part of hospital (Smooth Rock Falls).
- More mental health services are needed and they need to be coordinated among agencies so that people don't have to tell their stories so many times.

Enhancing Community-Based Care

- A Respite Care program is needed with protected beds.
- Increase home care services so seniors can stay in their homes.
- Keep all services under one roof.
- A system navigator is a good idea to help ensure people and patients are easily connected to the care they need and would be extremely beneficial to enhancing patient care. This could be accomplished by using CCAC case managers, having a person in the family health teams to assist individuals, or a lay person provide the service for the whole cluster.
- A Service Directory of health care services for the Cochrane Hub is needed. Both members of the public and health service providers are unaware of all the health care services available in each community, who the service provider is, and how to access the services.
- More home care and assisted living programs are needed to reduce hospitalizations/re-admissions/rates of alternate level of care, inappropriate long-term care placements.
- Transportation services are needed for out of town medical appointments where there is no public transit services available.
- More supportive housing is needed and assisted living services available to people living in them.

CCAC Specific

- Difficult to know how to access CCAC services: No consistent worker assigned to client and with seniors - many different people come to the door and they are scared to let the provider in as they don't recognize them; multiple assessments need to be done before any service

begins: in hospital, then again at home – and the delay is too long before services are received so ER visits are the only alternative.
- Centralization of CCAC has resulted in less care in communities.
- Local home care program in each community would save money.
- Staff could travel together rather than each discreet service going out from Timmins to the same community.
- There would be better quality of service through local providers as consistent providers for community and quality of care for clients/patients increases.
- The CCAC's RAI assessment tool needs to be changed. Many people are denied access to services as a result of the computer generated outcome from questions poorly understood by the client. There needs to be room for assessor input regardless of client answer.
- CCAC assessment before discharge, then home for two weeks with no service, then new assessment in home with computer generated score for services with no judgment allowed by CCAC staff -- this leads to re-hospitalization if home care service is denied.
- There is the perception that CCAC is cutting funding and its being inequitably distributed across the Cochrane Hub.
- CCAC policy for re-instatement of services following hospitalization needs revision. A person had to start process all over upon discharge and approved services were greatly reduced from before hospitalization.
- Need increased presence and services of CCAC.
- A full-time CCAC case manager should be located in Chapleau.
- Education on CCAC is needed to the public: How to access/where to call/how is home support arranged?
- Assessment criteria for CCAC needs to be adjusted to better meet the needs of people requiring care.

CONCLUSION

During the engagement sessions, a clear message was heard: the people of the Cochrane Hub want change and they want to be part of the solution. The sessions generated a large amount of feedback which mirrored the concerns, gaps and challenges people are facing, many of which were brought up in the 2011 sessions. However, there were many comments that were enthusiastically brought forward about initiatives and service providers making a significant difference in the lives of patients and families.

Also striking, were the numerous comments from all sessions around a desire for change which includes moving towards a "one system" model, as well as an appetite for the NE LHIN to catalyze and direct the process, if required.

The appetite for an integrated cluster model, the acknowledgment that the status quo is not sustainable, and the current momentum in the provincial arena are creating a powerful opportunity to transform the current system in the Cochrane Hub.

Currently, Ontario spends about 42 cents of every provincial program dollar on health care. That represents 61% more than was being spent in 2003. The health care system is facing an aging population, aging infrastructure, an unbalanced system of care and limited resources.

The only way the current system could be sustained, according to economist Don Drummond, is: we pay more taxes devoted to health care or, we squeeze out spending on all other public

services to make room for the ever-rising health care costs or we shift a significant portion of the health care costs to individuals to pay.

There are many facts, stats and figures that support the need for change in the Cochrane Hub and a need to deliver health care programs and services that are more focused on people.

We know that:

- Every year, the NE LHIN flows $128 million to the eight hospitals in the Cochrane Hub.
- Weekly reports submitted to the NE LHIN from these hospitals show that on any given day an average of 100 of the 426 hospital beds have no patients in them – they are vacant.
- In addition, about 109 people in these beds are inappropriately placed -- alternate level of care patients who could be cared for in community with the proper home care supports.
- Built decades ago, these same hospitals are also now victim to crumbling infrastructure and many of them are using their reserved funds to finance their debt. With a combined deficit of $5 million, this has decreased the working capital reserves to $12 million.
- About 25% of the area's hospital budgets go towards administration and support services.
- The seven small hospitals in the Hub have an 85% rate of low acuity visitors to their ER – patients who can typically be cared for outside of hospital for non urgent needs such as removal of stitches or ear aches. These same seven small hospitals also have very low numbers of people using their ER – about 145 people between the seven sites each day.
- All across Northeastern Ontario, there is a decline in population and the Cochrane Hub is no exception. It has sustained close to a 13% decline since 1996, compared to a near 20% increase in population across the province. And of the people who continue to call this great part of the province home, there are more of them who are over the age of 65.

Despite these changes over the years, one constant has remained -- the health care needs of people living in the Cochrane Hub communities.

This stark reality, coupled with the comments heard from approximately 650 people in recent months tells us that health system realignment in the Cochrane Hub is timely and the need to redefine the role of small hospitals is equally so.

The NE LHIN's seven principles for realignment must be followed in implementing this plan. As well, leadership is key to helping everyone move toward a "new normal." The end may not be clearly in sight but the process to get there is. As we move through the realignment, both the LHIN and each Cluster will have to set specific goals and timelines to be successful.

Without change, decline is sure to follow and, with change, we can expect resistance. Leaders will be required to be steadfast in the goal of realigning the system to be patient-centred within an integrated care model that provides culturally and linguistically sensitive services, has a high standard of quality, and provides value by using technology and innovative means to ensure effectiveness and sustainability.

APPENDIX A - NE LHIN REGION FACTS

- The North East LHIN's $1.4-billion annual budget goes directly into front-line health care through accountability agreements with 185 local health care providers. The region's 25 hospitals account for 68% of the budget.

- The NE LHIN region has 40% of Ontario's land mass, but only 4.3% of its population (550,000).

- For improved health care planning, the NE LHIN has divided its vast geographic region into five HUB areas.

- While the population of Ontario grew by almost 20% between the 1996 and 2011 census periods, it decreased in Northeastern Ontario by just over 5%.

- Approximately 17% of the population is older than 65 -- higher than the provincial average of 14%. This demographic will grow dramatically in our region in the coming two decades, to about 30% in 2030 (versus 22% for the rest of Ontario).

- 24% of people in Northeastern Ontario are Francophone; close to 10% are Aboriginal/First Nation/Métis.

- The region has a higher percentage of smokers, drinkers who report heavy drinking, obesity, and higher rates of chronic diseases.

- The NE LHIN has local decision-making through a Board of Directors that makes public decisions in the best interests of Northerners.

- The NE LHIN's 37 staff, who work in offices in North Bay, Sudbury, Sault Ste. Marie and Timmins, replaced the previous 98 Ministry/District Council staff. With the NE LHIN, there is system thinking for the North and patient-focused care, rather than organizationally focused silos of care.

APPENDIX B - COCHRANE HUB FACTS

- The NE LHIN funds 45 health service providers who receive $192 million each year to care for the 80,000 people living in the Cochrane Hub.
- Eight hospitals receive $128 million each year to operate 426 beds.
- On average, 100 of those 426 beds have no patients in them – they are vacant.
- About 109 people in these beds are inappropriately placed -- alternate level of care patients who could be cared for in community with the proper home care supports.
- On average, 145 people visit the emergency room of seven of the hospitals combined each day – Timmins Hospital ER alone receives about 110 visits per day.
- Between 55 and 85% of the people visiting the ERs are doing so for low acuity reasons (non urgent, non acute).
- According to 2011 Census data, the population in the Cochrane Hub as decreased by close to 13% since 1996.
- About 24% of the area's hospital budgets go towards administration and support services.
- Of the 622 beds in the area's eight long-term care homes, it is estimated some 17% of residents in long-term care homes could be cared for in community with proper support.

APPENDIX C - NE LHIN DECISION-MAKING FRAMEWORK

The NE LHIN will use the following decision-making framework to guide its evaluation of proposals for new programs and initiatives, changes to existing programs, and integration proposals.

Values	*Behaviours*
Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs & opportunities and act appropriately.
Equity	Opportunity for health & wellness for all.
Serve	Include NE Ontario geographic, cultural, demographic, and linguistic health & wellness needs in all activities.

*Criteria**	*Measures*
Accessible	People should be able to get the right care at the right time in the right setting by the right health care provider.
Effective	People should receive care that works and is based on the best available scientific information.
Safe	People should not be harmed by an accident or mistakes when they receive care.
Patient-Centred	Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.
Equitable	People should get the same quality of care regardless of who they are and where they live.
Efficient	The health system should continually look for ways to reduce waste, including waste supplies, equipment, time, ideas and information.
Appropriately Resourced	The health system should have enough qualified providers, funding, information equipment, supplies and facilities to look after people's health needs.
Integrated	All parts of the health system should be organized, connected and work with one another to provide high-quality care.
Focused on Population Health	The health system should work to prevent sickness and improve the health of the people of Ontario.

*Criteria as per Quality Improvement Guide of the Ontario Health Quality Council.

APPENDIX D - NE LHIN-FUNDED HEALTH SERVICE PROVIDERS IN COCHRANE HUB

In addition to the $192 million the NE LHIN invests through 45 health service providers in the Cochrane Hub each year, the Ministry of Health and Long-Term Care provides direct funding for six family health teams, two nursing stations and a public health unit, and each year people travel to receive care in other areas of Northeastern Ontario or at specialized care centres in Southern Ontario. The costs associated with this outflow for care have not been quantified.

Hospitals	Beds	Funding
Anson General Hospital - Iroquois Falls	34 beds	$7,879,419
Bingham Memorial Hospital - Matheson	37 beds	$5,727,669
Hôpital Notre Dame Hospital - Hearst	44 beds	$12,762,430
Hôpital Smooth Rock Falls Hospital	37 beds	$5,103,683
Lady Minto Hospital - Cochrane	33 beds	$9,506,519
Sensenbrenner Hospital - Kapuskasing	53 beds	$15,062,383
*Services de santé Chapleau Health Services	38 beds	$6,220,350
*Timmins and District Hospital	149 beds	$66,130,248
Total	**425 beds** (+ 58 LTC beds in hospitals – Bingham – 20, Chapleau – 18, Smooth Rock Falls - 20)	**$128,392,701**
Long-Term Care Homes		
Extendicare Kapuskasing	61 beds	$2,454,280
Extendicare Timmins	119 beds	$5,085,326
Foyer des Pionniers – Hearst	67 beds	$3,014,748
Golden Manor – Timmins	183 beds	$7,667,738
North Centennial Manor – Kapuskasing	78 beds	$3,286,370
South Centennial Manor – Iroquois Falls	69 beds	$2,855,318
Timmins and District Hospital (interim beds)	12 beds	$532,917
Villa Minto - Cochrane	33 beds	$1,462,393
Total	**622 beds**	**$26,359,090**
Community Support Sector		
Aboriginal Peoples Alliance of Northern Ontario (APANO) - Cochrane		$122,570
Access Better Living Inc. - Timmins		$805,423
Alzheimer Society of Timmins - Porcupine District Inc.		$118,657
*Centre de santé communautaire de Kapuskasing et région (seniors program) - Kapuskasing		$319,085
Chapleau Cree First Nation		$72,738
Constance Lake First Nation		$194,444
Corporation of the City of Timmins/Corporation de la ville de Timmins (community support services)		$204,035
*Services de santé Chapleau Health Services - assisted living program		$312,464

Soins palliatifs Horizon-Timmins Inc./Horizon - Timmins Palliative Care Inc.	$59,532
Taykwa Tagamou Nation - Cochrane	$17,470
Timmins Senior Citizens Recreation Centre	$18,185
Wabun Tribal Council - Timmins	$140,821
Timmins Finish Seniors Home	$11,906
Total	**$2,397,330**
Mental Health and Addictions	
Canadian Mental Health Association Cochrane/Timiskaming Branch – Timmins –	$5,758,103
Cochrane District Detox – Smooth Rock Falls	$785,191
Centre de Rééducation Cor Jésus de Timmins Incorporée (Jubliee Centre) - Timmins	$1,041,904
Hearst, Kapuskasing and Smooth Rock Falls Counselling Services - Kapuskasing	$2,235,476
La Maison Arc-en-ciel/ Centre de Réhabilitation du Nord de l'Ontario Inc. - Opasatika	$524,929
Maison Renaissance de la Réhabilitation - Hearst	$852,254
Minto Counselling Centre/Centre de counselling Minto - Cochrane	$1,167,105
North Cochrane Addiction Services/Service de Toxicomanie Cochrane Nord Inc. - Kapuskasing	$858,396
*Services de santé de Chapleau Health Services Turning Point/Point décisif - Chapleau	$405,297
South Cochrane Addictions Services Inc./Services de toxicomanie Cochrane-Sud - Timmins	$631,846
*Timmins and District Hospital (mental health outpatient programs)	$1,742,928
Timmins Consumer Survivors Network Inc.	$187,159
Timmins Family Counselling Centre	$75,368
Total	**$16,265,956**
Community Health Centres	
*Centre de santé communautaire de Kapuskasing et région - Kapuskasing	$2,004,022
Misiway Milopemahtesewin Comunity Health Centre - Timmins	$1,828,709
Total	**$3,832,731**
Regional HSP Funding Allocation for Cochrane	
Canadian National Institute for the Blind - Timmins	$130,741
Canadian Red Cross Society - Timmins	$1,179,571
March of Dimes	$105,627
North East CCAC (estimated)	$13,104,593
Total	**$14,520,532**
Cochrane Hub Grand Total	**$191,768,340**

Primary Care (in addition to CHCs) –The following primary care providers are funded directly by the Ministry of Health and Long-Term Care, including: two nursing stations (Mattice Community Clinic, Fauquier Health Centre); one public health unit(Porcupine Health Unit, Timmins); and six Family Health Teams (Anson General FHT – Iroquois Falls, Chapleau & District FHT – Chapleau, Cochrane FHT – Cochrane, East End FHT – South Porcupine, Nord-Aski Regional FHT – Hearst, Timmins FHT – Timmins)

** Note: Some health service providers offer more than one program and as a result which will be identified in more than one sector.*

APPENDIX E - NORTH EAST LHIN OPERATIONAL PLAN 2012-2013

NORTH EAST LHIN OPERATIONAL PLAN, 2012-2013

Ontario's Action Plan For Health Care

Better Patient Care Through Better Value From Our Health Care Dollars
With a focus on: Keeping Ontario Healthy; Faster Access and a Stronger Link to Family Health Care; Right Care, Right Time, Right Place.

North East LHIN Overarching Goal:

To Realign Northeastern Ontario health care providers in an effort to increase access to quality care for Northerners and ensure a more patient-centred and community based system.

2012-2013 Priorities

- Increase Primary Care Coordination
- Enhance Coordination and Transitions of Care
- Facilitate Realignment and System Transformation
- Make Mental Health and Addiction Programs and Services More Accessible

Enablers

- Targeting the needs of special population groups
  - Francophones
  - Aboriginal/First Nation/Métis
- Expanding eHealth Opportunities
- Enabling Recruitment and Retention of Health Care Professionals
- Accountability Agreements
- Local Health System Integration Act (LHSIA)

Outcomes/Metrics

Performance Indicators of the Ministry/LHIN Performance Agreement

APPENDIX F - SAMPLE INVITATION/ADVERTISEMENT

North East **LHIN**
RLISS du Nord-Est

Realigning Health Care Services in the Cochrane District

Did you know that the…

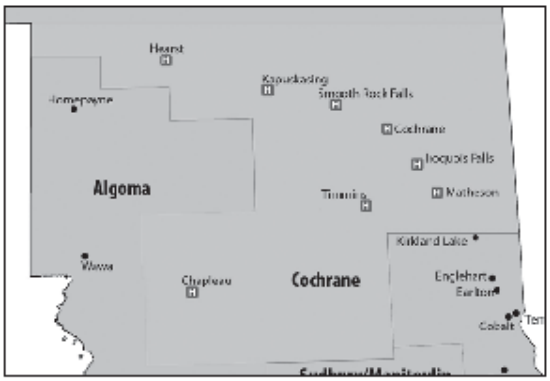
North East Local Health Integration Network (LHIN) flows $192 million each year to 58 health service providers to provide front-line care to 80,000 people living in the Cochrane District?

Are you getting the right care in the right place at the right time?

Join an independent facilitator from Northeastern Ontario and the North East LHIN and participate in a discussion on how to realign health care services in the Cochrane District to best meet your health care needs.

Date: Monday, February 27, 2012
Time: 7 p.m. to 9 p.m.
Place: Days Inn, 14 Mountjoy Street South, (Ballroom A and B)

Following a presentation, you will have the opportunity to offer one-on-one input on developing a more patient-focused, seamless and effective local health care system. **Everyone is welcome!** For more information, please contact at Robyn Bangs at 1-705-840-1252.



Réaligner les services de santé dans le district de Cochrane

Saviez-vous que…

Le Réseau local d'intégration des services de santé (RLISS) du Nord-Est verse 192 millions de dollars chaque année à 58 fournisseurs de services de santé qui offrent des soins de première ligne aux 80 000 habitants du district de Cochrane?

Recevez-vous les bons soins, au bon endroit et au bon moment?

Joignez-vous à une facilitatrice indépendante du Nord-Est et au personnel du RLISS du Nord-Est pour discuter des façons de réaligner les services de santé dans le district de Cochrane de sorte à mieux répondre à vos besoins de soins de santé.

Le lundi 27 février 2012
De 19 h à 21 h
Salle : Days Inn, 14, rue Mountjoy Sud, (salle de bal A et B)

Après une présentation, vous aurez l'occasion d'offrir des commentaires individuellement sur la création d'un système de santé local qui est davantage axé sur le patient, uniforme et efficace. **Tout le monde est bienvenu!** Pour en savoir plus, veuillez communiquer avec Robyn Bangs au 1-705-840-1252.

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

LHINS (ENGLISH/FRENCH)
PN-2169-NELHIN TimminsDP 5C.indd
Timmins Daily Press 5C (5.000") x 152ag

APPENDIX G - REFERENCES AND RESOURCES

Commission on the Reform of Ontario's Public Services
http://www.fin.gov.on.ca/en/refermcommission/chapters/report.pdf

Strong Action for Ontario. 2012 Ontario Budget. Queen's Printer for Ontario. Release date: 28/03/2012

See the World Health Organization statement on Primary Care:
http://www.who.int/topics/primary_health_care/en/

See NE LHIN RLISS NE web site for full access to the IHSP
http://www.nelhin.on.ca/page_ihsp.aspx?id=4020&ekmensel=e2f22c9a_72_204_btnlink

Ontario Health Quality Council: http://www.ohqc.ca/en/index.html

Resources/Primary Care

Ministry of Health and Long-term Care – Family Health Teams:
http://www.health.gov.on.ca/transformation/fht/fht_mn.html

Ministry of Health and Long-term Care – Nurse Practitioner-Led Clinics:
http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

Study comparing primary care models demonstrates the effectiveness of Ontario's Community Health Centres http://www.aohc.org/index.php?ci_id=9467&la_id=1
System Integration and Community Health Centers
http://www.aohc.org/index.php?ci_id=3116&la_id=1

Utilization of Nurse Practitioners to Increase Patient Access to Primary Healthcare in Canada – Thinking Outside the Box http://www.longwoods.com/content/22281

Resources/Community Based Care

Community-based care reducing ED wait times: www.albertahealthservices.ca

Red Cross Home Support: www.redcross.ca/HomeCare

Family Caregivers Unite!: www.familycaregiversunite.org/

Home Hospice Care www.saintelizabeth.com/pallative