Access / Quality / Value

A Proposed Plan for the Realignment of Health Services in the Temiskaming District

June 2012

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Community Engagement Sessions Facilitated by: Gisele Guénard

EXECUTIVE SUMMARY

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

> "Further engage with stakeholders in the Temiskaming 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 follows the Temiskaming District community engagement sessions of 2011. At that time, residents of Englehart, Kirkland Lake, Temiskaming Shores and surrounding communities voiced concerns about their ongoing lack of access to local community health care services. They voiced a need for an easier-to-navigate and less fragmented system of care. NE LHIN plans for moving forward with realignment are in keeping with the need to respond to a more patient-centred and community-based system of health care.

Built on feedback from engagement sessions with more than 250 participants from Englehart, Kirkland Lake and Temiskaming Shores in March of 2012, this report provides a recommendation and milestones for the realignment of health care services in the area.

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 Temiskaming District, 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.

- Every year, the NE LHIN flows close to $42 million to the three hospitals in the Temiskaming District.
- Weekly reports submitted to the NE LHIN from these hospitals show that on any given day, an average of about 46 of the hospitals' 151 beds have no patients in them – about 30% of them are vacant.
- In addition, about 35% to 43% of the people in these beds are inappropriately placed -- alternate level of care (ALC) 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 they are using their reserved funds to finance their debt (almost $1.9 million in reserved funds has been used to finance a current half-million-dollar combined debt).
- About 26% of the area's hospital budgets go towards administration and support services.
- We also know that the three hospitals in the District have an 80% 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. On average, 120 people visit the emergency rooms of the three hospitals *combined* each day (ranging from an average of 12 per day in Englehart, 48 per day in Kirkland Lake, and 60 per day in New Liskeard).

There is a decline in population all across Northeastern Ontario, and the Temiskaming District is no exception. It has seen close to a 14% 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 371 beds in the district's five long-term care homes, it is estimated some 14% 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 more than 250 people in recent months, tells us that

health system realignment in the Temiskaming District is timely and the need to redefine 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 Temiskaming District communities.

Decisions and plans for next steps will be made according to the NE LHIN Decision-Making Framework, which is based on the values and behaviours of the organization as well as criteria and measures for the evaluation of proposals for new programs and initiatives, changes to existing programs, and integration proposals.[1] The criteria for the NE LHIN's Decision-Making Framework are aligned with indicators found in the Quality Improvement Guide of the Ontario Health Quality Council.

In order to address the local health care needs within the themes of Access, Quality and Value, a plan is outlined in this report. It includes one recommendation and key milestones for realignment initiatives, to address patient concerns and needs. The communities within the Temiskaming District are keenly interested in engaging and participating in the positive change of their health care system. Next steps will include a communication and action plan to support implementation of this report's recommendation and key milestones that support implementation of the change required.

Recommendation: To create a less fragmented and more patient-focused continuum of care, the current NE LHIN-funded health service providers in the Temiskaming District will realign into a "Temiskaming District Health Governance Entity"

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

METHODOLOGY

Community engagement is a key element in the work of LHINs across Ontario. The participation of communities within the Temiskaming District is no exception. Residents and health service providers from the area have participated in many NE LHIN forums and initiatives in the past five years.

In partnership with the people of Englehart, Kirkland Lake, Temiskaming Shores 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, as well as to work with health service providers to ensure local programs and services are focused on the needs and priorities of local citizens.
Based on challenges in the area's health care structure and gaps in service, general awareness-building around the need for realignment has been part of the NE LHIN's work, with data and feedback coming largely from within the Temiskaming District communities and health service providers.

In June 2011, the NE LHIN held five community engagements in the Temiskaming District with more than 100 people participating. Residents voiced concerns that the area needed 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 March 2012, the NE LHIN facilitated engagement sessions focusing on how to realign the local health care system in the Temiskaming District communities, including:

- **March 6 – New Liskeard: Governance session for health service provider boards**
- **March 6 – New Liskeard: Temiskaming health service providers**
- **March 6 – New Liskeard: Physicians from the three hub areas within the Temiskaming District**
- **March 6 – New Liskeard: Temiskaming Shores community forum**
- **March 7 – Kirkland Lake: Kirkland Lake community forum**
- **March 7 – Englehart: Englehart community forum**

Approximately 250 residents attended these engagement sessions and were able to participate and engage in discussions in English and in French.

Prior to engagement sessions, the NE LHIN team communicated and met with area leaders including MPPs, Mayors and Reeves. On February 17, 2012, invitations were sent to all stakeholders for sessions planned in early March.

NE LHIN staff attended a meeting of the Temiskaming Health Service Provider Collaborative Committee on February 21, 2012. The Executive Council of the three Temiskaming Hospitals also met February 21 to discuss the actions to date on the Health Study that was conducted in 2007 (refresh in 2011).

Media advisories were released February 24 and 27 throughout the District. Advertisements were placed in *The Kirkland Gazette*, the *Northern Daily News*, the *Temiskaming Speaker* and *The Weekender*, followed by telephone follow-up with reporters Feb 27.

Each group was presented with statistical data and key information pertaining to their particular area, as well as the Temiskaming District as a whole. Presentations were simultaneously displayed in English and in French, with narration and discussion in both languages.[2]

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

[2] As part of the Invitations sent to Governance stakeholders, attendees were asked to read through the following key documents : Ontario's Action Plan for Health Care, Governance Resource and Toolkit for Voluntary Integration, Caring for Our Aging Population and Addressing Alternate Level of Care, Dr. Walker, June 2011

facilitated to capture as much feedback as possible. Réseau du mieux-être francophone du Nord de l'Ontario[3] representatives assisted with facilitation.

The engagement team included Cynthia Stables, NE LHIN Director of Communications and Community Engagement; Carol Philbin-Jolette, NE LHIN Senior Officer; and Gisele Guénard, (independent) Facilitator. Accompanying the team was Dr. Tim Zmijowskyj, the NE LHIN's Primary Care Lead. The objective of the meeting held with physicians was to inform them of the purpose of the focus group sessions in their communities and to begin the dialogue with Dr. Zmijowskyj on opportunities for change in primary care.

Francophone participants had the opportunity to engage in the French language at all sessions. The team was assisted by additional support from Sylvie Sylvestre, Agente de planification et d'engagement communautaire/Community Engagement and Planning Officer, Réseau du mieux-être francophone du Nord de l'Ontario.

THE NEED FOR CHANGE

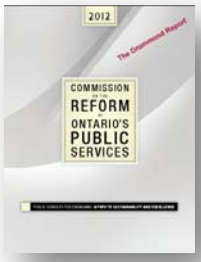
A Provincial Perspective

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 (the "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).[4]

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 Budget, 2012

[3] The NE LHIN has an agreement with a French Language Health Planning Entity (FLHPE) to engage with Francophones in Northeastern Ontario.
[4] Commission on the Reform of Ontario's Public Services http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf

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 and moving forward. It also supports in principle the positive changes the NE LHIN is leading. Some examples are:

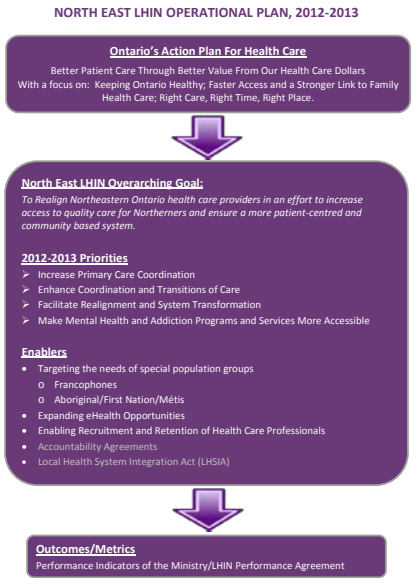
- Transforming health care to reduce the rate of growth of spending to an average of 2.1 per cent annually over the next three years;
- Enhancing community-based care to treat patients in alternative settings such as non-profit clinics and at home instead of in hospitals, where appropriate;
- Moving to patient-centred funding models to improve the value and quality of care. [5]

A Regional 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 is 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 (2012/2013). 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 annual budget flows to 25 hospitals, based on decades-old funding practices.

The NE LHIN's regional investment in community support services comes from within 3% of the North East funding envelope in order 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 Temiskaming District found the need for improvement in access to health care services and the need to realign funding to support people to stay in community or in their homes. Meeting these needs requires finding the dollars required 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.

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

The Temiskaming District service realignment is one of the four priorities of the NE LHIN 2012/13 Operational Plan – "facilitating realignment and system transformation (see full plan in Appendix D).

A Temiskaming District Perspective

The Temiskaming District is home to close to 33,000 people. Almost 24% are Francophone and 5% Aboriginal. There are three hospitals within one hour or less from each other. The population of the Temiskaming District has declined by almost 14% since the 1996 census. The population of the North East has declined by just over 5%, while the population of the province has grown by almost 20% during this same time frame.

Currently, the Temiskaming District receives approximately $74 million per year from the NE LHIN. This funding is provided to 15 district health care providers:

- ✓ 3 Community Support Providers ($2.4 million)
- ✓ 3 Community Mental Health & Addictions Providers ($3.7 million)
- ✓ 1 Community Health Centre ($4.4 million)
- ✓ 5 Long-Term Care Homes ($14.6 million)
- ✓ 3 Hospitals ($41.5 million)

The North East LHIN also funds the North East Community Care Access Centre with about $115 million each year, of which approximately $7.5 million goes towards caring for people in the Temiskaming District through personal support workers, case managers, nurses, physiotherapists, and other health care professionals in the community.

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

- 5 Family Health Teams, (Kirkland Lake, Englehart, New Liskeard, Haileybury, Temagami)
- 2 nursing stations (Elk Lake, Matachewan)
- 1 public health unit (Porcupine Health Unit)

In addition to the $74 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.

Many of the 151 beds in the Temiskaming District's three hospitals are not being used for their intended purpose (on average 46 beds on any given day are vacant and 35 of the beds are occupied by alternate level of care patients). In addition, hospital emergency rooms have many low acuity visitors (patients who could be cared for outside of hospital for non urgent needs such as removal of stitches or ear aches).

Another startling fact is that of the 371 beds in the area's five long-term care homes, it is estimated around 14% of the residents could be cared for in community with proper support.

Essentially, the Temiskaming District health system is unbalanced (due to high reliance on hospitals and not enough community-based care) and health service provider programs and services are not coordinated (16 NE LHIN-funded providers and eight provincially-funded primary care providers). This unbalanced system is also impacted by the fact that Statistics Canada census figures tell us that local population is both declining and getting older. A system realignment is timely.

Some coordination efforts have been successful over the years such as the Health Study, 2007 led by the three district hospitals, the establishment of the Temiskaming Health Service Provider Collaborative Forum,

and the recent discussion with the three district hospital boards to create a Joint Executive Committee to oversee integration opportunities. However, there is little evidence of voluntary patient-focused realignments occurring that have produced savings which could be redirected to community and home-based care.

It is important that the work of the realignment project be carried out under the guidance of specific principles as noted below.

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 Temiskaming District.

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.

RECOMMENDATION AND MILESTONES

Recommendation: To create a less fragmented and more patient-focused continuum of care, the current NE LHIN-funded health service providers in the Temiskaming District will realign into a "Temiskaming District Health Governance Entity"

There is an urgent need for realignment in the Temiskaming District in order to improve health care access, quality and value. This fact is strongly supported by the data submitted via health service providers, the feedback from all community engagements, as well as the fiscal and demographic realities within the province of Ontario.

Brief Description

The NE LHIN-funded health service providers within the Temiskaming District will become One "Health Care System" to provide services to patients within the entire District where appropriate. The creation of the Temiskaming Realignment Governance Entity is the catalyst, enabler and connector in creating this one system.

Health service provider boards will transfer into this entity, which will eventually have one accountability agreement with the NE LHIN. The common governance entity has one employee - a CEO.
Health service providers within the Temiskaming District will be better positioned to provide - Access, Quality & Valuable services to patients within the entire District where appropriate.

As per the seven principles for realignment, the Temiskaming Realignment Governance Entity will ensure the protection of French language services and improve the health status of the Aboriginal/First Nation/Métis people.

Collaboration with the NE LHIN includes the establishment of one Accountability Agreement for the Temiskaming District with one main area of focus and authority: *District-wide, patient-focused continuum of care. Note: Memorandums of Understanding will need to be established between the Temiskaming District Health Governance Entity and the NE CCAC, and possibly some long-term care homes.*

The existing Temiskaming Health Service Provider Collaborative Committee will be redefined as the "Temiskaming Realignment Team." This team will be an action-focused collaborative made up of various stakeholders representing the NE LHIN-funded HSPs, primary care, public health, education, private sector and others as appropriate. The main goal of the realignment team will be to develop a transition plan by March 31, 2013. The plan will include the milestones identified in this report.

System enablers for the development of the Temiskaming District Health Governance Entity include activities occurring from three platforms:

- **Community-based Realignment Activities**
- **Sector-based Realignment**
- **District-wide Realignment**

These three types of activities would continue, with enhanced, patient-centred focus, based on the Milestones outlined in this report, as well as other strategies to improve access, quality and value within the system, while a common governance entity is developed.

Community-Based Realignment Activities

Increased integration *within* each of the communities of Kirkland Lake, Temiskaming Shores and Englehart will contribute to District-wide realignment while simultaneously improving access to services, quality care and value for patients. As the work of developing a common governance entity proceeds, HSPs within each community need to continue to build on existing initiatives, step up innovation and collaboration amongst themselves and increase activity within each of their three geographic areas. HSPs will be active members of the Realignment Team as District-wide integration opportunities are explored on a continuing basis.

HSPs in collaboration with their partners may voluntarily eliminate administrative positions and pool resources, with the NE LHIN assisting with any elements related to Accountability Agreements. Task forces may take on initiatives and projects.

There exists within each community, expertise, resources, "bricks and mortar," and most importantly, the dedication of health service providers, volunteers and leadership to further develop existing health care community hubs. Ideas for community hub-based realignment expressed during the engagement sessions included:

- Building on successes with integration of FHTs, to expand primary health care access.
- Explore successes and best practices in developing assisted-living and initiate collaborative efforts to create housing.
- Reallocate resources to build on existing successes with the seniors' program at Centre de santé communautaire.
- Identify successes occurring in the supportive housing assisted-living sector, and explore initiatives to increase and expand all services.
- Build on the interest in developing short-term mental health beds and educational services.
- Re-organize under an "umbrella organization."

Sector-based Realignment

Realignment within sectors of service expertise should continue where it is contributing to increased Access, Quality and Value for patients. For example, building on their close proximity and common population needs, the three hospitals could look at opportunities to realign administrative and acute care services within the district. Separately from this initiative, all agencies providing mental health and addiction services could work "as one" for like initiatives.

Long-term care organizations, community support organizations and other HSPs could realign, simplifying and streamlining administrative and back office costs and human resources, including the time spent currently by many organizations repeating the same processes.

District-wide Realignment

As the work of developing a common governance entity proceeds, there are many opportunities for addressing needs voiced by the patients and residents of the Temiskaming District. In order to build on the work of the Temiskaming Health Service Provider Collaborative, it is recommended that the Realignment Team develop a district wide transition plan for health care services.

Opportunities

The opportunities for learning from others and moving forward with realignment based on best practices have grown significantly over the past few years. Several models for one-system integration are now in place globally, across northern and other regions of Canada including multi-hospital integrations in the North East and in many areas world-wide. Moving forward with system realignment at this time is in keeping with the expectations within communities across Ontario in light of Ontario's Action Plan on Health Care and the March 2012 provincial budget.

Other opportunities for success within the Temiskaming District realignment project include:

- "Every vacancy is an opportunity." This HR philosophy could be applied to seeing every new position vacancy within the system as an opportunity for the three communities to further realign the system.
- The NE CCAC Service Agreement being directly with the NE LHIN could act as an enabler for moving community-based recommended strategies forward.
- Proponents of sector-based realignment may begin to see the opportunities in a wider-based approach to providing services once initiatives are underway.
- A strong one-system governance body may have a stronger voice in developing partnerships with the private sector, including commercial entities currently benefiting from the mining boom in the Temiskaming District.
- A number of eHealth projects and initiatives are currently in progress at the NE LHIN. The need for electronic health records accessible to health service providers and eventually to the patient for personal access was raised at almost all engagement sessions. This may be an opportunity to create awareness about the initiatives underway and possibly trigger innovation even within the Temiskaming District on this issue.[i]

Temiskaming District has the leadership, the expertise and the will among the leaders and community members to emerge as an innovator in realignment of healthcare services. The people of the Temiskaming District can expect success with major system realignment. To that end, and with sustainability in mind, moving towards common governance is realistic and achievable in light of the following realities:

- The resources available to health care have changed, and all health service providers must innovate to provide services with existing funding envelopes.
- The recruitment and retention of health care professionals remains a challenge.
- The greater the distance between a northern community and a large urban centre - the more challenging it will be to recruit and retain skilled personnel and the leadership needed to lead our health care system organizations.
- The number of people who have the expertise, the time and interest to serve effectively on boards of directors is limited.

MILESTONES

The Recommendation and the following Milestones are geared to producing the most significant, timely and positive impact on the Access, Quality and Value issues in the Temiskaming District. Most would ideally be implemented District-wide, while community-specific strategies are included within these, or separately as appropriate. The focus is on enhanced health care services for the patients and people of Temiskaming District.

Milestone 1: The establishment of a *Realignment Team* 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 the Temiskaming District Common Governance Entity to negotiate the accountability agreement with the NE LHIN by fiscal 2013/14.

Milestone 4: As outlined in the Hospital Accountability Agreement, the Temiskaming District 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 Temiskaming District hospitals are to work collectively as a group and with the health service providers to address any deficit in the system. For Kirkland Lake, which has a HIP, the following criteria must be adhered to:

(a) The hospital to 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 5: The Temiskaming District Hospitals must continue with the establishment of a "Joint Executive Committee of the Hospital Boards" to oversee integration activities outlined in the 2007 Health Study Report (2011 Refresh). More specifically, the Committee will oversee the planning to:

- Re-purpose vacant hospital beds in the Temiskaming District so that resources can be redirected to increase community-based health care services, improve access to primary care, long-term care, and short stay beds for patients experiencing urgent mental health challenges. The plan will be submitted to the NE LHIN by March 31, 2013.
- Adjust staffing patterns within hospitals to eliminate overstaffing of patient care units where bed vacancies exist, enabling reallocation of human resources to community-based patient centered services. The plan will be submitted to the NE LHIN by March 31, 2013.
- Complete a shared back office services plan. The plan will be submitted to the NE LHIN by March 31, 2013.
- Implement a common Information Technology domain by December 2012. Once established, the hospitals will work closely with the Temiskaming District Realignment Team to roll out the service plan to the other health care sectors.

Milestone 6: The Joint Executive Committee of the hospital boards will develop the plan to merge into the Temiskaming District Common Governance Entity. The plan will be submitted to their respective Boards as well as the NE LHIN by March 31, 2013.

Milestone 7: The Temiskaming Realignment Team will develop and implement strategies to address gaps in discharge planning, referral and long-term care admission processes. The Realignment Team will complete the implementation plan by April 1, 2013. Implementation is targeted for 2013/14.

Milestone 8: The Temiskaming Realignment Team will develop and implement a collaborative evidence-based patient-centered approach to end-of-life care ("Pathways" or "Protocol"). The approach must be aligned with the Hospice Palliative Regional Plan, for the NE LHIN.

Milestone 9: The Temiskaming Realignment Team will develop a model for the expansion of the System Navigator role in the Temiskaming District. The Timmins and/or North Bay Navigator will assist in the development of the plan. The proposed plan will be submitted to the NE LHIN by December 30, 2012.

Milestone 10: The Temiskaming Realignment Team will establish a task group on Health Human Resources by September 30, 2012 and develop an implementation plan on human resource issues identified by the Temiskaming Health Service Providers Collaborative by March 31, 2013.

Milestone11: In collaboration with the Realignment Team, each community (Englehart, Kirkland Lake and Temiskaming Shores) will develop and implement a plan to:

- Increase access to primary care: i.e.: utilization of Nurse Practitioner services and partnerships with the Family Health Teams; specifically co-location of the Family Health Team with the hospital
- Increase community health care capacity
- Improve coordination of client navigation across the continuum of care in each community.
- Improve district non-urgent transportation

The plan will be developed and submitted to the NE LHIN by December 30, 2012.

Milestone 12: The three mental health and addictions agencies in the Temiskaming District will develop a plan to integrate and create one accountability agreement with the NE LHIN effective April 1, 2013.

As we move forward with the realignment of the Temiskaming District outlined in this report, other points to be considered include the following:

- The new governance entity needs to develop a clear Vision, Mission and Strategic Plan for the realigned system.
- Long-term care home legislations and regulations must be considered.
- A change management and project management approach is needed to: (a) support the process, (b) ensure success through the phases of system realignment, (c) address organizational culture issues for positive change.
- Memorandums of Understanding with regional health service providers must be considered.
- Initiatives for realignment which should be pursued further to implementation of this report, i.e. other non-LHIN-funded health service providers or programs, possibly now under the umbrella of other ministries.
- Elements to help patients navigate the system are integral to achieving a more patient-centred system of care in Temiskaming District.

ENGAGEMENT: COMMON THEMES

The importance of the NE LHIN priorities, as well as their currency, was evidenced in the feedback received through all of the Temiskaming District engagement sessions. Comments, ideas and feedback from community members and health service providers have been grouped under six themes in order to guide realignment planning to have the most positive impact.

One System

Residents of the Temiskaming District share a common concern: the desire for "one system" and a belief that the status quo is unsustainable. From feedback and conversation around communication issues, the geography of the area, the difficulty in attracting and retaining skilled professionals, lack of knowledge about services, and the general acknowledgment that the current system is not patient oriented, people said they want a system that works *as one*. Temiskaming District residents shared openly that maintaining current silos is not working. People want a one-stop concept for access to services in the sense that health service providers are working together, including LHIN-funded and non-LHIN-funded. “Hospitals need to work together,” said one participant. Another participant shared that working more closely with public health would also improve services.

Though a desire was voiced to “do more of” what is working well and to support the development of community hubs as opposed to “centralizing” all services, many participants specifically stated it was time to "find ways for boards to start working together." In Englehart, Kirkland Lake and in Temiskaming Shores, participants shared ideas for reinforcing existing areas of expertise or developing new ones in order to meet the needs of the District as a whole as well as their own smaller communities. There is a strong sense that by putting together plans where the patient is truly at the center, and governance as well as health service providers work as part of one team, challenges of access to care and quality could be solved.

It was felt by participants that a unified system which could include a “one board” concept, which should at least enable all heath service providers to work together as one team, would be a powerful enabler to solving the area’s challenges. As one participant stated, "an umbrella organization is needed to increase collaboration."

Service Gaps

Participants shared many stories, experiences and observations about current gaps in services. These include senior support and care, mental health, palliative care, transportation, long-term care, supportive housing, and community support services of all types.

People spoke of wanting to "uncomplicate healthcare for mental health and addictions." They spoke of needing timely access to care and services including primary care, mental health beds and transfer back from other facilities. Transportation issues were among some of the gaps most frustrating to residents of the Temiskaming area.

Lack of access to services such as physiotherapy and rehabilitation was mentioned frequently, often in conversation around the impact this has on individuals being able to return to, or stay in their home. Comments were also made about the fact that savings from realignment should and could be reallocated directly to patients. As one physician said, "using resources saved by addressing the patient transfer issue for actual patient care is what we should be doing."

Though the lack of community support services is being felt in many areas of Ontario, it is particularly evident in more remote and rural communities. The reasons for this are echoed in the current state of health care in the Temiskaming District. Human resources are scarce, volunteers are hard to come by, assisted living and

supportive housing is minimal to nonexistent, and the issues around an aging population are exacerbated by youth outmigration.

Knowledge & Education

Health care systems are complex, and so are the chronic diseases facing larger and larger percentages of the North East's population. With the region having a higher percentage of smokers, heavy drinkers, obesity and chronic diseases, the need for the right knowledge at the right time is crucial. Gaps in knowledge about "who to call," and where to go for information and services, were expressed in all engagement sessions. Combined with this was the desire for help in assisting patients and families with learning about how best to care for themselves, and how to access services. Additionally there were comments around gaps in knowledge about services, specialists, and palliative care protocols among health service providers.

Community members expressed that delivery of healthcare services should be reorganized with the inclusion of an Electronic Health Record as well as "system navigators," and that navigators should be bilingual. Public education about chronic disease was seen as a need, as well as finding ways for people to understand the roles of different health service providers.

Engagement participants noted that more prevention and education with a focus on "health, not illness, especially for certain groups such as diabetes," are needed. Increased linkages with educational organizations such as the Northern Ontario School of Medicine were cited as examples of positive changes which would have a significant impact.

Training and innovation to increase the pool of workers to provide support within home settings was stated as an important gap to be addressed as soon as possible.
Patients, families, and health service providers perceive knowledge as key to successfully addressing the challenge of system navigation.

Resource Utilization

Duplication of services was recognized as an opportunity for realignment. Examples of this included:mental health services currently being provided by more than one agency, and a significant amount of resources being used for administration. There was an awareness that home care services of all types are urgently needed, and that the resources need to be reallocated in that direction in order to develop a successful community-based health care system. "Human Resources is an issue: we need more people to provide services in the home," one resident stated. Several comments relating to the need for more Personal Support Workers were heard in all communities.

One individual stated "funds need to be reallocated to primary care and home care enabling hospitals to do what they should do: acute care." In order to oversee this alignment, and to ensure that primary care is the key to success in positive outcomes for patients, a call for the creation of an umbrella committee was heard from several participants. Many examples of resources which would be better allocated elsewhere were highlighted in the discussion, including repurposing vacant hospital beds and changing inappropriate transportation methods across the North.

Several participants shared that innovation is required in order to properly utilize resources and address the needs of the growing senior population. Some participants were quite specific in how this reallocation of funds could help. For example it was felt that patients could better receive care in the community such as palliative care, physiotherapy, occupational therapy and wheelchair posture assistance. Repurposing of hospital beds was discussed with a variety of ideas for mental health, assess and restore beds and long-term care services. Specific examples of models used elsewhere were brought up for discussion, with ideas and a desire to work together being at the heart of the dialogue.

Access to Primary Care

Temiskaming District residents do not want to use the emergency rooms for primary care: they want to increase hours of access to primary care providers. Many concerns were voiced about emergency rooms being used by patients unable to access primary care as well as long-term care. In all engagement sessions, communities expressed a hope for increased access to Nurse Practitioners, and the hope that access to Physician services would increase as well.

Community members related the significant difficulties in accessing primary care to increased admissions to hospital and long-term care, as well as increased rates of alternate level of care (ALC) patients. "Emergency rooms are vastly misused," said one participant. The need for after-hours access to care, such as walk-in clinics, was heard in all sessions. In particular, access to a primary care provider until “at least 11:00 o’clock at night” would truly help the community.

Coordination of care was seen as a service that should be a foundational element of primary care and that Nurse Practitioners could be instrumental in this work. Significant challenges for patients experiencing mental health challenges and trying to navigate the current system were noted. Stated one Temiskaming District resident, "we need to create a continuum of care, for example the hospital, long-term care, assisted living, mental health, family health team – all working together."

Participants in every community where engagements were held called for more Nurse Practitioners and access to Physicians, referring frequently to long wait times. The need for access to comprehensive primary health care and the long-standing gap in access to family Physicians in the North shows no end in sight. [6] The need for more support and improvement in the quality of palliative care within the home was expressed as well. This level of care is guided by a primary care practitioner.

Transition and Discharge

From difficulties for patients requiring urgent care in an acute mental health setting, and those patients’ health service providers struggling with transfer obstacles, to post-op discharge and transition to long-term care challenges, many transfer and referral issues were shared. "Discharge planning and referral processes need to improve," shared one participant. Community members voiced concerns about hospitals, as well as CCAC and community support service providers needing to work more closely together. Most pressing, is the need for policies to be revised and for these providers to work closely together to improve transfer and discharge planning processes.

Concerns for patients being discharged after receiving urgent mental health services, for palliative care, and those with developmental disabilities emerged in discussion. After sharing about a particularly difficult experience, one family member said, "We need to improve communication between providers, especially at the time of discharge." "Joint planning among all service providers is what is required," shared another resident.

Solution Thinking in Temiskaming

The above themes were shared by community members in tandem with a clear message: the people of the Temiskaming District want to be part of the solution. The five community engagement sessions held in the Temiskaming District generated a large amount of feedback which mirrored the concerns, gaps and challenges this population is facing, many of which were brought up in the 2011 sessions. However, there were many comments that were enthusiastically brought forward to tell us about initiatives and service providers making a significant difference in the lives of patients and families.

[6] In particular, in one area of the Temiskaming District, Kirkland Lake, the community continues to see limited service being provided, and solely by locum Physicians.

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. In particular, the following comments were expressed in the public forums:

- The new Assisted Living for High Risk Seniors policy is really helping. Now it needs to be applied everywhere.[7]
- Aging at Home works, and we need more.
- We need to continue more of this: prevention such as nutrition classes, exercise, and social activity to decrease isolation.
- There is an excellent use of our Nurse Practitioner. We also need them in the clinic, at the Community Health Center and in long-term care. They could do the walk-in clinics.
- What we need to do is start with a blank slate.
- We could realign with a steering body in place.
- We need to change the way we think - we need to as one health care system.
- An umbrella committee to oversee realignment could make it happen.
- The LHIN needs to propose a model/we need to focus/we need to get back to customer service.

Disparities in rural health care exist throughout the world. While having some correlation with disparities explored in the literature, the Access, Quality and Value challenges within the North East pale in comparison to those in many other countries. However, even in countries where critical health care gaps have long existed, collaboration and innovation are now contributing to great strides in positive change. People everywhere want an accessible, "one point of entry" model of health care where as many services as possible are accessed in the home. They want quality patient-focused care, delivered at the right place at the right time – and the system needs to be sustainable, effective and efficient, while being culturally and linguistically sensitive.

The appetite for an integrated 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 Temiskaming District.

[7] (SHAL: Supportive Housing in Assisted Living Policy to help frail seniors in the home)

CONCLUSION

Residents of Ontario are at a turning point in health care. The challenges faced by patients and health service providers across Ontario are even more significant for small pockets of aging populations located at long distances from major centres. The people of the Temiskaming District have spoken loudly and clearly. They expressed their deep appreciation for the opportunity to engage with the NE LHIN team during March of 2012, and to be able to speak of their concerns around their existing and future health care system.

Many of the stories heard were troubling, and yet the hope was strong that there are better days to come for patients in need of health care in the area. There was fear of change, but greater fear of no change in how health care is currently delivered given the large gaps, duplications, and fragmentation of the system as a whole. There are competent and caring leaders in the area, dedicated frontline staff in a host of agencies, primary care practitioners providing excellent care, and many other elements that make up the significant health care and system assets that belong to the people of the Temiskaming District.

We know that:

- Every year, the NE LHIN flows close to $42 million dollars to the three hospitals in the Temiskaming District.
- Weekly reports submitted to the NE LHIN from these hospitals show that on any given day an average of about 46 of the hospitals 151 beds have no patients in them – about 30% of them are vacant.
- About 35% to 43% of the people in these beds are inappropriately placed -- alternate level of care (ALC) 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 they are using their reserved funds to finance their debt (almost $1.9 million in reserved funds has been used to finance a current half-a-million dollar combined debt).
- About 26% of the area's hospital budgets go towards administration and support services.
- The three hospitals in the Temiskaming District have an 80% 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.
- On average, 120 people visit the emergency rooms of the 3 hospitals *combined* each day (ranging from an average of 12 per day in Englehart, 48 per day in Kirkland Lake, and 60 per day in New Liskeard).
- All across Northeastern Ontario, there is a decline in population and the Temiskaming District is no exception. It has seen close to a 14% 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.
- Of the 371 beds in the district's five long-term care homes, it is estimated some 14% of residents in long-term care homes could be cared for in community with proper support.

The Realignment project is about the client, the patient, and the people. We need to acknowledge and build on past and current progress while committing to improving Access Quality and Value for the population that calls Temiskaming District home.

There are many facts, stats and figures that support delivering health care programs and services differently in Temiskaming District and in a manner that is more focused on people. This stark reality, coupled with the comments heard from more than 250 people in recent months, tells us that health system realignment in the Temiskaming 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 health service providers 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.

The NE LHIN has the Decision-Making Framework, as well as the governance and staff expertise in place, to decide on the best course of action, and work with communities to make health care history and create a better system for the people who call Temiskaming home. As NE LHIN CEO Louise Paquette recently shared:

"Our strength is unequivocally our people –
the people who built this region and the current communities who continue to shape the North."[8]

[8] Paquette, Louise, CEO, NE LHIN RLISS NE, Engaging Community in Transforming Health Care in Northeastern Ontario, Speech, April 13 2012, OHA Conference, Transforming Organizational Culture

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, by about 30% in 2030 (versus 22% for the rest of Ontario).

- 24% of people in Northeastern Ontario are Francophone and 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: TEMISKAMING DISTRICT FACTS

- 16 NE LHIN-funded health service providers receive $74 million dollars annually to care for the 32,634 people in the Temiskaming District
- Four family health teams, two nursing stations and one public health unit, funded by the Ministry of Health and Long-Term Care, also serve the district.
- Three hospitals receive $41.5 million annually (in LHIN funding) to operate 151 beds.
- Overall about 30% of those 151 beds are vacant.
- 25-43% of the beds have alternate level of care (ALC) patients in them who could possibly be cared for in community.
- On average, 120 people visit the emergency room of the 3 hospitals *combined* each day (ranging from an average of 12 per day in Englehart, 48 in Kirkland Lake, to 60 per day in New Liskeard)
- About 80% of the people visiting the three ERs are doing so for low acuity reasons (non urgent, non acute)
- According to 2011 Census data, the population in the Temiskaming District has decreased by close to 14% since 1996.
- About 25% of the area's hospital budgets go towards administration and support services.
- Of the 371 beds in the district's five long-term care homes, it is estimated some 14% 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. All decisions will be viewed in the context of this framework.

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 healthcare 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	Healthcare providers should offer services in an 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: 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)

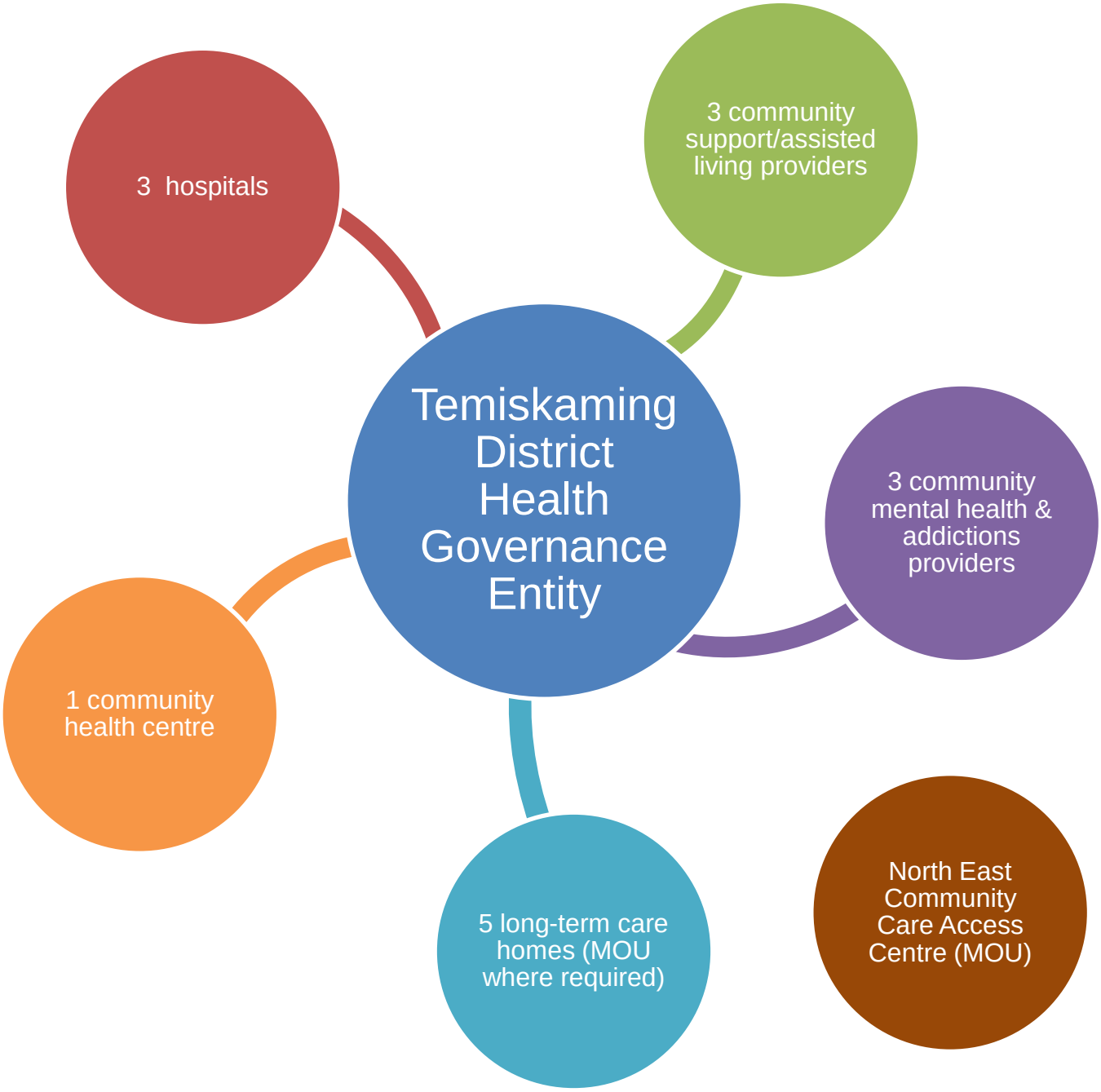
Outcomes/Metrics

Performance Indicators of the Ministry/LHIN Performance Agreement

APPENDIX E: LIST OF HEALTH SERVICE PROVIDERS

Hospitals	**Beds**	**Funding** (As at March 31 2012)
Englehart and District Hospital	30 beds	$5,424,677
Kirkland and District Hospital	62 beds	$18,538,978
Temiskaming Hospital	59 beds	$17,598,700
Total	**151 beds**	**$41,562,355**
Long-Term Care Homes		
Extendicare Kirkland Lake	100 beds	$4,036,944
Extendicare Tri-Town	60 beds	$2,279,604
Northview Nursing Home	48 beds	$2,048,162
Teck Pioneer Residence	81 beds	$2,994,232
Temiskaming Lodge	82 beds	$3,289,604
Total	**371 beds**	**$14,648,546**
Community Support Sector		
Centre de santé communautaire du Témiskaming		$134,084
Temiskaming Home Support/Soutien à domicile		$2,145,601
Temiskaming Palliative Care Network		$72,083
Total		**$2,351,768**
Mental Health and Addictions		
Board of Health for the Temiskaming Health Unit		$2,141,632
Pavilion Family Resource Center		$103,713
Canadian Mental Health Association Cochrane Timiskaming		$1,439,525
Total		$3,684,870
Community Health Centres		
Temiskaming Community Center/ Centre de santé communautaire du Témiskaming		$4,064,406
Total		**$4,064,406**
Regional HSP funding allocation for Temiskaming		
North East CCAC (estimated)		**$7,582,000**
Temiskaming Grand Total		**$73,893,945**
Primary Care (Currently funded by MOHLTC)		
Englehart and District FHT		
Haileybury Rural and Northern FHT		
Kirkland Lake FHT		
Great Northern FHT (New Liskeard)		
Elk Lake Nursing Station		
Matachewan Nursing Station		

APPENDIX F: VISUAL OF A REALIGNED HEALTH CARE SYSTEM IN THE TEMISKAMING DISTRICT



APPENDIX G: LINKS TO RESOURCES

Link to Temiskaming District Engagement Presentation: http://www.nelhin.on.ca/WorkArea/showcontent.aspx?id=12244

Primary Care Models & Integration

An Evaluation of Communication Practices in Family Health Teams http://www.nhsru.com/wp-content/uploads/2010/11/An-Evaluation-of-Communication-Practices-Final-Rpt.-Mar-31091.pdf

Healthcare Is at the Core of Everything We Do / Fact Sheet on the Value of Nurse Practitioners http://www.bcnpa.org/_tiny_mce/plugins/filemanager/files/Value_of_NPs_Fact_Sheet_November_7_2011.pdf

Integrating Physiotherapist into Family Health Teams in Ontario http://www.acreu.ca/pdf/pub5/09-02.pdf
Ministry of Health and Long-term Care – **Centres de santé communautaires /** Community Health Centres: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html

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

Examples & comments / primary care services with extended hours:

Stonechurch Health Clinic: many programs and services/ 3 teams: doctors, nurses, support staff, social worker, others HSPs. By appointment + available 24/7 days a week for urgent by phone. Weekend on-call clinic on Saturdays, Sundays and public holidays, to help deal with medical issues that cannot wait until regular clinic hours. (Can) http://www.stonechurchclinic.ca/clinic-info/finding-help-when-the-office-is-closed

Day One extended access family healthcare. See focused presentation on chronic disease management/diabetes. Open seven days a week, hours vary / Nurse Practitioners, Physicians, Physician assistants / large support staff (US). http://www.bcbsm.com/pdf/051110_DayOne_Morning_Best_Practice.pdf

Urgent care clinic in a hospital setting/open seven days a week: (US) http://www.tchosp.org/forms/healthlink_summer07.pdf

Calgary family health care clinic with MD access 24-7. *Note*: this is a private care model http://www.provital.ca/

Shagganapi Complex, Calgary, Community Health Centres provide a wide range of health services / extended hours / open alternate Saturdays / postpartum program is offered 24 hours/day, seven days a week /Telephone support offered at health centres is provided five days a week or after hours at 244-8351. Home visits are provided between 08:00 AM and 04:30 PM, seven days a week.

Beltlines Urgent Care Clinic Alberta, http://2.beltline.ca/node/674

Rural Health Challenges Being Addressed in other Countries

Addressing the shortage of primary care Physicians in Norway/success after increasing medical training options and new medical school: http://www.who.int/bulletin/volumes/88/5/09-072686/en/index.html
COAG Improving Access to Primary Care Services in Rural and Remote areas - s19(2) Exemptions Initiative: increasing access to primary health care services for rural and remote communities experiencing workforce shortages. This initiative recognises that where there is a lack of private GP practices, many rural and remote hospitals fulfil a role in meeting the primary care needs of their communities. http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/COAG_Improving_Access_to_Primary_Care_Services_in_Rural_and_Remote_areas-s19_2_Exemptions_Initiative

Developments in rural health planning and programming in Australia:
http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Your_health_care

Brazil and primary health care/ World Health Organization report: http://www.who.int/bulletin/volumes/86/4/08-030408/en/index.html

Topics: Literature

Abbeyfield model. A housing model for independent seniors who need common living. Community driven. http://www.abbeyfield.ca/houses--societies.html

Acute care Utilization report, LE LHIN 2006 http://www.ontla.on.ca/library/repository/mon/14000/262602.pdf

Clinical Continuity by Integrated Care http://interlinks.euro.centre.org/model/example/ClinicalContinuityByIntegratedCare

College of Physicians & Surgeons of Ontario Decision-making for the End of Life http://www.cpso.on.ca/policies/policies/default.aspx?ID=1582

Commission on the Reform of Ontario's Public Services (The Drummond report) http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf

Coordination between primary and secondary healthcare in Denmark and Sweden http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2663705/
Discharge Planning for Mental Health Sector http://www.ontla.on.ca/library/repository/mon/23010/294290.pdf

eHealth progress: January 2012. **Two Million People, and Counting/**North Bay, Sault Ste. Marie, Sudbury, Timmins and James Bay HUBS are now connected! http://www.hdirs.ca/LinkClick.aspx?fileticket=ODM%2Fjl%2BqX3k%3D&tabid=58

Frameworks of Integrated Care for the Elderly http://www.cprn.org/documents/49813_EN.pdf
HHR Steering Committee http://www.NE LHIN.on.ca/WorkArea/showcontent.aspx?id=12270

How Can Telehealth Help in the Provision of Integrated Care http://www.euro.who.int/__data/assets/pdf_file/0011/120998/E94265.pdf

Integrating Mental Health into Primary Care http://www.ncbi.nlm.nih.gov/books/NBK38628/

James Bay and Hudson Bay - Weeneebayko Area Health Authority (WAHA) http://www.weeneebaykohealth.ca/siteengine/activepage.asp

Mental Health/Ontario: Also see http://www.ontla.on.ca/library/repository/mon/24002/299251.pdf re 24-hour "safe Bed" option/Simcoe. See section 3 for Mental Health statistics.

Providing Integrated Health and Social Care for Older Persons in Denmark http://www.imsersomayores.csic.es/documentos/documentos/procare-providingdinamarca-01.pdf

Report on Personal Support Occupations (PSO) in the North East, 2010-2011 http://www.NE LHIN.on.ca/WorkArea/showcontent.aspx?id=12262

APPENDIX H: NURSE PRACTITIONERS

Nurse Practitioner Scope of Practice

A Nurse Practitioner (NP) is a nurse with advanced university education who works both independently and in collaboration with other health professionals to provide you with quality health care services. NPs take care of the physical, emotional, mental and social aspects of their clients' health needs.[9]

After the launch of the first Nurse Practitioner-Led Clinic, the MOHLTC has launched 24 more across Ontario. The following statement about the initiative, spearheaded in Northeastern Ontario, holds true for NPs providing primary care in FHTs, with the exception that in FHTs, the patient was not an "orphan" or "unattached patient", but rather, a patient within the roster of the MD.[10]

"Through a collaborative practice approach which includes Registered Nurses, Registered Practical Nurses, collaborating family Physicians, and other health care professionals, Nurse Practitioners provide comprehensive, accessible, and coordinated family health care services to populations who do not have access to a primary care provider (i.e. unattached patients)."

What does a Nurse Practitioner do?

NPs help keep their clients, client's family and community well. NPs provide care to individuals of all ages and focus on preventing disease. As a member of your health care team, NPs can:

- Diagnose illness and injuries
- Perform physical checkups
- Order and interpret diagnostic tests
- Provide counseling and education
- Provide treatment
- Order procedures
- Refer clients to other healthcare professionals and specialists
- Prescribe medication
- Manage chronic disease such as diabetes, COPD and asthma.

As of 2011, NPs can:

- Treat, transfer and discharge both inpatients and community outpatients from hospital. (NPs will be able to admit patients to hospital as of July 2012)
- Cast factors and reduce dislocations
- Order blood products and oxygen

[9] Nurse Practitioners in Ontario – Healthcare Is at the Core of Everything We Do. NPAO, 2012 http://npao.org/wp-content/uploads/2012/02/NPAO-brochure-jan12-web.pdf

[10] Nurse Practitioner-Led Clinics. MOHLTC, http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html