Rural Health Hub Implementation Guide

Table of Contents

Introduction

This guide is the latest in series of reports developed by the Ontario Hospital Association (OHA) to support the development of a rural health hub model for small, rural and northern (SRN) communities. It builds on the following reports:

> *"Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come"*, (OHA, May 2013)
>
> *"Enhancing Access Through Integration: How Small Rural and Northern Hospitals Are Innovating Partnerships and Building Health Hubs"*, (OHA, Nov. 2013)
>
> *"Rural Health Hubs Framework for Ontario"*, (Multi-Sector Rural Health Hub Advisory Committee, Jan. 2015)

The report has been prepared for SRN hospitals and their community partners to help them explore the benefits of a rural health hub model, and considerations when designing and implementing a rural health hub. The hub model is an integrated local solution that meets the needs of the community and is supported by the boards of all hub partners and their respective local health integration networks (LHINs).

Client/Caregiver Perspective

The goal in developing and implementing a rural health hub model is to provide better client care[1], and thereby improve health outcomes. As indicated above, the rural health hub model should be designed around the needs of the community (clients/caregivers). To help hospitals and their community partners better understand the client/caregiver perspective, it is recommended that hub partners follow the principles of patient centred care[2], namely:

1. Respect for patients' values, preferences and expressed needs
2. Coordination and integration of care
3. Information, communication and education
4. Physical comfort
5. Emotional support and alleviation of fear and anxiety
6. Involvement of family and friends
7. Transition and continuity
8. Access to care

---

1   The term "Client" will be used throughout the document in lieu of "Patient" to reflect a system-wide focus of the hub

2   The Eight Picker Principles of Patient-Centered Care originated with the Seven Dimensions of Patient-Centered Care, whose development as traced in the 1993 book *Through the Patient's Eyes*. Researchers from Harvard Medical School, on behalf of Picker Institute and The Commonwealth Fund, defined seven primary dimensions of patient-centred care.

Alignment with Health System Transformation

High-Performing Health Systems

The design and implementation of fully integrated rural health hubs are consistent with the best-practice evidence on high-performing health systems. Based on their research of international health systems, Ross Baker and colleagues (Baker, 2015) have identified the following 12 characteristics of high-performing health systems:

1. Focusing on Quality and System Improvement as the Core Strategy
2. Developing Leadership Skills
3. Enhancing System Governance
4. Investing in Capacity to Support Improvement
5. Improving Accountability and Performance Measurement
6. Enabling Comprehensive Information Infrastructures
7. Strengthening Primary Care
8. Improving Integration and Care Transitions
9. Enhancing Professional Cultures and Engaging Clinicians
10. Engaging Patients, Caregivers and the Public
11. Attending to Access and Equity Issues
12. Considering Population Health and Chronic Disease Management in Care Management Strategies

Together, these attributes comprise an important evaluation framework to support the implementation of rural health hubs as local, vertically integrated rural health systems.

Ministry of Health and Long-Term Care – *Patients First* Agenda

On August 7, 2016, Ontario Premier Kathleen Wynne announced that the government was proceeding with five rural health hub pilot projects in the following communities, situated in three different LHINs:

- Dryden Regional Health Centre
- Espanola Regional Hospital and Health Centre
- Haliburton Highlands Health Services
- Manitouwadge General Hospital
- North Shore Health Network (formerly Blind River District Health Centre)

The announcement is supported by a funding commitment of $2.5 million, spread over three years, which totals $500,000 for each rural health hub pilot site.

"A single funding envelope, single accountability agreement and single governance structure for providing leadership and oversight are also required.… The funding will enhance service integration at the five health care locations to help them become fully integrated health hubs that better meet the unique needs of rural communities and that provide high-quality care for patients.…It is expected that the hubs will evolve into fully integrated health care delivery systems by 2017-18." (OHA Healthscape website, Aug. 11, 2016)

Ongoing development and implementation of the Rural Health Hub model of local service integration also aligns with the Ministry of Health and Long Term Care's (Ministry) **Patients First** transformation agenda as described in Bill 41, *Patients First Act* 2016.

More specifically, rural health hub design and implementation align with the new LHIN sub-regions which will be the focal point for population-based planning, performance management, care coordination and service integration.
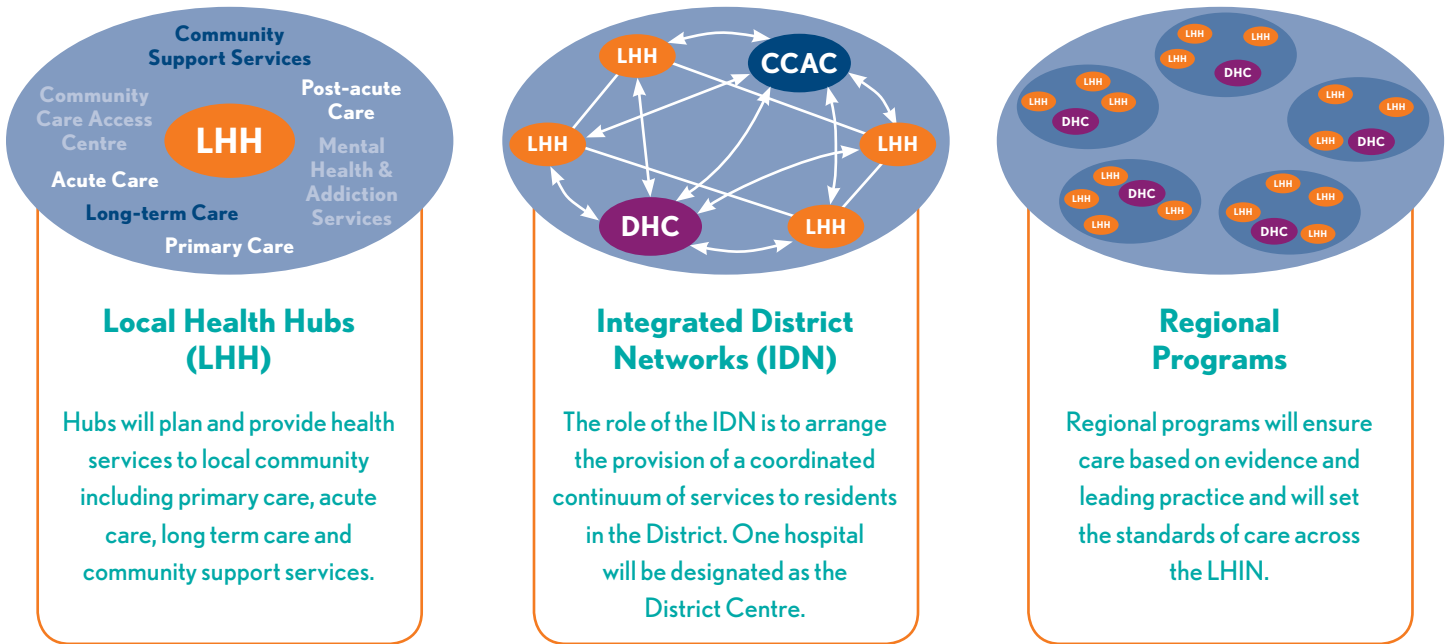
LHIN Integration Priorities

One of the implementation challenges associated with a rural health hub model is variation across LHINs in their approach to vertically versus horizontally integrated solutions. Many LHINs have historically focused on horizontally integrated solutions across different sized hospitals for certain regional clinical programs (e.g.,

surgery, oncology, etc.). The Health Links initiative has helped shift the focus towards more vertically integrated solutions for certain complex, high-needs patients. However, for SRN communities, the Health Links approach represents only a very small number of complex patients.

In contrast, the Rural Health Hub model is a vertically integrated solution for all local residents in the Health Hub catchment area.

Of the 14 LHINs, the North West LHIN's **Health Services Blueprint** (2012) aligns most closely with the development and implementation of the rural health hub model. Their integration strategy is based on the following local, district and regional levels:

Local Health Hubs (LHH)

Hubs will plan and provide health services to local community including primary care, acute care, long term care and community support services.

Integrated District Networks (IDN)

The role of the IDN is to arrange the provision of a coordinated continuum of services to residents in the District. One hospital will be designated as the District Centre.

Regional Programs

Regional programs will ensure care based on evidence and leading practice and will set the standards of care across the LHIN.

In addition to the five pilot project sites, rural health hub models supported by other LHINs include:

Community	Local Health Integration Network
Arnprior and Area Rural Health Hub Orleans Health Hub[4], and Barry's Bay	Champlain LHIN
Trenton Community Health Hub[5]	South East LHIN

---

3   The MOHLTC has recently announced over $5 million for this new 'suburban' Health Hub which will consolidate selected services from three hospitals and four community health service providers onto one site. The consolidated services include: ambulatory care, active rehab, diagnostic imaging, geriatric support and mental health services.

4   This recently announced Community Health Hub for Trenton will benefit patients by providing more integrated services closer to home including: primary and ambulatory care, addiction and mental health supports, chronic disease management, health promotion, community support services and care coordination.

Primer on Partnership Building

Collaborations provide opportunities to rethink how organizations within a community relate to each other and how they can collectively respond to the growing needs of their members and the community, often in the face of scarce resources.

Rural health hubs are based on strong local partnerships between and among health service providers. *What do we already know about collaboration and partnership-building?*

Research in the non-profit sector, including health care, confirms that successful collaborations are based on the following key ingredients:

Shared Vision
Collaborative Leadership
Shared Accountability
Process Orientation
Open, Transparent Communication
Involvement of Multiple Sectors
Finding "Early Wins"

We also know that[5]:

1. Collaboration depends upon trust and mutual respect

2. Trust and mutual respect grow as groups work together

3. People have to do things together to develop trust and respect

Rural Health Hubs are about collaborating across boundaries.

In his book *Working Across Boundaries*[6], Russell Linden, a management educator and author who specializes in organizational change methods, uses the following collaboration framework for groups of organizations that want to work together:

1. Ensure the 'basics' are in place

2. Begin forming relationships through initial exploratory meetings

3. Develop high stakes and sense of urgency

4. Create a constituency for collaboration

5. Build collaborative leadership

---

5   "The Community Collaboration Manual", The National Assembly of National Voluntary Health and Social Welfare Organizations

6   Russell Linden, Working Across Boundaries: Making Collaboration **Work in Government and Non-Profit Organizations**, (John Wiley & Sons, 2002)

Linden has developed the following checklist of questions to make sure the 'basics' are in place:

Have you:

- Got people at the table who can speak for all the stakeholder organizations?

- Discussed the parties' interests and goals regarding collaboration?

- Established a few simple ground rules for your collaboration discussions?

- Agreed that there is a compelling, shared interest that the parties want to pursue now?

- Felt comfortable asking questions and discussing doubts and concerns?

- Periodically asked if the process is clear and if the parties are comfortable with it?

- (If the stakeholder group is large), considered forming a smaller core group to take on certain leadership and management tasks?[7]

In terms of collaborative leadership, Linden has identified the following four qualities of Collaborative Leaders[8]:

1. Resolute and driven – especially about collaboration

2. Modest – a strong but measured ego

3. Inclusive – uses 'pull' instead of 'push' techniques

4. Collaborative mind-set – sees connections to something larger

A collaborative leadership style distributes power, authority and responsibility across the group. This type of leadership style fosters shared commitments, helps resolve conflicts, facilitates lasting relationships and stimulates effective action[9].

> *Collaborative leaders use 'pull' to engage people in collaboration in a variety of ways:*
> - *They give others control, autonomy and an invitation*
> - *They make use of personal commitment and belief*
> - *They make use of strategic thinking*
>
> - Linden, 2002, p. 156

Some have described this as 'servant leadership':

The servant-leader shares power, puts the needs of others first and helps people develop and perform as highly as possible….Servant leadership seeks to move management away from "controlling activities" and toward a more synergistic relationship between parties [10].

---

7   Linden, 2002, p. 90

8   Linden, 2002, p. 152

9   Anderson-Butcher, 2004, p. 3.3

10 The Center for Servant Leadership: https://www.greenleaf.org/what-is-servant-leadership/

Some Lessons Learned from Health Hub CEOs

In developing this implementation guide, CEOs of more mature and longstanding rural health hubs were interviewed to better understand what approaches, techniques and strategies they used to strengthen stakeholder partnerships within their rural health hub. The following are some lessons learned:

Focus on the Needs of Clients

Initial rural health hub discussions should always stay focused on the needs of clients/caregivers not on the interests of providers to help foster synergy, openness and collaboration. Communicating a common vision for all partners around better serving the needs of the community helps to mitigate resistance to change.

Focus on Opportunities

Implementation of the health hub model should not be seen as a 'take-over' by one party. Start conversations with a discussion about challenges and what can be done to address them.

Do The Right Thing
(even if it's not in the hospital's best interest)

If a new local integration strategy or initiative is good for patients and good for one or more community partners, find ways to support it even if it's not always in the financial interest of the hospital. It's the right thing to do if it's good for patients/clients.

Building Local Relationships is Key

Successful health hubs are based on strong working relationships between hub partners. By working together, you are building something better for the future.

Use New Language to Change Hospital-Centric Culture

Hospital-based acute and emergency services are only one part of a rural health hub model. Board members of current and emerging rural health hubs can help to avoid siloed thinking by defining themselves as governors of a local health system or a local health care corporation.

Bring the Entire Organization Along with You

It is very important to develop and implement a strong communication strategy for staff, physicians that highlights the overall goals (the 'why') of a rural health hub and the importance of building strong partnerships.

Create Quick Wins

For hospitals and community partners that are in the early stages of their collaboration journey, find ways to create some early success stories. Success generates success.

Haliburton Highlands Health Services is one of the most comprehensive rural health hubs in Ontario and was recently announced as one of the five rural health pilot project sites. Lessons learned from their 'integration journey' thus far are noted below.

Lessons Learned from Haliburton Highlands Health Services' Integration Journey:

Leadership: Critical to success; need positivity, commitment, and persistence; focus on what is best for the community

Project Management Resources: Should include dedicated project management support rather than adding stress to operational responsibilities of CEO and Management Team

Communication/Community Engagement: Should be done regularly and consistently with all internal and external stakeholders who would be directly impacted as well as the general public, using a detailed Communication Plan

Change Management: Integration is not easy and one must not underestimate organizational anxiety and upheavals that may result, including staff/management departures; need to have a comprehensive change management plan that includes significant communication and educational components.

LHIN Direction and Support: Strong and ongoing support is needed from the LHIN to support integration planning, including providing additional resources if required.

Integration Has Benefits: Alignment with LHIN / Provincial strategies yields organizational benefits; for example, Community Services Enhancements and funding.

SOURCE:

http://www.hhhs.ca/administration-and-board-contacts/integration-strategy

A Note About Hub Language:

The rural health hub model is a vertically integrated solution for rural and northern communities aimed at improving the quality and cost-effectiveness of patient-centred health care. Not all communities will choose *Rural Health Hub* as the descriptor of their local integration model. It is important that the hospital with its community partners choose language that resonates with everyone. It is also important to consider the language that is used when engaging with patients/clients so that everyone understands what this means for patient care delivery.

Roles and Responsibilities of Key Players

LHINs

To ensure a rural health hub is an accepted model of local integration in sub-LHIN integration plans and strategies [11]. This includes:

- Investing in physician/nurse practitioner recruitment

- Providing neutral facilitation resources to groups of health service providers (e.g., Physicians, Family Health Teams etc.) that want to explore and potentially implement the rural health hub model.

- Supporting health hub partners in preparing required LHIN documentation for voluntary integrations.

- Intervening and providing support (such as dispute resolution) when rural health hub partners are encountering roadblocks.

- Overseeing the establishment and negotiation of consolidated budgets and a single service accountability agreement for approved rural health hub pilot projects.

Hospitals

- Hospitals can help facilitate initial health hub discussions with community partners and offer administrative support at the outset.

- With the support of their hub partners, hospitals can be responsible for preparing the documentation necessary to support rural health hub discussions such as compiling background information, data analysis, funding proposals, business plans, etc.

- With the support of their hub partners, hospitals can provide access to specialized expertise to help support rural health hub discussions (e.g., legal, financial, change management, etc.).

- Hospitals can help engage clients in the design of a local health hub model. This should include identifying community candidates and preparing them to effectively participate in these discussions. It is important to create a safe environment that encourages honest and productive conversations, and to follow up with new developments and updates to ensure that they feel involved and engaged throughout the process.

Community Partners and Providers

- Community partners and other health providers can participate in rural health hub discussions as equal partners and contribute in-kind resources to support the process.

- Partners can work with hospitals and other community providers on collaborative leadership approaches.

- Community partners and providers can help to engage the "community" in the design of a rural health hub model. This should include identifying community candidates (clients/caregivers) to engage with, preparing these candidates to be able to effectively participate, creating a safe environment to have honest and productive conversations, and following up after to let them know what was heard.

---

11 Examples of how this has been done are through an Integrated Health Service Plan or the LHIN providing the hospitals with transformation funds to support health hub development.

It is recommended that hospitals, community partners and other providers use change management principles and strategies throughout their health hub journey. This includes a robust communication strategy for both internal (staff) and external (community) stakeholders. The 'why' of change can never be communicated enough and as new integration solutions are proposed, staff will want to understand what it means for their jobs. Community leaders will also expect to be updated as rural health hub discussions progress.

Clients/Caregivers

- Actively contribute to the planning, design, implementation and evaluation of the rural health hub.

- Community members are best engaged early in the development of the rural health hub. There is a continuum of engagement, and it is up to the partner organizations to decide which model is appropriate for their local context. There is a greater likelihood that the rural health hub will meet the needs of the community if they are considered to be a partner in the development process (partnership is on the far right of the engagement continuum). Organizations are encouraged to challenge their existing processes and consider how they can actively involve community members in assessing the current state, building the desired future state, prioritizing any recommendations for improvements, and defining what success will look like.

Please see resources section for community engagement resources.

Key Change Management Principles:

1. Address the human side of change systematically
2. Change starts at the top and begins on day one
3. Real change happens at the bottom
4. Confront reality, demonstrate faith, and craft a vision
5. Create ownership, not just buy-in
6. Practice over-communication
7. Explicitly address organizational culture
8. Prepare for the unexpected
9. Speak to the individual as well as to the institution

Senior leaders need to communicate about:
- Why the change is necessary
- The risk of not changing
- How the change aligns with organization's vision and strategic directions

Supervisors/managers should communicate about:
- How the change impacts the employees and their teams
- How the change might affect their day-to-day responsibilities
- What's in it for me (WIIFM)
- What's in it for us (team or workgroup)

SOURCES: Strategy& (formerly Booz and Company), *"Ten Guiding Principles of Change Management"*; and PROSCI, *"Seven Principles of Effective Change Management"*

Key Implementation Process Steps

Balancing Local Relationship Building with LHIN Integration Requirements

There is no single best path to creating a rural health hub.

In some communities where there are more mature or advanced health hub models in place, the development of an integrated service delivery model occurred incrementally over many years and was built one partner or sector at a time. In many cases, hospital leadership provided the overarching vision of co-locating hospital and non-hospital services in some type of 'one-stop-shopping' model. In some cases, the strategy was more opportunistic as a result of changes in local leadership, organizational capacity or Ministry funding. For some more remote northern communities, the Ministry invited the hospital to manage a particular community program because there were no other sponsorship options.

More recently, some newer rural health hubs have been created through LHIN-facilitated processes. In the case of the Haliburton model, the Central East LHIN initiated a facilitated integration process with all its health service providers which led to the development of a 'single entity' that would deliver all LHIN-funded services within Haliburton. As noted earlier, the North West LHIN is leading the implementation of its 10-year Blueprint by supporting the development of Integrated Health Care Organizations (IHCOs) in several 'early adopter' communities.

A locally driven process versus a LHIN-facilitated process are two very different integration approaches, each with pros and cons. In terms of finding the 'best of both worlds', a 'hybrid' approach is recommended that strikes a balance between these two approaches based on organizational strengths:
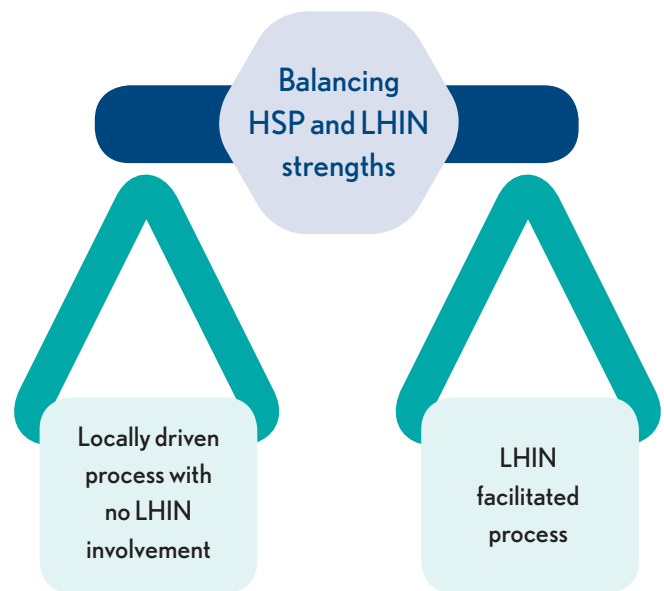
The recommended 'hybrid' approach, described in the rest of this section, is based on strong local relationship-building between the hospital and its community partners **before** formal LHIN engagement. Once the hub partners have developed a sufficiently strong working relationship, then engagement of the LHIN can proceed using a **voluntary integration** strategy.

Recommended Implementation Steps

The following key process steps are recommended for implementing vertically integrated rural health hub models. Each group of hub partners needs to decide where best to start their 'integration journey' depending on the extent of relationship building and integrated health services planning that has already taken place. While the steps are illustrated below as sequential, some phases can be accomplished concurrently.

1. Relationship Building Phase

2. Community Needs Assessment Phase

3. Voluntary Integration Phase

4. Fully Integrated Rural Health Hub
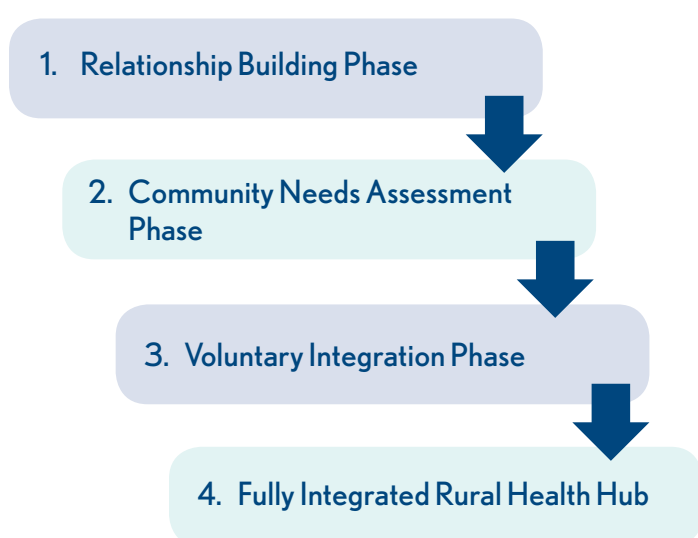
It is recommended that the first two phases be facilitated by a lead organization, in collaboration with all partners and community members. In those communities without a hospital, a community health hub model could be explored instead. As noted earlier, a collaborative leadership style is critical.

Successful voluntary integration in Phase 3 depends on strong collaborative partnerships **already being in place** prior to formal LHIN engagement. During Phases 1 and 2, hub partners need to keep their LHIN CEO apprised of discussions so that the hub development process can successfully move to Phase 3 with LHIN support.

Phase 1: Relationship-Building

Relationship-building between rural health hub partners should be based on finding collaborative solutions to improving client care.

In this section, the focus is on sector-specific partnership initiatives. Often, these have been identified in the hospital's strategic plan. In terms of partnering, each sector has some unique attributes and in this section, we identify some of those attributes and provide some collaboration examples. In the next section, we focus on the creation of multi-stakeholder committees that would support a community needs assessment process.

There is also an opportunity early in the relationship-building phase to assess alignment between strategic plans. What are the hospital's integration/collaboration/partnership priorities and do they align with priorities in the strategic plans of community partners?

While relationship-building is described as the first phase of rural health hub development, the reality is that relationship building is an on-going process for health hub partners and community members.

PARTNERING WITH PRIMARY CARE

Building strong relations with the primary care sector means first understanding how it is organized. Health Force Ontario identifies the various family practice models that exist in Ontario (below). Additional details about the models are found in Appendix A.

- Community Health Centres (CHCs) – introduced in the 1970's
- Comprehensive Care Model
- Family Health Group (FHGs) – introduced in 2002
- Family Health Networks (FHNs) – introduced in 2002
- Family Health Organizations (FHOs) – introduced in 2005
- Family Health Teams (FHTs) – Wave 1 FHTs started in 2005

Each model has different financial incentives and disincentives with a wide variety of physician payment plans, so it is important to understand which primary care model or models local family physicians belong to. The models also have different governance structures. In many cases, the local family physician group **is** the governance structure, but for FHTs, governance arrangements are more complex.

Understanding the primary care governance and funding model(s) in your community is an important first step in building relationships with local family physicians. Building

constructive working relationships with physicians is also based on:

- Two-way dialogue;
- Understanding their values, interests and motivations; and
- Recognizing and respecting their front line role as client care advocates and system integrators.

This is what physicians have said about engaging them as part of relationship-building:

What Matters to Docs?

- High quality patient care
- Time is valuable
- Evidence is meaningful
- Input and influence
- Recognition
- Relatedness and reciprocity – desire to connect and feel valued, but with the understanding that it's a two-way street

(SOURCE: "Engaging Physicians in an integrated Environment", Sarah Newbery M.D., OHA Rural and Northern Conference, May 6, 2016)

Suggestions for Maximizing Physician Engagement

1. Invest in Trusting Relationships with Physicians
   - Including physician wellness

2. Invest in Physician Leaders (e.g., PMI courses)

3. Connect Hospital Values to Physician Values/Interests:
   - Support their work
   - Support their careers
   - Support their calling: caring for others

(SOURCE: "Physician Engagement", Paul Preston M.D., OHA Rural and Northern Conference, May 6, 2016)

In many rural and northern communities, through this process of relationship building with primary care services generally, and family physicians specifically, a wide range of acute care-primary care partnerships have developed. Some examples are:

Figure 1: Examples of Hospital-Primary Care Partnerships along the Integration Continuum

Co-location:

The Hanover hospital provides office space to the Hanover FHT and has an adjoining building which houses the Hanover Medical Clinic.

Clinical Integration:

The South East Grey Community Health Centre (CHC) has an agreement with the South Bruce Grey Health Centre to follow-up with patients within 24 -hours of post-hospital discharge (instead of the current benchmark of 7 days post-discharge).

Collaborative Governance:

The Espanola Regional Hospital and Health Centre has a management services contract with the Espanola Family Health Team. The FHT and hospital boards have cross-appointments and have developed a single Quality Imporvement Plan.

Full Integration:

The Deep River & District Hospital governs and manages the North Renfrew Family Health Team as part of the North Renfrew Health Campus.

In 2011, the Rainbow Valley Community Health Centre formally integrated with the St. Francis Memorial Hospital in Barry's Bay.

PARTNERING WITH COMMUNITY MENTAL HEALTH AND ADDICTION SERVICES

A commitment to enhanced and more integrated mental health and addiction services figures prominently in all LHIN strategies. However, for many rural and northern communities, there continues to be considerable variation in the type and amount of services available for clients with mental health and/or substance abuse challenges. Many of the community-based mental health services in place today were funded to support individuals with a serious mental illness. Key services include Assertive Community Treatment (ACT) teams, case management, crisis support, and supportive housing. But for many individuals with a moderate mental illness who are not connected with a case worker, there are often insufficient community supports, and in times of crisis, they overly rely on emergency department (ED) visits.

Partnering with the Community Mental Health and Addictions sector means understanding the range of local clients that need help; whether that help is available locally, through tele-psychiatry, or requires a visit to a regional service provider; and how many individuals need more regular case management support versus more episodic care.

The Ministry, as part of its Mental Health Strategy, is defining a core basket of services to support local capacity planning for mental health and addiction services. The following service categories have been proposed (see Appendix B for more detail):

- Targeted Prevention Services
- Information, Assessment and Referral Services
- Counselling and Therapy Services
- Peer and Family Capacity Building Support
- Specialized Consultation and Assessment
- Intensive Treatment Services
- Crisis Services

For many small, rural hospitals, it is often the lack of 24/7 community crisis response capacity that leads to unnecessary visits to the hospital EDs. Hospitals and community mental health providers need to review together the types of clients who come to the ED and how they might be better supported in partnership with community providers.

In addition to understanding how the hospital might help to provide clinical supports to mental health and addiction clients, the hospital should also review what types of administrative and back office supports can be shared or purchased since most community-based providers have more modest operating budgets.

Hospitals and their mental health and addiction partners have created a broad array of clinical, administrative and governance partnerships (see Figure 2).

Figure 2: Examples of Hospital-Mental Health/Addiction Partnerships along Integration Continuum

Co-location:
Campbellford Community Mental Health Centre is a key partner on the Campbellford campus

Clinical Integration:
Mental Health Grey Bruce is a legal administrative alliance between the hospital and two community partners that supports shared staffing in geographic teams.

Collaborative Governance:
The Dryden Regional Health Centre governs and manages the Dryden Regional Mental Health and Addiction Services, and in so doing has created a numerous administrative and operational efficiencies.

Full Integration:
The Meno Ya Win Health Centre in Sioux Lookout manages a full range of outpatient & community based mental health and addiction services, as aell as a Traditional Healing program for First Nation Residents.

PARTNERING WITH LONG-TERM CARE

Long-term care encompasses a wide variety of services for both seniors and younger individuals with long-term care requirements. This latter group of clients includes individuals with physical disabilities, developmental disabilities, acquired brain injury and Alzheimer's disease/dementia.

Long-term care services funded by LHINs typically fall into three broad categories:

- Home care services coordinated by the community care access centres (CCACs, which are described in the next section)

- Facility-based care
  - Including long-term care homes, ELDCAP beds[12], respite care, specialized geriatric assessment, geriatric clinics

- Community support services
  - In-home personal supports, supportive housing, assisted living, adult day programs, primary care/wellness clinics, exercise programs, transportation, meals on wheels

Many small hospitals already govern and manage long-term care (nursing home) beds either within the hospital (ELDCAP) or in an adjoining or nearby facility. Because of the Ministry funding methodology for long-term care beds, some hospitals have expressed concerns over the past few years that insufficient funding has meant running a deficit in their non-profit long-term care operations. Sometimes this deficit has been 'subsidized' through the hospital's budget. This is one of the many reasons that a fully integrated rural health hub requires a single consolidated budget for all services.
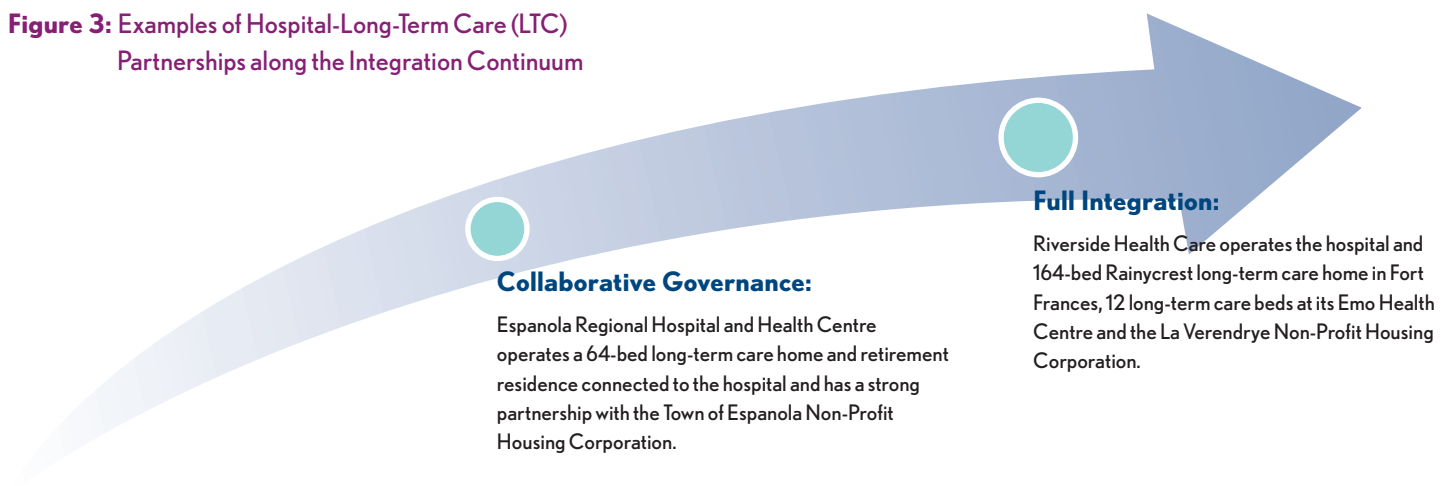
While some hospitals are exploring nursing home licensing opportunities to meet demands where community supports alone are not sufficient, the trend in health care is towards more assisted living arrangements and supportive housing options:

> As part of its multi-year Access to Care Strategy, the South West LHIN is increasing the capacity of Assisted Living/Supportive Housing/Adult Day Program services and supporting the implementation of 'Assisted Living Hubs' defined as:
>
> - *A geographical area where scheduled and unscheduled Assisted Living services are accessible on a 24-hour basis for clients that meet the eligibility requirements for High Risk Seniors or Special Populations. Clients who live in a variety of settings within the boundaries of the "hub" (private sector or non-profit housing such as individual, single family homes, townhouses, condominiums, housing co-operatives or traditional social housing buildings/apartments) may access these services.*

Figure 3 describes some examples of successful hospital-long-term care partnerships.

Figure 3: Examples of Hospital-Long-Term Care (LTC) Partnerships along the Integration Continuum

Collaborative Governance:

Espanola Regional Hospital and Health Centre operates a 64-bed long-term care home and retirement residence connected to the hospital and has a strong partnership with the Town of Espanola Non-Profit Housing Corporation.

Full Integration:

Riverside Health Care operates the hospital and 164-bed Rainycrest long-term care home in Fort Frances, 12 long-term care beds at its Emo Health Centre and the La Verendrye Non-Profit Housing Corporation.

---

12 **ELDCAP beds** are licensed nursing home beds, funded through the Elderly Capital Assistance Program (ELDCAP), and co-located within or near small hospitals in northern communities. They are subject to some but not all requirements of the *Long Term Care Homes Act* (2007) and are funded through a hospital's global budget.

PARTNERING WITH CCAC (Home Care)

Community Care Access Centres (CCACs) are responsible for:

- Information and referral;

- Long-term care assessment and facility placement; and

- Contracting with non-profit and for-profit home care agencies that provide professional health services (nursing and other allied health professionals) to patients who qualify for CCAC home care

In the last few years, there has been considerable emphasis on transitioning patients more quickly out of hospital through successful CCAC programs such as Home First [13].

With the restructuring of CCACs as a result of Bill 41, LHINs will become responsible for managing home care contracts with a variety of service providers. Some hospitals have already taken the initiative to become pre-qualified service providers and have been awarded CCAC service contracts (e.g., Dryden, Renfrew). As the Ministry and LHINs gain more experience with bundled payment models, there will be future opportunities to make home care funding part of the rural health hub budget with the hope that these changes enhance care coordination and provide seamless transitions across the continuum.

Some innovative examples of Hospital-CCAC partnerships include:

- The Champlain Community CCAC and Arnprior District & Memorial Hospital (ADMH) have combined the roles of the CCAC Case Manager and the ADMH Geriatric Emergency Management (GEM) Nurse. The Case Manager/GEM Nurse works with the care team in the ED to identify high-risk, frail seniors and screen for potential challenges. From there, the nurse works with the patient, family and inter-professional team to formulate an optimal plan and ensure appropriate

referrals and follow-up. The Case Manager/GEM Nurse also serves as an educational resource to health care practitioners regarding what services are available.

- The Dryden Regional Health Centre has a contract with the North West CCAC to provide physiotherapy and occupational therapy services to clients in their home or school in the communities of Dryden, Vermilion Bay, Sioux Lookout and Ignace.

PARTNERING WITH PUBLIC HEALTH

> *Hospitals have historically struggled to engage in prevention and health promotion activities because they have not been incentivized or held accountable for doing so.*
>
> - J. R. Graham, "Accountability for Community Benefit: A Reasonable Expectation for Canadian Hospitals", Health Policy, Vol. 11, No.4, 2016, p. 20

As part of Ontario's health system transformation, there is an increasing emphasis on a population health approach based on the determinants of health. As a result, all health service providers are having to re-consider and take a fresh look at what they can do, both individually and collectively, to support disease prevention and health promotion strategies in their local communities. A number of small hospitals have identified '*healthy rural communities*' as part of their vision.

Ontario's public health units have long been considered the lead agencies for this type of prevention and promotion work. Their work is guided by the *Health Promotion and Protection Act* (1990) and *Ontario Public Health Standards* (revised 2016). The latter document outlines the principles, goals, requirements and foundational standards for the following public health programs:

- Chronic Diseases and Injuries

- Family Health

- Infectious Diseases

- Environmental Health

- Emergency Preparedness

---

13 Home First is a philosophy, a shift in thinking where the focus is on discharging elderly patients home after an acute episode in hospital instead of assuming that a long-term-care home is the only option. Home First provides patients with an appropriate level of care in the comfort of their own home. It includes CCAC services such as nursing and personal support and community support services.

As part of their work, all health units are expected to partner with health care providers and other sectors such as education, social services, housing and the environment. While hospitals have typically turned to their local health unit for epidemiological data on community health status, all five of the public health program areas noted above can impact on the acute and non-acute services provided by hospitals.

The Determinants of Health include:

- Income and social status
- Social support networks
- Education and literacy
- Social and physical environments
- Personal health practices and coping skills
- Healthy child development
- Biologic and genetic endowment
- Gender
- Culture

Some interesting examples of Hospital-Public Health partnerships include:

- The Grey Bruce Health Network is a longstanding alliance between the three Grey Bruce hospital corporations, the Grey Bruce Health Unit and the Southwest CCAC which supports collaborative projects of mutual benefit through a legal agreement.

- The Manitouwadge General Hospital negotiated the transfer of funds from the Health Unit so that the hospital could provide a defined basket of local public health education services. This was consistent with one of the pillars in the hospital's strategic plan: *"To develop and implement a partnership approach to prevention and health promotion to delay onset of chronic conditions and their effects".*

Phase 2: Community Needs Assessment

The 2015 report from the provincial Multi-Sector Rural Health Hub Advisory Committee recommended the following needs assessment steps for groups of providers that want to begin a collaborative investigation of a rural health hub model:

A core group of local providers and community members should work together to address their shared need for improved health care service integration and undertake the following review:

PART A – Community Needs and Service Inventory

- What is the size of the community and the population density?

- What are the health and social service needs of the population?

- Who are the current health and social service providers in the community and what services do they provide (inventory of providers and services)?

- What are the critical gaps in available service?

- Consider health equity using available validated tools.

PART B – Referral Relationships and Partnership Inventory

- What types of relationships and collaborations already exist among these service providers?

- Beyond the local providers, what are the linkages to other levels of care and care providers? For example:
  - Patients leaving for specialized services and/or diagnostics
  - Physicians visiting the community for specialist clinics and/or services
  - OTN and/or other Telehealth services for access to specialists and/or services
  - Are there formal relationships with larger centres for referrals and/or repatriation of patients?
  - Common patient record

- Bring together willing participants/stakeholders for facilitated analysis of local strengths, weaknesses, opportunities and threats (SWOT) related to hub implementation.

To this recommended needs assessment process, we added:
Part C – Process Mapping for Patient Journey

- Involve groups of consumers (patients, clients and family members) in a facilitated process-mapping exercise to understand different patient journeys through the local health system. Focus on the transition points (i.e. the 'hand-offs') between service providers and collect patient stories to understand where system improvements can be made.

The work of a multi-sector committee in this phase will help with the relationship-building processes which began in Phase 1. The goal of the Hub partners in this phase is to develop consensus and a shared understanding of:

- Two-way dialogue;
- Capacity of existing local health resources;
- Key service gaps;
- Current partnership and referral arrangements;
- Patient and family experiences as they navigate the local health system; and
- Possible solutions for creating more integrated services.

Phase 3: Voluntary Integration

Under the Local Health System Integration Act (LHSIA), all health service providers: *"must identify opportunities to integrate the services of the local health system for the purpose of providing appropriate, coordinated, effective and efficient services"*.

As per LHSIA, the following integration approaches can be used to advance integration within the LHIN:

- **Providing or Changing Funding**: e.g., transfer of program funding or project funding distributed to multiple organizations and services (as outlined in Section 19 of LHSIA);
- **Facilitating or Negotiating integration:** e.g., integration activities among two or more individuals or agencies, involving at least one LHIN-funded HSP, and facilitated or negotiated by the LHIN (as outlined in Section 25 of LHSIA);
- **Requiring Integration:** e.g., the LHIN or MOHLTC may require HSPs to provide or cease to provide services, or transfer services from one location or HSP (as outlined in Section 26 of LHSIA); and
- **Integration Initiated by HSPs:** e.g., integration activities voluntarily initiated by HSPs (as outlined in Section 27 of LHSIA).

In most instances, it is the fourth, voluntary approach which best meets the needs of the LHIN and the hub partners. The group process work is handled by the hub partners rather than LHIN staff. It allows the hub partners to maintain overall control of the process. If the LHIN supports the intended integration, then it may provide funding for neutral facilitation services to support the hub development process.

Once there is sufficient trust developed among the hub partners and there is consensus about one or more integrated solutions that are worth pursuing, the partners should formally engage the LHIN by indicating that they would like to pursue a voluntary integration.

Similar to phases 1 and 2, the voluntary integration phase should be overseen by a rural health hub steering committee. This may or may not be the same multi-stakeholder committee involved in earlier phases. It will be important during this phase that the oversight committee includes board governors from participating health care organizations as well as LHIN representatives.

The types of integrations that would be expected during this phase would be clinical and/or administrative shared resources/services, but may also include exploration of collaborative governance models.

During this phase, participants should also prepare a **gap analysis** to describe current state vs. preferred state in terms of local hub model development. The framework from the original rural health hub paper identified two key dimensions for analyzing how integrated the partners currently are:
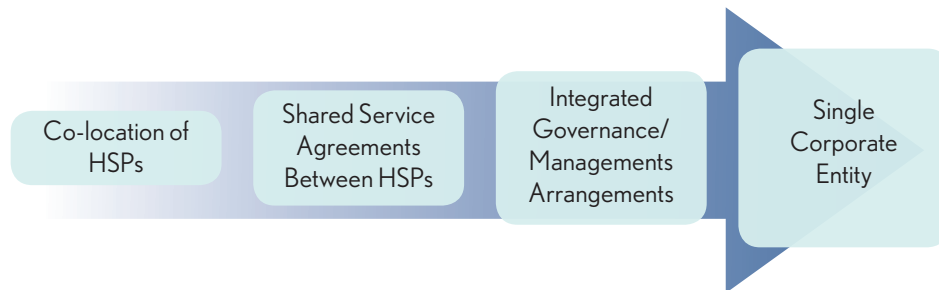
Examples of integration activities that would require LHIN approval include:

- *Coordination of services and interactions that have a significant direct impact on the use of services or resources funded by the LHIN, the Service Accountability Agreement, or the service system (e.g., transfer of a program or funding).*

- *Partnerships that significantly change the delivery of services including the co-location of health service providers that generate significant cost savings; impact on care and services; or back office support (e.g., purchasing, Human Resources, Information Technology).*

- *Partnerships that significantly change the way that people may access or receive services (e.g., implementation of a centralized access system).*

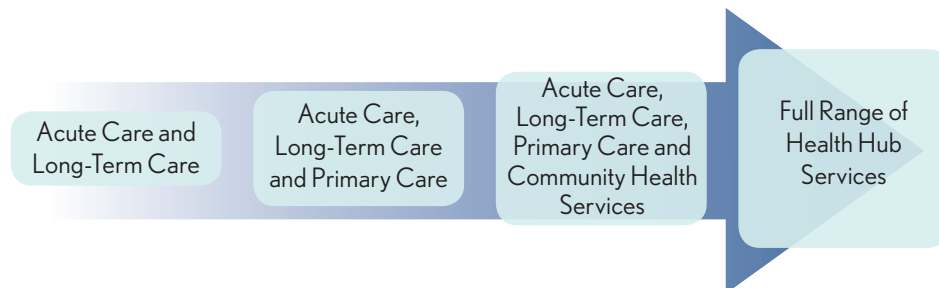-South West LHIN Integration Policy, Nov. 2015

Degree of Integration:
how **formalized** are the clinical, management and governance linkages between health service providers?

Co-location of HSPs → Shared Service Agreements Between HSPs → Integrated Governance/ Managements Arrangements → Single Corporate Entity

Degree of Comprehensiveness:
what **range of services** are locally available and co-located?

Acute Care and Long-Term Care → Acute Care, Long-Term Care and Primary Care → Acute Care, Long-Term Care, Primary Care and Community Health Services → Full Range of Health Hub Services

The gap analysis will help the partners to understand existing service and sector relationships and what partnerships need to be strengthened to support a comprehensive rural health hub model.

Following Phase 3 and with the assistance of a Decision Making Framework, if rural health hub partners decide that they would like to move to a fully integrated rural health hub and the LHIN supports this goal, then the hub partners in collaboration with the LHIN should move to the final Phase 4. The LHIN and the hub partners will need to determine if this final phase should be a voluntary or facilitated integration.

Phase 4: Fully Integrated Rural Health Hub

For fully integrated rural health hubs, the creation of a single governance entity with a consolidated budget and single accountability agreement can be accomplished as either a voluntary or facilitated integration under LHSIA.

As noted earlier, the implementation of the North West LHIN's Health System Blueprint is most closely aligned with the design and implementation of a fully integrated rural health hub model. In terms of designing a consolidated governance and management structure for a rural health hub, the North West LHIN recommends the following structure:

In the future state, the rural health hub/community in the North West LHIN would have one LHIN-funded Integrated Health Care Organization (IHCO) that provides end-to-end integrated services at the local level including public health, primary care, mental health, management of chronic diseases, acute care, home and community care, long term care, and palliative care. The IHCO would have one skills-based Board of Directors and one administrative body accountable for population health outcomes within the context of value based health care. This board would be responsible for delivering the full basket of services across the continuum of care in the local community. It is expected this board will align strategic direction and related planning and performance, including Quality Improvement Plans across all levels and subsidiaries of the organization.

Therefore, the rural Health Hub IHCO is a local, integrated health service delivery model where most, if not all sectors of the health system, are formally linked in order to improve patient access. The intent is improved coordination of care, improved access to community options, improved patient navigation and care closer to home.

The proposed organizational structure for an ICHO is as follows:
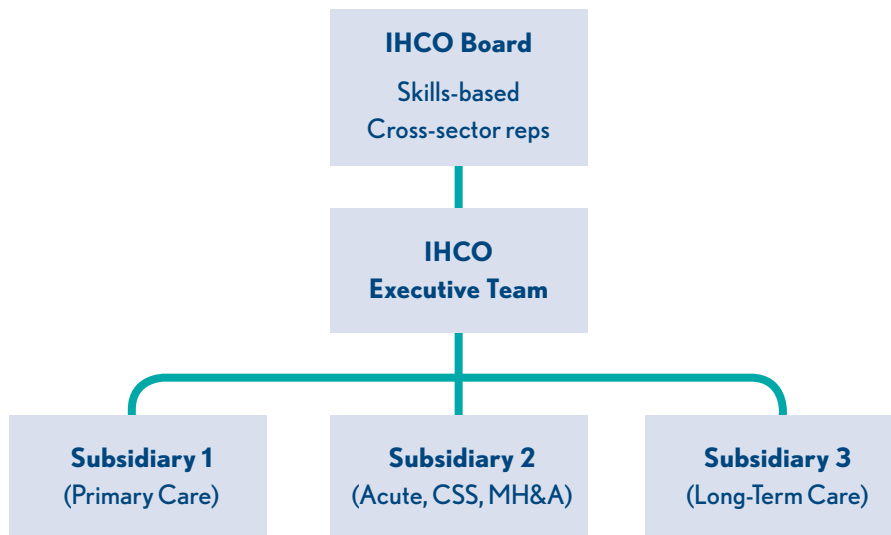
In terms of moving forward with piloting this integration model, the LHIN has identified 2 'early adopter' communities[14]:
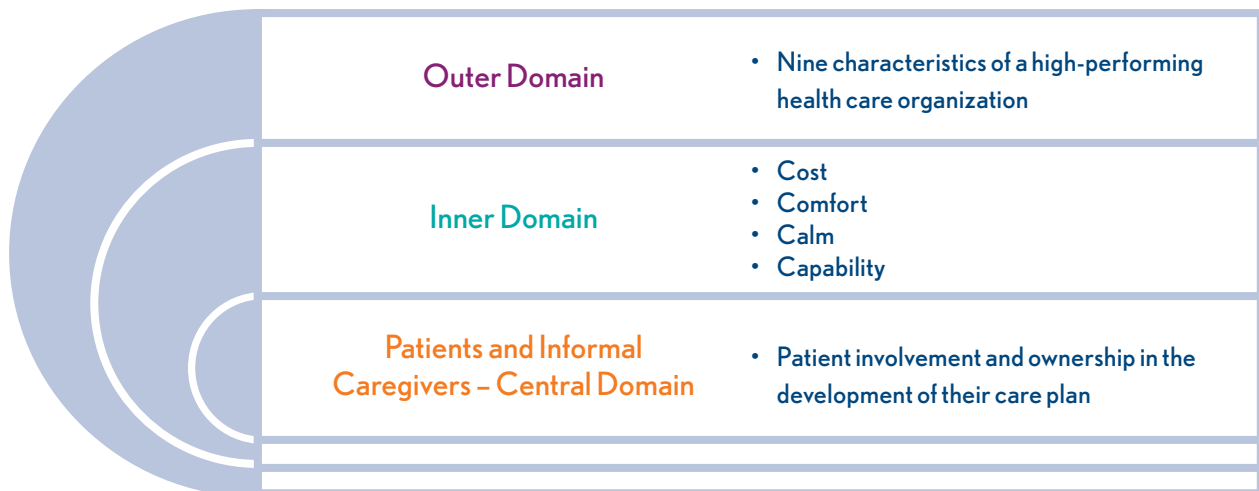
- Dryden
- Manitouwadge

---

14   Also recently announced by the Premier as two of the five rural health hub pilot project sites.

Prior to the recent Premier's announcement, the North West LHIN had established the following Year 1 process steps for the creation of an IHCO – the single governance entity that will oversee each designated rural health hub:

Figure 4: Year 1 Process Steps for Local IHCO Implementation

Stage 0 — **Defining the Scope** - Develop an IHCO Charter for the work to be undertaken including project governance, change management, communication plan

Stage 1 — **Establish a Working Group** - Based on the Charter, determine group leadership, membership, terms of reference, guiding principles

Stage 2 — **Current State Analysis** - Define opportunities across hub partners for inclusion in the future state

Stage 3 — **Define Future State** (including vision, gap analysis)

Stage 4 — **Submit Plan for LHIN approval**

IHCO implementation will take place over three years and will be based on an evaluation framework using the following three inter-related performance domains:

Outer Domain	• Nine characteristics of a high-performing health care organization
Inner Domain	• Cost • Comfort • Calm • Capability
Patients and Informal Caregivers – Central Domain	• Patient involvement and ownership in the development of their care plan

The ultimate goal of rural health hub development is better patient experiences across the continuum of care. The following 'checklist' is a powerful reminder of what really matters in terms of defining success for vertically integrated solutions:

How will patients know when an integrated health care system exists?[15] When they:

- Do not have to repeat their health history for each provider encounter.

- Do not have to undergo the same test multiple times for different providers.

- Are not the medium for informing their physician that they have been hospitalized or have undergone diagnostic or treatment procedures; been prescribed drugs by another physician; not filled a previous prescription; or been referred to a health agency for follow-up care.

- Do not have to wait at one level of care because of incapacity at another level of care.

- Have 24-hour access to a primary care provider.

- Have easy-to-understand information about quality of care and clinical outcomes in order to make informed choices about providers and treatment options.

- Can make an appointment for a visit to a clinician, a diagnostic test or a treatment with one phone call.

- Have a wide choice of primary care providers who are able to give them the time they need.

- With chronic disease, are routinely contacted to have tests that identify problems before they occur; provided with education about their disease process; and provided with in-home assistance and training in self-care to maximize their autonomy.

A final thought from Don Berwick, President Emeritus and Senior Fellow, from the Institute for Healthcare Improvement (www.ihi.org):

> *So many stories in health care are now layered over with the jargon of our search for some better way. My father would never have asked for "integrated delivery", but only to be passed gently and securely from the hands of one caring person to the other. He wanted no "guidelines" or "critical paths", but instead reliability and promises he could count on. He is less interested in "cost containment" than in the simpler aim that he not be harmed with waste or avoidable pain. He would not ask for "access"; he would ask instead that we be there when he needs us.*

The OHA and its Small, Rural and Northern (SRN) Hospitals' Council will follow closely the implementation of the five Integrated Rural Health Hub pilot projects and will continue to provide advice and lessons learned to the system as these projects unfold.

---

15   Leatt, Pink & Guerriere, 2009

REFERENCES

Anderson-Butcher, D. et al, *Collaboration and Collaborative Leadership*, (Chapter 3 in *The Implementation Guide for the Ohio Community Collaboration Model for School Improvement*), 2004

Baker, Ross and Dr. Renata Axler, "*Creating a High Performing Health Care System for Ontario: Evidence Supporting Strategic Changes in Ontario*", (University of Toronto), October 2015

Berwick, Don. *Escape Fire: Designs for the Future of Health Care*, (John Wiley & Sons), 2004

Graham, J. R. "*Accountability for Community Benefit: A Reasonable Expectation for Canadian Hospitals*", *Health Policy*, Vol. 11, No. 4, 2016

Kodner, Dennis. "*All Together Now: A Conceptual Exploration of Integrated Care*", Healthcare Quarterly special issue, Vol. 13, 2009

Leatt, Pink & Guerriere, "*Toward a Canadian Model of Integrated Healthcare*", Healthcare Papers, 2009

Linden, Russell. *Working Across Boundaries: Making Collaboration Work in Government and Non-Profit Organizations*, (John Wiley & Sons, 2002)

Loehrer, Saranya et al. "*Cross-Continuum Collaboration in Health Care: Unleashing the Potential*", *Population Health Management*, Commentary, 2015

National Assembly of Health and Social Service Organizations, *The new community collaboration* manual, 1997

Ontario Hospital Association, "*Redefining Health Care: A Dialogue on Health Policy*", Issue 1, Fall 2016

Ontario Hospital Association, "*The Case for Implementing Fully Integrated Rural Health Hubs on a Pilot Project Basis*", 2015

Ontario Hospital Association, "*Local Health Hubs for Rural and Northern Communities: An Integrated Delivery Model Whose Time Has Come*", 2013

Premier's Community Hubs Framework Advisory Group, *Enabling and Celebrating Community Hubs*, (One-Year Progress Update on Community Hubs in Ontario: A Strategic Framework and Action Plan), August 2016

Provincial Multi-Stakeholder Hub Advisory Committee,

Shortell, Stephen et al, "Evaluating Partnerships for Community Health Improvement: Tracking the Footprints", *Journal of Health Politics, Policy and Law*, 2002, Vol. 27, No. 1

Steiner, B.D. et al, "*Improving Care Through Community Health Networks*", *Annals of Family Medicine*, July 2008, Vol. 6, No. 4

Online Resources

A Checklist for Attitudes About Patients and Families as Advisors (Institute for Patient and Family Centered Care)

Central LHIN Integration Resources

Experience-based Co-design Toolkit (The King's Fund)

Greenleaf Center for Servant Leadership

Patient and Family Engagement: A Framework For Understanding The Elements and Developing Interventions and Policies (Health Affairs)

Patient Engagement Framework (Health Quality Ontario)

Redefining Health Care Journal (Ontario Hospital Association)

Resources for Health Care Providers (Health Quality Ontario)

Resources for Patients, Families and Caregivers (Health Quality Ontario)

Seven Principles of Effective Change Management (prosci)

Sharing Your Story: Tips for Patients and Families (Institute for Patient and Family Centered Care)

South West LHIN Integration and Collaboration

Ten Guiding Principles of Change Management (Strategy& and PWC)

Tips for How to be an Effective Patient or Family Advisor: A Beginning List (Institute for Patient and Family Centered Care)

The Change Foundation

APPENDIX A – Family Practice and Compensation Models in Ontario[17]

Family Practice Models

The Ministry of Health and Long-Term Care (Ministry) emphasizes comprehensive care that encompasses health promotion and disease prevention as well as treatment and disease management. The system accommodates a wide range of practice models but encourages group-based practice and interdisciplinary teams. Below are details about the province's different family practice:

Comprehensive Care Model (CCM)

- Designed for solo primary care physicians
- Patient enrolment is strongly encouraged.
- Regular office hours plus one three-hour session of extended hours (weekday evenings and/or weekends)
- Sign agreement to join

Family Health Groups (FHGs)

- Three or more physicians practicing together – not necessarily in the same office space but in close proximity
- Patient enrolment is strongly encouraged.
- Regular office hours and three to five sessions of extended hours (weekday evenings and/or weekends) based on number of group physicians. Patient volume may require additional sessions. Each after-hours session must be a minimum of three hours in duration.
- Nurse-staffed, after-hours Telephone Health Advisory Service provides advice to enrolled patients.
- Sign agreement to join

Family Health Networks (FHNs)

- Three or more physicians working together as a group – not necessarily in the same office space but in close proximity
- Physicians commit to enroll patients.
- Regular office hours and three to five sessions of extended hours (weekday evenings and/or weekends) based on number of physicians. Patient volume may require additional sessions. Each after-hours session must be a minimum of three hours in duration.
- Nurse-staffed, after-hours Telephone Health Advisory Service provides advice to enrolled patients.
- Sign governance and Family Health Network agreements to join
- Family Health Networks can apply to the Ministry for funding to add allied health professionals if they are successful in their application for a Family Health Team.

Family Health Organizations

- Three or more physicians work together as a group – not necessarily in the same office space but in close proximity.
- Physicians commit to enroll patients.
- Regular office hours and three to five sessions of extended hours (weekday evenings and/or weekends) based on number of physicians. Patient volume may require additional sessions. Each after-hours session must be a minimum of three hours in duration.

17 http://www.healthforceontario.ca/en/Home/Physicians/Training_%7C_Practising_
in_Ontario/Physician_Roles/Family_Practice_Models/Family_Practice_
Compensation_Models

- Nurse-staffed, after-hours Telephone Health Advisory Service provides advice to enrolled patients.
- Sign governance and Family Health Organization agreements to join
- Family Health Organizations can apply to the Ministry for funding to add allied health professionals if they are successful in their application for a Family Health Team.

Family Health Teams (FHTs)

- Work in interdisciplinary teams
- Patient enrolment is strongly encouraged
- Regular and extended hours

Rural-Northern Physician Group Agreement (RNPGA)

- Serves rural and northern communities with a complement of one to seven physicians
- Regular hours and one to five sessions of extended hours (weekday evenings and/or weekends) based on the size of the RNPGA
- Nurse-staffed, after-hours Telephone Health Advisory Service provides advice to enrolled patients.
- Sign agreement to join
- Rural and Northern Physician Groups can apply to the Ministry for funding to add allied health professionals if they are successful in their application to become a Family Health Team.

Community Health Centres (CHCs)

- Interdisciplinary teams serve hard-to-serve communities and populations that may have trouble securing health services.
- Centres focus on addressing the underlying conditions that affect people's health, such as social determinants of health, poor diet and literacy.
- Regular and extended hours
- Physicians are salaried employees of the Community Health Centre.

Family Practice Compensation Models

The Ministry and the Ontario Medical Association have developed a selection of attractive compensation models that reward family physicians for providing comprehensive care to their patients. Compensation is based on blended payments. This means that while a model may be predominantly one form of payment (e.g., capitation), it will have a blend of financial incentives, premiums and other types of payments.

Compensation	Applies To:
Fee-for-service plus some incentives and bonuses for services to enrolled patients Rostering and Patient Fees (i.e. New Patient Fee) and some incentives, premiums and bonuses, chronic disease management and preventive care are paid for eligible services to enrolled patients. Additionally, physicians receive monthly comprehensive care capitation payments for all enrolled patients.	Comprehensive Care Model Family Health Groups
Blended Capitation Model Capitation based on a defined basket of primary care services provided to enrolled patients based on age/sex of each patient. Fee-for-service paid for other services. Additionally, physicians receive monthly comprehensive care capitation payments for all enrolled patients. Rostering and Patient Fees (i.e. New Patient Fee), and bonuses, premiums and special payments are paid for services such as chronic disease management, preventative care, pre-natal care and home visits for enrolled patients, and for hospital visits, obstetrical care and palliative care for all patients.	Family Health Networks Family Health Organizations
Complement-based base remuneration plus bonuses and incentives A base payment for a full-time equivalent "complement" in a given community/ geographic area in addition to overhead payments, locum coverage, continuing medical education, etc.	Rural-Northern Physician Group Agreement
Blended Salary Model Physicians are salaried employees of Community or Mixed Governance Family Health Teams: salary based on number of enrolled patients, plus benefits, bonuses.	Community-Sponsored Family Health Teams
Salaried Model Physicians are salaried employees of Community Health Centres that provide care to a specific identified population.	Community Health Centres

APPENDIX B – Core Basket of Services for Mental Health and Addictions

Patients with mental illness and addiction have to deal with multiple service providers, which in some cases, require transitions from one sector to another. The patients, families and/or caregivers who have to navigate the system often have trouble finding out where to get help. As a result of the complexity of the system, people sometimes fall out of care and stop receiving services. Moreover, the services offered to patients can differ across different areas of the province. These challenges contribute to health outcomes that are often sub-optimal and negatively impact the patient's experience.

Based on this, Ontario's Mental Health and Addictions Leadership Advisory Council has recommended the adoption of core mental health and addition services across Ontario in the following broad categories:

• Prevention, Promotion and Early Intervention

• Information, Assessment and Referral Services

• Counselling and Therapy Services

• Peer and Family Capacity Building Support

• Specialized consultation and assessment

• Crisis Services

• Intensive Treatment Services

• Social Determinant Supports

For more information, please see Appendix 2 of the 2016 Annual Report of Ontario's Mental Health & Addictions Leadership Advisory Council. (Moving Forward Better Mental Health Means Better Health, 2016)

200 Front Street West, Suite 2800
Toronto, Ontario M5V 3L1
www.oha.com