

# The Case for Implementing Fully Integrated Rural Health Hubs on a Pilot Project Basis



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# Executive Summary

**The purpose of this project is to demonstrate the feasibility, patient benefit and administrative efficiency of implementing fully integrated rural health hubs for a number of small hospitals in Ontario on a pilot project basis. For these already well-developed health hubs, full integration means a single funding envelope for most if not all local health services and a single governance structure.**

The OHA selected the following 8 health hub reference hospitals as the project working group:

- Arnprior Regional Health
- Blind River District Health Centre
- Dryden Regional Health Centre
- Espanola Regional Hospital and Health Centre
- Haliburton Highlands Health Services
- Manitouwadge General Hospital
- Riverside Health Care
- Sioux Lookout Meno Ya Win Health Centre

All of these hospitals are already managing a wide range of acute and non-acute services including long term care, primary care, community support services and mental health and addiction services. In many cases, these health hub hospitals are functioning as multi-site, multi-sector health care corporations where there is no meaningful distinction between hospital and community services.

While there have been some synergies achieved by managing these different budgets and accountability agreements for patients/clients/residents, a survey of

these health hub hospitals revealed the following types of **additional** benefits that would result from full integration:

- Benefits to patients/clients/residents;
- Benefits to hub partner organizations;
- Administrative efficiencies;
- Local system planning and governance; and
- Additional community partnerships.

In terms of benefits for patients/clients/residents, the following were specifically identified:

- Greater responsiveness to the needs of patients/clients/residents
- Improved access and transitions of care to improve patient/client/resident experiences
- Reduced travel costs based on care closer to home
- Shared (common) client intake process so patients only have “To Tell Their Story” once
- More robust patient and family engagement
- Better system navigation and transitions of care
- Comprehensive supports for seniors
- Shared electronic patient records

The benefits of moving to fully integrated rural health hubs are consistent with key components of the Ministry of Health’s action plan (Patients First) including:

- Quality Improvement Planning focused on the transitions of care for patients/clients
- Coordinated Care Planning for complex patients through Health Links
- Integrated Funding Pilots and bundling of payments as part of the Reform of Home and Community Care
- Move to Population-based Funding as part of Health System Funding Reform
- Comprehensive range of home, community and hospital-based services for seniors

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Based on a review of legislation plus stakeholder interviews, there are no barriers that actually prevent the implementation of fully integrated health hubs in Ontario but there are potential implementation challenges. Probably the most significant challenges result from potential labour adjustment costs arising from legislation and the integration of long term care homes into fully integrated delivery models.

To support moving forward with fully integrated rural health hub pilot projects, the working group recommends the following:

**That the rural health hub pilots be based on the following parameters:**

- A single funding envelope that includes **as a minimum:**
  - All of the LHIN funding currently being managed by the Hub hospital (as defined by existing service accountability agreements - HSAA, MSAA, LSAA etc.)
  - The funding for primary care allied health professionals (as per FHT or CHC budgets)
  - An allocation for homecare services to be delivered by the hub hospital
  - A per diem adjustment for hub hospitals managing long-term care homes
- Beyond these minimum requirements for defining the health hub envelope, the Ministry and participating LHINs determine, prior to the start of the pilot projects, if there are additional local health services that should be included in the health hub funding envelope
- A single, consolidated service accountability agreement with performance metrics to be developed collaboratively by the Ministry, the participating LHINs and the pilot hub hospitals
- A single governance structure (either the existing hospital board or a collaborative governance structure agreed to by all health hub partners) for providing oversight to the health hub pilot
- A single, consolidated quality improvement plan (QIP) to be developed collaboratively by the Ministry, Health Quality Ontario and the pilot hub hospitals;

**That the Ministry of Health and Long-Term Care, in consultation with LHINs and the OHA, select up to 10 pilot project sites based on the following criteria:**

- Hospitals already managing multiple service agreements;
- Hospitals with demonstrated health system leadership including change readiness;
- Sufficient variation between the hub pilot sites to allow for evaluation and comparison of different components of the Health Hub model;
- Demonstrated commitment from the hospital, providers and community partners to a fully integrated rural health hub model;
- Strong links to the community to ensure the right care, at the right place, at the right time;
- Identified opportunities to improve the patient/client/resident experience;
- Advanced stage of maturity with respect to integration and moving towards a health hub model; and
- The potential to demonstrate administrative synergies and cost savings.

**That the pilot projects operate for a minimum period of at least 36 months to allow sufficient time for pilots to achieve financial and clinical efficiencies;**

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**That the evaluation of the rural health hub pilot projects be based on:**

- An economic evaluation of health hubs conducted by the University of Toronto
- The quality indicators for rural hospitals/health services currently being developed by the North West LHIN
- Other efficiency/utilization indicators developed for the consolidated LHIN accountability agreement for pilot Hub hospitals
- Patient engagement process based on the principles of Experience-based Design
- Patient experience measures

**That the rural health hub pilot projects be provided with one-time funding of \$300,000 to coordinate the implementation of a fully integrated health hub. The pilot project budget should include the following:**

- Project management fees;
- Administrative support;
- Legal costs;
- Education/training of staff to assume new roles;
- Transitional one-time HR costs associated with changing/consolidating bargaining agents;
- Outreach/communication; and
- Evaluation.

# Background and Project Rationale

At the request of the former Minister of Health and Long-Term Care (the Hon. Deb Matthews), the Ontario Hospital Association (OHA) published a discussion paper (*Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come*) in the spring of 2013. Following a period of consultation with OHA members, the Ministry of Health and Long-Term Care (Ministry) and other health care partners, the OHA in collaboration with the Ontario Medical Association (OMA), co-sponsored a **Multi-Sector Rural Health Hub Advisory Committee** in early 2014. The purpose of the Advisory Committee was to “...assist rural and northern communities to design and move forward with the implementation of Rural Health Hubs” with the following specific deliverables:

- The examination of existing local coordinated health care delivery models within rural and northern communities;
- A mapping exercise to examine the alignment of Rural Health Hubs with the Health Links model and how it fits at the provincial and local health integration network (LHIN) level; and
- Consensus on guiding principles and a new framework for enhanced coordinated health care delivery within rural and northern communities and an action plan to address the policy and regulatory barriers impeding integration.

The Advisory Committee’s final report was released January 2015 and included a number of recommendations for rural communities and for the Ministry to support the voluntary development of community-driven rural health hub models. Specifically the report recommends that the Ministry:

*Recognize rural health hubs as a key approach to service delivery for rural communities by supporting policy change that:*

- Provides flexible community funding for rural hub development in support of sustainability of the health care system, which will lead to local innovation, stable service capacity and a sustainable work force.*
- Creates incentives for health and social service providers who choose to participate in a rural health hub. (Multi-Sector Rural Health Hub Advisory Committee, p. 11)*

With the recent release of the Ministry’s *Patients First: Action Plan for Health Care*, there is considerable interest, and a wide range of readiness, among health service providers to move forward with the planning and implementation of locally-driven, community-based rural health hub models. While some communities are just starting their journey of exploring collaborative partnership opportunities, there are a number of smaller rural hospitals that have already achieved a high degree of success in local health system integration and are ready to establish ‘fully integrated’ rural health hubs.

These smaller hospitals have essentially been operating as rural health hubs for many years and have the demonstrated maturity and readiness to move towards a fully integrated rural health hub model in terms of managing a single funding envelope with an integrated governance structure.

Over the past three years, there have been a number of papers written on local or rural health hubs, all for different purposes and audiences. The most recent document that was submitted to the Ministry from the

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Multi-Sector Rural Health Hub Advisory Committee in January 2015 was intended to provide a planning framework for communities that are just embarking on the creation of a rural health hub.

The purpose of this paper is to provide the Ministry with advice on how it could assist already well-developed rural health hubs achieve full integration. Full integration, for these communities, and the benefits that come with it, is dependent on Ministry policy intervention and support.

*This paper is intended to demonstrate the feasibility, patient benefit and administrative efficiency of implementing fully integrated rural health hubs for a number of small hospitals in Ontario on a pilot project basis.*

# Original Local Health Hub Concept

**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 and a single funding envelope is provided to a fundholder organization to manage the health of the local population.**

The OHA's 2013 report defined the following as 'core services' for local health hubs:

1. Emergency, Acute and Post-Acute Care (typically provided by small hospitals)
2. Comprehensive Primary Care – family physicians working with a team of allied health professionals, such as Family Health Teams (FHTs) or Community Health Centres (CHCs)
3. Long-Term Care – long-stay beds as well as shorter term respite
4. Community Support Services – wide range of community services to support seniors in their homes
5. Mental Health & Addictions – community-based treatment and support services plus access to specialty beds (when required)
6. Home Care Services

In terms of local health hubs providing professional homecare services, the original report noted that some small hospitals have already qualified as contract service providers with their respective Community Care Access Centres (CCACs).

*Small hospitals recognized as homecare providers in the CCAC's current managed competition process should be considered an interim step, with the longer term goal of having CCAC funding devolved to the hub so that it can manage local homecare services.* (OHA, 2013, p. 5)

This is also consistent with recommendations from the 2012 Sinha report,<sup>1</sup> including:

- Implementation of 'Hospital at Home' models
- More standardized approaches to collaborative care

In addition to these core services, it was recommended that local health hubs partner with the following health services:

- Public Health
- Ambulance (EMS) and Non-Urgent Patient Transport Services

Depending on local circumstances, the local health hub would also be expected to pursue a range of community partnerships with non-health care providers (e.g. social services, housing, recreation etc.). These services could include but are not limited to:

- Supportive Housing/Assisted Living
- Seniors Affordable Housing

A key component of the Local Health Hub model is the creation of a single funding envelope (bundled payment) which is provided to a lead organization or designated

<sup>1</sup> Dr. Samir Sinha, "Living Longer, Living Well"



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agency (the hub). The benefits of moving to a single fundholder model have been well-documented by the OHA and others:

- Removes the longstanding problem of incompatible funding silos
- Reduces the administrative costs of preparing multiple accountability agreements and separate financial reporting requirements
- Reduces overlap and duplication of governance oversight and administration
- Aligns with the system trend to population-based funding
- Facilitates timely allocation of funds for new service delivery models that could emerge from initiatives, such as Health Links
- Creates much needed flexibility to better manage patient/client/resident care across the continuum

*There is recognition among provider groups that existing funding methods, and the resulting financial incentives, perpetuate a silo-focused approach to managing care. Funds are allocated to individual organizations in separate and distinct envelopes, without any mechanisms for sharing or pooling financial resources between organizations in order to improve coordination in care delivery (OHA, 2000, p. 2).*

*Providers, organizations or sectors will not be integrated (however defined and by whatever model) unless mechanisms are used to integrate funding as well, by traversing or connecting the silos. (OHA, 2007, p. 9).*

# Alignment with Current Ministry and LHIN Priorities

## Ministry of Health and Long-Term Care

The implementation of fully integrated health hubs for select rural and northern communities aligns well with the following components of the Ministry's new Action Plan (*Patients First*):

1. Modernize Home and Community Care
2. Ensure Sustainability and Quality
3. Improve Health System Integration

### 1. Modernize Home and Community Care

The Donner report on reforming Home and Community Care (*Bringing Care Home*) has recently been released, and two of the key themes are “better coordination and integration of services” and “providing more efficient approaches to service delivery”. To this end, the report recommends:

(In support of a more flexible funding envelope),

- *That the Ministry of Health and Long-Term Care allow the LHINs discretion to direct funds to reflect the priorities within their region to meet client and family home care and community service needs, even if that means re-allocating money across the various funding envelopes.* (Recommendation #6, Donner report)

(In support of a lead fundholder organization)

- *That the Ministry of Health and Long-Term Care direct the Local Health Integration Networks to select and fund the most appropriate lead agency or agencies to design and coordinate the delivery of outcomes-based home and community care for populations requiring home and community care.* (Recommendation #11, Donner report)

The report further recommends<sup>2</sup> the following minimum requirements for a designated ‘lead agency,’ which are consistent with the functioning of an integrated health hub model:

- Offer the full bundle of services for a defined population.
- Document the funded services in a care plan and work with the family to determine which of those services will be provided.
- Identify one care coordinator for each family.
- Reflect a client and family-centered care model that includes caregiver support.
- Provide assistance to the family to find any unfunded services required.
- Ensure that every individual receiving services is assigned to a primary care provider and incorporate an explicit role for a primary care provider.
- Provide a care plan with timelines available to all members in the circle of care.
- Include a formal evaluation by an independent third party.

### 2. Ensure Sustainability and Quality

Key Action Plan elements include:

- Extend Health System Funding Reform (HSFR) to community sector in support of population health
- Expand Quality Improvement efforts across sectors
- Implement a Procurement Strategy that improves efficiency and cost-effectiveness

<sup>2</sup> Bringing Care Home, March 2015, p. 28

As part of HSFR and Home and Community Care reform, the Ministry is moving forward with its Integrated Funding pilot projects. The benefits of bundling payments for acute and post-acute care are now well-documented and the goal of these new pilot projects is:

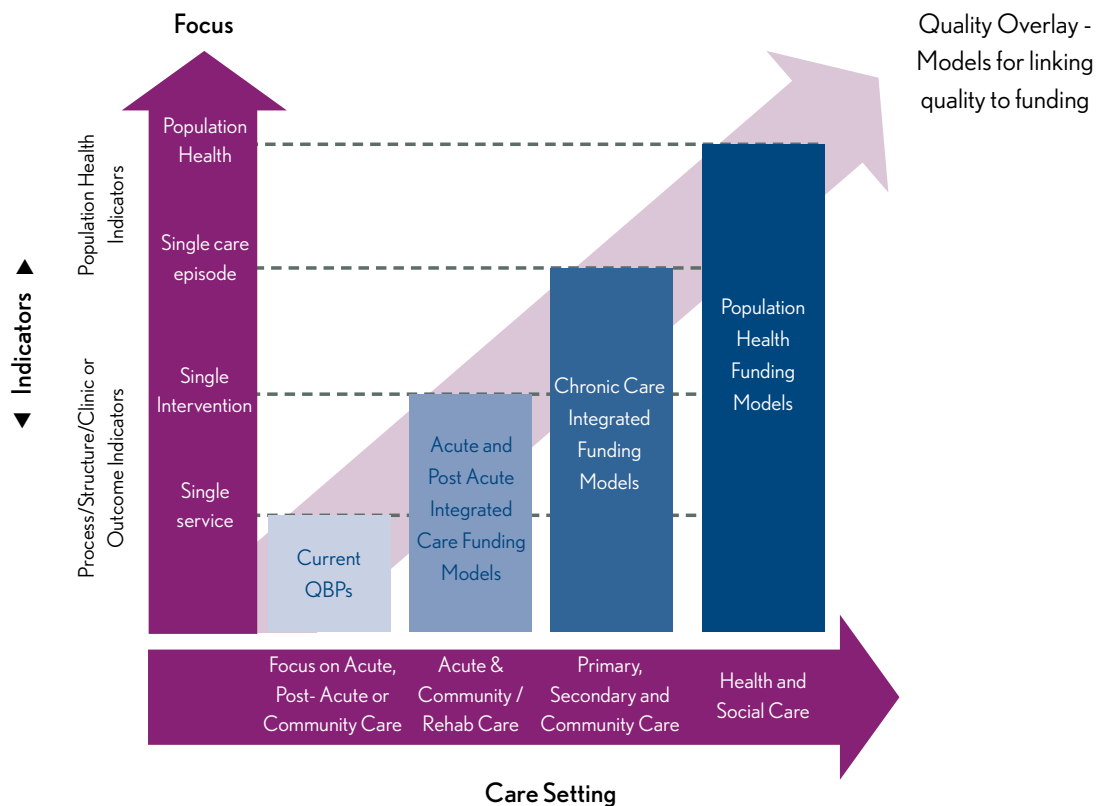
*“To promote high quality patient centred care across the care continuum by bundling payment to incent coordination of care and quality outcomes” (Ministry of Health and Long-Term Care, Expression of Interest, Feb. 9, 2015)*

While larger hospitals can offer a certain critical mass in terms of staffing and patient volumes that may be attractive for these Integrated Funding projects, recent research has confirmed that small hospitals would also

benefit from bundled payments. Specifically, an analysis of 2013-14 patient discharges from all small hospitals in Ontario showed that average length-of-stay (ALOS) was 47 per cent higher for patients discharged to homecare than for patients discharged to other locations – this higher than expected length of stay is the functional equivalent of 19 small hospital beds per annum (see Appendix B). Significant efficiencies are possible if small hospitals are able to manage the discharge and post-acute care phases for homecare clients.

The development of a single funding envelope for rural health hubs is also consistent with HSFR’s goal of moving to a Population-Based Health funding model:

### HSFR Moving Forward: Integration and Quality Overlay



### 3. Improve System Integration

Key Action Plan elements include:

- Integration of health, community and social services for complex patients
- Integrate eHealth systems to support comprehensive health care planning
- Providers working to their full scope of practice and trained for integrated care

All hospitals have been encouraged to support local Health Links processes. However, because of the original minimum population requirement of 50,000 used by the Ministry for

defining a Health Link catchment area, the coordinated care planning for complex patients has become more of a district or regional planning process involving many stakeholders across larger geographies, especially in northern Ontario. Fully integrated health hubs represent an opportunity for better local management of relatively small numbers of ‘high-need, high-use’ patients living in rural and northern communities.

In Table 1 (below), the fully integrated Rural Health Hub model is contrasted with Health Links and the Integrated Funding Pilots. For small rural and northern communities, the Local Health Hub model makes more sense and represents a comprehensive approach to fully integrated patient care.

Table 1 – Contrasting Health Links, Integrated Funding Pilots and Rural Health Hubs

Criteria/ Prerequisites	Health Links	Integrated Funding Pilots	Rural Health Hubs
Population Size	Minimum 50,000	Not yet determined but Ministry is expecting certain critical mass in terms of “sufficient patient volumes”	Less than 20,000 but there may be exceptions for remote northern communities
Patient Focus	Top 5 per cent (high cost/ high use) with complex needs	Post-acute patients discharged from hospital to home	All patients in Hub catchment area
Patient /Family Engagement	Expected	Expected	Expected
Providers/ Services	Key Partners: Hospital, CCAC, Primary Care, Specialists, Mental Health & Addictions	Potential Partners: Hospital, CCAC, Primary Care	Core Services: Acute Care (inpatient & outpatient), ER, Complex Continuing Care, Rehab, Long Term Care facilities and community support services, Community Mental Health & Addictions, Homecare, Primary Care  Additional Partners: EMS, Public Health, Social Services

Criteria/ Prerequisites	Health Links	Integrated Funding Pilots	Rural Health Hubs
Governance and Accountability	<p>One “Lead Organization” with partnership agreements with other health service providers.</p> <p>Collaborative governance structure is flexible and based on local requirements and relationships</p>	Not yet determined but Hospitals are expected to be the “Lead Organization”	Single Governance Structure (achieved through voluntary or facilitated integration process)
Expected Outcomes/ Deliverables	<p>Coordinated care plans shared and implemented for Health Link patients;</p> <p>Improved experience for small group of complex patients and their caregivers;</p> <p>Improved efficiencies and value for money</p>	<p>Improved quality outcomes for patients (e.g., keeping people at home; reducing emergency department visits, readmissions, and length of stay in hospital);</p> <p>Improved experience for post-acute discharged patients;</p> <p>Improved efficiencies and value for money</p>	<p>Clinical integration through pathways and quality improvement (QI) processes to support inter-professional, team-based care;</p> <p>Improved experience for all patients served by health hub;</p> <p>Sustainable integrated model for rural health services</p>
Performance Measurement	Report on 12 indicators selected by Ministry	<p>Improved value (outcomes relative to costs);</p> <p>Improved health outcomes;</p> <p>Reduced variation in care pathways</p>	<p>Financial performance indicators in single LHIN accountability agreement;</p> <p>Access and patient experience indicators in consolidated Quality Improvement Plan;</p> <p>Economic evaluation by University of Toronto;</p> <p>Additional quality indicators under development for rural hospitals</p>
Connectivity	Ability to share information (via EHR) between all Health Link participants	Not yet determined	Ability to share information (via EHR) between all health hub participants

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## Local Health Integration Networks

### North West LHIN

In 2012, the North West LHIN released its **Health Services Blueprint** – a 10-year plan for transforming health care in the northwestern Ontario. The plan is based on three geographic levels of service planning and delivery:

- Local Health Hubs
- Integrated District Networks
- Regional (Specialized) Programs

The Local Health Hubs recommended by the LHIN are very consistent with the OHA’s Health Hub model:

*Local Health Hubs will be comprised of health service providers in and around specific communities. The local hubs will plan and provide health care services based on the unique needs of their community, to meet the health care needs of the population they serve and to support individuals in accessing care as close to home as possible. There will be 14 local health hubs corresponding to the communities with hospitals in the North West LHIN.*

*Local Health Hubs will focus on improved access to care for stable patients, including those with chronic conditions and mental health and addictions issues. Services at the local level will include:*

- Primary care
- Community support services
- Community mental health and addictions
- Acute care
- Post-acute care (rehab, complex continuing care, transitional care)
- Long-term care



## North East LHIN

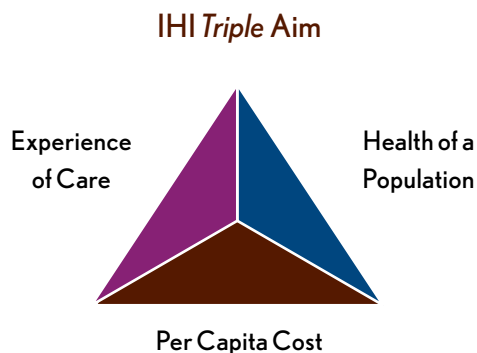
Over the last few years, the North East LHIN has been supporting service realignment processes within several geographic Health Hubs (Cochrane, Temiskaming). Each of these Health Hubs is unique but the overall goal for realignment processes within Hubs remains the same:

*To create a less fragmented and more patient-focused continuum of care...*

Realignment in the geographic hubs requires organizational integration both at the governance level and the service delivery level. For northern communities interested in exploring more integrated service models like health hubs, the North East LHIN has also developed a step-by-step guide for communities.<sup>3</sup>

## Central East LHIN

The Central East LHIN's Integrated Health Services Plan (IHSP: 2013 - 2016) is grounded in the Triple Aim approach as a framework for improving system quality. Key components of this framework include:



- Focusing on individuals and families
- Redesigning primary care services and structures
- Managing the health of a particular population

- Establishing a cost-control platform
- Reinforcing system integration and execution
- Building coalitions with other sectors

Their IHSP has 4 strategic aims:

- Reduce the demand for long-term care so that seniors spend more days at home.
- Improve the vascular health of residents.
- Strengthen the system of supports for people with Mental Health and Addiction issues.
- Increase the number of palliative patients who die at home by choice.

As part of this multi-faceted integrated strategy, the LHIN has been very supportive of the unique role played by small hospitals in a regionalized health system as well as the evolution of local health hub models.

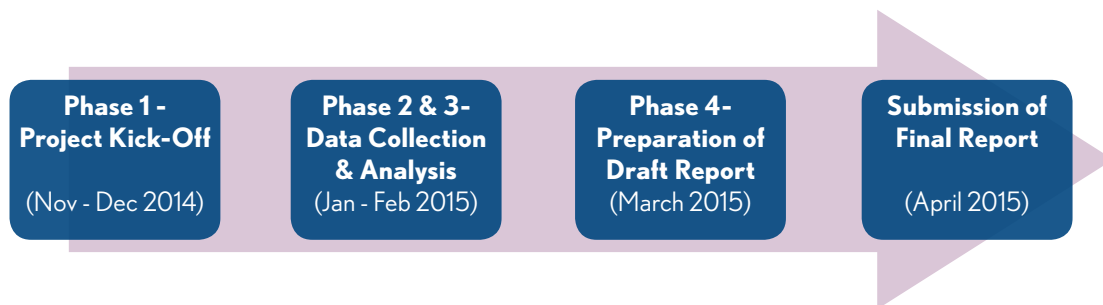
In February 2012, the Board of the Central East LHIN passed a motion supporting a Community Health Services Integration Strategy; the LHIN's facilitated integration strategy for Community Support Services (CSS) agencies and CHCs, to commence in April 2012 and be completed by 2015. In November 2012, hospitals were included in the Northumberland and Haliburton County/City of Kawartha Lakes processes. The aim of the community health services integration strategy was to design and implement a cluster-based delivery model for community support services, community health centres and small rural hospitals by 2015 through integration of front-line services, back office functions, leadership and/or governance to:

1. Improve client access to high-quality services,
2. Create readiness for future health system transformation,
3. Make the best use of the public's investment.

<sup>3</sup> North East LHIN, "North East Rural Communities Framework for Achieving Improved Health System Coordination", January 2014

# Project Methodology and Process

The OHA selected eight small hospitals that have well-developed local health hub models to create a Health Hub reference group. This reference group (see Appendix A) supported by OHA staff provided important ‘lessons learned’ about their local integration journeys as well as many insights about the challenges and benefits of moving to fully integrated rural health hubs.



Project Phases	Data Collection and Analysis
<b>Phase 1 - Project Kick-Off</b>	Confirmation of Health Hub reference group membership and project charter
<b>Phase 2 - Data Collection</b> (survey of hub hospital CEOs)	For each reference hospital: <ul style="list-style-type: none"> <li>• LHIN allocation (by main budget categories)</li> <li>• Staffing, full-time employees (FTEs)</li> <li>• Key utilization statistics</li> </ul>
<b>Phase 3 - Analysis of Integration Barriers</b> (Survey of hub hospital CEOs plus review of legal/legislative issues)	Description of integration barriers organized by category (legal, structural, etc.) <ul style="list-style-type: none"> <li>• What are the key barriers that are preventing you from moving to a fully integrated local health hub model?</li> </ul>
<b>Phase 4 - Analysis of Integration Benefits/Costs</b>	Detailed description of integration benefits (specifically administrative, financial and clinical) in terms of: <ul style="list-style-type: none"> <li>• What opportunities/benefits have you already seen from managing hospital and non-hospital budgets?</li> <li>• What additional benefits and efficiencies do you anticipate if allowed to manage a single multi-sector budget?</li> <li>• What additional costs or risks need to be factored in to fully integrated model? (e.g. labour adjustment costs)</li> </ul>



# Overview of Health Hub Reference Hospitals

The eight health hub reference hospitals are described in Table 2 below:

TABLE 2 – Beds and Facility Locations for Health Hub Reference Hospitals

Hospital Corporation	Health Care Sites	Catchment Population	Acute Beds	CCC/ELDCAP <sup>4</sup> / LTC Beds	Other <sup>5</sup>
Sioux Lookout Meno Ya Win Health Centre	Sioux Lookout	30,000	44	5/20	5 <sup>6</sup>
Dryden Regional Health Centre	Dryden	15,000	31	10	
Riverside Health Care	Fort Frances, Emo, Rainy River	20,000	41	20/33/164	
Arnprior Regional Health	Arnprior	20,000	30	14/60	20
Blind River District Health Centre	Blind River, Thessalon, Richards Landing	13,000	20	10/10/22	16
Espanola Regional Hospital and Health Centre	Espanola	14,000	15	32/32	49
Haliburton Highlands Health Services	Haliburton, Minden	17,000	14	92	
Manitouwadge General Hospital	Manitouwadge	2,100	9	9	

Additional detail for the health hub reference hospitals in terms of utilization statistics is found in Appendix C.

4 ELDCAP beds are licensed nursing home beds, funded through the Elderly Capital Assistance Program, 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.

5 Assisted living units and/or seniors apartment units

6 Withdrawal management services

## Health Hub Service Budgets

The Hospital Service Accountability Agreement (HSAA) budgets managed by the eight reference hospitals total \$150.4 million (M). HSAA budgets range in size from \$30.7M (Sioux Lookout) to \$6.3M (Manitouwadge). The health hub reference group average for HSAA budgets is \$18.8M. HSAA as a percentage of the total budgets managed by the reference hospitals ranges from 91 per cent (Manitouwadge) to 58 per cent (Haliburton) (see Chart 1 below).

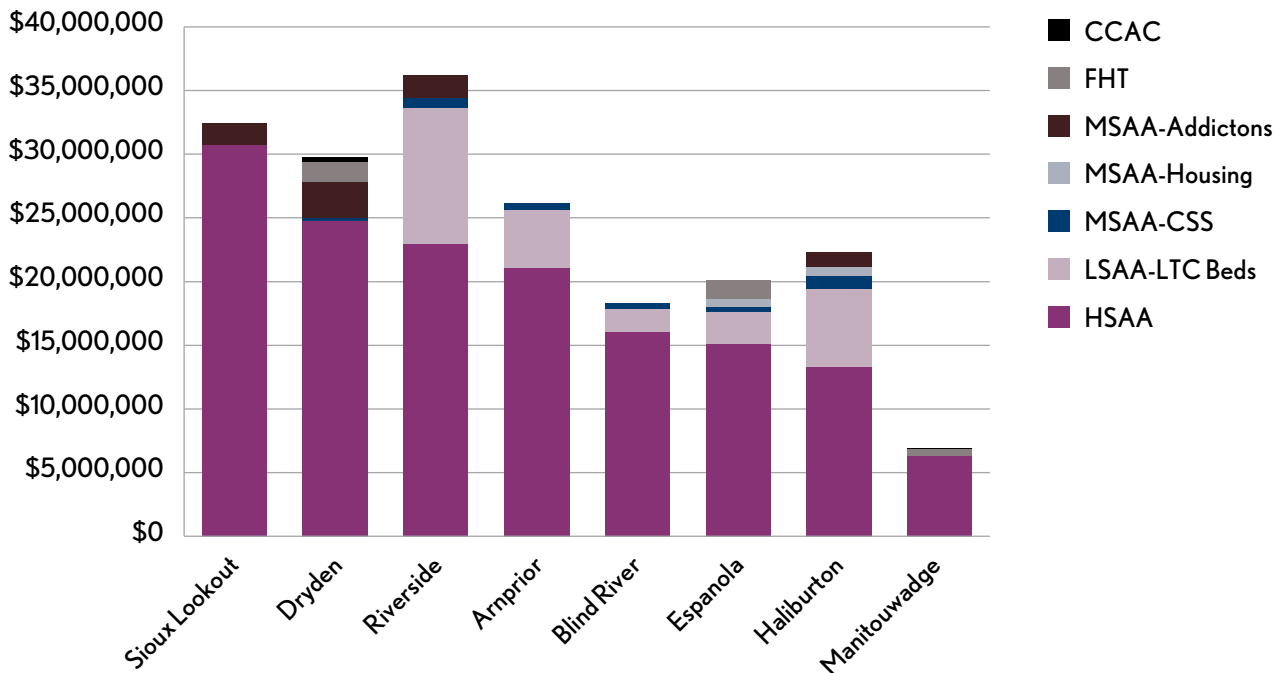
Each of the eight hospital corporations is governing and managing at least one non-acute service funding agreement in addition to their HSAs. Other service budgets managed by the eight reference hospitals totals \$41.8M. The average size of non-HSAA budgets being managed by the hospitals is \$5.2M.

Together the funding agreements currently being managed by the hub reference hospitals represent all of the ‘core services’ for health hubs as articulated in the original health hub paper including primary care, long term care services (community-based and facility beds) and local mental health and addiction services.

In support of a fully integrated Health Hub model,

- Five of the eight hospital corporations are managing long term care (nursing home) beds;
- Five of the eight hospital corporations are managing ELDCAP (long term care) beds;
- Three of the eight hospital corporations are managing a FHT budget;
- Two of the eight hospital corporations are providing homecare services through a CCAC contract

CHART 1 – Funding Agreements Managed by Health Hub Reference Hospitals



## Health Hub Staffing (FTEs)

Of the total staffing complement managed by the eight health hub reference hospitals, the non-HSAA, non-acute portion ranges from a low of 6.6 per cent (Sioux Lookout) to a high of 55.5 per cent (Espanola). Non-acute staff work

in a range of settings including long term care, primary care and community-based services. Since ELDCAP (long-term care) beds are funded through the acute (HSAA) hospital budget, the number of staff working in long term care is actually higher than reported. In some cases, HSAA-funded staff provide support for community-based programs but remain as hospital employees.

TABLE 3 – HSAA and Non-HSAA Staffing (FTEs) for Health Hub Reference Hospitals

Hospital Corporation	Acute (HSAA)	Non-HSAA	Non-HSAA as % of Total FTEs
Sioux Lookout Meno Ya Win Health Centre	352	25	6.6%
Dryden Regional Health Centre	174	50.5	22.5%
Riverside Health Care	250.8	173.8	40.9%
Arnprior Regional Health	140.5	63.6	31.3%
Blind River District Health Centre	127	24.7	16.3%
Espanola Regional Hospital and Health Centre	78.4	97.6	55.5%
Haliburton Highlands Health Services	98.5	50.7	34.0%
Manitouwadge General Hospital	54	5.3	8.9%

## Health Hub Governance

Non-acute health services currently governed (G) or managed (M) by the health hub hospital corporations are described below in Table 4.

TABLE 4 – Non-Acute Services Governed/Managed by Health Hub Hospitals

Hospital	Long Term Care Home	Addictions & Mental Health	Other Senior Services and CSS <sup>7</sup>	Family Health Team	Home Care <sup>8</sup>
Sioux Lookout		YES (G)			
Dryden		YES (G)		YES (G)	YES (M)
Riverside Health Care	YES (G)	YES (G)	YES (G)		
Arnprior	YES (G)		YES (G)		
Blind River	YES (G)		YES (G)		
Espanola	YES (G)		YES (M) <sup>9</sup>	YES (M)	
Haliburton	YES (G)	YES (G)	YES (G)		
Manitouwadge	YES*			YES (G)	YES (M)

<sup>7</sup> Other Community Support Services funded through MSAA include assisted living, supportive housing, adult day programs, diabetes education, hospice/palliative care, geriatric assessment, meals on wheels.

<sup>8</sup> Hospital is a contracted service provider with the CCAC.

<sup>9</sup> Espanola hospital has a management services contract with the Seniors Non-for-Profit Housing Corporation.

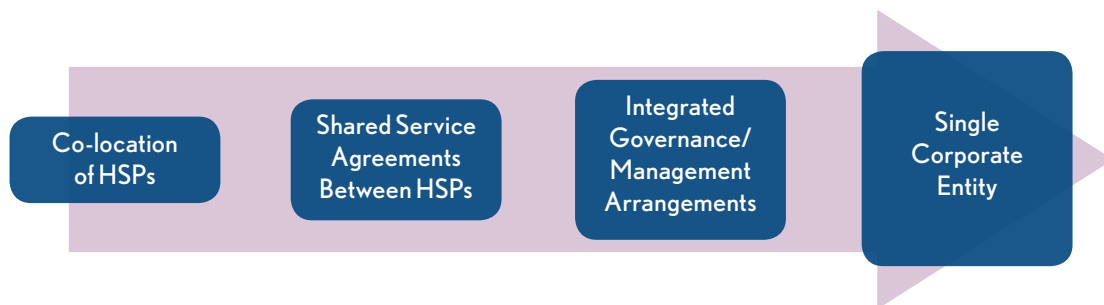
\* ELDCAP Beds

# Benefits of Moving to Fully Integrated Rural Health Hubs

The concept of local health care hubs is not new. Many small hospitals in Ontario have already developed or are developing rural health hub models linking acute care (inpatient and outpatient) with primary care, long term care and other community-based services such as mental health and addictions.

Existing health hub models in rural and northern Ontario share some similar features but tend to vary along the following two dimensions:

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



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



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The survey of health hub reference hospitals identified the following benefits of moving to fully integrated rural health hubs:

- Benefits to patients/clients/residents;
- Benefits to hub partner organizations;
- Administrative efficiencies;
- Local system planning and governance; and
- Additional community partnerships.

## Benefits to Patients/Clients/Residents

Collaboration between health hub partners and the “breaking down of barriers” between organizations have direct and indirect benefits to patients:

*In separate systems, the focus is often on the mandate of an institution and some patients can fall through gaps in processes, but when everyone is on the same team, the conversation is not; “we are not funded or this is not our mandate”, but rather Mr. X needs help with XYZ and how can we best meet that need (Manitowadge General Hospital).*

Specific benefits to patients identified by health hub reference hospitals include:

- Responsiveness to the needs of patients/clients/residents
- Reduced travel costs based on care closer to home
- Shared (common) client intake process so patients only have “To Tell Their Story” once
- More robust patient and family engagement
  - *We will be engaging patients and families in future service/program planning, delivery and evaluation (Dryden Regional Health Centre)*

- Better system navigation and transitions of care
  - Through better integration of care afforded through the hub model, we are able to strengthen the coordination and transitions of patient care through better hand-off/transfers across the continuum of care. If a bottle-neck/obstacle is found in patient transition, we are able to immediately meet with affected individuals/organizations (as we are all one and the same) and quickly identify and implement solutions. (Espanola Regional Hospital and Health Centre)
- Comprehensive supports for seniors
  - Our Assisted Living program is a local success story in that 50 per cent of our tenants are aged 90+ and able to live independently with minor assistance. Our 19 bed home currently has a wait list that more than doubles our number of units. Seniors who live in our Assisted Living are able to thrive in this environment thus reducing dependency on Acute, ED and LTC. Most amazing, our Assisted Living project receives no public funding. It is totally self-sustaining through market rents and cost savings generated in other parts of our health hub model. (Espanola Regional Hospital and Health Centre)
- Shared electronic patient records
  - *See shared electronic records success story from Arnprior Regional Health (below)*
- Improved access and transitions of care to improve patient/client/resident experiences
  - *See patient stories provided by the Manitowadge General Hospital (below)*

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### Patient Story 1: Manitowadge General Hospital

#### Friendly Calling

A resident of our community was reported by friends and neighbours to be increasingly isolating herself and not following through with her basic needs. This individual was brought to the attention of the health hub team and her needs were discussed at a team meeting. The FHT Social Worker (SW) made telephone contact with the resident, starting out with a general conversation. The calls were scheduled on a bi-weekly basis; however after the first call the individual became comfortable and would call the FHT sporadically just to talk. If the SW was not available, a member of the hub team would chat with her for a few minutes, which was sometimes all that was really required. Initially, the individual stated she did not need/want to see anyone; however, after a period of time, the individual's confidence increased which led to an office appointment. This individual is now setting goals to complete required tasks at home. The scheduled calls remain to ensure the resident is continuing to manage in her home. This proactive program called Friendly Calling allows early intervention for individuals who exhibit signs of neglect and deterioration. In the past, this person would have ended up in the hospital via ambulance before any services could be identified. Early interaction has resulted in stopping or slowing the decline in her condition, thus avoiding expensive health care costs in institutions.

### Patient Story 2: Manitowadge General Hospital

#### Hospital –FHT Collaboration

The Family Health Team (FHT) received a request to accommodate a patient with a rare blood disorder. Without the support of the FHT, the patient would be required to travel to Thunder Bay (800 km return trip) for IV treatment on a biweekly basis. Patient required weekly IV for six weeks followed by two weeks with an indefinite end date. This IV therapy has a price tag of \$500,000 per year and must be delivered in a clinic setting only for funding eligibility. In addition to this cost, the Northern Health Travel Grant Program would provide more than \$9,000 per year to subsidize patient travel costs.

As IV starts are not a routine procedure in the FHT, a partnership with Manitowadge General Hospital addressed the FHT RN's concern regarding IV competency level. The FHT RN was able to draw on the support of the hospital's ER RN for initial IV starts and as a result of the frequency of this treatment regime, RN competency has increased and all starts are now done in the FHT setting. Had the patient IV been done in the hospital, the medication would not have been funded and the patient would have had to travel to Thunder Bay bi-weekly.

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## Benefits to Health Hub Partners and Staff

In theory, clustering and co-location of service providers has benefits for participating organizations in terms of both clinical and administrative efficiencies. The hub reference hospitals identified the following benefits – specifically for their partner organizations:

- Synergies of co-location
  - *As all health care services (and entities) are co-located on one site, many of the non-hospital organizations benefit financially through synergistic efficiencies of being part of the hub. As the hospital owns/administers/operates all healthcare services within the hub, all of the non-hospital organizations such as LTC, FHT, seniors housing, assisted living, etc. do not have to establish a critical mass (support services) to maintain their operations as these are provided by the hospital at lower cost (due to economies of scale). For example, LTC and assisted living do not have to create a kitchen/dietary services within their operation as the hospital provides this service.... Additionally, the LTC does not have to retain separate 24 hour on-site RN services, required by legislation, as this requirement is provided through RN working in the hospital (24/7).* (Espanola Regional Hospital and Health Centre)
- Improved recruitment and retention (ability to offer improved wages and benefits for non-acute staff working in a health hub)
- Shared staffing positions (ability to create full-time jobs from part-time FTEs in different budgets)
  - *Shared pharmacist and IT between Blind River District Health Centre and the FHT is cost-efficient and provides quality services to a small organization* (Blind River District Health Centre)
- Access to education and training opportunities for non-acute staff
- Shared responsibility for crisis coverage in the ER (when hospital is short-staffed).

- Local critical mass for programs & staffing
  - *Comprehensive health hub model establishes a critical mass of local programs/services that promote a more stable workforce (less turnover) which translates to better patient care* (Espanola Regional Hospital and Health Centre)
- Coordination and consolidation of volunteer and fundraising resources (Haliburton Highlands Health Services)

## Administrative Efficiencies

- Back-office efficiencies
  - *The FHT does not need to contract individual ancillary services or staff to deal with maintenance, housekeeping, IT, finance, HR, payroll, quality improvement planning, etc. as the hospital provides this for a nominal fee. As such, these organizations are able to operate much more efficiently through shared services arrangements with the hospital. If the FHT had to hire/contract for individual (small scale and scope) services, it could be at risk of less stability and reliability as there tends to be a higher turnover in organizations that lack critical mass.* (Espanola Regional Hospital and Health Centre)
- Shared electronic health records
  - *See shared electronic records pilot project from Arnprior Regional Health (below)*

### Shared Electronic Health Records: Arnprior Regional Health

Long-term care residents are often transferred to an acute care setting for enhanced care, tests or procedures. At Arnprior Regional Health, the hospital and long-term care home (The Grove) are working together to make these transitions more efficient and effective. In particular, a new opportunity to share electronic health records has had a major impact for both residents and staff. In 2014, two key staff members at the Grove Long Term Care Home (Director of Care and the Assistant Director of Care) were provided with training and direct access to the hospital's electronic health record, allowing connectivity between the two organizations. The electronic health record included discharge summaries, lab tests, diagnostic imaging and other allied health providers assessment and treatment recommendations.

The successful pilot project, which ran from August to November 2014, identified a number of key benefits of long term care staff accessing hospital electronic health records. These quality improvements include:

- a more resident-centred approach to care
- enhanced patient safety
- the avoidance of additional tests and/or duplication of tests
- more effective and efficient use of human resources to find and relay information
- integrated care between members of the residents' care team

A key success factor for this pilot was that both the hospital and the long-term care home are part of the same corporation - Arnprior Regional Health. The shared electronic health record initiative is part of Arnprior Regional Health's ongoing commitment to creating a more integrated health system.

- Reduced administration costs from having single senior management team
  - *See administrative efficiency benefits identified by Dryden Regional Health Centre (below)*

### Administrative Efficiency Story: Dryden Regional Health Centre (DRHC)

In its current health hub model, DRHC provides the following supports to the Dryden Family Health Team and the Community Mental Health and Addictions Program:

- Governance oversight
- Senior management leadership
- Human resources
- IT/ telephone services (shared IT services: risk management, policies/ procedures, data management, leadership evaluation),
- Facilities management
- Financial services (payroll, audit, financial management, supplies)
- Ontario Telemedicine Network (OTN) coordination
- Integrated quality improvement planning across sectors
- Facilities management
- Shared committee structure, i.e. Joint Occupational Health and Safety Committee, Medical Advisory Committee, Accountability Team (Quality and Service)

If Dryden Regional Health Centre was not functioning as a health hub, the local FHT and the Community Mental Health and Addictions Program would have separate administrations and separate governance structures representing additional system costs, which are eliminated under a Health Hub model. In small rural and northern communities, it is the local hospital that has the governance and management expertise necessary for Health Hub development and sustainability.



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## Local System Planning and Governance

- Local health system planning
  - *BRDHC is re-examining patient care gaps along our total catchment area and working with various partners, such as Physically Handicapped Adults' Rehabilitation Association (PHARA), Algoma Manor, etc. (Blind River District Health Centre)*
- Strengthened partnerships between all providers
  - *Local/regional Board of Directors are engaged at a governance level to formalize partnerships, increase collaboration opportunities and integrate services where appropriate. (Dryden Regional Health Centre)*
- Enhanced governance
  - *It can be challenging to find good local board members in small rural and northern communities. One strong local health board with skilled and experienced board members is much better than having many local boards with varying degrees of governance competence.*
- Health system governance focus
  - *As board members oversee more than hospitals, they gain better knowledge, understanding and capacity of the local healthcare system...health hub model will provide board members with a systems perspective when making decisions regarding resource allocations and supporting the implementation of best practices across the whole system. (Espanola Regional Hospital and Health Centre)*

## Community Partnerships Supported by Health Hub Hospitals

In the original health hub paper, it was noted that local health hubs would also be expected to pursue a range of community partnerships. The health hub reference hospital survey identified the following additional community partnerships that have developed as a result of having a high functioning local health hub model:

### Arnprior

- Health Link sponsor
- Meals on Wheels in partnership with Community Home Support

### Blind River

- Liberty Handi-Transit program – funded by municipality, LHIN and hospital
- Sponsor of Emergency Helpline
- Income tax clinic for seniors
- Dawson Street Partnership Group – hospital and local health care partners participate in collaborative service planning for the town of Thessalon
- Huron North Professional Recruitment and Retention Committees – three committees share one physician recruiter with support from the hospital and local municipalities

### Espanola

- Not-for-Profit Housing Board – hospital provides admin and maintenance services
- Seniors Drop-In Centre

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## Haliburton

- Community Paramedicine pilot project – hospital is a partner with Haliburton Paramedical Services

## Manitouwadge

- Public Health Unit – prenatal classes, Best Start, FHT nurse delivers public health unit programs in community
- Seniors Centre – comprehensive older adult program
- High School – dietician led cooking classes
- Hospice Northwest
- CNIB Eye Van

## Other Benefits

- Budget flexibility to allocate resources based on local needs
  - *Being able to shift resources to where they are needed the most and determine the best mix of services (community and institutional) for the area. (Dryden Regional Health Centre)*
- New investments and access to additional services
  - *Recent announcement of \$985,000 funding for Haliburton Highland Health Services (HHHS), along with \$115,000 funding for the Central East CCAC to support the new HHHS community services, is a direct result of the integration of HHHS with local community support services. (Haliburton Highlands Health Services)*

# Challenges of Moving to Fully Integrated Rural Health Hubs

Previous reports have identified the following barriers of moving to fully integrated rural health hub models:

- Lack of a comprehensive rural health policy framework that supports integrated rural health hubs and sustainable rural health services;
- Lack of an all-government (municipal and provincial) approach to the provision of health care services with a focus on rural and remote communities
- Lack of alignment between different levels of government impedes health and social service organizations from achieving funding efficiencies
- Lack of local health care labour supply in rural and remote communities
- Complexity related to relevant policy and regulatory differences between different service providers (e.g. *Public Hospitals Act*, *Long-Term Care Homes Act*, etc.)
- ‘Turf protection’ and more reluctant service provider partners that are not interested or willing to participate in more integrated models of care

The only barrier that may prevent the implementation of fully integrated health hubs in Ontario is Regulation 79/10, s. 153 under the *Long Term Care Homes Act (LTCHA)* which states that “Every person or entity that is not a community care access corporation within the meaning of the *Community Care Access Corporations Act*, 2001 is ineligible for designation as a placement coordinator”. This means that hospitals or hospital staff cannot carry out the placement coordination function currently performed by CCAC staff. This has implications for the homecare portion of the health hub envelope discussed later in the report.

Additionally there are many potential implementation challenges that are preventing well-developed rural health hubs from realizing additional benefits through further integration. Probably the most significant challenges result from existing legislation, potential labour adjustment costs arising from that legislation, and the integration of long term care homes into fully integrated delivery models.

## Labour Legislation

The health care sector is highly regulated and there are a number of pieces of legislation that may impact local health system integration and present potential challenges for implementing fully integrated rural health hubs including:

- *Local Health System Integration Act (LHSIA)*
  - LHSIA sets out the regional framework for funding and organization of the health system. It is designed to promote integration through service and organization integration which can take a variety of forms. LHSIA specifies that most integration is subject to the PSLRTA.
- *Public Sector Labour Relations Transition Act (PSLRTA)*
  - PSLRTA sets out a process for rationalizing, consolidating, and organizing bargaining units when public sector entities, including hospitals and other health providers are amalgamated, services are transferred, etc. Where it applies, it replaces the “successor rights” provisions in the Ontario Labour Relations Act. PSLRTA allows interested parties to apply to the Labour Board with respect to a “health services integration.”
- *Hospital Labour Disputes Arbitration Act (HLDA)*
  - HLDA sets out the mandatory interest arbitration scheme that applies to hospitals and bargaining agents during the collective bargaining process where the parties are unable to come to an agreement.

See Appendices D and E for additional information on how existing legislation may impact the ability of hospitals to adopt more integrated patient care structures like rural health hubs.

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## Labour Costs

The experience of Haliburton Highlands Health Services (HHHS) has been instructive in terms of the cost impacts of moving to fully integrated Health Hub model:

*The Haliburton Health Services integration yielded a relatively small net savings of approximately \$42,000 arising from administrative and back office savings of \$113,000 and increased wage and benefits harmonization costs of approximately \$71,000. Since the integration date was October 1, 2014, a full year of operational experience has not taken place to determine whether this net saving will take place. It is hoped and expected that the integration will be cost-neutral as certain positions may be upgraded with higher qualifications and hours of work. Over time, it is the goal of HHHS to utilize the integrated organizational structure to improve quality and access to services. However, one should not underestimate the work entailed prior to, during and post integration, including triggering PSLRTA. (Haliburton Highlands Health Services)*

The Health Hub Reference Group survey revealed that some community positions (e.g. MSAAAs, FHT budgets) currently managed by the hub hospitals are already being paid hospital-level salaries so the move to full integration and the requirements of PSLRTA are not expected to generate significant labour adjustment costs. Labour adjustment cost estimates range from \$50,000 - \$300,000. As was the case with Haliburton, most Health Hub hospitals calculate that increased labour costs will be offset by new operational and administrative efficiencies in a fully integrated model. The exception may be for hospitals already managing long-term care homes (see below).

## Long-Term Care Homes

As previously noted, a number of the health hub reference hospitals are already managing the LSAA budget for their local long-term care home. This presents a challenge because it has long been recognized that the Ministry's level-of-care per diem funding methodology does not sufficiently support the operations of long-term care homes with fewer than 96 beds. As a result, health hub hospitals operating nursing homes have been subsidizing their long-term care operations from acute hospital budgets for many years. In addition, some homes owned/operated by small hospitals were required by legislation to align salaries to the higher (hospital) level. In most cases, the higher wage costs have been offset by savings and efficiencies achieved through integration of acute and long term care services. However, in moving to a fully integrated rural health hub model, consideration should be given to a long-term care home per diem adjustment factor when creating a single funding envelope.<sup>10</sup>

In a number of rural and northern communities, there are already demonstrated patient care and efficiency benefits from the co-location of hospitals with long-term care homes. In communities where the long-term care home is managed by but not co-located with the hospital, this is not an impediment to implementation of fully integrated health hub hospital on a pilot project basis. If a long-term care home is eligible for re-development then co-location is an option that should be explored over time. In communities where the hospital does not manage the long-term care home, separate ownership does represent an integrated health hub implementation challenge and would likely require a facilitated integration process under LHSIA.

The Ministry's current plan to redevelop 30,000 long term care beds, many of which are in rural and northern communities, is an opportunity to align fully integrated rural health hubs with the Ministry's long-term care redevelopment initiative.

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<sup>10</sup> Review of nursing home costing is underway in North East LHIN and on the work plan for the HSFRL Long Term Care working group.

# Implementation of Fully Integrated Rural Health Hubs on a Pilot Project Basis

There are four key implementation issues for piloting rural health hubs:

- Achieving a single governance structure
- Developing a single funding envelope and accountability agreement
- Developing a consolidated quality improvement plan
- Evaluation of the health hub model

All of these implementation issues will need to be supported by a robust change management plan.

## Towards a Single Governance Structure

Of the eight health hub reference hospitals, the one that comes closest to a fully integrated rural health hub model is Haliburton Highlands Health Services. Its single governance structure was achieved through a voluntary integration process supported by the Central East LHIN.

*On February 22, 2012, the Central East LHIN Board of Directors approved a Community Health Services (CHS) Integration Strategy to address demographic pressures, adjust to changing expectations of patients and families and to meet provincial expectations on improving access, quality and value for money/investment.*

The process was guided by the Haliburton County/City of Kawartha Lakes Integration Planning Team (IPT). After reviewing a variety of governance structures that could

support back office, front-line service and leadership integration opportunities, the IPT recommended:

*The creation of One Entity in Haliburton County, with a single board of governors, accountable for providing the LHIN-funded acute and community based services. The services would include:*

- *All services currently provided by Haliburton Highlands Health Services (HHHS);*
- *All services currently provided by Community Care Haliburton County (CCHC);*
- *Hospice/palliative services currently provided by Supportive Initiatives for Residents in the County of Haliburton (SIRCH);*
- *Adult Day programs currently provided by Victorian Order of Nurses (VON).*

The One Entity in Haliburton County was eventually realized through a voluntary merger between Community Care Haliburton County and Haliburton Highlands Health Services and the transfer into the One Entity of the accountability to deliver hospice/palliative services currently provided by SIRCH and Adult Day Program services currently provide by VON. The decision was made that the governance and management of the hospital would be the foundation for the new single corporate entity for all Haliburton services. Directors from the CCHC joined the HHHS board in 2014 and began the wind-down of the CCHC corporation.

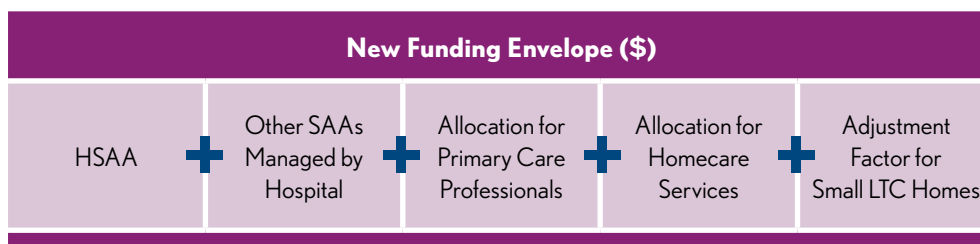
Other health hub single governance options include:

- Transfer of Health Service Provider (HSP) program/organizational funding to health hub hospital corporation
  - For example, the funding and accountability for two small hospital sites (Matthews Memorial and Thessalon) were transferred from the Sault Area Hospital to Blind River District Health Centre (BRDHC) in 2012/13 as part of a voluntary integration process supported by the North East LHIN. Some changes were required to BRDHC's by-laws and geographic representation on the board.

- Amalgamation to create a new corporation
  - All local health care corporations including the hospital corporation are dissolved to create a new health care corporation with a new community health board. The new corporation assumes all assets, liabilities and contractual obligations of the former health corporations.
- Alliance agreement between hub partners
  - Legal agreement to confirm the hospital as the ‘fundholder’ on behalf of a group of hub partners for a defined period of time with defined reporting requirements to alliance partners
  - Agreement should include an understanding that the alliance would work on integrated governance solutions over the course of the hub pilot project – this would build on existing inter-agency governance/management committees where they exist

## Developing the Single Hub Funding Envelope

As a minimum, the hub funding envelope should include the following funding components:



The funding allocation for primary care professionals should be based on the operating budget of the local FHT. As per Ministry-OMA agreements, physician funding will remain outside of the health hub budget and continue to flow directly to the physician group (FHN, FHO).

The determination of an appropriate allocation for homecare services should be guided by the methodologies being developed in response to the Ministry’s new Integrated Funding Pilot Projects with some type of rural/northern adjustment factor in recognition of large rural catchment areas with low population densities and significant travel distances. This homecare allocation should be for relevant professional health services normally contracted by the CCAC. As noted earlier, regulations under existing long term care home legislation would need to be changed in order to delegate the CCAC’s placement coordination function to the health hub.

The implementation of a single funding envelope for health hubs should include a per diem adjustment factor for health hub hospitals that are managing small long-term care homes.

Combining the funding from current service accountability agreements managed by a hub hospital (with additional allocations as noted above) is the most efficacious way to implement a single health hub funding envelope on a pilot project basis. However, rural health hub pilot projects do represent an opportunity for the Ministry and the LHINs, in consultation with the OHA and other provincial health associations, to develop and evaluate different population-based funding models for rural and northern communities consistent with the goals of HSRF.

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Other options for defining a single rural health hub funding envelope that could be explored as part of the pilot project include but are not limited to:

- Population & service-based funding
  - The HBAM (or similar) methodology could be used to calculate a health service funding envelope for a defined rural population, but small hospitals have thus far been excluded based on financial modelling gaps in the HBAM methodology.
- Capitation (per person) funding
  - Capitation funding models are already well-developed in Ontario, particularly for a defined basket of primary care services and there is a considerable body of Canadian and American research recommending some type of capitation funding model for vertically integrated health systems.<sup>11</sup>

## Developing a Consolidated Quality Improvement Plan

The move to fully integrated health hubs represents an opportunity to move from measuring quality within separate health sectors (acute care, long term care, primary care, community care) to measuring quality for a comprehensive package of rural health services based on a common set of health system indicators. While there is some overlap in performance indicators being used in current Quality Improvement Plans (QIPs)<sup>12</sup>, the current QIP development and monitoring process for hospitals, CCACs, long term care homes and primary care services

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11 The most recent integrated care model in the United States is an **Accountable Care Organization (ACO)**. Created through the *Affordable Care Act*, ACOs are defined as a “healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients”. ACOs are normally composed of doctors, hospitals and other health care providers.

12 All current QIPs have some measure of patient/client/resident experience and most have some measure of unplanned or inappropriate Emergency Department utilization

(FHTs and CHCs) are separate and distinct. This places an unnecessary administrative burden on health hub hospitals that are ultimately responsible for the same group of patients/clients/residents and does not adequately capture the patient experience as individuals transition through the system and use multiple health services.

Two of the eight health hub reference hospitals are currently participating in a North West LHIN project that has the potential to provide a common set of quality indicators for all small, rural and northern (SRN) hospitals. The North West Hospital Rural Indicators Project is one of number of projects funded by the Small Rural and Northern Hospital Transformation Fund and supported by the North West LHIN:

*The purpose of this project is to confirm a starting set of quality indicators for rural hospitals in Ontario. The goal is to find existing indicators that are most useful in understanding quality for small and rural hospitals in Ontario.*

This project has achieved consensus (using a Delphi approach<sup>13</sup>) with a panel of 11 rural hospitals on a short list of quality indicators (see table below) that have the potential to become the foundation for a new consolidated Quality Improvement Plan for rural health hubs. The following key themes<sup>14</sup> emerged from the North West hospitals’ Delphi process:

- A focus on patient centered care and experience
- Measuring the quality of patient care transitions
- Making patient safety a priority
- Commitment to clinical best practices

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13 The Delphi method is a structured communication and consensus technique which relies on a panel of experts. The experts answer questionnaires in two or more rounds. After each round, a facilitator provides an anonymous summary of the experts’ forecasts from the previous round as well as the reasons they provided for their judgments. Delphi is based on the principle that decisions from a structured group of individuals are more accurate than those from unstructured groups. (Wikipedia)

14 Similar quality themes emerged from a Supportive Housing Network Quality Indicators project recently reported at the annual convention of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS)

Table 5 – Select Rural Hospital/Health Hub Indicators from NWLHIN Quality Indicators Project

Quality Dimension	Recommended Indicators (Draft)
Accessible	<ul style="list-style-type: none"> <li>• % transfers from rural hospital to referral centre for high-acuity patient with significant avoidable delay;</li> <li>• 90th percentile time from arrival in ED to physician/NP/PA assessment</li> </ul>
Integrated	<ul style="list-style-type: none"> <li>• % patients with confirmed family physician follow-up;</li> <li>• 30-day readmission rate;</li> <li>• % of high-risk patients with advanced care directives;</li> <li>• % of patients scored for risk of readmission using standard tool (e.g. LACE)</li> </ul>
Patient-Centred	<ul style="list-style-type: none"> <li>• % patients rating discharge transitions as very good or excellent;</li> <li>• % patients rating ‘responsiveness to concerns/requests’ as very good or excellent;</li> <li>• % patients who rate ‘overall care’ as very good or excellent;</li> </ul>
Safe	<ul style="list-style-type: none"> <li>• % patients undergoing medication reconciliation at admission &amp; discharge;</li> <li>• % patients with high risk of falls with a falls prevention plan;</li> <li>• % of elderly patients (65+) receiving at least one delirium screen within 48 hours of admission</li> </ul>

## Evaluation of the Health Hub Model

To assist with the implementation of Health Hubs for rural and northern communities, the OHA has retained the services of the Canadian Centre for Health Economics (CCHE) to develop an economic evaluation framework specifically for:

*“the evaluation of the reorganization of the local health care system among existing local/regional entities (e.g. hospitals, clinics, CCAC, etc.) focusing on efficiency and productivity gains that might follow from integrated service delivery within the use of a local health hub structure.”*

The local health hub model for rural and remote communities is well suited for developing new analytical

and empirical approaches to further the understanding of a whole range of factors that come together to influence the health of the population. CCHE researchers will use a two-step process:

- First, the research aims to provide guidance for the evaluation of the local health hub pilot projects.
- Second, it aims to provide a unified framework that will permit valid comparison of outcomes across different approaches to service integration and efficiency improvement.

The CCHE paper will draw on the economic literature on efficiency assessment, looking at both production efficiency and cost efficiency, with particular attention to efficiency gains:

<sup>15</sup> Final list of agreed-upon indicators will be available upon release of final project report.



*The conjectured efficiency gains might be found from the integration of services or production. Investigation and discussion on how this type of gain can be applied to the local health hubs will be performed. Additionally, the paper will examine both cost and production dimensions. From a theoretical perspective there are few areas the CCHE researchers will highlight and expand in their discussion. First, since the Hub structure holds input or service levels constant, total cost may well not change, although average cost should change as a result of gains in care or production efficiency. Second, budgetary savings in total cost are more likely to arise in the long run rather than the short run meaning that short run productivity improvement is more likely to be observed in patient volumes, waiting times and quality of care. Moreover, Health Hub efficiency gains might arise from two areas: (1) economies of scale, (2) economies of specialization. These efficiency gains might occur with no change in the scale of production as measured by level of staffing or capital use (input).*

In addition to this economic analysis, implementation of health hub pilot projects must be evaluated from the patient/client perspective. It is expected that the consolidated Quality Improvement Plans for health hubs will include some patient/client experience indicators<sup>16</sup>. However, since the provision of patient-centred care goes beyond a few basic survey questions, it will be important that Health Hub evaluation include a more rigorous and robust approach to assessing patient experience, especially the transitions of care. The principles of Experience-based Design and the success of the Northumberland PATH<sup>17</sup> project reinforce the benefit of creating a health hub culture where patients and their families are true partners in the evaluation and ongoing design of local health services – ‘doing with’ patients instead of ‘doing to’ or ‘doing for’ patients<sup>18</sup>:

Doing To Patients	Doing For Patients	Doing With Patients
Provider makes rules and controls all schedules	Patient/family have some input	Patient/family as source of control
Information not shared with patients	Some transparency, public data	Shared knowledge and decision-making
“I talk, you listen”	“We help you”	“We walk together”
Compliance focus	Improvement focus	Co-design focus
Unilateral	Benevolent	Partnership

<sup>16</sup> For example, as part of Quality Improvement Plans for Primary Care entities (FHTs, CHCs), patients are asked when they see their physician or nurse practitioner: “Were they able to spend enough time with their primary care practitioner?”, “Were they able to ask questions about their treatment plan?” “Were they as involved as they wanted to be in decisions about their care?”

<sup>17</sup> See The Change Foundation website: [www.changefoundation.ca](http://www.changefoundation.ca)

<sup>18</sup> From the Change Foundation, “PATH - Partners Advancing Transitions in Healthcare” (slide presentation), PANORAMA Kick-Off Event, September 2012

# Recommendations for Fully Integrated Rural Health Hub Pilot Projects

**That the Ministry of Health and Long Term Care and the LHINs support the implementation of rural health hubs<sup>19</sup> on a pilot project basis for small hospitals that already have well-developed local health hub models;**

**That the rural health hub pilots be based on the following parameters:**

- A single funding envelope that includes **as a minimum:**
    - All of the LHIN funding currently being managed by the Hub hospital (as defined by existing service accountability agreements - HSAA, MSAA, LSAA etc.)
    - The funding for primary care allied health professionals (as per FHT or CHC budgets)
    - An allocation for homecare services to be delivered by the hub hospital
    - A per diem adjustment for hub hospitals managing long-term care homes
  - Beyond these minimum requirements for defining the health hub envelope, the Ministry and participating LHINs determine, prior to the start of the pilot projects, if there are additional local health services that should be included in the health hub funding envelope
- A single, consolidated service accountability agreement with performance metrics to be developed collaboratively by the Ministry, the participating LHINs and the pilot hub hospitals
  - A single governance structure (either the existing hospital board or a collaborative governance structure agreed to by all health hub partners) for providing oversight to the health hub pilot
  - A single, consolidated quality improvement plan (QIP) to be developed collaboratively by the Ministry, Health Quality Ontario and the pilot hub hospitals;

**That the Ministry of Health and Long-Term Care, in consultation with LHINs and the OHA, select up to 10 pilot project sites based on the following criteria:**

- Hospitals already managing multiple service agreements;
- Hospitals with demonstrated health system leadership including change readiness;
- Sufficient variation between the hub pilot sites to allow for evaluation and comparison of different components of the Health Hub model;
- Demonstrated commitment from the hospital, providers and community partners to a fully integrated rural health hub model;
- Strong links to the community to ensure the right care, at the right place, at the right time;
- Identified opportunities to improve the patient/client/resident experience;
- Advanced stage of maturity with respect to integration and moving towards a health hub model; and
- The potential to demonstrate administrative synergies and cost savings.

<sup>19</sup> As defined by the provincial Multi-Sector Rural Health Hub Advisory Committee's report - "Rural Health Hubs Framework for Ontario" (Jan 2015) and the Ontario Hospital Association's report - "Local Health Hubs for Rural and Northern Communities" (May 2013).

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**That the pilot projects operate for a minimum period of at least 36 months to allow sufficient time for pilots to achieve financial and clinical efficiencies;**

**That the evaluation of the rural health hub pilot projects be based on:**

- An economic evaluation of health hubs conducted by the University of Toronto
- The quality indicators for rural hospitals/health services currently being developed by the North West LHIN
- Other efficiency/utilization indicators developed for the consolidated LHIN accountability agreement for pilot Hub hospitals
- Patient engagement process based on the principles of Experience-based Design
- Patient experience measures

**That the rural health hub pilot projects be provided with one-time funding of \$300,000 to coordinate the implementation of a fully integrated health hub. The pilot project budget should include the following:**

- Project management fees;
- Administrative support;
- Legal costs;
- Education/training of staff to assume new roles;
- Transitional one-time HR costs associated with changing/consolidating bargaining agents;
- Outreach/communication; and
- Evaluation.

# Suggested Next Steps

1. Creation of provincial Ministry-LHIN-OHA working group to:
  - a. Develop methodology for rural health hub funding envelope
  - b. Confirm selection criteria for health hub pilot sites
  - c. Confirm evaluation methodology/criteria for health hub pilots
  - d. Develop templates for consolidated accountability agreement and quality improvement plan
2. Selection of rural health hub pilot project sites
3. Selected small hospitals and their respective LHINs finalize parameters for each pilot
4. Selected small hospitals and their respective LHINs meet with local health hub partners to discuss requirements/parameters of pilot projects
5. Fully Integrated rural health hub pilot projects are launched

## References

- Central East LHIN, “Community Health and Hospital Services Integration Planning Process, Integrated Governance and Service Delivery Model for Haliburton County and the City of Kawartha Lakes” (September 2013)
- Expert Group on Home and Community Care, “Bringing Care Home” March 2015
- Multi-Sector Rural Health Hub Advisory Committee, “Rural Health Hubs Framework for Ontario” (January 2015)
- North East LHIN, “North East Rural Communities Framework for Achieving Improved Health System Coordination (January 2014)
- North West LHIN, “Health Services Blueprint” (2012)
- Ontario Hospital Association, “Local Health Hubs for Rural and Northern Communities: A Model Whose Time Has Come” (May 2013)
- Sinha, Samir. “Living Longer, Living Well”, (Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario) (December 2012)
- Small, Rural and Northern Hospitals Leadership Council, “Enhancing Access Through Integration: How small, rural and northern hospitals are innovating partnerships and building health hubs” 2013
- The Change Foundation, “PATH project – Partners Advancing Transitions in Healthcare” 2012 - 2014

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## Appendix A

### OHA Health Hub Reference Group

**Jocelyn Bourgoin**

CEO  
Manitouwadge Hospital

**Varouj Eskedijian**

CEO  
Haliburton Highlands Health Centre

**Eric Hanna**

CEO  
Arnprior Regional Health

**Ray Hunt**

CEO  
Espanola General Hospital

**Allan Katz**

Former CEO  
Riverside Health Care

**Gaston Lavigne**

CEO  
Blind River District Health Centre

**David Murray**

CEO  
Sioux Lookout Meno-Ya-Win Health Centre

**Wade Petranik**

CEO  
Dryden Regional Health Centre

**Michelle Caplan**

Policy Advisor  
Ontario Hospital Association

**Lou Reidel**

Chief System Planning and Performance Officer  
Ontario Hospital Association

**Hal Fjeldsted**

Consultant  
Hal Fjeldsted Consulting Inc

**Jim Whaley**

Consultant  
Whaley & Company

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## Appendix B

### Arnprior Regional Health Small Hospital Analysis (Jan 2015)

#### Length of Stay Analysis for Patients Discharged to Home Care vs Discharges to Other Locations

##### Introduction/Background

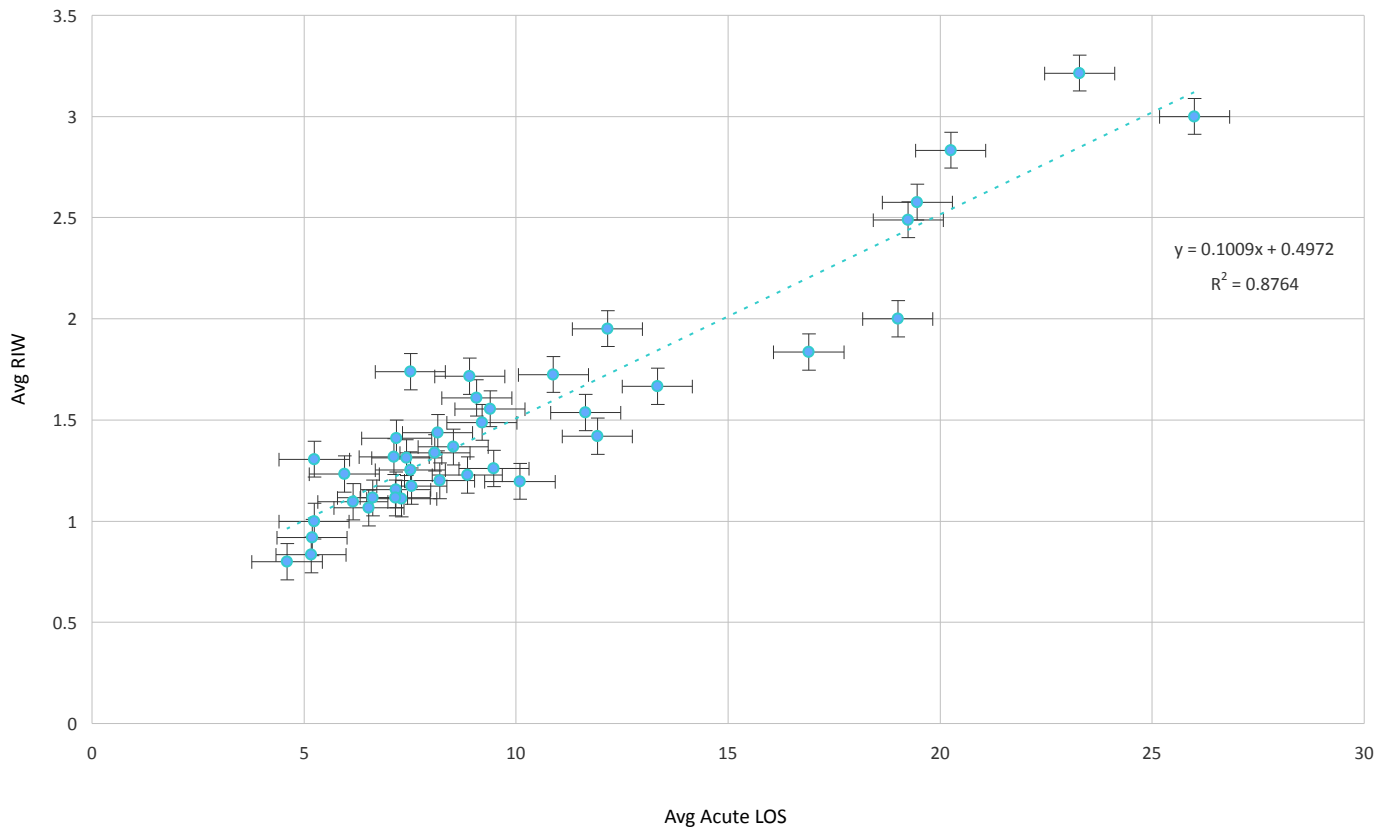
- Arnprior Regional Health (ARH) has in place programs and processes to identify and address ways in which the hospital can increase its efficiency, and improve the overall patient experience.
- Rather than limit its efficiency assessments to the hospital only, ARH takes a more holistic approach and examines the entire episode of care, which can include multiple service providers.
- A recent study identified a higher than expected number of acute inpatient days associated with patients who were discharged from the hospital to home care.
- This was deemed an opportunity that the hospital could pursue as a way in which it could reduce inpatient hospital stays, as well as in providing a more coordinated approach to delivering care.
- As part of its follow-up investigation, ARH assessed this issue as it impacts all small hospitals in Ontario.

##### Analysis/Methodology

1. Analysis of 54 small hospitals in Ontario using 2013-14 inpatient data.
2. The inpatient volumes for the small hospitals were quantified by Major Complications and Comorbid Conditions (MCC) and sorted.
3. To standardize the comparison (i.e., compare ‘apples’ to ‘apples’), the analysis was based on the top MCCs delivered in small hospitals. The top four MCCs, which accounted for approximately 50 per cent of the overall discharges in small hospitals, were identified.
4. The four MCCs were bundled on a hospital-specific basis and were divided into those that were discharged to home care, and those that were not.
5. The average acute length of stay and average RIW was calculated for each MCC category (i.e., to home care, and discharged elsewhere), on a hospital specific basis.
6. The relationship between average acute length of stay and average RIW was assessed to confirm a linear relationship (see Graph 1).
7. Using the RIW and LOS relationship, an ‘expected’ average length of acute stay was calculated using the cases discharged elsewhere, for the home care inpatients.
8. The ‘expected’ and actual average acute lengths of stay were compared, in relation to the number of home care discharges to determine the variation between the actual and ‘expected’ acute days.
9. The resulting surplus, or deficit, days were summed over the small hospital sector and converted to beds, based on a small hospital occupancy rate of 80 per cent to identify the overall opportunity in the sector.
10. The results were summarized for ARH, the Champlain LHIN, and the province, by LHIN.

Graph 1 – Relationship Between ALOS and Avg. RIW for Small Hospitals

Small Hospital Home Care Acute ALOS vs Avg RIW (Excl Moose Factory)



**Results**

For ARH, there were approximately 200 discharges to homecare with an ALOS of 8.9 days. For other discharges, the ALOS was seven days. For all small hospitals, ALOS for patients discharged to homecare was 47 per cent higher (8.8 days) compared to other discharges (6.0 days).

		Home Care				
Hospital LHIN	Small Hospital	Discharges	Acute Days	Wt. Cases	ALOS	Avg RIW
Champlain	(1799) Arnprior Regional Health	202	1,788	248	8.9	1.2

		Other				
Hospital LHIN	Small Hospital	Discharges	Acute Days	Wt. Cases	ALOS	Avg RIW
Champlain	(1799) Arnprior Regional Health	431	3,006	533	7.0	1.2

Home Care					
Hospital LHIN	Discharges	Acute Days	Wt. Cases	ALOS	Avg RIW
Central	232	1,216	303	5.2	1.3
Central East	149	1,621	257	10.9	1.7
Champlain	750	7,469	1,107	10.0	1.5
HNHB	102	1,609	212	15.8	2.1
North-East	499	4,284	700	8.6	1.4
North-West	285	3,234	512	11.3	1.8
South East	142	1,148	190	8.1	1.3
South West	857	6,531	1,153	7.6	1.3
Waterloo Wellington	197	1,187	199	6.0	1.0
<b>Total - All LHINs</b>	<b>3,213</b>	<b>28,299</b>	<b>4,633</b>	<b>8.8</b>	<b>1.4</b>

Other					
Hospital LHIN	Discharges	Acute Days	Wt. Cases	ALOS	Avg RIW
Central	754	2,535	719	3.4	1.0
Central East	484	3,220	696	6.7	1.4
Champlain	2,263	16,059	3,218	7.1	1.4
HNHB	763	5,862	1,042	7.7	1.4
North-East	2,602	16,084	3,491	6.2	1.3
North-West	2,213	12,947	2,608	5.9	1.2
South East	621	3,829	754	6.2	1.2
South West	4,065	22,704	4,453	5.6	1.1
Waterloo Wellington	926	4,191	845	4.5	0.9
<b>Total - All LHINs</b>	<b>14,691</b>	<b>87,431</b>	<b>17,826</b>	<b>6.0</b>	<b>1.2</b>

### Summary Findings

- In considering inpatients discharged to home care, in relation to those discharged to other locations, the number of acute days is typically higher than expected, when adjusting for case mix and complexity.
- Arnprior had 389 more acute days than expected – 1.3 acute beds
- Champlain LHIN had 1,945 more acute days than expected – 6.7 acute beds.
- All small hospitals had 5,576 more acute days than expected – 19.1 acute beds.



## Appendix C

### Additional Utilization Statistics for Health Hub Reference Hospitals

Hospital Corporation	ER Visits	Acute Patient Days	LTC Bed Occupancy Rates
Sioux Lookout Meno Ya Win Health Centre	17,200	13,734	98%
Dryden Regional Health Centre	16,215	12,335	NA
Riverside Health Care (3 sites)	19,094	7,943	97%
Arnprior Regional Health	17,252	11,092	100%
Blind River District Health Centre (3 sites)	19,050	7,191	100%
Espanola Regional Hospital and Health Centre	14,000	4,350	99%
Haliburton Highlands Health Services (2 sites)	24,437	4,391	98%
Manitouwadge General Hospital	4,777	1,785	98%

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## Appendix D

### Key Legislation Impacting Health Hub Integration

#### Public Sector Labour Relations Transition Act (PSLRTA)

PSLRTA presents a barrier to integration generally and to adoption of the health hub model in particular. Generally, there are a number of up-front administrative costs and ongoing cost increases that occur due to the current labour framework.

PSLRTA applies specifically to all “health services integrations.” The definition is quite broad and is inclusive of:

*an integration that **affects the structure** or existence of one or more employers or **that affects the provision of programs, services or functions** by the employers, including but not limited to an integration that involves a dissolution, amalgamation, division, rationalization, consolidation, **transfer**, merger, commencement or discontinuance...* (emphasis added)<sup>20</sup>

It also explicitly applies, although in somewhat modified form, to “partial integrations” that is to instances where *“some or all of the programs, services or functions performed by employees in a particular bargaining unit at a predecessor employer are transferred to or otherwise integrated with a successor employer, and... the predecessor employer continues to operate.”* (emphasis added)<sup>21</sup>

As such, there are very limited circumstances where PSLRTA will be found not to apply. The type of healthcare restructuring that is contemplated in the Health Hub models will, in almost all cases, fall under the full and partial integration provisions of PSLRTA where there is some movement of work from a unionized employer to another employer and where each employer is a “health service provider”, or “an employer whose primary function

is or, immediately following the integration, will be the provision of services within or to the health services sector...”.

#### Up-front/administrative costs:

There are a number of one-time administrative costs that may occur when PSLRTA is triggered:

- Change of bargaining agents representing employees of successor employers;
- Consolidation of bargaining units;
- Trigger of seniority and bumping rights in collective agreements;
- Trigger of severance provisions in collective agreements where work is transferred.

#### On-going cost increases:

There are also a number of ongoing costs that are likely when services are integrated in hospitals:

- Formerly non-union employees at the successor employer become unionized;
- Pressure for compensation harmonization at higher rates.

Depending on the complexity of the health services integration and the number of unions involved, the resolution of bargaining unit descriptions and who will be the bargaining agent(s) may take many months and, potentially years, to resolve.

If there are multiple unions involved, it also can be very difficult from an operational perspective for successor employers to function day-to-day under a “composite” collective agreement that has different terms and conditions for employees performing the same work, but in different bargaining units.

20 Section 2 of PSLRTA.

21 Sections 19.1 to 19.6 of PSLRTA.

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## *Hospital Labour Disputes Arbitration Act (HLDAA)*

HLDAA also creates additional on-going costs for services that are integrated (e.g., in health hubs) in terms of increased compensation and benefits.

Employers and employees that fall under the HLDAA must have their collective agreement negotiations resolved by interest arbitration (as opposed to strike or lockout) if the employers and bargaining agents are unable to resolve outstanding issues at the bargaining table.

The more that community healthcare services become coordinated, or centralized through a local hospital, the more likely the employees of these services will be seen to be “hospital employees” for the purposes of HLDAA. This would be the case if, for example, a health hub hospital became responsible for the delivery of post-acute care that is now carried out by the CCACs.

This means that the interest arbitration framework as envisaged in the HLDAA will apply to employees that would have been outside this framework had the employees remained employed by external community agencies. This often results in upward pressure on wages to meet hospital levels, which is often more attainable by way of interest arbitration under HLDAA.

## Appendix E

### Legislative and Other Challenges for Implementation of Fully Integrated Rural Health Hubs

Legislation	Integrated Health Hub Implementation Challenges
<p>1. <i>Public Hospital Act</i></p>	<p>There are different requirements/obligations in the role of the board to achieve the requirements of the PHA:</p> <ul style="list-style-type: none"> <li>• Section 4 of the PHA represents a potential barrier for hospitals seeking to amalgamate with any corporation other than other hospitals. This section also restricts any physical expansion of hospitals and any hospital-like activities.</li> <li>• S. 4(3) – ministerial permission for additions and new facilities</li> <li>• S. 4(4) – ministerial permission for sale, lease, mortgage, etc. of property</li> <li>• S. 32(4) – financial reports by hospital subsidiaries</li> </ul>
<p>2. <i>Long-term Care Homes (LTCH) Act, 2007 and its Regulation</i></p>	<p>There are different requirements for board/management in the LTCH act compared to the PHA:</p> <ul style="list-style-type: none"> <li>• Family Council – s. 59, 60</li> <li>• Continuity of care – limit on temporary, casual or agency staff - s. 74</li> <li>• Reports to Director – s. 88</li> <li>• Records – s. 92; records kept at the home (s. 232 – reg)</li> <li>• Annual Reporting (s. 239 – reg)</li> <li>• Notice of change of directors/officers (s. 108)</li> <li>• Approval to gain controlling interest (s. 109)</li> <li>• N.B. exemption for entities “premises falling under the jurisdiction of... the PHA”</li> </ul>
<p>3. <i>Home Care and Community Services Act</i></p>	<ul style="list-style-type: none"> <li>• No transfer, encumbrance – s. 19</li> <li>• Revocation/takeover powers unnecessary (Part X)</li> <li>• Service provider reporting – s. 30</li> <li>• RFP link to services</li> <li>• CCAC funded services</li> </ul>

Legislation	Integrated Health Hub Implementation Challenges
4. <i>Community Care Access Corporations Act</i>	<ul style="list-style-type: none"> <li>• Application of provisions of the OBCA – s. 4(6)</li> <li>• Ministerial approval re acquire/ dispose real property; borrow/ security against property - s. 6(2), (3)</li> <li>• Board of Directors – s. 7</li> <li>• Executive Director – s. 10 ( ED cannot be member of Board)</li> <li>• Placement by CCAC in LTC and CCC/Rehab</li> </ul>
5. <i>Public Sector Labour Relations Transition (PSLRTA)</i>	Many health system integrations cannot occur without the unintended expansion of unionized bargaining environments or other unaffordable and costly processes such as enhanced severance payment or early retiree benefits offerings.
6. <i>Local Health System Integration Act</i>	<ul style="list-style-type: none"> <li>• Decision process for required integrations – ss. 25, 26</li> <li>• Process for voluntary integrations – s. 27</li> <li>• Application of PSLRTA – s. 32</li> </ul>
7. <i>Corporations Act</i>	<ul style="list-style-type: none"> <li>• Restricts the integration of unlike entities</li> <li>• Lacks clarity on hospital authority to formalize integration relationships</li> <li>• Section 113 of the Act places restrictions on the amalgamations of non-share Ontario corporations (such as public hospitals, psychiatric Hospitals and nursing homes)</li> <li>• In order to amalgamate, the two corporations must have the same or similar objects in their letter patent.</li> </ul>
8. <i>Public Guardian and Trustee Act</i>	The pervasive oversight of the charitable objects and use of trust property of a public hospital by the Office of the Public Guardian and Trustee presents a level of approval to the amalgamation or changed use of hospital property.
Other Implementation Challenges	
9. <b>Silo Funding:</b>	<ul style="list-style-type: none"> <li>• Funding arrangements are inconsistent and impede integrated/coordinated approaches to service delivery</li> <li>• Silo funding, restrictions in funding (line item funding rather than a global budget which reduces flexibility)</li> </ul>
10. <b>Capital Planning &amp; Funding:</b>	<ul style="list-style-type: none"> <li>• Capital planning does not adequately support integrated solutions (co-location)</li> <li>• Considerable variation in capital funding available for different sectors</li> </ul>
11. <b>Labour Issues:</b>	<ul style="list-style-type: none"> <li>• Collective agreements are often distinct between the various sectors e.g. hospital, and long term care.</li> </ul>

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## Other Implementation Challenges

### 12. Lack of Alignment Between Accountability Agreements:

- Multiple SAAs creates more redundant work in the reporting process; it reinforces the existing silos and prevents hospitals from realigning budgets based on where the services are most needed
- While the LSAA permits a consolidated operating position across all fund types of the health hub, e.g. the nursing home can have a deficit (as per the technical interpretation of LSAA)
- With respect to the calculation of debt the LSAA does not permit a consolidated position (as per technical interpretation of LSAA)
  - As this indicator is calculated at the long-term care home level and not the corporate level, the long-term care home must report only the current portion of long-term debt related to the reporting long-term care home operations.
- Only the HSAA permits surpluses, and ability to add to retained earnings.

### 13. Quality Improvement Plans:

- Multiple data reporting requirements and different performance indicators across sectors

### 14. Patient/Client/Resident Relations:

- Different processes/surveys used by different types of health care organizations

200 Front Street West, Suite 2800  
Toronto, Ontario M5V 3L1  
[www.oha.com](http://www.oha.com)

