



Local Health Hubs for Rural and Northern Communities

An Integrated Service Delivery Model Whose Time Has Come

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1 Introduction

At the OHA's annual Rural and Northern Health Care conference held in May 2012, the Honourable Deb Matthews, Ontario's Minister of Health and Long-Term Care, noted that small hospitals functioning as 'Local Health Care Hubs' was an idea "*whose time has come*". Her informal conference polling indicated there was widespread support of this idea among rural and northern hospital delegates.

The purpose of this paper is to provide the Minister and her staff with advice on advancing the rural/northern health hub concept from a provincial policy and regional LHIN planning perspective.

This paper has been developed by the OHA's Small, Rural and Northern Hospitals Advisory Group (see Appendix A).

2 | Local Health Hub Concept

The following is a suggested working definition of the Local Health Hub model:

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.

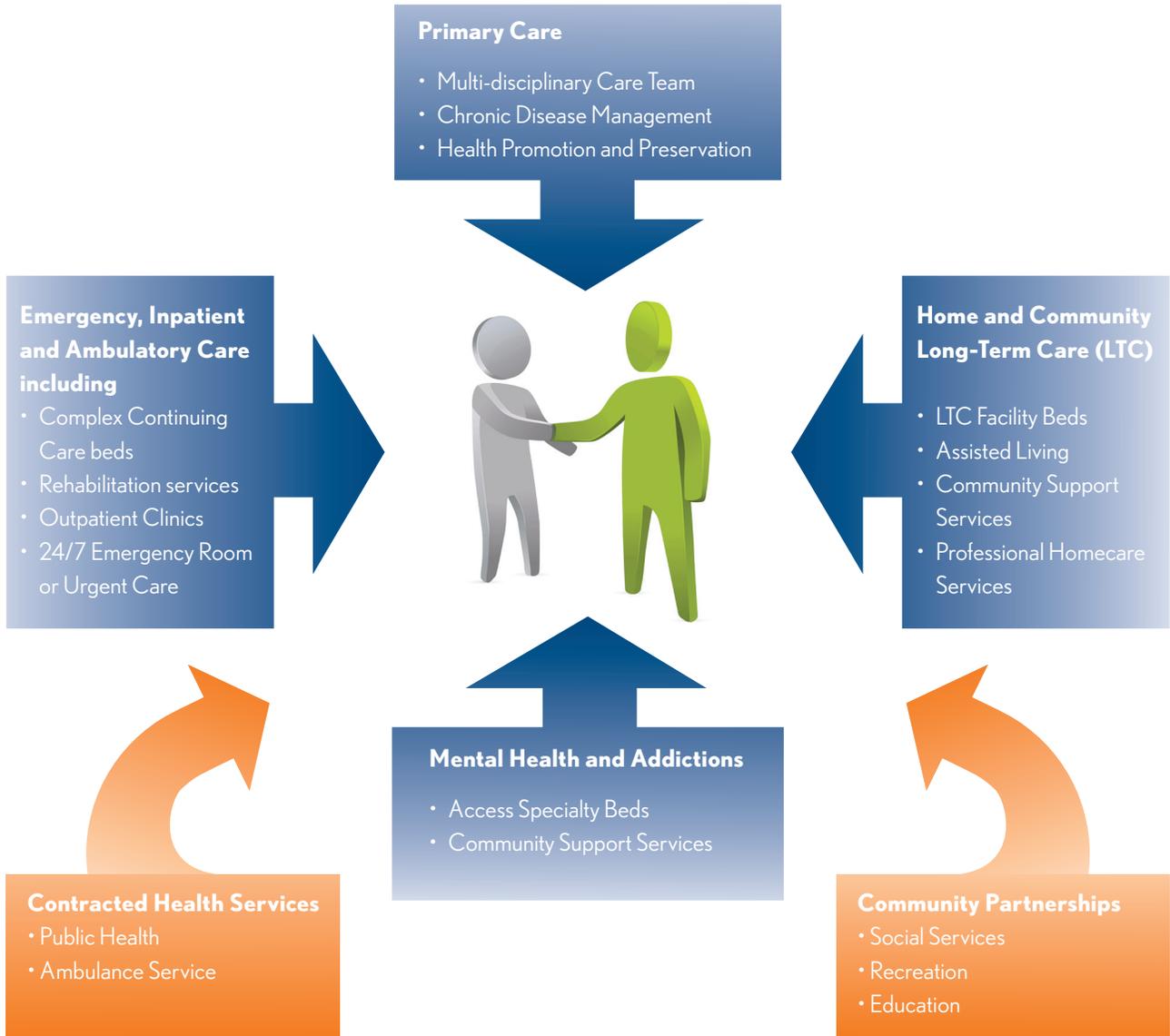
Core Hub Services

Core service requirements to be provided by a Local Health Hub are: (see Figure 1)

1. Emergency and Inpatient Care typically provided by small hospitals¹ (i.e., acute, rehabilitation and complex continuing care);
2. Comprehensive Primary Care – family physicians working with a team of allied health professionals (e.g., Family Health Teams and Community Health Centres) with a strong focus on population health and chronic disease management;
3. Home and Community Long-Term Care – long-term care facility beds, assisted living units, community support services for seniors and professional homecare services (nursing, therapies etc.); and,
4. Mental Health and Addictions – community-based treatment and support services, access to specialty beds (when required), and traditional healing services for First Nation communities.

¹ Possibly including re-designated ALC beds as per the recommendations of the Dr. David Walker report (June 2012)

Figure 1 - Core Health Hub Services with Contracted Health Services and Community Partnerships



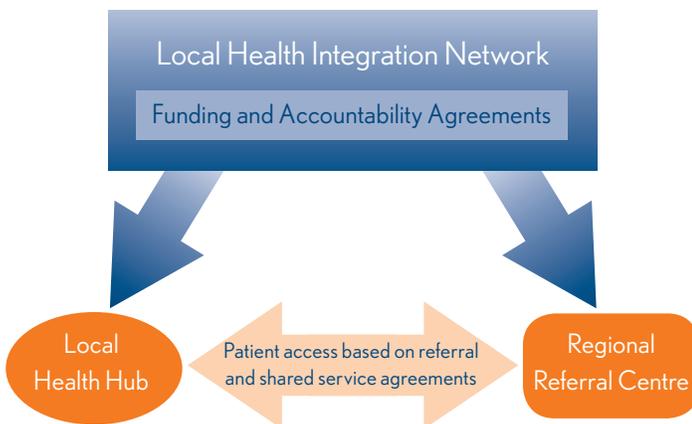
The Health Hub would partner with local municipalities in order to contract with Ambulance (EMS) and Public Health Services. Depending on local circumstances, the Local Health Hub would also be expected to pursue a range of community partnerships with local health and

human service providers (e.g., social services, recreation and fitness services, for-profit health services etc.) to ensure that local residents have access to a comprehensive range of treatment, support and prevention services.

Funding and Referral Relationships

To be successful, Local Health Hubs need to have formal linkages and agreements with at least one regional referral centre to ensure access to specialized care (see Figure 2).

Figure 2 – Local Health Hub Relationships with the LHIN and Regional Referral Centres



In support of improved patient access, these agreements need to clearly define:

- the outreach services and clinics to be provided by the regional referral centre to the Hub (both on-site and through telemedicine);
- the referral mechanisms for sending Hub patients to the regional referral centre;
- the types of patients that can be repatriated back to the Hub for convalescent and post-acute care;
- expanded telemedicine services to minimize travel for Hub clients; and
- academic linkages to support ongoing education, training and support for Hub clinicians.

Single Funding Envelope

An important enabler of the Local Health Hub model is the creation of a single funding envelope which is provided to a lead organization (the Hub Sponsor). 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
- Is consistent with the system trend of population-based funding.

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).

The Ministry of Health and Long-Term Care's (Ministry) Rural and Northern Health Care Panel recently recommended the following:

Implement flexible funding models that support integration at the local level across existing funding silos....and that are responsive and sensitive to the unique local circumstances of communities in rural, remote and northern Ontario. (Recommendation 1-10, 2011, p. 13)

There are a variety of methodologies that could be used to create the Local Health Hub funding envelope (see Appendix B). Development of a single, comprehensive funding envelope and/or alignment of payment models/structures of health providers will take time and require flexibility on the part of all stakeholders (Ministry, LHINs, OHA etc.) and may require a series of interim implementation steps, including the designated “Hub Sponsor” who will manage several different budgets.

The OHA would be available to serve on a provincial working group to determine the best methodology for creating a Local Health Hub funding envelope.

CCAC Services

A key component of the core service package for the Local Health Hub is professional homecare services currently funded by the Community Care Access Centre (CCAC). Across rural and northern Ontario, CCACs are having challenges serving smaller and more remote communities because of human resource shortages and lack of sufficient volumes for contracted homecare agencies. There is also frustration with CCAC’s centralized decision-making which is sometimes not sensitive to the distance needs of rural and northern clients and their families. Because the development and implementation of a single, comprehensive funding envelope for Hubs may take some time, it would make sense for the identified Hub sponsoring agency (local hospital or other health centre) to be recognized as a “preferred CCAC provider”. A few small hospitals have already pre-qualified to bid on CCAC contracts (e.g. Barry’s Bay, Dryden, Manitouwadge and Renfrew), but there is much the Ministry could do to make the CCAC RFP requirements less complex and less costly for smaller health care organizations. 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.

Hub Catchment Population

Catchment population size and travel distances for rural and northern Local Health Hubs are key planning variables. With respect to catchment population, others have recommended a variety of regional hub models centered around secondary or tertiary care hospitals.²

These regional hub models are based on a structural integration solution where new regional health organizations are created to serve much larger catchment areas. Local Health Hubs, which are purposely smaller in scale, are in the best position to coordinate local health services and meet the unique needs of rural and northern communities. In terms of travel distances for more remote communities in northern Ontario, appropriate catchment population size for Local Health Hubs will need to be balanced against distances between small hospitals and larger referral centres.

Quality Improvement Plans

Moving to a Local Health Hub model for rural and northern communities will also provide the critical mass and necessary expertise for quality improvement planning. As *Excellent Care for All Act* requirements are implemented outside of the hospital sector in primary care, long-term care and community health services, small, rural and northern health organizations will find it challenging to prepare, implement and monitor Quality Improvement Plans (QIPs). Having a lead organization act as Hub Sponsor and fundholder also means that a single QIP can be developed for the Health Hub with an appropriate range of quality indicators that cover both hospital and community services. In other jurisdictions, this collaborative approach to quality has helped rural health systems

2 Ontario PC Caucus White Paper (Sept. 2012) has recommended 30-40 existing hospital corporations become Regional Health Hubs and take over the LHIN and CCAC functions; John Ronson, Lead, Health Strategy, Policy and Evaluation, TELUS Health Solutions, has recommended the creation of 30-40 Integrated Health Organizations (June 2011)

establish stronger quality improvement support structures and assisted rural professionals in acquiring the knowledge and tools to improve quality.³

In addition to a more coordinated approach to quality improvement, the Hub model for rural and northern communities would support a stronger patient navigation approach across all core Hub services beyond the current case management system used by CCACs. The Hub's more integrated approach to care transitions will also help health care professionals working in the Hub model tackle the growing prevalence of chronic diseases in rural and northern Ontario.

In summary, the key prerequisites for a Local Health Hub model are:

- Single funding envelope for a defined population with a consolidated accountability agreement with the LHIN;
- Availability of core health services (see above) that are or can be formally linked using the following linkage mechanisms:
 - Clinical integration through pathways and quality improvement (QI) processes to support inter-professional, team-based care, and
 - Integrated governance/management processes and structures;
- A health care facility or health centre that can serve as the 'Hub Sponsor' and fundholder;
- Information technology (IT) infrastructure to create a shared electronic patient record; and

3 Institute of Medicine, *Quality Through Collaboration: The Future of Rural Health*, 2005

- Sufficient critical mass in terms of size of catchment population, but still recognizing the significant travel distances in northern Ontario⁴.

The key benefits of moving to a Local Health Hub model are:

- Improves client access based on a "care closer to home" philosophy;
- Supports a patient-centred approach to coordinating local health services with stronger patient navigation and shared clinical pathways;
- Strong links to community options for Hub clients and patients to ensure right care, at the right place, at the right time;
- Supports a population health mandate that would collaborate with public health to address the health care needs of the community;
- Supports quality improvement planning for local health systems in rural and northern Ontario;
- Creates administrative synergies between service providers in the Health Hub including the potential for shared back office opportunities;
- Reduces the number of accountability agreements that the LHINs have to manage; and
- Removes the barriers and disincentives created by silo funding and creates more streamlined reporting.

4 Based on a recent Institute for Clinical Evaluative Sciences (ICESs) analysis of primary care catchment areas, LHIN recommendations and international rural health models, a Health Hub catchment population of 10,000 - 40,000 is a reasonable planning guideline for rural, southern Ontario. Smaller rural communities that are relatively close may need to work together to create sufficient critical mass. For more remote communities in northern Ontario, there needs to be flexibility with respect to appropriate Hub catchment population size.

The Local Health Hub model is consistent with:

- The OHA’s previous restructuring advice on ‘population health networks’⁵;
- Key elements of the Ministry’s 2012 Action Plan, including:
 - Improved access and stronger links to Family Health Care,
 - Access to high-quality, timely care as close to home as possible, and
 - Funding follows the patient;
- Recent LHIN integration reports, strategies and decisions regarding rural and northern communities, and the concept of Integration as defined by the *Local Health System Integration Act* (2006); and
- International evidence on decentralized and integrated rural service delivery models.

The model also builds on a variety of successful health hub models that already exist in rural and northern Ontario.

5 Population health networks – defined as fund holders for hospital, CCAC, primary care, specialty medical services, and community health services with ambulance services, and public health devolved from municipalities (OHA Position Statement, 2011, p.8)

3 | The Supporting Evidence

Previous Provincial Policy Support

Previous provincial policy recommendations in support of local integrated models for rural and northern Ontario include the following:

Rural and Northern Healthcare Framework (Jan. 2011)

The provincial government's Rural and Northern Health Care Panel made the following recommendations:

- R6: Support a “local hub” model of health planning, funding and delivery in rural, remote and northern communities, which integrates services across health sectors at the local or multi-community level, and includes broader social services, where feasible.
- R6.1: Leverage the role of small health care facilities and their catchment areas as potential ‘local hubs’ of integrated health care services.

Joint Policy and Planning Committee (JPPC) Core Services Review (2007)

The JPPC report suggested the following types of integration opportunities for small hospitals:

1. Enhance and Extend Primary Care

- Small hospitals partnering with multi-disciplinary primary health care teams such as Family Health Teams, Nurse Practitioners, and Community Health Centres in order to cost-effectively share space, clinical staff, and administrative resources.

2. Expand Community Networks

- Small hospitals acting as catalysts to develop local access points for health, not just health care, by providing support to community-based health care and social service providers, community agencies, volunteer associations and human service organizations in their catchment area.

3. Expand Hospital Networks

- Strengthen existing, or build new, affiliations with urban multi-hospital systems in order that small hospitals get the resources and technical assistance they need to provide services that otherwise would not be available to patients unless they traveled (e.g., satellite chemotherapy, dialysis, visiting specialists and clinics).

4. Integrate and Manage Primary, Acute and Long-Term Care

Rural and Northern Health Care (RNCH) Framework (1997)

While the primary emphasis of the 1997 RNCH framework was the creation of horizontal networks of hospitals, the long-term policy goal at the time was to evolve the role of small hospitals as local hubs:

- Support small hospitals to develop or enhance their current roles in communities as a focal point for the provision of other health and related services, and for non-institutional patient care. The hospital may be further developed as a nucleus within the network from which medical, dental and other health professionals, could offer their services on a permanent basis or provide accommodation for visiting specialists.

International Models of Decentralization and Rural Health Integration

In terms of international health systems development, a recent review by Dash and colleagues (2009) indicates that a key design system principle that is emerging to ensure appropriate patient access and system cost-effectiveness is:

“Decentralize where possible, centralize where necessary.”

They describe the benefits of decentralization as follows:

“First, decentralization results in better access, with people benefiting from the convenience of having core health services close to where they live. The goal is to provide a “one-stop-shop” where initial consultation and diagnosis can happen in a single place and a single visit. Rooting services in primary care can also reduce unnecessary referrals, prevent overreliance on hospitals, and give primary care providers a more holistic view of patients’ health...” (Dash, 2009, p. 31).

In addition to supporting decentralization and care closer to home, the Local Health Hub model is also consistent with the well-documented benefits of vertical integration which can be achieved through a variety of linkage strategies. Vertical integration is defined as:

“A network of organizations that provides or arranges to provide a coordinated continuum of services to a defined community, and is held clinically and fiscally accountable for the outcomes and health status of those served.” (Devers et al., 1994)

“Vertical integration, the combination or coordination of different stages of production, may be achieved in a variety of ways such as contracts, relationships or ownership.” (Walston et al., 1996)

Multi-Purpose Services in Australia

“In Australia, the Multipurpose Service (MPS) Program, established in 1993, is a partnership between the Commonwealth and State Governments to address the problems of access to, and sustainability of, health services in small rural communities. The program pools funding and sets aside the normal program guidelines and constraints to allow small communities to integrate acute and aged care services.

Multipurpose services bring together a range of health and residential aged care services on one site. General practitioner and ambulance services may also be co-located. The program benefits small rural communities by enabling older residents to ‘age in place’ and provides small rural communities with access to a range of coordinated acute, aged care and community services.” (Australia, p. 35)

Rural Health Networks in the U.S.

In the United States, ‘Rural Health Networks’ are a well-documented and successful model of rural integration. They are defined as:

“A formal organizational arrangement among rural health care providers that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved.” (Wellever, 2001, p. 2)

These service networks have the following attributes:

- Established as a separate legal entity (i.e., non-profit corporation);
- Include at least one rural hospital;
- A written agreement that specifies the purpose and membership of the network, and duties/obligations of network members;

- Individual autonomy of members (but delegation of limited portions of their autonomy to the Network to foster greater coordination and integration); and,
- Joint plan of collaborative action.

These structures (variously known as affiliations, alliances, consortia, cooperatives) have become an increasingly popular strategy for addressing community health care issues. Rural health networks in the United States typically pursue a wide range of objectives including:

- Developing local service capacity;
- Expanding health improvement and risk reduction services; and,
- Strengthening service coordination.

Ultimately, the goal of these rural networks is the creation of healthy rural communities:

“Healthy rural communities depend on strong integrated systems that include the provision of health care services through family practice clinics, local hospitals, ambulance services, skilled nursing facilities, hospice and homecare services and local public health services.” (Minnesota Department of Health, 2009, p. 26)

Rural Health Centres across Canada

There are a wide range of non-hospital based rural health centres and multi-service centres operating across Canada. For example, Vancouver Island Health Authority funds four Northern Rural Health Centres to provide services to the remote communities of Zeballos, Ehattesaht, Oculije, Kyuquot, Tahsis, Esperanza, Tsaxana and Gold River. The typical range of services provided by the centres is as follows:

- Urgent Care Centre
- X-Ray
- Laboratory
- Physiotherapy
- Primary Care
- Homecare Nursing
- Home Support
- Child Health Clinics
- Mental Health and Addictions for Youth and Adult Populations
- Communicable Disease Control

Recent LHIN Integration Reports

While most LHIN integration initiatives have been focused on horizontal (sector) integration, some LHINs have released integration reports and strategies in the last couple of years that support a vertically integrated local health hub model (see Appendix C for more detail).

North East LHIN Realignment Plan for Temiskaming (June 2012)

*“There exists within each community, expertise, resources, ‘bricks and mortar,’ and most importantly, the dedication of health service providers, volunteers and leadership to further develop existing **health care community hubs**... Increased integration within each of the communities of Kirkland Lake, Temiskaming Shores and Englehart will contribute to District-wide realignment while simultaneously improving access to services, quality care and value for patients. As the work of developing a common governance entity proceeds, health service providers within each community need to continue to build on existing initiatives, step up innovation and collaboration amongst themselves and increase activity within each of their three geographic areas.” (NE LHIN, 2012, p. 11)*

North West LHIN Health Services Blueprint (Feb. 2012)

*“At the local level, **Local Health Hubs** will form the foundation for an integrated healthcare system in the North West LHIN and will plan and provide health care services based on the unique needs of the local community. Initially, Local Health Hubs will be located in communities that currently provide hospital care services and will involve the co-location (achieved by either optimizing facilities or virtually connecting providers) of health service providers within the existing physical plant, if possible.” (NWLHIN, 2012, p. 186)*

Champlain LHIN Vision – Redesigning Healthcare for the 21st Century (2010)

As part of the implementation of its *Integrated Health Services Plan: 2010-2013*, the Champlain LHIN released a comprehensive vision statement which included a description of a desired future integrated system with the following four components:

- Regional Hospital
- District Hospitals
- Polyclinics⁶
- Local Health Centres

Local Health Centres would serve a population of 10,000 – 20,000 and provide primary care, urgent care, health promotion, CCAC services, long-term care services, community support and social services.

The Champlain Vision also made it clear that a new approach was required for rural communities and recommended a rural **Community Health Integrated Network** (CHIN) – a proposed new entity with a single governance and administrative structure for all health services in a defined rural area.

Since the release of this Vision, the LHIN has:

- Approved the development of the Orleans Family Health Hub (based on the Polyclinic model);
- Supported the redevelopment of the Carleton Place District & Memorial Hospital with an adjoining Health Village (see Appendix D);
- Supported the Madawaska Communities Circle of Health – a coalition of service providers and community representatives working together to create a more integrated health system for the rural residents of Madawaska Valley;
- Approved the integration of the St. Francis Memorial Hospital (Barry’s Bay) and the Rainbow Valley Community Health Centre; and
- Approved the Rideau Valley Health Centre (RVHC) as a satellite of the Kemptville District Hospital. RVHC (www.rvhc.ca) is a newly constructed primary care health hub, which houses a group of family physicians, an urgent care centre, hospital operated diagnostic services and a wide range of health partners including CCAC, diabetes education and a community lab.

⁶ An integrated service delivery model for densely populated urban/suburban communities (50,000 – 100,000 catchment population) that combines hospital ambulatory services and clinics, 24/7 urgent care, and primary care under one roof.

Waterloo Wellington LHIN Rural Health Care Review (2010)

The service delivery model recommended for rural areas in the Waterloo Wellington LHIN consists of the following key components:

- Comprehensive Primary Care – the foundation for creating healthy rural communities;
- Care Closer to Home – including more specialist visits through on-site clinics and telemedicine; and
- Integrated Rural Health Services – formal linkages between acute care, primary care, homecare, long-term care, mental health services and community support services.

In terms of integrated facility development, the LHIN's rural review recommended:

“THAT current and future redevelopment projects for rural facilities maximize opportunities for service integration/coordination between acute, primary care, long-term care and community health services.” (WWLHIN, 2010, p. 5).

As a result of these rural recommendations, the LHIN approved the redevelopment of hospital facilities in Fergus, Mount Forest and Palmerston based on a Rural Health Hub model.

4 Existing Rural and Northern Health Hub Models

The concept of Local Health Care Hubs is not new. In fact, many small hospitals in Ontario have already developed or are developing 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 care hub models which are small hospital-based use different descriptors such as “health care campus” or “health village”, but all are based on co-located services and utilize a variety of management and clinical linkages between the health service providers. The following small hospitals with their campus partners are just some examples of well-developed ‘hub’ models in rural and northern Ontario:

- Arnprior Regional Health (www.arnpriorregionalhealth.ca)
- Campbellford Memorial Hospital (www.cmh.ca)
- Deep River District Hospital (www.drdh.org)
- Dryden Regional Health Centre (www.drhc.on.ca)
- Hanover and District Hospital (www.hanoverhospital.on.ca)
- Espanola Regional Hospital and Health Centre (www.espanola-hospital.com)
- Riverside Health Care Facilities Inc. (www.riversidehealthcare.ca)
- Sioux Lookout Meno-Ya-Win Health Centre (www.slmhc.on.ca)
- West Parry Sound Health Centre (www.wpshec.com)

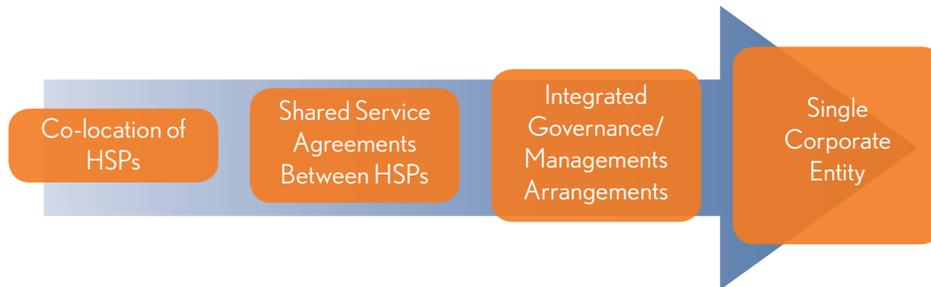
For several small hospitals, their LHINs have recently approved capital redevelopment plans based on a Rural Health Hub model:

- Carleton Place & District Memorial Hospital (www.carletonplacehospital.ca)
- Groves Memorial Community Hospital (www.gmch.ca)
- North Wellington Health Care (www.nwhealthcare.ca)
- Markdale Rural Health Centre (see Appendix E)

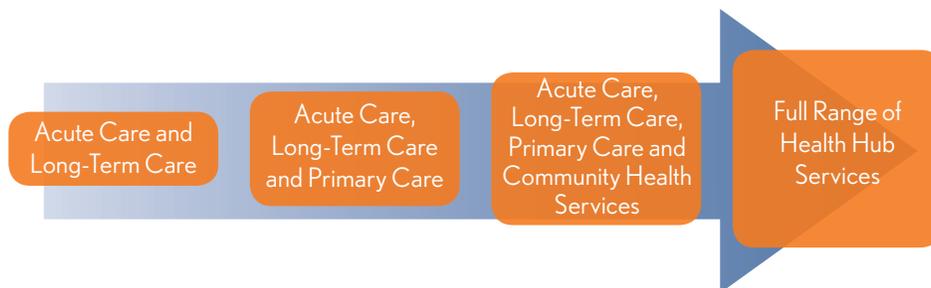
One of the key ‘building blocks’ for the Health Hub model is the integration of acute and primary care. For many small hospitals, the same family physicians staff the hospital, the emergency room and provide primary care services to their patients at the local medical clinic or health centre. However, because of Ministry policy decisions and silo funding approaches, these two sectors remain stubbornly separate in terms of funding and organizational structures. A handful of small hospitals (Barry’s Bay, Deep River, Dryden, Espanola) have managed to break through the silos to create integrated models of acute and primary care. Under a Local Health Hub model, these integration examples would become the norm instead of exceptions to the rule.

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

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



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

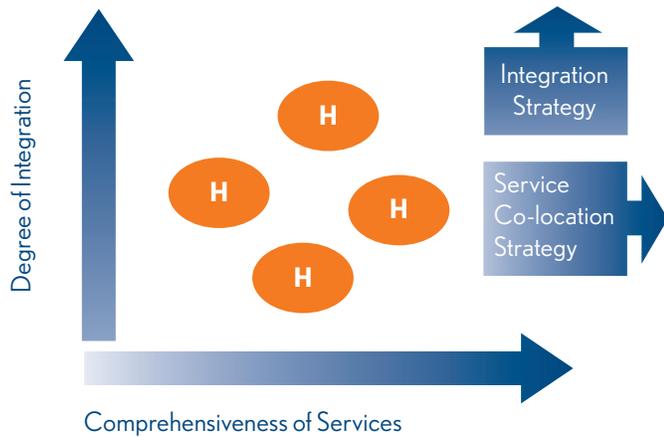


Putting these two dimensions together (Integration and Comprehensiveness) creates a potential strategy map for all small hospitals in Ontario (see Figure 3). A hospital’s “starting point” on the map becomes the basis for their strategic directions related to Integration and Service Co-Location.

For example, one of the new strategic directions for the Mattawa Hospital is *Developing the Hospital as the Local Hub for Health Services*. The resulting short-term action plan in support of this strategy has two key components:

- Stronger linkage with long-term care – specifically an **integration strategy** involving a new management services agreement with the local nursing home.
- Stronger linkages with primary care – specifically a **service co-location strategy** to create renovated office space for family physicians to move into the hospital.

Figure 3 – Strategy Map for Small Hospitals Moving Towards Health Hub Model



In addition to hospital-based hub models, there are a variety of non-acute care hub models. These hubs are described as primary care centres, urgent care centres or ambulatory care centres. Some examples include:

Willett Urgent Care Centre, Paris (part of Brant Community Healthcare System – www.bchsys.org)

- The Centre provides daily urgent care, primary care, diagnostic imaging service and a full range of recreation, occupational and physiotherapy services on an outpatient basis. Community health services include counselling, a Community Well-being Team, fitness classes and health and wellness education activities.

Woolwich Community Health Centre (CHC), St. Jacobs (www.wchc.on.ca)

- This CHC is a comprehensive rural primary care centre with on-site pharmacy, dental office, chiropractic clinic, naturopathy clinic and midwifery services. In addition to treatment and prevention services provided by a team of family physicians and allied health professionals, the centre offers the following community programs:

- Exercise Programs
- Seniors' Programs
- Programs for young children and their parents
- Farm Safety Education Programs
- Nutrition Counselling and Education
- Hospice
- Caregiver Support
- Healthy Lifestyles

Because of the major restructuring that the Ministry and LHINs are contemplating for the primary care sector, combined with the Ministry's new *Health Links* pilot projects and Health Quality Ontario's *Best Path* initiative, it is important to stress that in many rural and northern communities without a local hospital, an existing primary care organization or health centre could serve as the local Hub sponsor.

5 Implementation Issues and Recommendations for Action

While some LHINs are already moving forward with the implementation of Local Health Hubs in their respective regions, there is real benefit to creating some consistency across the province for the benefit of all rural and northern communities. The intent of this paper is to provide a useful framework for the Ministry, the LHINs and other key stakeholders to use in order to achieve consensus on the core service elements and funding envelope requirements necessary to support Local Health Hubs. There are some key components of the Hub model that will require legislative, regulatory and policy changes including:

- Integration of hospital funding (including acute, rehabilitation, complex continuing care, mental health and emergency care, etc.) and primary care funding;
- Integration of CCAC (homecare) funding into the Hub envelope; and
- Integration of Ambulance and Public Health funding into the Hub envelope.

Because of these implementation challenges, it is recommended that Local Health Hubs be implemented, with the support of LHINs, on a voluntary pilot project basis. Ongoing evaluation of these pilots will help to determine which funding and integration mechanisms make most sense for rural and northern communities. The OHA is recommending that creating a single legal hub entity through merger of small hospitals with other community health agencies is NOT the appropriate starting point for development of Local Health Hubs unless the organizations and communities are ready to do so on a voluntary basis. Instead, a Hub sponsor (small hospital or local health centre) would be selected as the fundholder on behalf of all the local health services that form the Hub.

In order for this fundholder model to work, there would need to be a collaborative governance structure in place for all participating Health Hub partners. This governance structure should not be prescribed, but jointly developed by participating local boards. The purpose of the collaborative Hub governance is to initially provide collective oversight to the consolidated accountability agreement with the LHIN. With improved board-to-board communication and the building of trusting relationships, the collaborative Hub governance structure may want to review other options for creating more integrated governance and management structures. Over time, the Hub's collaborative governance structure may be an interim transitional step to the creation of a single legal entity for Local Health Hub services.

In some rural and northern communities, one of the impediments to further collaboration is existing infrastructure and lack of facility space for co-location. As Health Hub models continue to develop, capital planning requirements by the Ministry and Infrastructure Ontario will need to better align with the need for more integrated facility space shared by a variety of health care partners. For rural and northern communities not initially selected as Hub pilot projects, there are still steps a small hospital can take locally to support the implementation of a Local Health Hub model, including:

- Updating the hospital's strategic plan to embed the Health Hub concept and create actionable strategies for co-locating additional services; and
- Hosting of local meetings with other health care partners to discuss interest in the Health Hub model.

The following recommendations are offered to support implementation of Local Health Hubs for rural and northern communities.

Recommendations for Action (Ministry and LHINs)

1. THAT the Ministry and all LHINs that serve rural and northern communities formally recognize the Local Health Hub model as a viable local integration strategy;
2. THAT the Ministry create a provincial working group to determine the best approach for creating a single funding envelope for Local Health Hubs;
3. THAT certain ancillary services (e.g., hospital vs. community labs) may require further study as part of the single funding envelope concept;
4. THAT the Ministry and LHINs determine an appropriate catchment population size range for local Health Hubs which is sensitive to more distant rural and remote communities and which has an upper size limit that differentiates the Local Health Hub model from Regional Health Hub or Network models;
5. THAT the Ministry and LHINs initially use a voluntary approach to Local Health Hub implementation with a number of pilot projects in northern Ontario and rural, southern Ontario;
6. THAT existing Health Hub models that are most advanced in terms of integrated and comprehensive services, be recognized as “early wins” and considered as initial pilot project sites;
7. THAT the Ministry work with the OHA, OMA and other key stakeholder groups to examine the merits of a single funding envelope, a consolidated accountability agreement, a single quality improvement plan and a collaborative governance structure for Hub services;
8. THAT the Ministry work with the OHA, Ontario Medical Association (OMA) and other key stakeholder groups to identify and remove the regulatory, policy and financial barriers for aligning acute and primary care in rural and northern communities;
9. That the Ministry work with the OHA, OMA and other key stakeholder groups to align physician remuneration and incentives between primary care and hospital services with the goal of maximizing local family physician’s participation in providing both hospital and primary care services; and,
10. THAT the Ministry work with Infrastructure Ontario to ensure that capital planning and facility redevelopment requirements support the creation of Local Health Hubs for rural and northern communities.

Recommendations for Action (Small Hospitals)

11. THAT small hospitals incorporate the Local Health Hub model into their strategic plans if they have not done so already;
12. THAT revised small hospital strategic plans include strategies for co-locating additional services with an emphasis on primary care, long-term care and mental health and addiction services (where feasible);
13. THAT small hospital Board Chairs and CEOs convene meetings with local health partner organizations to discuss mutual benefits of moving towards a Local Health Hub model; and,
14. THAT small hospitals work with their LHINs to garner support for Local Health Hub implementation as a voluntary integration strategy.

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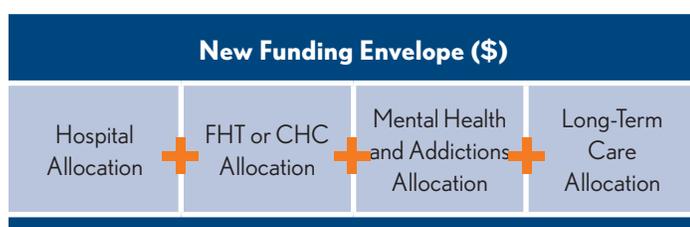
Appendix A – OHA SRN Advisory Group Membership

Name	Position	Organization
David Murray	CEO	Sioux Lookout Meno-Ya-Win Health Centre
Kelly Isfan	CEO	Norfolk General Hospital
Wade Petranik	CEO	Dryden Regional Health Centre
Ray Hunt	CEO	Espanola General Hospital
Colin Goodfellow	CEO	Kemptville General Hospital
Dick Mannisto	Chair	Region 1 Regional Council Executive Committee
Katrina Wilson	CEO	Hanover and District Hospital
Mary Atkinson	Trustee	Huron Perth Healthcare Alliance
Jim Whaley	Consultant	Whaley & Company
Elizabeth Carlton	Director, Policy, Legislative and Legal Affairs	OHA
Michelle Caplan	Policy Advisor	OHA

Appendix B – Methodologies for Creating Single Funding Envelope for Local Health Hubs

1. Consolidating Existing Budgets

This approach would involve consolidating current LHIN funding earmarked for separate organizations into a new single funding envelope.



From an administrative standpoint, this may be the easiest approach, but it assumes that current funding levels are appropriate for the local population currently being served. There are also large service provider organizations (e.g., CCACs) which serve many communities and it would be difficult to determine what proportion of the CCAC budget, for example, should be allocated to the Local Hub.

2. Patient-Based Funding

The Health-Based Allocation Model (HBAM) funding model is currently being implemented over a three-year period in order to move hospitals away from global budgets. In theory, the HBAM model could be used to calculate a health service funding envelope for a defined population, but currently, 55 small hospitals are being excluded from HBAM because of concerns with the methodology.

3. Capitation (Per Person) Funding

Capitation funding models are already well-developed in Ontario, particularly for primary care, and there is a considerable body of Canadian and American research recommending some type of capitation funding model for vertically integrated health systems. Previous Ministry policy on integration models recommended a capitation funding envelope for Integrated Health Systems (IHS)⁷ in order to serve a defined population. Capitation rates for Health Hubs would have to be much higher than existing primary care capitation rates for FHOs and FHNs.

⁷ Also referred to as Integrated Delivery Systems (IDS) and Comprehensive Health Organizations (CHOs)

Appendix C – Recent LHIN Reports Supporting Health Hubs for Rural and Northern Communities

NE LHIN Realignment Plan for Temiskaming (June 2012), pp.10-11

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

Brief Description

The NE LHIN-funded health service providers within the Temiskaming District will become One “Health Care System” to provide services to patients within the entire District where appropriate. The creation of the Temiskaming Realignment Governance Entity is the catalyst, enabler and connector in creating this one system. Health service provider boards will transfer into this entity, which will eventually have one accountability agreement with the NE LHIN. The common governance entity has one employee - a CEO. Health service providers within the Temiskaming District will be better positioned to provide - Access, Quality and Valuable services to patients within the entire District where appropriate.

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

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

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

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

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

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

Community-Based Realignment Activities

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

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

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

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

Sector-based Realignment

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

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

District-wide Realignment

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

NW LHIN Health Services Blueprint (Feb. 2012), pp.186-187

Recommendation: All Health Service Providers within the Local Health Hub and the surrounding community will collaborate, partner and/or merge to deliver safe, quality care consistent with evidence based practice, to the population served.

Overview

At the local level, the Local Health Hubs will form the foundation for an integrated health care system in the North West LHIN and will plan and provide health care services based on the unique needs of the local community. The goal of the Local Health Hubs will be to provide improved access to care closer to home for stable patients including those with underlying chronic conditions and mental health and addictions issues.

Initially, Local Health Hubs will be located in communities that currently provide hospital care services and will involve the collocation (achieved by either optimizing facilities or virtually connecting providers) of health service providers within the existing physical plant, if possible.

Where physical co-location is not possible, providers will be virtually connected through technology. As the model develops, it is anticipated that new Local Health Hubs will be established in other communities.

Scope of Services

Services provided in each Local Health Hub will be tailored to the unique needs of the community, and staffed by health service providers currently employed in those local communities. Providers will be collocated (achieved by optimizing facilities or virtually connecting providers) and this may include:

- Inpatient services including post-acute, transitional, palliative, and complex continuing care/long-term care beds;
- Emergency Department in existing hospitals designated as Local Health Hubs;
- Urgent Care Clinics in future Local Health Hubs;
- Chronic Disease Clinic utilizing the CDPM Model;
- Mental health services;
- Tele-homecare services will be delivered to the patient through the Local Health Hub but will be monitored and tracked at the regional level; and
- Community Care Access Centre staff.

In addition, the following services may be provided within each Local Health Hub:

- Primary care providers/family health teams;
- Interprofessional care teams (e.g. Chiropodist, Dietitian, Occupational Therapists, Physiotherapists, Speech Language Pathologists, etc.);

- Visiting specialists clinics (e.g. cardiology, rehabilitation);
- Visiting community partners (e.g. Alzheimer's Society, Arthritis Society, Cancer Palliative Services, etc.);
- Organized volunteer/peer support services (e.g. meals on wheels, drivers, etc.); and
- Tele-medicine services.

Local Health Hubs will also form formalized partnerships with other community-based services that focus on self-management, health and wellness. These services may include:

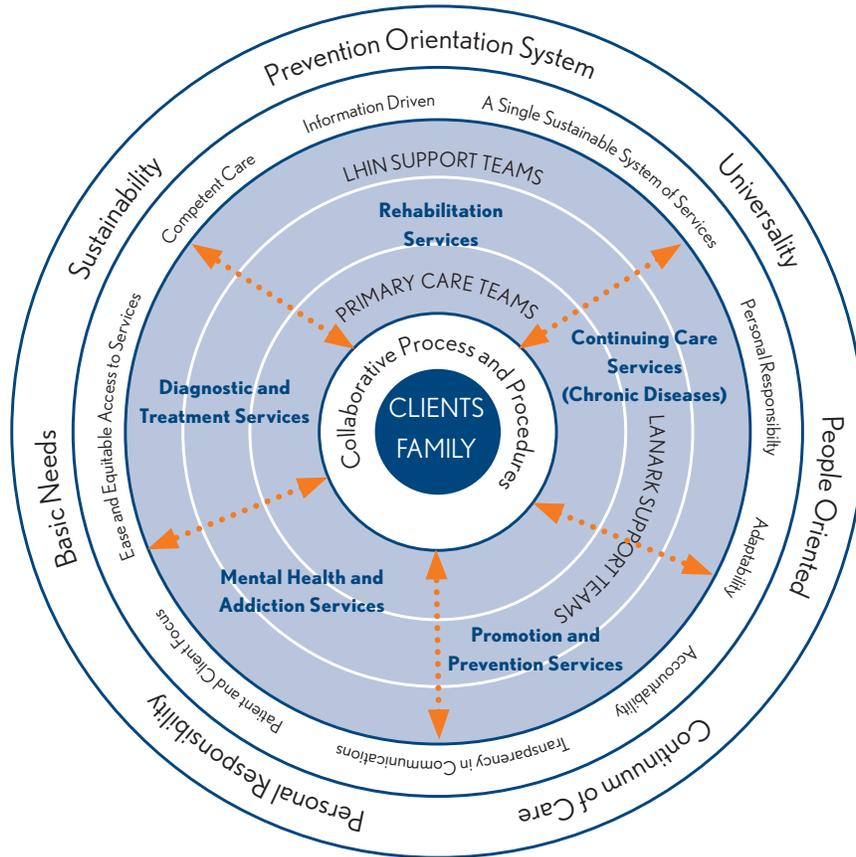
- Community centres
- Faith based social and activity groups
- Community service clubs
- Social service agencies
- Public Health

Service providers with a provincial or national mandate will be co-located (achieved by optimizing facilities or virtually connecting providers) within the Local Health Hub and will be involved in planning for service delivery. These service providers, however, will not be governed by the single management structure within the Local Health Hub. Examples of these service providers may include:

- Canadian Red Cross
- Canadian National Institute for the Blind
- Canadian Hearing Society

Appendix D – Carleton Place Hospital Health Village Model

Health Village Model



Health Village Integration

The Carleton Place hospital as a ‘hub’ hospital within the health village supports a myriad of integration strategies; from membership in networks of hospital and community service providers to co-location of partners, administrative cost-sharing and service planning, common clinical pathways and shared support services. The Village Integration Agenda:

- Optimize access for all residents in the most appropriate care environment anchored within a system of care;
- Guides residents and caregivers as they navigate along the continuum of care;
- Creates operational and clinical synergies to enhance quality and safety;
- Communicates easily across health information systems;
- Strengthens system sustainability by leveraging back office functions;
- Creates opportunities to share talent management and succession planning;

- Supports the growing training, learning and education needs of medical, nursing and allied health professionals ensuring the implementation of full scope of practice; and
- Offers an environment that is conducive to research and the adoption of best practices.

The Health Village incorporates a client-centered approach to the delivery of health and social services, utilizing a collaborative, integrated process of service delivery and includes the following characteristics:

- The right services
- The most appropriate provider
- The best setting
- The correct time
- The most efficient and economical manner
- Public participation
- Shared accountability
- Information gathering and sharing

Health Village Partners

Hospital partners that have expressed interest and commitment include:

- Champlain CCAC satellite
- North Lanark Community Health Centre
- Lanark County Mental Health
- Lanark County Health Unit
- Community and Primary Health Care of LLG
- Family Health Organization (Medical Centre)
- Alzheimer Society
- Red Cross
- United Way
- Local IDA Pharmacy

Health Village Design

The hospital has conducted a study of a variety of

integrated local health care models where there is an integration of small hospital acute care, primary care and community based services. In each of the demonstration ‘hubs’, the hospital programs and leadership partnered with multi-disciplinary primary health care teams and community agencies to cost-effectively share space, clinical staff, and administrative resources to provide an attractive professional practice to recruit both specialists and regional satellite programs.

The hospital health village development contemplates the hospital acute care emergency, inpatient units and surgery within an acute care facility on a new site with the spatial capacity to meet current and future standards of patient care. The development project positions the hospital ambulatory care programs housed among community agency and social services partners within a linked ‘village’ building.

SOURCE: Carleton Place & District Memorial Hospital, Stage 1 Proposal Update: Health Village Integration Project, June 2012, pp. 17-19

Appendix E – South West LHIN Briefing Note for Markdale Rural Health Centre

Addressing the Health Care Needs of Rural Ontario - The Markdale Rural Health Centre (March 2009)

What is a Rural Health Centre?

A rural health centre combines primary care and acute care services into one facility, providing a “one-stop shop” for the health care needs of a rural Ontario community.

A rural health centre will offer such services as:

- Primary care (coordinated first-point-of-access to doctors and other health professionals);
- Around-the-clock emergency department with holding beds;
- Routine medical/diagnostic procedures, such as colonoscopy;
- Ambulatory surgical services (day surgery);
- Recovery beds for diagnostic and ambulatory surgical services;
- Diagnostic imaging; and
- Laboratory services.

A rural health centre operates under a regional framework, utilizing nearby hospitals for more complex health services such as inpatient surgery and other traditional secondary level hospital services. In return, rural residents receive the primary care they need, a round-the-clock emergency department, and day surgeries and diagnostics that a rural community requires.

With a significant primary care component, the primary care needs of a rural community can be addressed, while the need for additional ambulatory and emergency department space in the facility is reduced. Comprehensive primary care, combined with the acute services associated with a hospital, will also assist in the retention of physicians in a rural community.

Why a Rural Health Centre in Markdale?

- Markdale has ministry approval for a community health centre (CHC), and received a planning and design grant from the Government of Ontario for a new hospital;
- The rural health centre would combine the components of both a CHC and a hospital to meet the needs of a rural community;
- A “one-stop shop” for care is also a vehicle for physician recruitment in an area of the LHIN that has the highest number of primary-care physician vacancies; and
- Developing the two projects in partnership supports physician collaboration in the provision of care to local residents.

Partners Working Together

The leadership of Grey Bruce Health Services (the hospital), the community health centre (the CHC) and the LHIN are supportive of a rural health centre. Hospital, CHC and LHIN leaders are discussing the rural health centre concept with community champions. Early conversations indicate community players (the community has had considerable fundraising success for the proposed hospital in Markdale) are willing to work together to craft a functional health care facility to support the population of south east Grey County.

Why a Rural Health Centre Maximizes the Use of Resources

A rural health centre would combine the fiscal and physical resources of both the CHC and the hospital, thereby creating efficiencies, and likely decreasing cost. Using a continuum of care philosophy, the hospital and CHC can also plan together for services and programs.

This continuum of care philosophy is further enhanced by the proximity of the proposed rural health centre to a long-term care facility. Land donated for the proposed hospital is on the same site as a long-term care facility. This also promotes easy access for practitioner support and reduces the travel time between various locations.

This initiative provides an opportunity to look at programs and services currently offered by the hospital and proposed for the CHC to see how they can support rather than duplicate services and programs. In a small rural community, investments should be made in one facility as opposed to multiple, unconnected facilities.

Thirty percent of visits to the emergency department (ER) at the hospital are unattached patients. An on-site primary care facility that focuses on delivering primary care services to unattached patients provides the opportunity to look at the space needs for the ER. Patients seen in the ER are often there for primary care or ambulatory care needs, such as prescription refills or wound care. The current Markdale ER consistently has 70 to 75 per cent of their visits within less urgent level 4 and 5 triage codes. These are services that could be handled by a CHC and fit well in a CHC model of care.

Supporting a New Model of Care for Rural Ontario

A rural health centre can be one component of the government's vision for health care in rural communities across Ontario.

In 2006, the Ontario Joint Policy and Planning Committee (JPPC) report, *Core Service Role of Small Hospitals in Ontario*, identified access to primary care services and difficulties in recruiting and retaining staff as two of the primary challenges faced by small and rural hospitals. Recommendations included enhancing and extending primary care, expanding community networks, and integrating primary, acute and long-term care more effectively. The proposed rural health centre moves these recommendations from concept to reality. As noted in the conclusion and next steps of the JPPC report, ". . . hospitals can, collectively, chart the course for the future of small hospitals in Ontario, achieving a celebrated mission for each, through collaborative planning and integration at the local health system level, in conjunction with Local Health Integration Networks" (pg. 4).

The Ontario Hospital Association (OHA) vision statement for Small, Rural and Northern (SRN) Hospitals (Nov 2008) states, "We envision a future where SRN hospitals facilitate a range of innovative models of integrated local health care in partnership with other local health providers. In some rural and northern communities, a health care campus model may develop in which the hospital is co-located with, and electronically linked to, a range of community-based and primary care services" (pg. 1). Proceedings from the OHA Discussion Forum: *Development of a Rural/Northern Hospital Strategy* (May 2008), identified, "Developing Integrated Models of Rural Health Care," as a key opportunity for growth and integration for small hospitals.

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