Introduction

Ontario Hospitals Support Patient-Centred Care

Ontario hospitals are committed to working with government, system partners and patients to enhance quality of care and create a better experience for our patients and clients. The Ontario Hospital Association (OHA) represents Ontario’s 147 public hospital corporations. Ontario’s hospitals, alongside their many valued health system partners, are an integral component to Ontario’s health system and its long-term success. In every way, hospitals of all sizes, types and geographic locations strive to deliver high-quality, equitable care to the communities we serve.

Approximately 14 million visits were made to hospitals last year (excluding surgeries) and more than 6 million visits were made to hospital emergency departments. Despite this growing demand, Ontario hospitals have become among the most efficient in Canada, with the second-lowest per-capita hospital expenditure of all the provinces, aside from Quebec (CIHI, 2015). The efficiencies generated from hospitals save the province approximately $4.5 billion each year, allowing for critical investments in other important areas of the health system – including home and community care and long-term care.

However, the wider health system continues to face ongoing capacity challenges. At any given time, more than 4,000 patients and clients (occupying 14 per cent of Ontario’s hospital beds) are waiting to be moved to a more appropriate setting (Access to Care, 2015). The demand is greatest for spaces in long-term care, home care, assisted/supervised living, as well as for frail and elderly patients with cognitive, behavioural and mental health challenges, and with other complex, physical conditions.

Ontario Hospitals to Provide Supportive Role

In effect, the Patients First proposal provides for an entirely new regional entity with very significant roles and responsibilities. As such, these new organizations will require new expertise at all levels to fulfill their mandate. When called upon, Ontario hospitals will be willing and eager to work closely with their system partners to actively support the creation of the new entities and related implementation efforts. The OHA welcomes efforts to establish new approaches to patient-centred care, particularly those that will facilitate the creation of a high-performing healthcare system that is focused on putting the needs of patients and clients first.

The focus of the government’s reform proposal is on strengthening the home and community and primary care sectors. The OHA looks forward to playing a supportive role during this transition, recognizing that providers can no longer work in silos. Hospitals have created meaningful partnerships with community, long-term and primary care providers, and are working collaboratively to provide care to patients and clients. For example, 34 hospitals currently have community-support-service expenditures, spending $471 million on community-sector services. Hospitals are committed to ongoing collaboration with their health system partners, and to sharing the sector’s expertise, resources and capacity.

Significant evidence exists about the factors that are needed to create high-performing health systems. Research from the University of Toronto’s Institute for Health Policy Evaluation and Management, published in late 2015 (Baker & Axler, 2015), reveals there is much Ontario can learn about the factors the lead to high performance. This research has been instrumental in informing the OHA’s submission.
Proposal 1: More Effective Integration of Services

Expanding Integrated Models of Care

Improving integration of services across the continuum of care is one component of a high-performing healthcare system (Baker & Axler, 2015). Effective teamwork and communication is needed to efficiently transfer patients across the continuum of care (Denis, et al., 2011). In Ontario, hospitals are already working collaboratively with other providers to deliver more integrated, patient-centred care.

Ontario hospitals support expanding and creating models of care that are flexible in nature and meet the needs of the communities they serve. In creating these models, consideration needs to be given to factors such as population density, geography and other system goals. Ontario hospitals support the continuation of existing funding mechanisms, but it will be important to ensure that innovative models of care do not lead to the creation of new silos.

Two emerging models of care have been successful in creating end-to-end integration and enhancing patient outcomes: bundled care and health hubs. Ontario hospitals support the development of a provincial strategy to expand bundled payments for post-hospital care and to expand health hubs in rural and remote communities. Ontario hospitals view integrated models of care as the way of the future. Now is the time to build on these early successes and expand these models to other settings and regions of the province.

a. Bundled Care

It is vitally important that Ontario continue to innovate funding and care models. One such example is bundled care, which is an integrated model of care that includes a specific package of care and services, generally for a particular condition, such as acute care. In this model, the payer provides a single payment to a fund-holder for services from multiple providers and across multiple settings (James, et al., 2015; Painter, 2012). Providing care through one bundled payment has been shown to encourage collaboration while better meeting the needs of patients as they navigate the healthcare system (Jacobs, et al., 2015; de Brantes et al., 2009). When physicians align with non-physician partners, such as hospitals, it also often results in lower costs and improved efforts to monitor, manage, and coordinate patient care (Jacobs, et al., 2015; Sen and Burns, 2014). There are many successful examples of integrating hospital and community care services at a local level, including St. Joseph’s Healthcare in Hamilton and St. Mary’s General Hospital in Kitchener, but the model has broad applicability for the province of Ontario and should be explored further.
Bundled Care – St. Joseph’s Healthcare

The Integrated Comprehensive Care (ICC) Initiative was launched in 2012 at St. Joseph’s Healthcare in Hamilton. This model of bundled care eliminates existing system fragmentation and coordinates acute and home care services to improve the patient experience and outcomes while also providing value to the health care system. Some advantages of the ICC bundled care program include:

• better experience and outcomes for patients,
• empowering patients to thrive at home,
• providing patients continuous access to clinical care, including, surgeons, nurses, physiotherapists and personal support workers, and
• 24/7 access to an ICC care coordinator.

This model has been expertly third-party evaluated for patients with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF), and its findings show:

• patients spend 28 per cent fewer days in hospital,
• readmissions dropped from 43 per cent to 29 per cent, and
• readmissions within 60 days decreased from 79 per cent to 29 per cent.

St. Mary’s General Hospital (also part of St. Joseph’s Healthcare System) has replicated the ICC and achieved similar results. They have added a further innovation called ‘virtual home care.’ When patients are discharged, they follow a standard ICC care path, which includes virtual home care for those patients not requiring a standard number of homecare visits. Virtual care includes check-in phone calls and a telephone number that patients can call 24 hours a day, seven days a week, to have questions answered by a care professional with access to their hospital records. Although it has only been six months, preliminary results are showing a 28 per cent reduction in home care, readmission, and emergency room costs combined. As such, when bundled care done right and a single provider is made responsible for the complete care episode, innovation will improve patient experience, outcomes, and costs.

b. Health Hubs

Health hubs have been implemented in many rural communities across the province. The model supports a single funding envelope and single governance structure – whereby most, if not all, sectors of the healthcare system are formally linked to create end-to-end integration. Each rural health hub is locally defined and tailored to the community. This patient-centred approach improves access by providing care closer to home and making it easier to transition from one care provider to the next.

Under this model, many small hospitals are 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, health hub hospitals are functioning as multi-site, multi-sector healthcare corporations where there is no meaningful distinction between hospital and community services. In smaller communities where critical mass of staff is a significant issue across all sectors, proactively sharing staff and resources goes a long way in strengthening the system.
While some communities are just beginning 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.

**Health Hubs – Dryden Regional Health Centre**

At Dryden Regional Health Centre, the health hub model has made better use of limited community resources to support the delivery of safe, appropriate, quality health care. Dryden provides governance oversight and senior management leadership to the hospital, the Dryden Area Family Health Team and the Community Mental Health and Addictions Program. Primary care chronic disease management staff visits patients when they are in hospital to help connect them with resources and supports to help them manage their chronic illness post-discharge. These staff members also do a home visit within 72 hours of discharge to see how patients are coping, ensure medications are being taken appropriately and answer any questions or concerns.

**Manitouwadge General Hospital** is one campus and an integrated governance structure that provides acute care, emergency, diagnostics, rehabilitation, family health teams, mental health, public health, home care, diabetes education, outpatient, physician practice management, seniors’ community programs and long-term care services. Thanks to the health hub model, cost-savings have been achieved and patient satisfaction has been improved. As one example of success, the family health team’s collaboration with the hospital on wound care has led to a 50 per cent decrease in visits to the emergency department.

**Supporting New Sub-Regions**

Ontario hospitals welcome an evidenced-based, population health planning approach to health system planning and performance. A population-level view and strategy would examine and address the needs of specific local patient populations, addressing issues of access and equity (Baker & Axler, 2015). Ontario hospitals look forward to the opportunity to work closely with their system partners to support the creation of sub-regions at the local level and related implementation efforts. Hospitals have the ability to leverage resources and expertise to create system efficiencies and look forward to doing so if called upon.

Some Local Health Integration Networks (LHINs) have already defined sub-regions, including the North West LHIN, which has identified a basket of services from local, district and regional levels. While plans for these sub-regions may be well-advanced, it is recommended that any consideration of new boundaries take into account population size, density, critical mass, geography as well as the existing service delivery patterns.

In developing the sub-regions, the government should consider the future role and organization of specialized, regional and provincial hospitals, programs and services. The regional and provincial delivery of specialty services, such as children’s health, geriatrics, mental health, cardiac and cancer care allows for specialty care providers to deliver on their mandates and broadly support providers along the continuum of care, regardless of geography. As one example, providing health care to children with complex needs is vastly different than adults, necessitating close coordination between multiple care providers from across the province. It is abundantly clear that these models of care do not fit neatly within the construct of a sub-region. The Ministry of Health and Long-Term Care (Ministry) and LHINs should therefore continue to work with specialty hospitals to ensure that the needs of those requiring unique or specialized care continue to be met as we transition to a newly configured health care system.
Additionally, the *Local Health System Integration Act* (LHSIA) currently does not account for the existing provincial programs and networks (e.g., Cancer Care Ontario, Cardiac Care, and Child Health Network) that have been, and continue to be, instrumental in advancing patient-centred approaches to health services. According to LHSIA, the LHINs’ ability to plan in a coherent and effective manner requires that legislative or regulatory authorities recognize the roles of specialized facilities and programs, which by definition, operate across LHIN boundaries. The relationship of the new entities to these programs needs to be articulated and clearly defined to allow the new entities to plan in a coherent and effective manner. Greater recognition of these provincial programs would support the capacity planning process and reduce duplication of efforts and allow for adoption of best practice.

**The OHA recommends that the Government of Ontario give consideration to:**

- The creation of a provincial strategy to expand bundled payments and other innovative funding models to enhance patient outcomes.
- The expansion of rural health hubs in rural and remote communities to ensure more integrated care for patients.
- Leveraging the resources and expertise that already exists in hospitals as the sub-LHIN regions begin to take shape.
- The delivery of specialized services to ensure that the unique needs of populations requiring specialized care continue to be met.
Proposal 2: Timely Access to Primary Care

Supporting a Strong Primary Care System

Enhancing primary care and strengthening its linkages to acute and community-based care is critical to achieving a high-performing health system (Baker & Axler, 2015). Researchers have shown that investments in primary care are needed to produce better health outcomes and better patient experiences (Baker & Axler, 2015; Denis, et al. 2011). Evidence shows that population-needs-based primary care planning and delivery work best when supported by team-based inter-professional primary care providers working to their full scope of practice (Baker & Axler, 2015).

Ontario hospitals support efforts to strengthen the primary care system so that all Ontarians receive effective, team-based care in their communities. The sector looks forward to working with health system partners to support and facilitate the development of system-wide, robust, primary care models that provide greater accountability, particularly at the sub-region level, with appropriate governance and accountability mechanisms in place. Integrating primary care will not only help improve synergy between hospitals and primary care providers – but will also help patients feel supported throughout their journey in the health care system.

Improving Physician Engagement

We know that positive and effective relationships between hospitals and physicians can lead to engaged communication, trust and respect with physicians as engaged partners. If needed, hospitals could be leveraged to help improve physician engagement. Given their current connected relationship, hospitals are uniquely placed to strengthen relationships between hospital-based specialists, family physicians and other primary care practitioners. Further, significant advancements can be made when there is alignment of purpose and effective team work among hospital staff, physicians and administration.

Supporting Primary Care Providers – ARTIC Program

The Adopting Research to Improve Care (ARTIC) Program, created by the Council of Academic Hospitals of Ontario (CAHO), and now delivered in partnership with Health Quality Ontario, is designed to use research evidence to transform front-line care. Two mental health projects currently underway through this accelerated change management structure provide support to primary care providers.

First, the META:PHI integrated care pathway is an approach to integrate alcohol and opioid addiction treatment provided by hospital Emergency Department staff, addiction physicians, and primary care providers. Second, the DA VINCI project supports the implementation of an Integrated Care Pathway across a variety of health care organizations to ensure patients with major depressive disorder and alcohol dependence have increased access to treatment for concurrent disorders, and is customized for use in either a hospital or primary health care setting, delivered by an interdisciplinary team.

A core tenet of the ARTIC change management model is spreading what is known and proven to work - with a focus on standardization with customization to local need. Without facilitated implementation it can take 17 years for new discoveries to be widely adopted; with the ARTIC infrastructure, this timeline has been brought down to two. Ontario hospitals are eager to share the infrastructure and expertise from ARTIC with government and system partners.
Enhancing Communication with Clinicians – the Re-Engineered Discharge (RED) Toolkit

The hospital discharge is a complex process requiring integrated communications among the inpatient care team, primary care team, community services, the patient, and the patient’s caregivers. There are many opportunities for improved discharge processes at hospitals that, if accomplished, could lead to reduced re-hospitalization of patients. One way is through improved communication with clinicians providing care for the patient, after discharge. The RED consists of a set of 12 mutually-reinforcing actions the hospital undertakes during and after the hospital stay to ensure a smooth and effective transition at discharge:

1. Determine need for language assistance.
2. Make appointments for follow-up care.
3. Plan for the follow-up of results from tests or labs that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicine and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicine.
9. Review, with the patient, what to do if a problem arises.
10. Assess the degree of the patient’s understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians caring for the patient.
12. Provide telephone reinforcement of the discharge plan.

The RED has shown significant positive results in a randomized controlled trial by improving patient readiness for discharge and improving primary care provider follow-up. In the United States, hospitals have reduced 30-day readmission rates by 25 per cent and reduced emergency department visits by 16-24 per cent.

The OHA recommends that the Government of Ontario give consideration to:

- Enhancing primary care and strengthening its linkages to acute, specialty hospitals and community-based care.
- Ensuring that primary care planning and delivery is supported by team-based inter-professional primary care providers working to their full scope of practice.
- Ensuring that there are opportunities for meaningful engagement of physicians in the strengthening of primary care.
Proposal 3: More Consistent and Accessible Home and Community Care

Providing Post-Hospital Home Care

Ontario hospitals look forward to continued close collaboration with their partners in an effort to strengthen the home and community care sector and improve access to services. This is critically important in ensuring Ontario has a high-performing health system.

Currently, on any given day, more than 4,000 patients are in hospital waiting for discharge to another more appropriate setting. Many of these patients can’t be discharged because home and community services are not yet available to meet their needs. Bringing Care Home, the Report of the Expert Group on Home and Community Care, suggested that a comprehensive redesign of all functional elements of home and community care is needed to minimize fragmentation in care and ensure consistency across Ontario. Ontario’s hospitals agree with this approach. In particular, the existing system of homecare contracts needs to be evaluated to ensure the proper accountabilities are in place.

Hospitals can play a meaningful role in helping government and system partners integrate, streamline and enhance the delivery of home and community care services. Ontario hospitals are well positioned to play a direct, hands-on role in the provision of post-hospital home care in order to strengthen quality and access for patients. Hospitals have mandated patient assessment tools with associated clinical assessment protocols that can be extended to provide integrated plans for a patient as they move along the continuum of care. The existing infrastructure and decision support skills that exist among hospitals and providers could also be leveraged.

Currently, 34 per cent of total mental health and addiction outpatient sector expenditures are covered by hospitals. Thirty-four hospitals in Ontario currently have community-support service expenditures, and hospitals already spend $471 million on community sector services. Family health teams and hospitals already share a number of resources, governance structures, and back-office arrangements. Additionally, there are countless joint initiatives with other health service providers (e.g., inter-professional teams), community organizations (e.g., Meals on Wheels and YMCA), regional police, colleges and universities, etc. Building on this foundation, Ontario hospitals look forward to continuing to enhance post-hospital care for patients by playing a more consistent, direct and hands-on role on the provision of post-hospital care across the province.

Many of the case managers and care coordinators will work in different settings, including hospitals. Given the clinical abilities of hospitals and the programs already underway in the community, there are natural partnerships that can be leveraged. Consideration should be given to the whether patient care may be improved by transferring community care staff and functions to other providers. For example, those who are responsible for discharge planning and post-hospital care could be employed by or contracted to hospitals.

Innovation in Post-Hospital Care – CAMH

In Ontario, the Centre for Addiction and Mental Health (CAMH) has a variety of post-hospital programs in place to support patients. The Home Intervention program has 15 different partners to support people experiencing psychosis and to transition patients into the community. Shared Care Teams help patients find appropriate resources, including mental health, physical health, financial, housing, recreational, and vocational programs. Geriatric Outpatient Services provide services to seniors in long-term care homes and their home environments. The Northern Psychiatry Outreach program provides early tele-psychiatry with family health teams and the Ontario Psychiatric Outreach Program includes special tele-video consultation. Further, specialty clinics offer legal expertise, a work stress program and dual-diagnosis resource services.
Investing in Information Technology Systems

Robust information technology (IT) systems are critical for success in an integrated health care system, and will need updating to achieve more consistent and accessible home and community care. Information systems must be interoperable to facilitate information sharing between providers (Baker and Axler, 2015). Integrating electronic medical records will provide clinicians with improved access to clinical information in a timely and secure manner. This has potential to create a superior patient experience, particularly in meeting the needs of patients after they are discharged from hospital.

Accelerating Scaling of Virtual Care Tools

Given the new fiscal reality, demand for integration, and explosion of virtual care tools and apps, an opportunity exists to scale virtual care. The Ontario Telemedicine Network (OTN) helps Ontarians get more out of the health care system by bridging the distance of time and geography to bring more patients the care they need, where and when they need it. Using innovative technology, OTN streamlines the health care process, while also expanding the way knowledge is shared and how the medical community interacts with each other and with patients.

Over the past two years, OTN has been migrating its service model, adding new online services and moving towards a less expensive, software-based model that leverages lower cost technology and network capabilities. Moving forward, Ontario hospitals support testing, evaluating and growing new clinical models of health care delivery that leverage telemedicine, remote monitoring and mobile health to create better outcomes for patients and better value for health care providers.

Ensuring Clear Accountabilities

As the government moves forward with its proposal of an enhanced role for LHINs, their responsibilities and accountabilities should be carefully examined. As currently proposed, the new regional entities will become both the service provider as well as the funder/planner of home and community care. Ontario hospitals will continue to be funded by these entities and will also be reliant on them to ensure that home and community services are available for discharging patients in a timely manner. Hospitals will be challenged to meet their accountabilities to the regional entities if there are insufficient community supports provided by these same organizations.
Under these circumstances, careful consideration will need to be given to the accountability relationship between hospitals and new regional entities, as well as the accountabilities between the new regional entities and the Ministry. The Ministry must carefully monitor the system to ensure that all system players are held to the same high standards.

The OHA recommends that the Government of Ontario give consideration to:

- The continued collaboration between hospitals and their partners to facilitate flow and strengthen the home and community care sector and improve access to services.
- Hospitals playing a direct, hands-on role in the provision of post-hospital care.
- Implementing robust IT systems and integrated electronic medical records to provide clinicians with improved access to clinical information in a timely matter.
- Ensuring that careful consideration is given to the accountability relationship between hospitals and the new regional entities, as well as the accountabilities between the new regional entities and the Ministry.
Proposal 4: Stronger Links between Public Health and Other Services

Integrating Public Health

Population health and chronic disease management are two elements of a high-performing healthcare system. There is a growing trend in many jurisdictions to consider the wide array of services, such as social services, education, public health and education, to improve patient outcomes and experiences (Baker & Axler, 2015). Collaborating with public health allows care providers to address health challenges that are especially important for at-risk populations, such as First Nations communities in northern Ontario. Many Ontario hospitals provide a full spectrum of treatment, support and prevention services to the community – especially those in small, rural and northern communities that have successfully integrated public health into the health hub model.

Population health initiatives can help reduce the use of certain health services, thereby lowering costs (Lewis & Sullivan, 2013). Increased efforts to motivate and inform citizens need to be integrated into primary and community-based care (Baker & Axler, 2015). If the aim is to arm individuals with the resources needed to self-manage their conditions outside the formal healthcare system, it will require redefining the role of public health in relation to primary care.

Community-Based Planning – Hamilton Health Services

Hamilton Health Services offers a variety of services, in partnership with public health, to prevent the development of certain diseases or injuries and to help improve health outcomes. For example, the Screen for Life Mobile Cancer Screening Coach offers three cancer screening tests in one convenient, traveling bus. Breast and cervical screening along with colorectal screening kits are provided on a 45-foot bus, which has a state-of-the-art digital mammography suite, two change rooms, an exam room, a sitting area, Wi-Fi communication and full wheelchair accessibility. The goal of the Mobile Coach is to overcome the linguistic, social, economic and cultural barriers that some people may experience in communities where screening rates are low.

Additionally, LiveWell, a partnership with YMCA, McMaster University and two LHINs is dedicated to helping people with cancer, spinal cord injury, mobility impairment, heart disease, or those who are recovering from stroke or heart attack. Healthy Hearts is an exercise and education program, in partnership with YMCA, for individuals who have completed rehabilitation at the Hospital. Lastly, CanWell is an exercise and education program with McMaster University and YMCA for individuals who have been diagnosed with cancer.

Ontario hospitals support a population health approach to integrating the needs of local populations with public health planning. Collaboration with public health can help address the broader health care needs of a community and address key determinants of health. Given the geographic diversity of Ontario, a local, tailored approach to public health will ensure that solutions meet the unique needs of the community.

The OHA recommends that the Government of Ontario give consideration to:

- A population health approach to integrating the needs of local populations with public health planning.
- Integrating efforts to motivate and inform citizens with primary and community-based care. If the aim is to arm individuals with the resources needed to self-manage their conditions outside the formal healthcare system, it will require redefining the role of public health in relation to primary care.
Clarifying Roles and Responsibilities

In the past, the roles of the LHINs and the Ministry have not been clearly defined and delineated. In 2008, when KPMG reviewed and reported on the effectiveness of the LHINs, it was noted that this lack of clarity was hampering LHINs’ functioning and, by extension, impeding progress to health system transformation. KPMG signaled the existence of “authority grey areas” where it was unclear what aspects of authority and decision-making rested with the LHINs and what authority the Ministry retained. As one example, the report indicated that the LHINs felt the Ministry launched new priorities and programs with little notice or consultation.

The experience of the OHA and its members suggests that these remain enduring challenges. As the Ministry moves forward with the creation of a new entity with strengthened role, we would suggest clarifying roles and responsibilities at the strategic, local and provider levels to stabilize the policy-making and funding environments. This will help all parties manage routine and new initiatives more smoothly, create a better patient and client experience and increase public confidence.

Best Practices in Good Governance

Governance and leadership are critical components of healthcare leadership, and can impede or facilitate high performance (Baker & Axler, 2015). Organizational governance plays an important role in improving quality and safety, and boards should create an environment where front-line staff and leadership is committed to enhancing quality and putting the needs of patients and clients first (Baker & Axler, 2015; Baker, Denis, et al., 2010).

In effect, the Patients First proposal provides for a significant increase in the roles and responsibilities of LHINs, creating a greatly enhanced entity. As such, these new organizations will require new expertise and enhanced skills and capacity at all levels to fulfill their new mandate as system managers. Organization and governance of these new entities should be based on leading practice.

LHIN board members are currently appointed by Order-in-Council (OIC) appointments. The OHA would ask government to instead consider voluntary, skills-based appointments. The OHA believes that the board members should continue to be representative of the communities they serve while also employing principles of good governance in respect to size, composition, skill/competency mix, and term-length of board members. A focus on regional representation will ensure directors are accountable to the regions they serve. Additionally, LHSIA should be amended to empower the Ministry to appoint an investigator and/or recommend the appointment of a supervisor when warranted, similar to the Public Hospitals Act.

Supporting New Governance Structures

It will be critically important for board members to have the necessary education and training to discharge their responsibilities effectively. The OHA’s Governance Centre of Excellence (GCE) could be leveraged as the industry leader in governance training and evaluation, if called upon to do so. Given that many of the OHA’s members have developed into integrated health care systems, the OHA’s GCE has a wide array of experience advising on governance practices for all health service providers, including integrated health systems. The GCE has also developed leading best practices for a variety of not-for-profit organizations, and would be well-suited to provide needed education and training as well as serving in an advisory role.
The OHA recommends that the Government of Ontario give consideration to:

- Clearly articulating the roles and responsibilities of the new regional entities vis-a-vis the Ministry
- Ensuring that the new regional entities have the needed expertise and resources to fulfill their mandate.
- Requiring that appointments are based on leading governance practice: skills-based, voluntary and local; not subject to provincial Order-in-Council processes.
- Amending LHSIA to empower the Ministry to appoint an investigator and/or recommend the appointment of a supervisor when warranted, similar to the Public Hospitals Act.
Conclusion

Transitioning to a New Governance Structure

The OHA recognizes that a different governance structure may be required during the transition period – or while the government and health system partners work to establish the new entities. The over-arching goal should be on maintaining access to high-quality patient and client care. With time, health system restructuring has the potential to improve access to primary and home and community care, thereby easing pressure on hospitals and reducing wait times for patients and clients. We know that increased funding is needed for home and community services. This investment in capacity is essential for meeting patient and client needs now and in the future. But, the sector must also work together to provide stability in the interim.

We believe that different expertise and skills may be required during the transition period than when the new entities are established and operating on a daily basis. As such, Ontario hospitals recommend the creation of a Provincial Transition Task Force (or Expert Panel) to provide leadership and direction towards the implementation of the new structure, as we have seen in the past with the creation of transitional councils for the regulatory colleges, as well as for the major change initiatives that have far-reaching, sector-wide implications. The Task Force would ensure a seamless transition, while ensuring ongoing continuity of care for patients. The membership of the Task Force should extend to individuals with relevant skills and expertise, such as health care operations, governance, and change management, to name a few. Their focus will be on ensuring that important health service programs are maintained during this transition.

Putting Patients First

Ontario’s hospitals and the OHA maintain a long-standing commitment to advancing quality, integration and value, and appreciate the opportunity to work closely with our health system partners to improve patient-centred care. Ontario hospitals are committed to actively supporting the creation of the new sub-regional entities and related implementation efforts, if they are called upon to do so.

Our comments and suggestions, as set out above, are offered in the spirit of advancing health system priorities in order to achieve a high-performing health system. We look forward to continued discussions with government and other care providers as we work toward creating a high-performing health care system that is truly focused on putting the needs of patients and clients first.
References

Access to Care—Alternate Level of Care Informatics, Cancer Care Ontario. Provincial Monthly Alternate Level of Care Performance Summary; December 2015, Toronto, Ontario.


