

Rural Health Hubs Framework for Ontario

By: Multi-Sector Rural Health Hub Advisory Committee
January 2015



afhto association of family health teams of ontario



Association of Ontario Health Centres
Community-governed primary health care
Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

HOME CARE
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Ontario Community Support Association

OHA ONTARIO HOSPITAL ASSOCIATION

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OMA
ONTARIO MEDICAL ASSOCIATION

Ontario
Local Health Integration Network

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Introduction

Rural communities face unique challenges in delivering high-quality care due to lack of critical mass and economies of scale. Over the years, these communities have worked to overcome these challenges by creating sustainable health care systems through innovative local solutions. They are, therefore, well-positioned to continue to improve access to care as part of health system transformation. It is the existence of these local solutions that led to the establishment of the Multi-Sector Rural Health Hub Advisory Committee (Advisory Committee).

This Advisory Committee was established by the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA) with broad stakeholder representation to learn from existing rural health hubs in Ontario and to develop a framework to support rural communities in moving forward with the implementation of successful rural health hubs.

As rural health hubs are not a “one size fits all” model, this framework document features a process and recommendations that promote collaborative relationships and flexibility in design tailored to meet the unique needs of the communities being served.

Background

Rural local health care providers are facing unprecedented challenges in ensuring the right mix of services is available to meet the health care needs of their local communities. These communities are often located in remote settings and have many gaps in clinical services and other health social services. They also tend to have both a high prevalence of chronic disease and mental health conditions which result in a high burden of care and difficulty attracting and retaining qualified clinical, inter-professional and administrative staff.

In response to these challenges, many rural local health care providers have developed innovative solutions and have begun to work collaboratively to improve access, strengthen efficiencies and enhance the quality of health care for their communities. With the work that has already been accomplished, rural communities are well-positioned to leverage these existing collaboration and relationship-based referral processes towards the establishment of a rural health hub. Some rural communities have not yet initiated a rural health hub process and other communities have gone as far as they can without the support of government policy and/or legislation.

In recognition of the opportunities offered by existing rural health hubs, in 2012, then Ontario Minister of Health and Long-Term Care, Deb Matthews, requested advice from the OHA on rural health hubs. This led to the release of a report in 2013 entitled, *Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come (Report)*.

Some of the key benefits of moving to a rural health hub model which were highlighted in the Report include:

- Improvements to health care access based on a “care closer to home” philosophy
- Support for a person-centred approach to coordinating local health services with improved patient navigation and shared clinical pathways amongst service providers
- Support for quality improvement planning for local health systems in rural and northern Ontario

Following the release of this Report, the OHA met with key health system partners, including Local Health Integration Networks (LHINs), community health care providers and the OMA to discuss how to obtain needed support from rural communities and other key health care associations in terms of moving forward with a rural health hub.

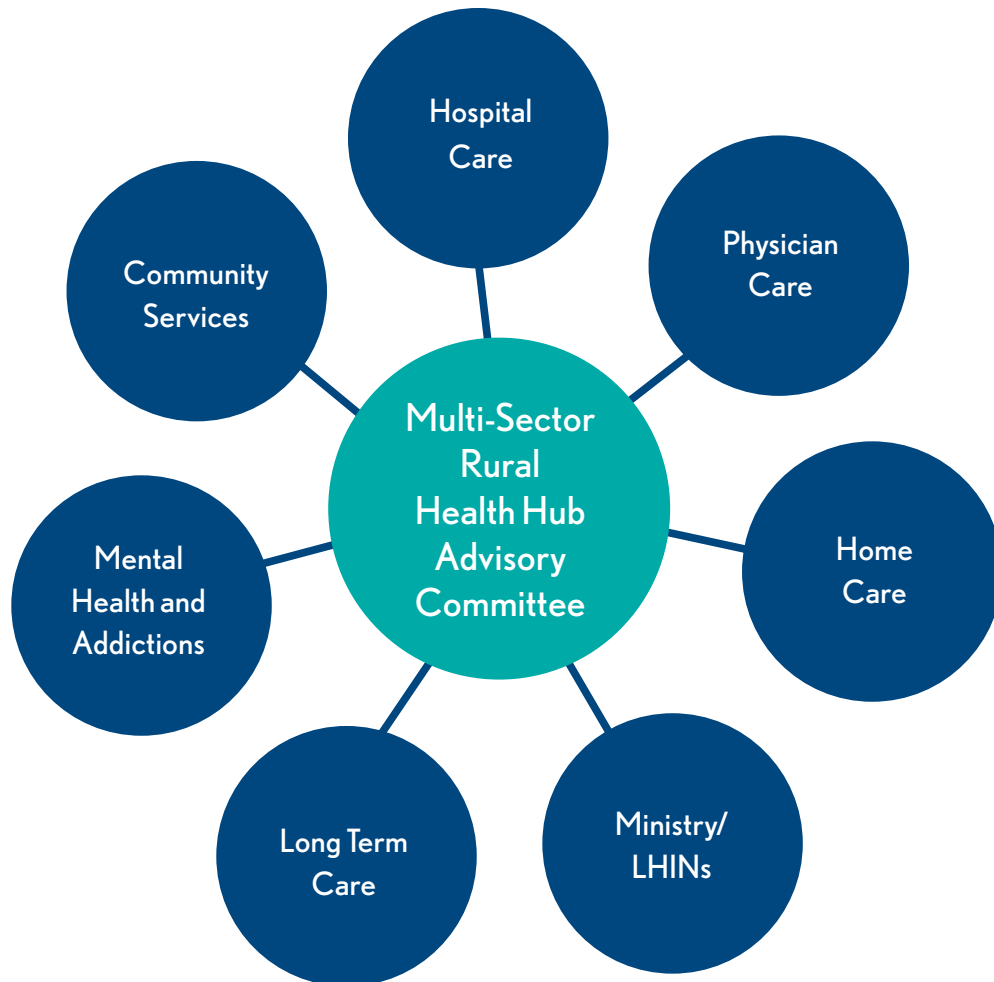
It was agreed that rural health hubs and improved health and social service integration are important to all local providers, including physicians in rural and remote practice. Therefore, the OHA and the OMA agreed to establish a Multi-Sector Rural Health Hub Advisory committee (Advisory Committee) with broad stakeholder representation (Table 1) to develop this framework to encourage the implementation of rural health hubs in Ontario (Terms of reference).

This framework was developed using insights from existing rural approaches to collaborative local health care, including the work of some LHINs and the recommendations of the 2010 *Rural and Northern Health Care Panel Report (RHCPR)*. The RHCPR recommends “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.”

The Advisory Committee recognizes the government’s mandate and vision to improve health care for patients with high-cost needs through the implementation of Health Links across the province. Similar to the rural health hubs approach, the Health Links’ vision encompasses the need to foster collaboration across the continuum of local health and social service providers. Given the similarities between

the two models and their potential contribution toward a sustainable local health care system, the Advisory Committee is hoping for a similar commitment from government that will support the implementation and sustainability of rural health hubs. (See Appendix C for a Health Link/ Hub comparison chart)

Figure 1: Multi-Sector Advisory Committee Representation



Rural Health Hubs in Ontario

Vision

The creation of rural health hubs will encourage and enable local health care and social service providers such as hospitals, health centres and physicians in rural communities to work together to create a rural health hub tailored to their local community's needs in a way that enhances seamless, sustainable service integration and the effective delivery of person-centred, equitable, high-quality, timely health care, whether it is delivered locally or referred to a regional partner.

Principles

1. Person-Centred and High-Quality Care

A rural health hub will:

- ✓ Be designed with and for the community
- ✓ Be accessible, safe, effective and informed by evidence
- ✓ Be informed by and be supportive of research within the rural health care context
- ✓ Meet the diverse needs of people in the community along the continuum of care using a health equity lens
- ✓ Enhance the person's experience by providing well-coordinated care, taking into consideration the needs of patients including the delivery of care as close to home as possible, while supporting effective access to care outside the hub when needed.
- ✓ Support physical and mental wellness and health promotion within the community

2. Enhanced Collaboration and Efficiencies

A rural health hub will:

- ✓ Be appropriately resourced and efficiencies will be realized where possible
- ✓ Recognize the contribution of each of the independent providers in the continuum
- ✓ Deliver care collaboratively based on trusting relationships, using inter-professional teams
- ✓ Maximize the effectiveness of local human resources and service delivery capacity
- ✓ Enhance communication and transparency
- ✓ Be supported by an integrated Information Technology strategy
- ✓ Be supported by shared capital and building infrastructure, where possible

3. Accountability

The health and social service providers will:

- ✓ Ensure viability of the rural health hub
- ✓ Adhere to good governance standards
- ✓ Support timely, relevant and transparent data analysis and reporting in support of decision making, quality improvement and accountability (performance and reporting)

Key Characteristics of Rural Communities

The Advisory Committee identified a number of unique features of rural communities that may impact the provision of health care services.

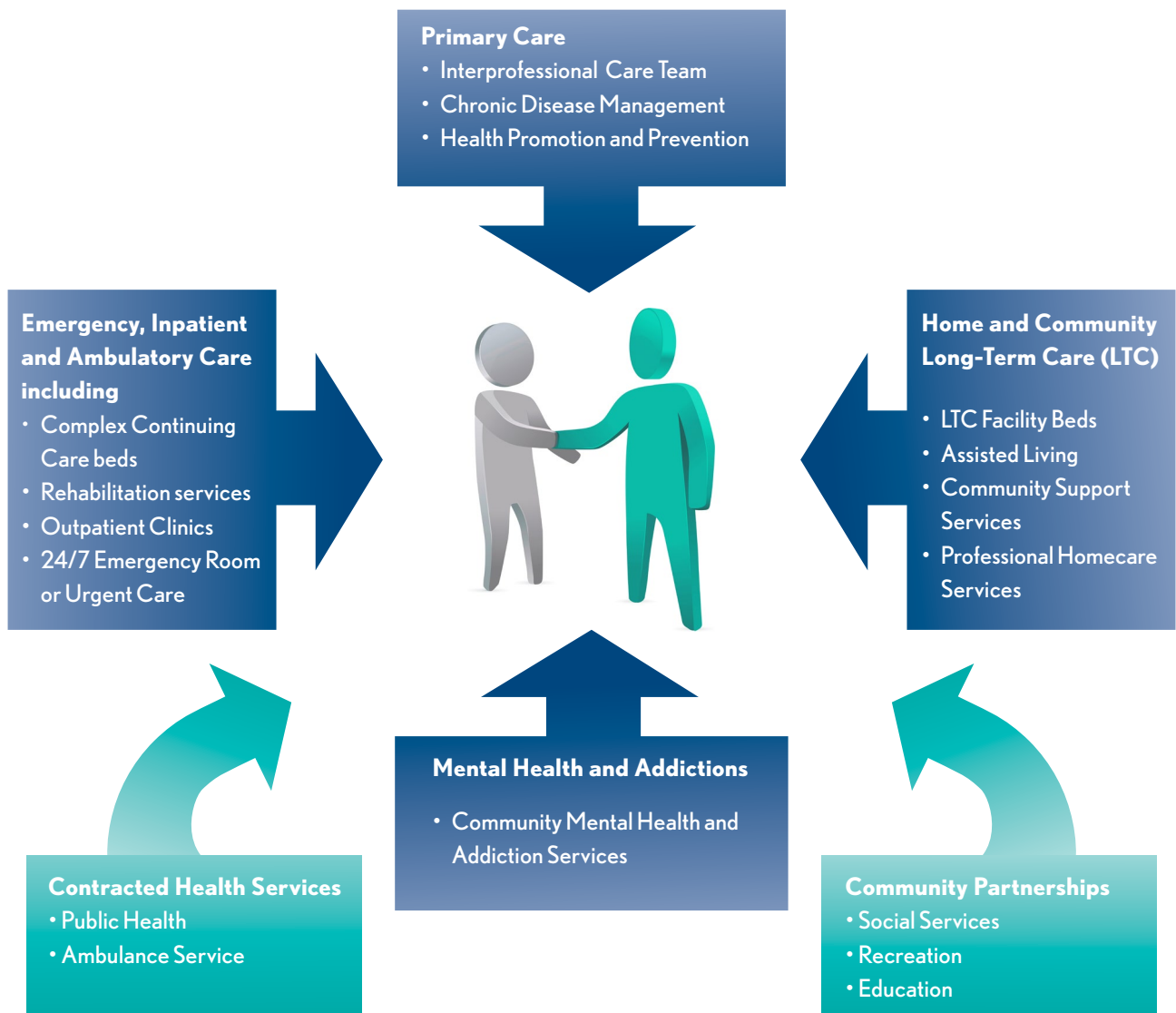
- Geographically remote and isolated
- Low population density
- Long travel times for services not locally available
- Weather extremes and inadequate public transportation impact access to care
- High density of elderly, Aboriginal and other distinct populations (such as francophone, migrant workers, etc.)
- High burden of chronic disease
- High use of tobacco, alcohol and other substances
- High prevalence of mental illness and social isolation factors
- Limited health service options
- Limited health care provider availability
- Gaps in secondary/tertiary level clinical services and limited community and support services available
- Limited mental health and addiction services
- Requirement to maintain service capacity in spite of lower volumes
- Pressure from service regionalization initiatives that may impact critical mass and stability of clinical service provision
- Recruitment and retention:
 - Staff providing service at multiple organizations that have competing obligations
 - Salary/income differentials among local health service providers limiting ability to recruit and retain
 - Community economics that may not support employment opportunities for family members
 - Lack of competitive salaries and incentives to attract system leadership
- Low service volumes and small data sample sizes make meaningful statistical analysis difficult

Defining a Rural Health Hub

The Advisory Committee agreed on the following definition of a rural health hub:

“Rural Health Hubs will allow local health and social service providers, through formal agreements and partnerships, and on-going community consultation, to improve the coordination and effectiveness of care for a defined population and/or geographic area. Each rural health hub will be locally defined and tailored to the community. A rural health hub is flexible, not one size fits all, is innovative, based on local need and provides coordinated access to care. (Figure 2 lists services that may be included in a rural health hub)

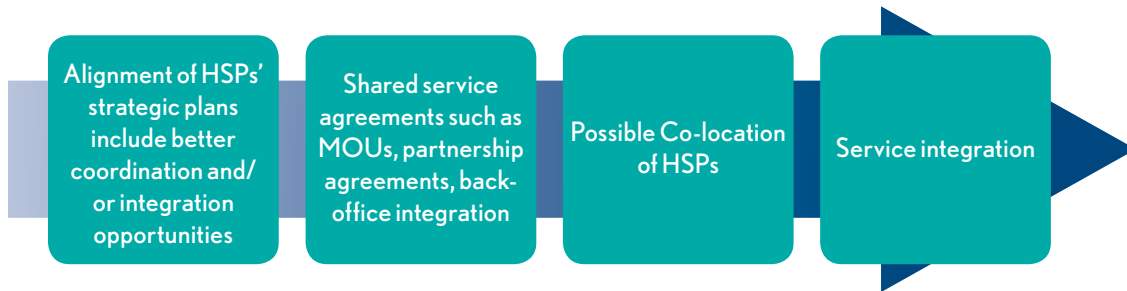
Figure 2: Services That May Be Included In A Rural Health Hub



There are many examples of rural health hubs across the province that tends to vary along two dimensions:

1. The **degree of service integration** describes how formalized the clinical and support linkages are between health and social service providers. The service integration continuum below outlines possible options available.

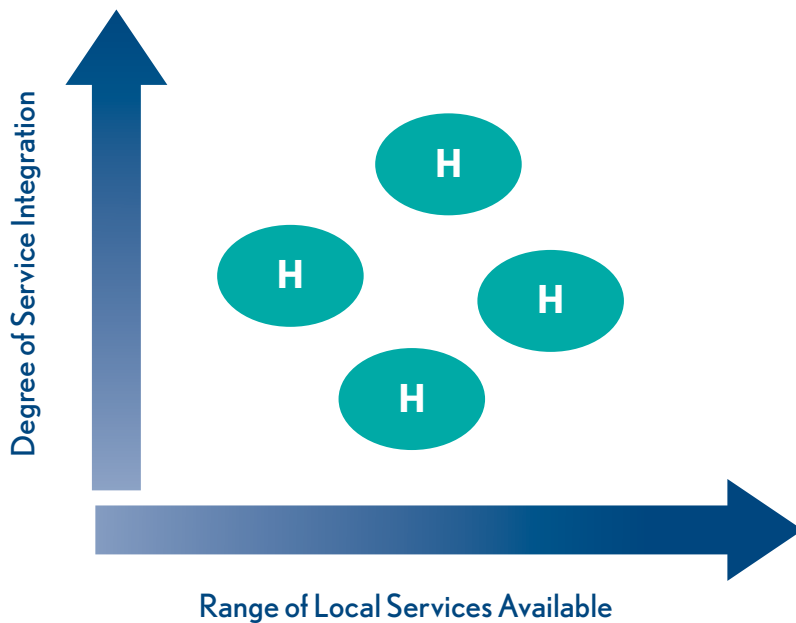
Figure 3: Degree of Service Integration



2. The **range of local services available** in the hub describes the number and type of services that are locally available and the extent to which they are coordinated and/or co-located.

These two dimensions create a potential strategy map for communities seeking to implement a rural health hub. A summary of some of the existing rural health hubs is available in Appendix A.

Figure 4: Rural Health Hub Strategy Map



Key Elements of a Rural Health Hub

The Advisory Committee studied and met with representatives of existing local health hubs in Ontario (Appendix A). This review provided a good deal of insight into the current environment and allowed the Advisory Committee to summarize the following critical success factors and potential barriers to the implementation of a successful rural health hub.

Critical Success Factors

- An identified shared need for local health and social system providers to work together to provide high-quality health care for the community
- Local history of successful collaboration and an opportunity to build on existing collaborative relationships
- Local credible champions/leaders who support a common vision and the need for increased collaboration
- Shared clinical pathways, including the need for smooth access to urgent/emergent and specialized care only available outside of the hub
- Access to reliable and timely patient and/or sample (i.e. laboratory) transportation
- Strong community/regional supports including resources and expertise (i.e. change management) that enable enhanced local collaboration and dialogue
- Existing collaboration that aligns with local, regional or provincial strategic goals or initiatives such as:
 - care planning and coordination
 - formal quality plans
 - quality best practices
 - shared back office (information technology, payroll etc.),
 - facilities planning and management (shared campus and/or facilities)
 - shared management structures
- Development of a local Community Health Plan which:
 - Includes a common vision and shared goals
 - Is people-, community- and patient-centred
 - Includes capacity planning and service mapping
 - Builds on local demographics and assets
- Strong community consultation and communication strategy
- Existing advanced information technology
- Consolidation of IT bandwidth among health service providers

Implementation Barriers

Many of these barriers are not unique to rural communities. However, the impacts of each may be magnified in these communities. They include:

- Lack of an all government (municipal and provincial) approach to the provision of health care services and a lack of a strategy for rural and remote communities
- Lack of alignment between and within federal and provincial ministries and municipal governments continues to be a barrier to integration and coordination of services, as it impedes health and social service organizations from achieving funding efficiencies
- Lack of local health care labour supply in rural and remote communities
- Complexity related to relevant policy and regulatory differences between providers (for example, *Public Hospitals Act*, *Excellent Care For All Act*, Broader Public Sector procurement directives, *Public Sector Labour Relations Transition Act*, *Local Health System Integration Act*, *Long-Term Care Homes Act* and its Regulations and the *Occupational Health and Safety Act*)
- The risks related to integration, such as:
 - Unequal organizational financial capacity and/or stability
 - Organizational salary differentials
 - Lack of coordinated, formal planning across the continuum
 - Different organizational missions and cultures
 - Lack of agreement on the relative priority of integration activity
 - Multiple accountability agreements, licenses and service agreements
 - Multiple data reporting requirements and different performance indicators
 - Lack of standardized performance/outcomes measurements
 - Risk to benchmarks, accountabilities and funding formulas due to statistically insignificant data given the low volumes
 - Legislative wage freeze not applied consistently across all employee groups
 - Scarce leadership resources with limited capacity to take on incremental major project work
 - Lack of change management expertise/resources
 - Potential impact on local economy and human resources
- Community capital barriers:
 - Limited fundraising capacity
 - Government capital funding does not adequately support integrated solutions
 - Lack of existing infrastructure and facility space for co-location

Guidance for Developing a Rural Health Hub

The following high-level suggestions were provided by the Advisory Committee to support the further development of rural health hubs in rural Ontario communities.

Review of Current State

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

1. What is the size of the community and the population density?
2. What are the health and social service needs of the population?
3. Who are the current health and social service providers in the community and what services do they provide (inventory of providers and services)?
4. What are the critical gaps in available service?
5. What types of relationships and collaborations already exist among these service providers?
6. Beyond the local providers, what are the linkages to other levels of care and care providers? For example:
 - Patients leaving for specialized services and/or diagnostics
 - Physicians visiting community for specialists clinic and/or services
 - OTN and/or other Telehealth services for access to specialists and/or services
7. Are there formal relationships with larger centres for referrals and/or repatriation of patients?

8. Bring together willing participants/stakeholders for facilitated local strength, weakness, opportunity and threat (SWOT) analysis related to hub implementation.
9. Consider health equity using available validated tools.

Implementation

The steps to begin implementation of a rural health hub include the following:

1. Establish a community/provider engagement process.
2. Using a health equity lens, engage the community and all local health and social services providers in the development of a local Community Health Plan, including:
 - a. A common vision and shared goals;
 - b. Capacity planning and service mapping; and
 - c. The desired end state (Figure 3).
3. Build on local demographics and assets.
4. Form a local working group and identify local champions.
5. Obtain formal agreement for local health service providers and agencies to work together.
6. Develop a project charter and work plan.
7. Ensure each organization's strategic plan is updated to include better coordination and/or integration opportunities and/or strategies for co-locating services.
8. Identify and obtain required change management resources.
9. Develop a communication and information management strategy.

Recommendations

The Advisory Committee also developed the following recommendations in support of rural health hubs in Ontario.

Short-Term Recommendations

To Rural Communities:

1. Establish a core group of local champions/leaders, including LHINs, to:
 - a) Develop a local Community Health Plan that is responsive to the local context and uses a robust, ongoing community engagement process inclusive of both community members and all providers
 - b) Where appropriate, embrace a rural hub approach to local health and social service planning
 - c) Develop a communications strategy that uses consistent messaging among health and social service providers

To the Ministry of Health and Long-Term Care:

2. Recognize rural health hubs as a key approach to service delivery for rural communities by supporting policy change that:
 - a) Provides for flexible community funding for rural hub development in support of sustainability of the health care system, which will lead to local innovation, stable service capacity and a sustainable work force.
 - b) Creates incentives for health and social service providers who choose to participate in a rural health hub.

- c) Establishes an implementation approach similar to Health Links in Ontario that supports a voluntary approach that brings individual providers together, with the engagement of the community, to create innovative local solutions that address the unique needs of their respective communities.
- d) Supports capital planning and facility redevelopment requirements to enable co-location, where appropriate.
- e) Creates an accountability process that is aligned (where appropriate), simple to manage, facilitates shared learnings among communities and supports the monitoring of health outcomes.

Long-Term Recommendations

To the Ministry of Health and Long-Term Care:

3. Undertake an extensive, inclusive consultation process on the Rural and Northern Health Care Panel Report.
4. Using feedback from the consultation process, establish a Rural and Northern Health Care Strategy to enable the development of an effective health care system for Rural and Northern Communities.

Appendix A

Health Hub Examples

These are examples of health hubs from across the province that demonstrate the range of possible local solutions to better coordinate and integrate care.

Organization	Population/Community	Services Available	Success Factors	Barriers To Success
<p>Manitouwadge Community Care</p> <p>One campus</p> <p>Integrated governance</p>	<p>5 hour drive to Thunder Bay</p> <p>Catchment population: 2,100</p>	<p>Acute care</p> <p>Emergency</p> <p>Diagnostics</p> <p>Rehabilitation</p> <p>Family Health Team (FHT):</p> <ul style="list-style-type: none"> Primary Care CCAC Social Work <p>Mental health</p> <p>Public Health</p> <p>Outpatient</p> <p>Long-term care</p>	<p>Shared governance</p> <p>Shared campus</p> <p>Shared IT</p> <p>Shared staff</p> <p>Shared back office</p> <p>One or % of FTE programs</p>	<p>FHT Program managers and MOH oppose hospital-based FHT</p> <p>Silo program funding, i.e. mental health</p>
<p>Guthrie House (satellite of Country Roads Community Health Centre)</p> <p>Health and social services hub (co-location and coordination of services)</p>	<p>Total population 10,000 with no community larger than 800</p> <p>20 minutes to main CHC site, 40 minutes to nearest hospital</p> <p>High senior population with significant access issues</p>	<p>Guthrie House enhances access to primary care and social services for rural residents of Rideau Lakes Township.</p> <p>Primary care services</p> <p>Prevention and wellness</p>	<p>Funded with assistance of United Way who have evaluated the pilot as successful</p> <p>Numbers of residents accessing services has greatly increased</p> <p>Increased numbers of volunteers involved</p>	<p>Operating with part-time coordinator</p> <p>It is important to find ongoing dollars for this role as it is key to success and growth of the hub</p>

Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		Chronic disease management OTN-Telemedicine Employment services Ontario Works Adult mental health Geriatric psychiatry outreach Alzheimer's support Children's mental health Chiropractic treatment Hearing society Community meeting rooms for local groups Community development	Evident community engagement and support from municipal council Patient feedback overwhelmingly positive Tenant feedback overwhelmingly positive Collaborative governance	
Waasegiizhig Nanaandawe'iyeg wigamig Health Access Centre Integrated, comprehensive core services plus partnerships	10,000 Anishaabe people in Kenora and surrounding First Nations communities Urban Rural Remote On-reserve	Prevention/wellness Health promotion (including oral health) Primary health care Diabetes education Venipuncture clinic Chronic disease management OTN/telemedicine Traditional healing Oral health outreach Mental health, including intergenerational trauma	Formed as a partnership of stakeholder communities Voluntary and consensus-based Range of integration solutions, including co-location, partnerships (formal and informal) Community-driven, population needs based planning Each scenario unique, in order to respond to community's specific needs	Salary differential Recruitment and retention No volunteer base Ministry restrictions on spending to achieve full efficiencies Lack of standardized performance/outcomes Meeting demand within limited budgets Funding to address client complexity (staff training and other costs)

Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		Hostel Healing Lodge All services (except residential) available through outreach in partner communities	Shared operational efficiencies Improved access to breadth of health and social services, and care coordination Information Management System – including a common Electronic Medical Record for all Community Health Centres and Aboriginal Health Access Centres Expanded, collaborative, interprofessional team, with everyone working to full scope	Capital policies that are barriers to integration Funding silos
Community Care City of Kawartha Lakes Multi-service agency (fully integrated, including governance) plus partnerships	3,083 sq. km catchment area, High proportion of seniors, children living in poverty, low education levels, high chronic disease prevalence	Prevention/wellness Health promotion Primary care Community development Hospice Oral health/low income dental Social services Community support services Non-urgent transport OTN/Telemedicine Chronic disease management	Improved client-centred care coordination and access to care Integrated quality improvement plan (QIP) Back office efficiencies Access to volunteers Collaborative partnerships	Silo funding/funding restrictions Recruitment/retention Salary differential with acute care and long-term care Limited IT resourcing to make improvement with partners Capital policies that are barriers to integration

Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		<p>Assisted living</p> <p>Adult day programs</p> <p>Specialized geriatric services</p> <p>Occupational Therapy and Physical Therapy</p>		
<p>Espanola Regional Hospital and Health Centre</p> <p>Integrated health campus</p>	<p>80km west of Sudbury</p> <p>Catchment 14K</p> <p>High proportion of seniors, aboriginals and chronic disease</p>	<p>Acute care</p> <p>Ambulatory care</p> <p>Long-term care</p> <p>Assisted Living</p> <p>Seniors' apartments</p> <p>Physiotherapy</p> <p>Pharmacy</p> <p>CCAC office</p> <p>FHT, primary care</p>	<p>Integrated governance (acute, long-term care, primary care)</p> <p>Require trust and legal framework</p> <p>Operational efficiencies: communications, purchasing, IT, etc.</p> <p>Improved care coordination and access</p> <p>Integrated QIP</p>	<p>Developing board and staff skills</p> <p>Risk of assuming other entity liabilities</p> <p>Salary differential</p>
<p>Dryden Regional Health Centre</p>	<p>320km to Thunder Bay</p> <p>Catchment 15K</p> <p>3 communities</p> <p>3 First Nations</p>	<p>Acute care</p> <p>Emergency care</p> <p>Ambulatory care</p> <p>Visiting specialists</p> <p>Complex Continuing Care</p> <p>Ontario Telemedicine Network consults with specialists</p> <p>Community Mental Health and addictions FHT (multiple services)</p> <p>Community rehabilitation</p>	<p>Skills-based Board</p> <p>Several board committees</p> <p>Single management</p> <p>Shared support services</p> <p>FHT/Acute care integration</p> <p>Mental health crisis response</p> <p>Less duplication, increased critical mass</p> <p>Coordination around patient needs</p>	<p>Funding silos, various funding sources</p> <p>Regulatory differences</p> <p>Compensation/unions</p> <p>Local vs. district vs. regional governance</p>

Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
OHA hub model (proposed 2013)	<p>10k – 40k is a guideline for rural, southern Ontario.</p> <p>For more remote communities, there needs to be flexibility with respect to the size of hub.</p>	<p>Emergency and inpatient care</p> <p>Comprehensive primary care</p> <p>Home and community long-term care</p> <p>Mental health and addictions.</p>	<p>Supports a patient-centred approach to coordinating local health services with stronger patient navigation and shared clinical pathways</p> <p>Strong synergies between service providers in the hub</p> <p>Improves client access</p> <p>Supports quality improvement planning for local health systems in rural and northern communities</p>	
North Dumfries Community Health Centre, a satellite of Langs	<p>Catchment: 10,000</p> <p>North Dumfries Township and Plattsville, Drumbo, New Dundee</p>	<p>Primary care</p> <p>Social work</p> <p>Registered dietician</p> <p>Diabetes education</p> <p>Health promotion</p> <p>Community programs, especially youth and seniors</p> <p>Early years program</p> <p>Venipuncture clinic</p> <p>Care coordination, including for Health Links</p>	<p>Increased access for region</p> <p>Providing services identified by the community that were previously unmet</p> <p>Community-driven process from inception to ongoing operations, including a community advisory committee</p> <p>Co-located within a recreation complex with access to NHL-sized ice rink, senior's lounge, walking track, youth room, community meeting rooms</p>	<p>Capacity to expand services exist with additional resources</p> <p>Limited to non-existent mental health services</p> <p>Difficulty accessing locums</p> <p>High degree of part-time staff</p> <p>Salary differential between health sectors</p> <p>Limited IM/IT resourcing</p> <p>LHIN targets difficult to achieve with limited resources</p>

Appendix B

Tools and Resources

Resources

1. North West LHIN Health Services Blueprint. Please see www.northwestlhin.on.ca
2. North East Rural Communities Framework for Health System Improvement – to help stakeholders at the community level determine the appropriate service delivery model. Please see www.nelhin.on.ca
3. Governance Collaboration. Please see www.thegce.ca

Tools

Examples of templates include:

1. Lease Agreement
2. Letter of Understanding for services and payment terms for non-emergency transportation
3. Purchase of Service Agreement
4. Amendment to Agreement for Privacy and Billing

Appendix C

This section highlights the differences between Health Links and rural health hubs. It is important to note that the two can easily and beneficially co-exist with health

hubs being a very local model of care delivery within, and supporting the goals of, a Health Link.

Criteria/ Prerequisites	HEALTH LINKS:	Rural Health Hub:
Population Size	Minimum 50,000	Less than 20,000. However, there may be some exceptions depending on the remoteness of some communities.
Focus	High cost/user i.e. top 5% who need extra care coordination	All
Providers/ Services	Minimum hospital, CCAC, primary care, specialists	Could include: emergency and inpatient care (i.e. acute, rehab and complex continuing care), comprehensive primary care (e.g. FHTs, CHCs), home and community support services, long term care, social services, and mental health and addictions. The hub could partner with local municipalities in order to contract with EMS and public health
Primary Care	Minimum 65% of primary care providers in the defined region	No threshold
Connectivity	Ability to share information (via EHR) between all Health Link participants	Ability to share information (via EHR) between all hub participants
Quality Improvement	n/a	Clinical integration through pathways and quality improvement (QI) processes to support inter-professional, team-based care among core services
Data Reporting	Ability to report on 12 indicators selected by the Ministry of Health and Long-Term Care	Simplified and valid
Governance and accountability	One “Lead Organization” with partnership agreements with other health service providers. Leadership, governance and degree of integration is flexible and based on local requirements and relationships	Leadership, governance and degree of integration are flexible and based on local requirements and relationships.

Appendix D

Acknowledgements

Multi-Sector Rural Health Hub Advisory Committee:

Dr. Adam Steacie, Family Physician (OMA Co-Chair)

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Appendix E

Multi-Sector Rural Health Hub Advisory Committee

Terms of Reference

Approved - June 27, 2014

Background

In the spring of 2013, the OHA released a paper entitled *Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come*, which was developed in response to a request made by the Honourable Deb Matthews, Ontario's Minister of Health and Long-Term Care. This paper presented the Health Hub Model as a concept rather than a rigid framework, one that can serve as a springboard for discussion and collaboration among health system partners towards the development of an action plan.

Immediately following the release of the paper, the OHA hosted a Small Hospital Working Session which was attended by hospitals, a number of health system partners and LHINs, where ideas for moving forward with the implementation of Health Hubs were discussed. In addition to identifying a number of challenges respecting the creation of such Hubs, participants expressed the need for a provincial-level, multi-stakeholder advisory committee to refine the model and address the barriers that could potentially affect implementation. Because these issues are critically important to physicians in rural practice, the OHA and the OMA have partnered to convene this table.

Purpose

Within the context the Ministry of Health and Long-Term Care's Action Plan for Health Care and Health Links, the Multi-Sector Rural Health Hub Advisory Committee (Advisory Committee) will assist rural and northern communities to design and move forward with the implementation of Rural Health Hubs.

Rural Health Hubs are comprised of health service providers, working together through formal agreements and partnerships that improve the coordination and effectiveness of care for a defined population and/or geographic area.

Strengthening and creating the coordination of health care organizations in rural communities will support the delivery of effective and high quality health care to people living in those communities as envisioned by strategies such as Health Links (there are other programs such as CCO initiatives and Senior Health Initiative which would benefit from effective rural health hubs).

As many rural and northern communities, across the province, have already implemented their own models of a Rural Health Hub, the lessons learned from these models and others will inform the development of principles, and enabling tools and also help identify and address barriers that are impeding integration.

Key deliverables will include:

1. The examination of existing local coordinated health care delivery models (such as a Rural Health Hub) within rural and northern communities to help:
 - Inform the development of a common vision and principles of a coordinated health care delivery model;

- Identify the policy and regulatory barriers impeding integration; and
 - Identify successful models and leading practices across the province that can be profiled
2. A mapping exercise to examine the alignment of Rural Health Hubs with Health Links Model and how it fits at the Provincial and LHIN level
 3. Consensus on guiding principles and a new framework for enhanced coordinated health care delivery within rural and northern communities and an action plan to address the policy and regulatory barriers impeding integration
 - The development of tools to assist communities with implementing the new model(s) of coordinated health care delivery
 - Provide advice on strategic investments related to the multi-year \$20 million Transformation Fund for Small and Rural Hospitals (informed by lessons learned)

Membership

Membership to include, but not limited to the following:

- Ontario Association of Community Care Access Centres
- Addictions and Mental Health Ontario
- Ontario Hospital Association
- Ontario Long Term Care Association
- Association of Ontario Health Centres
- Ontario Medical Association
- Association of Family Health Teams of Ontario
- Ontario College of Family Physicians
- Ontario Home Care Association
- Ontario Community Support Association
- Association of Non-Profit Homes and Services for Seniors
- North East LHIN

- North West LHIN
- South West LHIN
- Champlain LHIN
- Ministry of Health and Long-Term Care

As the Advisory Committee works through their key deliverables, there may be opportunities to engage with other stakeholders as needed.

Chair Position

The Advisory Committee will be co-chaired by the OMA and the OHA.

Meetings

Meetings of the Advisory Committee will be held in-person on a bi-monthly basis or at the call of the co-chairs.

Support

The OHA and OMA staff will provide support and guidance to the Advisory Committee.

Reporting Relationship

Members will report through the appropriate internal structures within each organization and to the Board of Directors of each organization in advance of the final report's presentation to the Ministry of Health and Long-Term Care.

Working Group

Co-Chairs may wish to appoint an ad-hoc Working Group with defined Terms of Reference, as appropriate, to work through key deliverables.

Timelines

The first meeting will take place January 2014 and deliverables will be completed by the end of 2014.

