

Rural and Northern Health Care Framework/Plan

Stage 1 Report

FINAL REPORT

Ministry of Health and Long-Term Care

Copies of this report can be obtained from

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Panel Chair Foreword

On behalf of the Rural and Northern Health Care Panel we wish to express our sincere appreciation to the Minister of Health and Long Term Care for this opportunity to assist the Government, Local Health Integration Networks (LHINs), health care providers and communities to plan how access to health care services can be improved in rural and northern Ontario.

Panel members are all long time residents of rural and northern communities and each member brought a unique perspective based on their knowledge of health care and experience living in rural and northern Ontario. The Panel has undertaken a comprehensive process to review and understand the issues and challenges facing rural, remote and northern Ontario. We are confident that the proposed Stage 1 Rural and Northern Health Care Framework will position the Ministry of Health and Long Term Care (MOHLTC), LHINs and local communities/providers to address these challenges.

The Panel recognizes that a critical next step in the Ministry's planning process is public engagement, and that although preliminary public input was gathered through the Ministry's website for this Stage 1 report, a more comprehensive engagement process is needed to provide insight, and build momentum and buy-in for the vision proposed:

A health care system that provides appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians

I would personally like to thank the Panel members for their participation and commitment to this important work to improve health care in rural and northern Ontario. Many of the members have indicated their willingness to continue to support the Ministry as it proceeds with Stages 2 and 3 of this planning process to establish a final Rural and Northern Health Care Framework for the province.

Hal Fjeldsted, Chair
Rural and Northern Health Care Panel

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Glossary of Terms

Term	Description
AHSC	Academic Health Science Centre
LHIN	Local Health Integration Network
MIZ	Metropolitan area and census agglomeration influenced zones
MOHTLC	Ministry of Health and Long-Term Care or Ministry
NHS-UK	National Health System, United Kingdom
NOSM	Northern Ontario School of Medicine
NP	Nurse Practitioner
OHA	Ontario Hospital Association
OMA	Ontario Medical Association
OMAFRA	Ontario Ministry of Agriculture, Food and Rural Affairs
OTN	Ontario Telemedicine Network
RIO	Rurality Index of Ontario
Tertiary	Highly acute and specialized services provided in large community and academic hospitals
UAP	Underserviced Area Program

Executive Summary

Introduction

Access to quality health care in rural, remote and northern communities is a long standing issue in Ontario. The challenges of providing appropriate access to health care in these communities stem from multiple factors: geographic remoteness, long distances, low population densities, less availability of other providers and inclement weather conditions. Building on previous planning for rural and northern health services that started in the late 1990's, Ontario has successfully launched a number of initiatives designed to address the access issues in rural, remote and northern communities in the province.

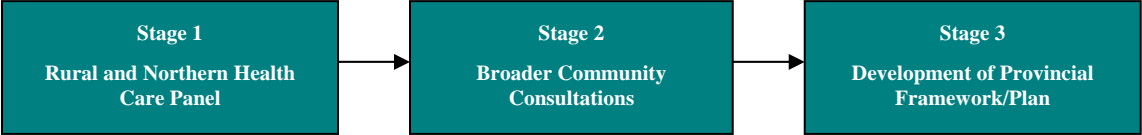
Since then the landscape of the Ontario health care system has undergone transformational changes. One of the most significant changes for Ontario's health care system has been the introduction of the Local Health Integration Networks (LHINs). The LHINs are assigned the accountability to coordinate health care services that meet the needs of local communities; however, the LHINs, as well as other stakeholders in the system, struggle to effectively provide services to rural, remote and northern populations.

The government, as part of its 2007 Platform, committed to examining these issues and providing a Provincial Framework/Plan to support improved access to health care in rural, remote and northern communities. Now that LHINs are well established in their roles, the government has determined that the time is right to move forward on that commitment. To formalize this commitment, focused on improving access to health care services for the more than 1.9 million¹ Ontarians living in rural, remote and northern areas of the province, the Ministry established a Rural and Northern Health Care Panel.

Mandate

The Rural and Northern Health Care Panel (the Panel) is tasked with defining a vision, guiding principles, strategic directions and guidelines that will assist the MOHLTC and LHINs to address access to care as one dimension of quality of care in rural, remote and northern communities. Panel members include a mix of health care providers and administrators, physicians and nurse practitioners, municipal representatives and administrators, aboriginal health experts, and Members of Provincial Parliament, all familiar with the access challenges faced by rural, remote and northern communities.

The Panel's work is the first of a three-staged approach by government to developing the Province's Rural and Northern Health Care Framework/Plan. Although not part of the scope of this mandate, the Panel considers the second stage of broader public consultation as critical to the finalization of the Provincial Framework/Plan that meets the objective of improving access to health care services in rural, remote and northern Ontario.



¹ Based on the Rural and Northern Health Care Panel definition of rural, remote and northern, as described in Section C of this report.

The Panel believes that setting the appropriate context for its recommendations on improving access is important, specifically with respect to the impact of access on quality and overall health status, and of the different factors that influence access. Specifically, the Panel recognizes that access is only one of several dimension of health care quality: according to the Ontario Quality Health Council², quality care can only be optimized when patients have access to the system. While the broader quality agenda is not a part of the Panel's mandate, it will be important that the Panel's recommendations on access are considered by other quality initiatives impacting health care in rural, remote and northern communities. Further, the Panel recognizes that efforts to improve health care access will contribute to, but not alone achieve, improvements to overall health status of rural, remote and northern communities. This said, the Panel is confident the focused efforts of this Framework/Plan to improve access will contribute to a broader vision of achieving equitable health outcomes for rural, remote and northern Ontarians.

Health care access challenges are experienced by communities throughout the province; however, certain access challenges are uniquely exacerbated in rural, remote and northern Ontario. Given its mandate, the Panel focused on the impact of geography and proximity to services as it explored issues, challenges and strategies to improve health care access. The Panel further recognizes that socioeconomic status, income, education, cultural and linguistic background and other factors also contribute to access. These factors were explored by the Panel as it started to deliberate on the key issues, challenges and strategies to improve access, and are considered throughout the Panel's recommendations where appropriate. However, the Panel believes that these broader factors of access will need to be explored further during the Stage 2 consultations as the MOHLTC finalizes its Rural and Northern Health Care Framework/Plan.

The Panel's Methodology and Approach

A comprehensive process was undertaken by the Panel to ensure appropriate focus on the wide variety of challenges and strategies to improve access to health care in rural, remote and northern communities. To accomplish its work, the Panel established a series of day-long working sessions, supported by additional documentation and external literature review and discussion. The total duration of the Panel's work was from July 2009 – February 2010.

Supporting the Panel's working sessions, a number of activities were also completed to inform the discussion and decisions of the Panel, including: an environmental scan and jurisdictional review, development of an inventory of services funded by the MOHLTC, individual consultations with panel members, discussions with external health care organizations in Ontario, and preliminary public engagement through the MOHLTC website.

Defining Rural, Remote and Northern Ontario

As a critical first step to the Panel's work, it was recognized that the terms "rural", "northern" and "remote" must be defined. Across Ontario the degree of each is relative. Rurality can be measured on a sliding scale, and demarcation between rural and non-rural areas may be both unclear and rapidly changing. For the north, it includes both urban and remote populations widely dispersed over vast geography.

Defining Rural

Several definitions and considerations related to 'rural' and 'rural health' exist, however no standard definition exists. It is clear that multiple definitions/approaches for determining the relative degrees of "rurality" between communities exist, each for different planning purposes. For example, Panel members recognize the merits and appropriateness of these other methods for the purposes of the programs they are used for, such as the Rurality Index of Ontario (RIO2008_BASIC) for the Underserved Area Program (UAP). However, the Panel collectively feels that a more appropriate definition is needed for the specific purposes of the Framework/Plan.

² http://www.ohqc.ca/en/access_efficiency.php, Accessed January 2010

Based on the deliberations of the Panel, it was determined that typically:

‘Rural’ communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000.

In deriving this definition, Panel members recognized that communities with more than 30,000 residents typically have a broader scope of health care services available than smaller communities. These larger communities, of 30,000 residents or more typically have a broader range of specialty and sub-specialty inpatient hospital services, expanded community-based programs, and often serve as hubs for regional programs.

It is understood that there will be some communities that are unquestionably rural, while others may have a gradation of rurality, and further that access challenges in southern and northern rural Ontario are different – these points of differentiation are noted, and help to inform ongoing discussion about access needs in rural Ontario. The Panel believes that each LHIN will need to establish the level at which its communities are defined (i.e. by census subdivision or at a more local community level), and determine the rurality of its communities, using this definition to help guide planning discussions.

Definition of North or Northern

In defining ‘northern’, the Panel is aligned with the current government planning parameters of Parry Sound and north to be considered ‘northern’, such that the North East and North West LHINs are considered the two ‘northern’ LHINs. Specifically, the Panel accepts the current government definition of Northern Ontario (2009) as:

Northern Ontario is comprised of 10 territorial districts (145 municipalities): Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound. This area covers over 800,000 square kilometres, representing nearly 90 percent of the Province of Ontario’s land area. It extends across two time zones, from the southern boundary of the District of Parry Sound, north to Hudson Bay and James Bay, and westerly from Quebec to the Manitoba border.

Further it is noted that within ‘northern’ is a set of defining subgroups that form a continuum. For example, the north includes five ‘urban’ centres: North Bay, Sault Ste. Marie, Sudbury, Timmins, and Thunder Bay. The geography of the north is also stratified into the ‘near’, ‘mid’ and ‘far’ north, as these different geographies of the north have different needs, resource availability and access to services.

Defining Remote

For the purpose of defining remote communities in the Framework/Plan, the Panel establishes that typically:

‘Remote’ communities are those without year-round road access, or which rely on a third party (e.g. train, airplane, ferry) for transportation to a larger centre.

Examples of these communities include Moose Factory and Pikangikum. It is further noted that a continuum exists across the definitions of ‘remote’ communities, and the different access challenges they face.

While identification of key issues for remote, isolated and distant communities were considered in the development of this Stage 1 Framework/Plan, the Panel believes that an additional separate process will also be needed to further develop a framework specific to the unique and underserved needs of those communities. The Panel has recommended the initiation of this process to Government.

Understanding Health Status and Access in Rural, Remote and Northern Ontario

With clear definitions established, a review of the health status in rural, remote and northern communities was examined. In Ontario, as across Canada, health status of rural residents has been found to be lower than residents in urban areas. The following indicators support this general finding:

- Life expectancy at birth is generally lower in rural areas compared to urban areas
- The all-cause mortality rates (age-standardized mortality rates) of both Canadian men and women of all ages increased with increasing remoteness of place of residence.
- Statistically higher proportions of rural residents reported having a fair/poor health status compared with urban Canadians.
- Significantly greater proportions of rural Canadians aged 20 to 64 years reported being overweight than urban Canadians

Building on this fundamental difference of health status between rural and urban Canadians, differences in health status are also noted between southern and northern rural Ontarians. Overall, northern Ontario has a lower proportion of residents that report very good or excellent health status compared to southern rural areas. Northern Ontario also has higher rates of hospitalization due to injury, and for conditions where outpatient care could prevent or reduce the need for admission to a hospital. These indicators are two examples that underscore the Panel's overall perspective that northern rural Ontarians face more intense challenges in accessing health care services than do southern rural Ontarians.

Access Challenges

Based on findings from all of the key inputs into this planning process, in addition to the Panel's deliberations, highlights of the broad challenges and barriers to accessing health care in rural, remote and northern Ontario are summarized below, which set the stage for the key areas of focus that must be addressed by the Framework/Plan:

- Access challenges exist across the continuum of care. For example, the role of hospitals as the default primary care provider where other services are not available is a further challenge within the continuum, and may explain why hospitalization rates tend to be higher in rural and northern area, even for conditions that are usually addressed within ambulatory settings in urban areas
- Availability of health care services across local communities with similar needs varies due to health resources, infrastructure or other factors, which impacts access to a range of services (e.g. community services, primary care / family health teams, emergency medical services, public health)
- Limited availability of cultural and linguistically appropriate services (e.g. Aboriginal, Francophones), which impacts access and outcomes
- Scarcity of resources (e.g. health human resources, infrastructures, technologies, etc.) and varied enablement of health professionals to work at the full scope of practice limit the capacity of the system to deliver care at an acceptable standard – although the Panel recognizes that many rural and northern practitioners practice to their full scope of practice, policy, infrastructure and other tools are needed to enable this more consistently in rural and northern areas
- Inconsistent implementation of potential interprofessional models across local communities, which are considered an important element of improved access to local health care (e.g. varied levels of investment in primary care models such as Family Health Teams across local communities)
- Availability of transportation (emergent, inter-facility and non-urgent) in some northern, remote and rural areas is limited
- Travel distance can make access to services difficult, and influences which services individuals seek.
- Lack of rural perspective applied in planning at the provincial or LHIN levels, and the need for increased flexibility at the local level to drive innovations related to scope of practice, funding and system integration

- A recognition that the health care access challenges and needs in rural communities differ between southern Ontario and northern Ontario, and that challenges are typically accentuated in the north
- The historic trend toward centralization in health system design, which limits local responsiveness and reduces access; need to create local capacity to focus on synergies across the continuum of care and sectors
- Inter-sectoral and cross-jurisdictional challenges and fragmentation of the funding, management and coordination of different components of the health system (e.g. emergency medical services, public health)
- Limited sharing of health records and information across professionals within the system

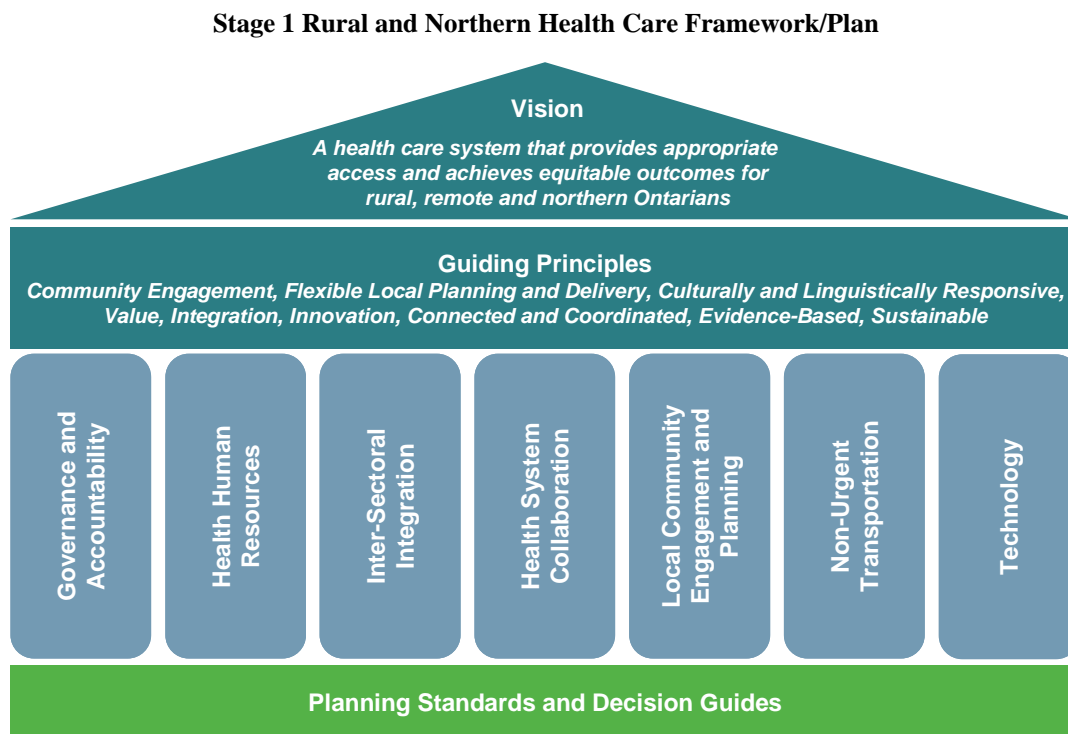
Identifying Services that Improve Access

Equally important to identifying challenges is understanding the current programs and strategies already in place to improve access to rural, remote and northern Ontario. As part of the Panel’s work, an inventory of current programs that the MOHLTC funds to address access issues in rural, remote and northern communities was established, which range in the types of services funded, including: disease-focused programs, health professional recruitment and retention, interprofessional care models, local community or population specific initiatives, travel grants and technology-enabled access solutions.

While a specific review of these programs was not conducted by the Panel, there was general acceptance of the contribution that these provincial commitments have toward improving access in rural, remote and northern Ontario.

Stage 1 Rural and Northern Health Care Framework/Plan

Based on the inputs and insights gathered through its planning process, the Panel is proposing the following Stage 1 Framework/Plan, which outlines a vision, guiding principles, planning standards and decision guides, strategies and guidelines for the MOHLTC and LHINs.



Vision

At the core of the Panel's work is a vision designed to guide the implementation of the proposed Framework/Plan by the MOHLTC, LHINs and local communities – one which the Panel believes will appropriately direct efforts to improve access to health care for rural, remote and northern communities:

A health care system that provides appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians

The Panel feels this vision will serve rural and northern Ontario residents well, and is aligned with the province's broader vision for health care: to help people stay healthy, deliver quality care when and where they need it and to ensure the sustainability of the health system for future generations.

Guiding Principles

To focus planning efforts toward this vision, the following set of nine guiding principles are also identified. These guiding principles are intended to foster health care planning and delivery that is innovative, locally responsive and sustainable.

Community Engagement: To encourage transparency and accountability in identifying local access issues and solutions, a community's residents, health providers and other local stakeholders should be active participants in the decision-making process.

Flexible Local Planning and Delivery: To improve access to health care, planning and delivery of services should directly involve local communities and be flexible to adapt to local needs; be responsive to different community needs; and to balance need, quality, critical mass and accessibility.

Culturally and Linguistically Responsive: To improve the accessibility and appropriateness of services, planning, and delivery of services should be responsive to the cultural and linguistic needs and differences of individuals and communities.

Value: Health facilities and the corresponding concentration of health professionals are a local base of health resources in rural and northern communities which should be viewed as 'assets' that can improve the overall efficiency and cost-effectiveness of regionalized delivery systems, and which support local ownership and sustainability of health services.

Integration: Planning, delivery and targeted initiatives must integrate across traditional health care and inter-sectoral silos at the local level.

Innovation: Exploration of new models of care delivery, health human resource roles and integration should be supported.

Connected and Coordinated: To enable coordination of access, planning and delivery at the local level must also be connected to and across LHIN and provincial initiatives and organizations.

Evidence-Based: To ensure access is appropriate, initiatives must be evidence-based, supported by ongoing research and evaluation of standards and outcomes.

Sustainable: To maintain and improve access, new initiatives must present solutions that are sustainable with respect to financial, human and other resources.

Planning Standards and Decision Guides

In support of the vision for appropriate access and equity of outcomes, the Panel is proposing the following set of ‘planning standards and decision guides’. The intent of these planning standards and decision guides is to support the province, LHINs and local communities in coordinated planning at all levels for improved access for residents in rural, remote and northern Ontario.

The planning standards and decision guides are intended as ‘visionary’ guidelines for health system planning by the Ministry and LHINs. These standards are not designed as ‘rules’ to indicate minimum or maximum access guarantees, provide decision on whether to build or close hospitals or inpatient beds, or to increase or reduce current service levels. Further, it is recognized that these standards may not be feasible for some populations in rural and remote Ontario, and that further work by the province and LHINs will be needed at the local level to engage communities to define appropriate access needs and standards, and identify alternative solutions.

- **90% of residents in a community or local hub will receive primary care within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive emergency services (24/7/52) within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive basic inpatient hospital services within one hour travel time from their place of residence**
- **90% of residents in a community or local hub will receive specialty inpatient hospital and tertiary diagnostic services within four hours travel time from their place of residence**

Travel time presumed travel by road, under normal road conditions and travel within posted speed limits.

A critical first step in using these planning standards will be for each LHIN to work with their residents to define local communities, and to then assess the degree to which local communities are served by the access levels identified.

Strategies and Guidelines

The Panel identified 12 recommended strategies and guidelines across three main themes, with consideration of the provincial, LHIN and local community/provider roles in their implementation. The recommendations and primary responsibility for implementation are summarized below:

Governance and Accountability

The Panel believes that assigning accountability provides the potential to align initiatives across the province, ensure a rural perspective is applied for planning activities at the provincial level, and implement effective performance management to assess whether the desired vision and goals have been achieved. In addition, the Panel feels that a separate planning process is needed to identify strategies and guidelines that address the complex health care access needs for First Nations and Aboriginal communities, and other remote, isolated and distant communities. The following recommendations and supporting sub-recommendations are proposed within this theme of governance and accountability:

R1: Create a point of accountability within the MOHLTC leadership focused on rural, remote and northern health, and responsible for leading the definition and monitoring of standards for health care access (Provincial Strategy)

R1.1. Carrying forth the recommendations of the Panel and monitoring their implementation

- R1.2. Leading collaborative initiatives with LHINs and local communities/providers to define and monitor performance goals and standards for access, supported by ongoing evaluation of access initiative outcomes**
- R1.3. Identifying a mechanism to stay closely engaged with the LHINs, local communities and providers in a collaborative dialogue on access to rural, remote and northern health care (e.g. through an Advisory Council or other mechanisms as deemed appropriate)**
- R1.4. Working with LHINs, local providers, universities, research centres and researchers to support research and disseminate best practices of models of care, community engagement and other knowledge**
- R1.5. Supporting provincial-health professional planning to identify the roles, expectations and accountabilities of health system-physician relationships to support health care access in rural, remote and northern Ontario**
- R1.6. Establishing clear linkages within the MOHLTC to facilitate coordination of initiatives that address health care access issues, as well as across other initiatives that impact the broad determinants of health to improve the health status of rural, remote and northern Ontarians**
- R1.7. Stewarding inter-sectoral integration of funding and policy across MOHLTC portfolios, other Ministries and provincial agencies to improve health status of rural, remote and northern Ontarians**
- R1.8. Stewarding the provincial role for coordinating policy across provincial and federal health jurisdictions to improve access**
- R1.9. Applying a ‘rural, remote and northern perspective’ to validate the appropriateness of provincial initiatives, and setting relevant targets for access in rural, remote and northern Ontario**
- R1.10. Implementing flexible funding models that support integration at the local level across existing funding silos (e.g. LHINs, primary care, EMS, Public Health, community agencies), and that are responsive and sensitive to the unique local circumstances of communities in rural, remote and northern Ontario**

R2: Establish a process to identify strategies and guidelines to improve access to health care services for First Nations and Aboriginal communities, and which also considers the needs of remote, isolated and distant communities (Provincial Strategy)

Health Human Resources

The scarcity of health human resources is particularly felt by rural, remote and northern communities, which has limited the access to care in these communities. To address these challenges, the Panel is proposing the following recommendation and supporting sub-recommendations specific to rural, remote and northern communities and encompasses a broad array of health care professionals:

R3: Continue to establish innovative health human resource models for rural, remote and northern Ontario, and integrate this planning perspective into existing provincial health human resources strategies and programs (Provincial Strategy)

- R3.1. Champion inter-professional care and a focus on healthy workplace as key principles for health human resource planning (e.g. support models such as Family Health Teams, Anaesthesia teams)**
- R3.2. Further support enhanced scopes of practice for health providers working in these communities to improve access (e.g. Nurse Practitioners, Pharmacists, Paramedics, Midwives, Unregulated Workers), and eliminate policy, regulation or practice barriers that inhibit health providers from working to their full scope of practice, and enable unregulated workers to take on additional responsibilities where appropriate**
- R3.3. Provide incentives and models for working in these communities to all health professionals**

- R3.4. Invest in leadership development at all levels to lay the foundation for future leaders in rural, remote and northern communities, and provide continued momentum to improve access to health care**
- R3.5. Use appropriate recruitment strategies to attract the right individuals as health care professionals and leaders into rural, remote, and northern communities**
- R3.6. Create the required mechanisms and support to provide mentorship and development for new graduates across all health professionals that instill the requisite skills to work in rural, remote and northern communities**
- R3.7. Increase responsibility for all universities, colleges and training institutes across the province that train health professionals to address workforce challenges in rural, remote and northern Ontario, including:**
 - a. Align health professional training programs in universities, colleges and institutes to be representative of the population of rural, remote and northern Ontario (e.g. if the population represents 15-20% of Ontario, have 15-20% of learners from the population; and provide teaching/faculty support for in-community training)**
 - b. Increase on-site education experiences in rural, remote and northern communities, with a linkage to ongoing mentorship and leadership development programs for new graduates**
 - c. Increase the outreach of faculty to deliver education, research and clinical care in rural, remote and northern communities**

Integration

Inter-sectoral Integration

Limited coordination in the planning and delivery of health services impacts access in rural, remote and northern communities. Two components of the health continuum are specifically noted by the Panel as needing improved integration and alignment at a provincial and/or LHIN level, Emergency Medical Services and Public Health, to enable improved coordination and access, and address identified population health needs, resulting in the following recommendations and supporting sub-recommendations:

R4: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Emergency Medical Services (land and air) with the planning and delivery of local health services, at both the provincial and LHIN levels (Provincial and LHIN Strategy)

R5: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Public Health services at both the provincial and LHIN levels, to enable integrated planning and delivery of health services (Provincial and LHIN Strategy)

Health Care System Collaboration

In its deliberations, the Panel identified the need to formalize and expand existing points of collaboration within and among LHINs and providers, to create a foundation for improved health system coordination that will in turn improve access for rural, remote and northern Ontario communities. The following recommendations and supporting sub-recommendations are proposed to enhance existing health system collaboration:

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 (LHIN Guideline)

- R6.1. Encourage local community engagement in planning and delivery across the health continuum**
- R6.2. Leverage the role of small health care facilities and their catchment areas as potential ‘local hubs’ of integrated health care services, incorporating geographic variations of each hub to establish sub-LHIN planning areas**

R6.3. Determine the most appropriate balance of services delivered close to home versus in local/multi-community hubs or through LHIN/provincial-level resources

R7: Establish clear roles, responsibilities and supporting infrastructure for health providers that fosters improved collaboration, defines referral networks and pathways, and coordinates access to services (LHIN Guideline)

R7.1. Identify and establish LHIN-based and cross-LHIN referral centres and outreach networks, with clear accountabilities that extend from an organization's governance through to front-line professionals

R7.2. Establish coordinated approaches across referral centres and outreach networks to improve service coverage and facilitate patient transfers for acute services

R7.3. Identify telemedicine hubs, referral networks and supports needed to improve access

R8: Establish provincially coordinated formal referral and outreach networks between academic health sciences centres and local providers in rural, remote and northern communities, with clear roles and responsibilities (Provincial Strategy)

R8.1. Build on the many existing referral and outreach networks established in the province in which regional referral centres and local providers in rural, remote and northern communities leverage the specialized resources of AHSCs.

R8.2. Formalize a referral and outreach relationship between AHSCs across the province so that every local community or multi-community cluster within the LHINs is formally linked with an AHSC, which establishes clear accountabilities that extend from an organization's governance through to front-line professionals

R8.3. Provide specialized expertise to local areas through in-community education, planning and service delivery.

R8.4. Improve the equity of access of rural, remote and northern Ontarians to specialized services.

R8.5. Leverage the use of electronic health records and telemedicine to enhance and expand the access to services enabled through these networks.

Local Community Engagement and Planning

Moving beyond traditional community engagement, the Panel believes that more active involvement of local communities in the decision-making process for health care planning, funding and delivery is needed to improve the responsiveness of health care to local access needs. The Panel recognizes that this increased community engagement and role must occur within the bounds of the LHINs' legislated role and mandate for health system planning, and the responsibility of the LHINs as being ultimately accountable for health system planning and funding. The following recommendation and supporting sub-recommendations are proposed to enhance existing local community engagement in improving access to health care in rural, remote and northern Ontario:

R9: Engage local communities to actively participate in the decision-making process for health care planning, funding and delivery, to foster improved collaboration and dialogue between the public, providers and LHINs on health access needs and health system capacity (LHIN Guideline)

R9.1. Improve the assessment of community health care access needs at the local level

R9.2. Support, co-own, facilitate and be active participants in identifying local solutions to access challenges, support broader health status issues, and engage communities in local decision-making processes

R9.3. Provide leadership in seeking opportunities to integrate funding across the health and social services silos within a local community, supported by local community engagement in the decision-making process

R9.4. Foster local community leadership and capacity to apply for Ministry and other government funded programs that improve access to health care services (e.g. Family Health Teams, nurse practitioner clinics)

Non-Urgent Transportation

Availability of non-urgent transportation in many rural, remote and northern areas of the province is limited. As a result, residents in these communities are not able to travel to areas to receive health care services or they incur high out-of-pocket costs to travel to health service centres. Further, there is limited coordination between the health providers and EMS for inter-facility transfers and non-urgent transportation that may require health professional accompaniment, leading to fragmentation and potentially ineffective use of limited non-urgent transportation resources. To improve the availability and utilization of non-urgent transportation as a mechanism for improving access to health care in rural, remote and northern Ontario, the following recommendations and supporting sub-recommendations are proposed.

R10: Conduct a review targeted at improving planning, coordination and funding of inter-facility transfers and transportation that may or may not require health professional accompaniment (Provincial/LHIN/Local Strategy)

R11: Conduct a review targeted at enhancing community-based non-urgent transportation solutions as part of access initiatives (Provincial/LHIN/Local Strategy)

R10-11.1. Link to the previously identified recommendation to strengthen alignment of Emergency Medical Services with the planning and delivery of local health services, to enable coordinated service planning and delivery across urgent, inter-facility and non-urgent transportation

R10-11.2. Improve the utilization of limited health resources for inter-facility transfers and non-urgent transportation of individuals that may require accompaniment by a health professional

R10-11.3. Enable local policy and funding flexibility that establishes funding models for inter-facility transfers, transportation that may require health professional accompaniment and non-urgent transportation, to facilitate the development of solutions that meet LHIN and local community needs

R10-11.4. Review existing travel grant programs for opportunities to better align programs to the different needs of residents across rural, remote and northern Ontario

Technology

Across rural, remote and northern Ontario, opportunities exist to improve the use of technology to enable improved information sharing, establish clinical networks, connect providers and individuals, and support ongoing health professional development. The following recommendation and supporting sub-recommendations are proposed by the Panel to improve the use of technology as a tool for improved access to health care services in rural, remote and northern Ontario:

R12: Enhance provincial information management, clinical and education technology availability (e.g. eHealth, telemedicine, simulation learning), and related health professional networks and incentives to encourage use (Provincial Strategy)

R12.1. Use should be encouraged and incented both in rural, remote and northern communities and at the larger referral centres and AHSCs to ensure effective outreach support is being delivered to rural, remote and northern Ontario

R12.2. Use should be supported for both clinical consultations to help improve access to specialist resources, and for education applications to improve and maintain core skills of rural, remote and northern health professionals

R12.3. Information and technology connections within local communities, and across local hubs and regional referral centres, should be enabled to improve access and care delivery

Call to Action

The Stage 1 Rural and Northern Health Framework/Plan established by the Panel sets forth a clear vision, guiding principles, planning standards, strategies and guidelines that, if implemented will improve access to health care in rural, remote and northern Ontario. Implementation of this Framework/Plan will achieve several fundamental shifts in the policy and funding relationships between the Ministry, LHINs, local communities and providers. These shifts present both challenge and opportunity to all stakeholders in the health care system, but if achieved, will set the stage for significant improvement to health care access and achievement of the vision established:

A health care system that provides appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians

The Panel recognizes, however, that its work is only the first of three stages as the province defines its vision and framework. A critical next step to validate this Stage 1 Framework/Plan will be the planned consultation by the Ministry in Stage 2 of this planning process. The Panel believes that a comprehensive engagement process with the LHINs, local communities and providers is necessary to learn key insights, and build momentum and buy-in to a common vision.

In parallel, the Panel recommends that the Ministry and LHINs start work immediately to collaboratively develop a process for implementing the **full** set of recommendations of this Framework. The intent of this parallel implementation planning process is to enable implementation of the Framework to proceed quickly, once the final recommendations are determined in Stage 3 of the Frameworks' development. Critical to this parallel implementation planning process is that it must consider the perspectives and revisions to recommendations identified through the Stage 2 consultations. The Panel believes this combined approach of parallel planning and consultations will best contribute to achieving the goal of this planning initiative in a timely manner: improved access to health care in rural, remote and northern Ontario.

Section A: Introduction

1. Background

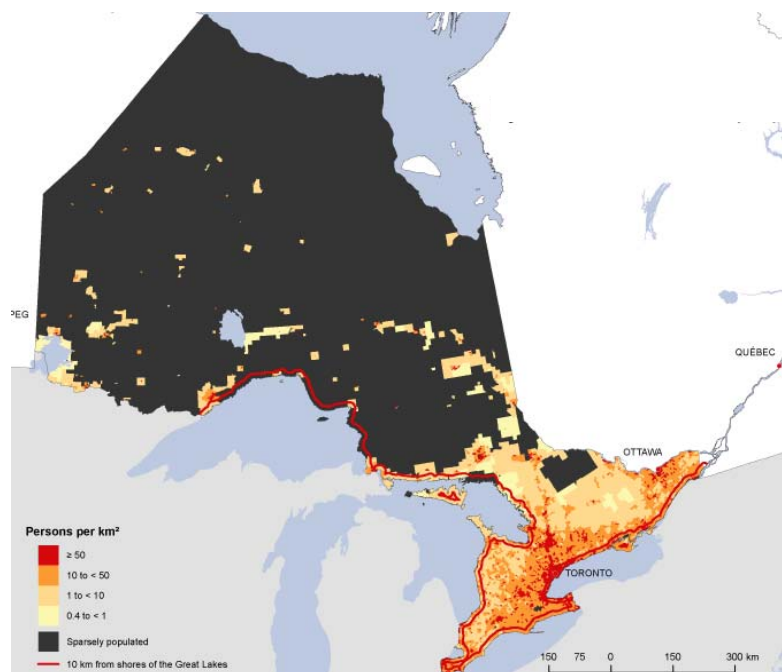
Access to quality health care in rural, remote and northern communities is a long standing issue in Ontario. The challenges of providing appropriate access to health care in these communities stem from multiple factors: geographic remoteness, long distances, low population density, lower availability of health providers and inclement weather conditions. The map of Ontario below demonstrates these challenges, especially for northern Ontario, which is characterized by a notably sparse population distributed across the large geography. Please refer to Appendix A for a larger map.

In 1997, the Government released a Rural and Northern Health Care Framework which presented a Vision, Principles and Planning Directions with the intention to integrate and coordinate health care in these communities leading to improved access for residents. This framework led to the launch of a number of initiatives to address the access issues in rural, remote and northern communities in the province.

Six years after the implementation of the 1997 Framework, a review was undertaken by the Ontario Hospital Association and Ministry of Health and Long-term Care (the Ministry or MOHLTC). Recommendations were made with the intent to facilitate the effective implementation of networks, and not to revise the Framework. Since then the landscape of the Ontario health care system has undergone transformational changes. One of the most significant changes for Ontario's health care system has been the introduction of the Local Health Integration Networks (LHINs). The LHINs are assigned the responsibility to coordinate health care services that meet the needs of local communities; however, the LHINs, as well as other stakeholders in the system, struggle to effectively provide services to rural, remote and northern populations.

The government, as part of its 2007 Platform, committed to examining these issues and providing a Provincial Framework/Plan to support improved access to health care in rural, remote and northern communities. Now that LHINs are well established in their roles, the government has determined that the time is right to move forward on that commitment. To formalize this commitment, focused on improving access to health care services for the more than 1.9 million³ Ontarians living in rural, remote and northern areas of the province, the Ministry established a Rural and Northern Health Care Panel.

Ontario's Population Distribution by Dissemination Area, Census 2006



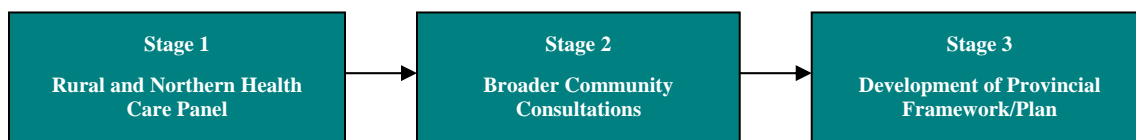
Source: Statistics Canada, Census 2006

³ Based on the Rural and Northern Health Care Panel definition of rural, remote and northern, as described in Section C of this report.

2. The Rural and Northern Health Care Panel

The Rural and Northern Health Care Panel (the Panel) is tasked with defining a vision, guiding principles, strategic directions and guidelines that will assist the MOHLTC and LHINs to address access to care as one dimension of quality of care in rural, remote and northern communities.

This Stage 1 Rural and Northern Health Care Framework/Plan is the result of the Panel's work, which is only the first of a three-stage approach by government to developing the Province's Rural and Northern Health Care Framework/Plan. Although not part of the scope of this mandate, the Panel considers the second stage of broader public consultation as critical to the finalization of the Provincial Framework/Plan that meets the objective of improving access to health care services in rural, remote and northern Ontario.



The Panel comprises a broad collection of individuals with relevant experience and background from working in various rural, remote and northern areas across Ontario. Members include health care providers and administrators, physicians and nurse practitioners, municipal representatives and administrators, aboriginal health experts, researchers, and Members of Provincial Parliament.

The mandate of the Panel is to:

- Review and examine existing historical and current work underway through community-based organizations, the Ontario Hospital Association, the Ontario Medical Association, LHINs and MOHLTC, to address rural, remote and northern health issues
- Develop a literature review on how other jurisdictions have addressed health delivery systems issues for their rural, remote and northern communities and summarize the lessons, evidence and leading practices
- Review different approaches to defining “rural”, “remote” and “northern”
- Highlight existing programs, services and investments targeted to improving access in rural, remote and northern Ontario
- Based on the current outcomes and the leading practices in Ontario, the lessons from other jurisdictions and the existing evidence, recommend key characteristics for a model of improved access for rural, remote and northern health care in Ontario
- Identify any metrics that are revealed through the work above that measure how access, quality, safety, service, efficiency and sustainability can be achieved through coordinated investments to address unique health system needs in rural/northern Ontario
- Identify strategies that can be customized by LHINs for making local decisions
- Recommend guidelines for LHINs to be used when considering changing roles for health facilities, including sequencing of related changes
- Call for a plan to be developed to implement these recommendations by leveraging, coordinating, optimizing and aligning existing and available programs, opportunities and best practices.

It is also important to understand what is out-of-scope for the Panel. The Panel recognizes the following out-of-scope elements are important to improved access to rural, remote and northern healthcare, but understands that parallel processes are underway within the MOHLTC to address them:

- In recognition of the contemporaneous work of a select committee of the Legislative Assembly, mental health services/programs will not be reviewed.
- As funding decisions are the purview of the Government, the Panel will not make recommendations that require new investments beyond any amount approved or planned by the Government.
- The Panel will not review any decision made by a LHIN with the intent of overturning or questioning the decision.
- While identification of key issues for remote, isolated and distant communities will be in-scope for this initiative, an additional separate process will also be needed to further develop a framework specific to the unique and underserved needs of those communities. Similarly, Panel members felt that given the complexity of governance and funding authorities for Aboriginal communities, and the unique cultural and geographic characteristics of these populations, this same separate process would be more appropriate to determine suitable recommendations. The Panel has recommended the initiation of this process to Government.

For further detail on the Panel's mandate, terms of reference and membership, please refer to Appendix B.

3. The Focus on Access

One of the criteria that provinces and territories must fulfill as part of the Canada Health Act is accessibility. The intent of the accessibility criterion is to ensure insured persons in a province or territory have reasonable access to insured health services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges or other means (e.g., discrimination on the basis of age, health status or financial circumstances). Consistent with its commitment to the Canada Health Act, the Government of Ontario has invested in several initiatives across the province to improve access to health care services (e.g. through the Access to Health Services and Wait Times Strategy). With the establishment of the Rural and Northern Health Care Panel, the province is renewing its commitment on improving access to health care services in rural, remote and northern communities of Ontario.

The Panel believes that setting the appropriate context for its recommendations on improving access is important, specifically with respect to the impact of access on quality and overall health status, and of the different factors that influence access. As noted further below, access to health care services is one of the contributing factors to overall health status and outcomes. By focusing on improved health care access, the Panel believes this Framework will contribute to a broader vision of achieving equitable health outcomes for rural, remote and northern Ontarians.

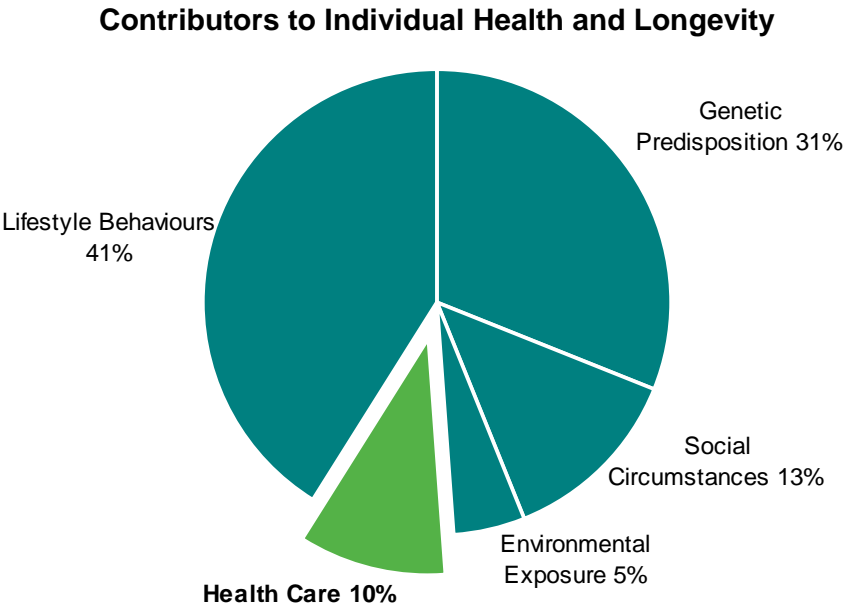
Impact of Access on Quality and Health Status

As early discussions of the Panel proceeded, it was quickly accepted that its focus on access must be considered in the broader context that access is only one of several dimension of health care quality: according to the Ontario Quality Health Council⁴, quality care can only be optimized when patients have access to the system. While the broader quality agenda is not a part of the Panel's mandate, it will be important that the Panel's recommendations on access are considered by other quality initiatives impacting health care in rural, remote and northern communities.

⁴ http://www.ohqc.ca/en/access_efficiency.php, Accessed January 2010

The Panel further recognizes that efforts to improve health care access will contribute to, but not alone achieve, improvements to overall health status of rural, remote and northern communities. Research demonstrates that a number of factors contribute to an individual’s health and longevity (see figure on the following page). Some of these factors can be only minimally influenced, such as genetic disposition, while other factors such as social circumstances and environmental exposure indicate a role for broader coordination across government ministries and agencies to support improvements to population health status. Lifestyle behaviours play the most significant role in affecting health status, and point to the importance of each individual in taking responsibility for his./her own health and wellness. While the many other factors contributing to health status are considered important by the Panel, these were not a focus of the Panel’s mandate or recommendations.

Health care services, and access to them, typically represent a 10% contribution to an individual’s health and longevity, or overall health status (see figure below). The degree that improved access to health care contributes to health status will vary in each community; however this estimate provides an overall frame of reference for the impact of improving access on health outcomes.



Source: New England Journal of Medicine, Vol. 357, No. 12, S. Schroeder (From McGinnis et al)

Key Factors that Influence Access

Health care access challenges are experienced by communities throughout the province; however, certain access challenges are uniquely exacerbated in rural, remote and northern Ontario. Given its mandate, the Panel focused on the impact of geography and proximity to services as it explored issues, challenges and strategies to improve health care access.

The Panel further recognizes that socioeconomic status, income, education, cultural and linguistic background and other factors also contribute to access. These factors were explored by the Panel as it started to deliberate on the key issues, challenges and strategies to improve access, and are considered throughout the Panel’s recommendations where appropriate. However, the Panel believes that these broader factors of access will need to be explored further during the Stage 2 consultations as the MOHLTC finalizes its Rural and Northern Health Care Framework/Plan.

4. Overview of the Report

This report to the Minister of Health and Long-Term Care is the result of the Panel's work over several months. The objective of the Panel's report and recommendations is health service delivery policy coherency, recognizing that the implementation of policy may vary widely between contexts, as appropriate. This work also focuses on the basic features of accountability that need to be in place to achieve success across the Panel's recommendations, including identifying the locus and scope of responsibility, common expectations, and ability to objectively measure performance.

The remainder of this report is organized as follows:

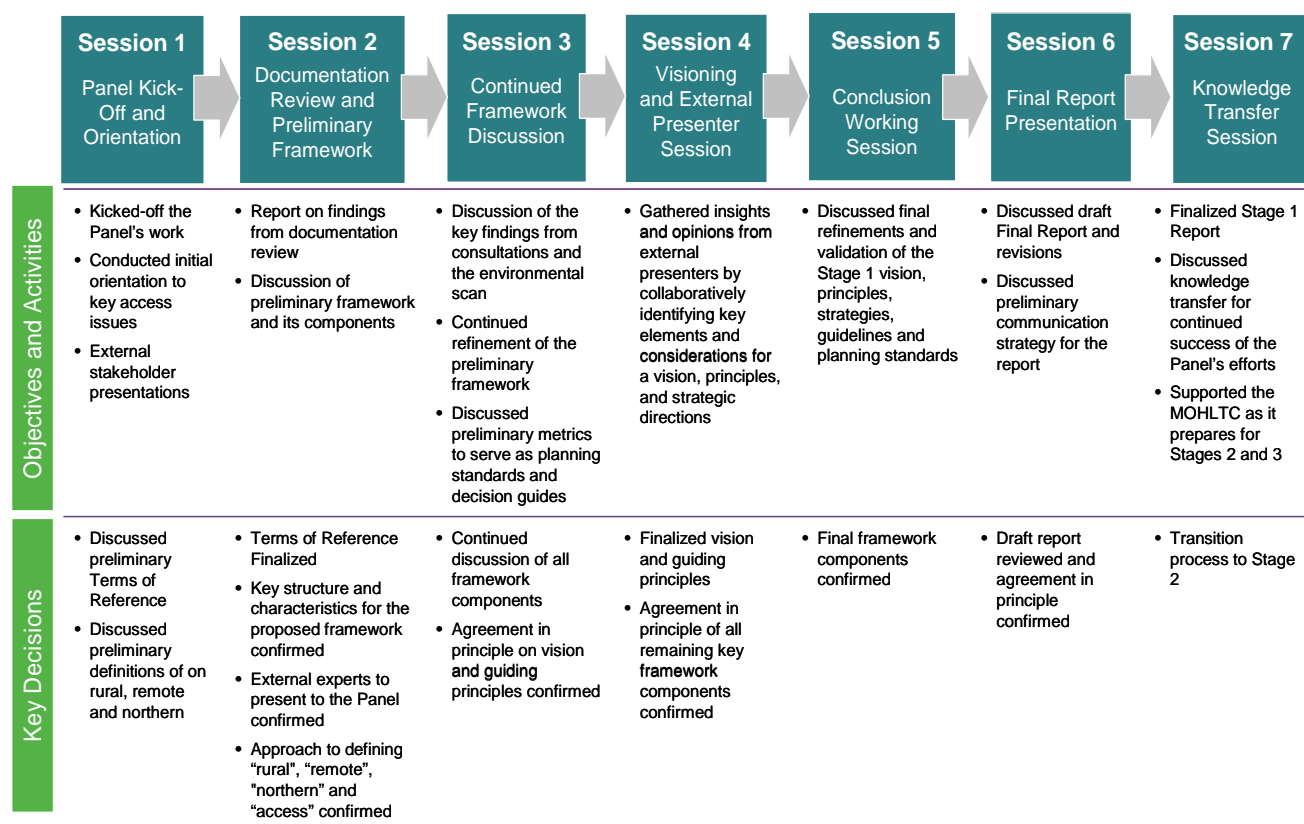
- **Section B: Overview of Methodology and Approach** - Provides an understanding of the comprehensive process undertaken by the Panel to develop its recommendations
- **Section C: The Context for Health Care Access in Rural, Remote and Northern Ontario** - Provides rationale for defining the key terms being used by the Panel for planning purposes; the distinct characteristics that define rural, remote and northern communities in Ontario; key challenges to accessing health care services in these communities; and the differences in access challenges that exist across southern and northern rural and remote communities across the province.
- **Section D: The Expert Panel's Deliberations and Recommendations** – Summarizes the Panel's recommendations to the Ministry as it contemplates the vision, guiding principles, strategies, guidelines and planning standards for improved access to health care in rural, remote and northern Ontario.
- **Section E: Consolidated List of Recommendations** - Presents a consolidated list of the Panel's recommendations for ease of reference.

Section B: Methodology and Approach

5. Overview of Methodology and Approach

As the Panel initiated its work, consensus across Panel members was that a comprehensive process was needed to ensure appropriate focus on the wide variety of challenges and strategies to improve access to health care in rural, remote and northern communities. To accomplish its work, the Panel established a series of day-long working sessions, supported by additional documentation and external literature review and discussion. The total duration of the Panel’s work was from July 2009 – February 2010.

The chart below provides an overview of this methodology and approach, including the key objectives and decisions/outcomes of Panel working sessions.



A number of activities were also undertaken between working sessions, to inform the discussion and decisions of the Panel.

Research and Documentation

Environmental Scan and Jurisdictional Research

- An environmental scan of relevant documentation gathered by the Panel and MOHLTC was completed, and key findings and themes were summarized to inform Panel discussions. Please refer to Appendix C for a complete bibliography of the documents reviewed.

- A broad jurisdictional scan was also conducted, which researched publicly available information on jurisdictions that have developed similar frameworks and metrics related to rural, remote, and northern health care access. Jurisdictions included a range of other provinces in Canada, as well as international jurisdictions such as Australia, New Zealand, the United Kingdom and others.
- To support the jurisdictional research, targeted consultations were also conducted with representatives from jurisdictions that developed specific strategies and measurements/targets on access to services: British Columbia and Australia.

Development of an Inventory of Services Funded by the MOHLTC

- To provide insight into the programs funded by the MOHLTC targeted at improving access to rural, remote and northern health care, a list of key services and initiatives were gathered from across the MOHLTC.
- This list was validated by the Panel as a preliminary inventory of programs aimed at innovatively improving access to health care in rural, remote and northern communities.
- Please refer to Appendix D for this inventory of services and additional commentary from the Panel.

Consultations

Panel Member Insights and Consultations

- Individual consultations with Panel members were conducted to gather insights and perspectives.
- Key themes from Panel deliberations during working sessions were also gathered and summarized to inform decision-making.

Discussions with External Health Care Organizations in Ontario

- A number of discussions with external organizations involved in Ontario's health care system were conducted to provide perspectives from stakeholder groups on key issues, challenges and strategies in accessing care in rural, remote and northern communities. These organizations included: *Association of Municipal Emergency Medical Services of Ontario, Chiefs of Ontario Committee on Health, Ontario Association of Community Care Access Centres, Ontario Hospital Association, Registered Nurses Association of Ontario, Society of Rural Physicians of Canada* and the *Ontario Medical Association*.
- Additional discussions were conducted within the MOHLTC and with the LHINs, as two key stakeholders to which the Panel's recommendations are directed: HealthForceOntario on the Underserved Area Program (UAP), and the Local Health Integration Network Collaborative.

Public engagement through the MOHLTC website

- Although public consultation is not formally part of the Panel's mandate, a public website on the MOHLTC website was established to provide initial insights to the Panel.
- Input received through this public website was reviewed and incorporated into Panel discussions.
- The Panel is clear that this initial public consultation does not replace the formally planned broader public consultation planned as Stage 2 of the development of this Framework/Plan.

The Panel is confident that this combined approach of working sessions and additional inputs has given it a comprehensive understanding of the key issues, challenges and strategies to form this Stage 1 Rural and Northern Health Care Framework/Plan. The Panel recognizes that not all possible inputs or stakeholders were consulted during its deliberations, which is a reflection of the mandate and terms of reference established. As stated, the Panel further recognizes the importance of the planned Stage 2 broader consultations with Ontario citizens and other stakeholders across the health care system, which are anticipated to provide key insights to further augment this Stage 1 Framework/Plan. This consultation will be critical to informing the MOHLTC as it works in Stage 3 to finalize the Framework/Plan to improve access to rural, remote and northern health care.

Section C: The Context for Health Care Access in Rural, Northern and Remote Ontario

Across the Panel’s deliberations, three clear issues emerged that must be addressed to understand the recommendations outlined in this report:

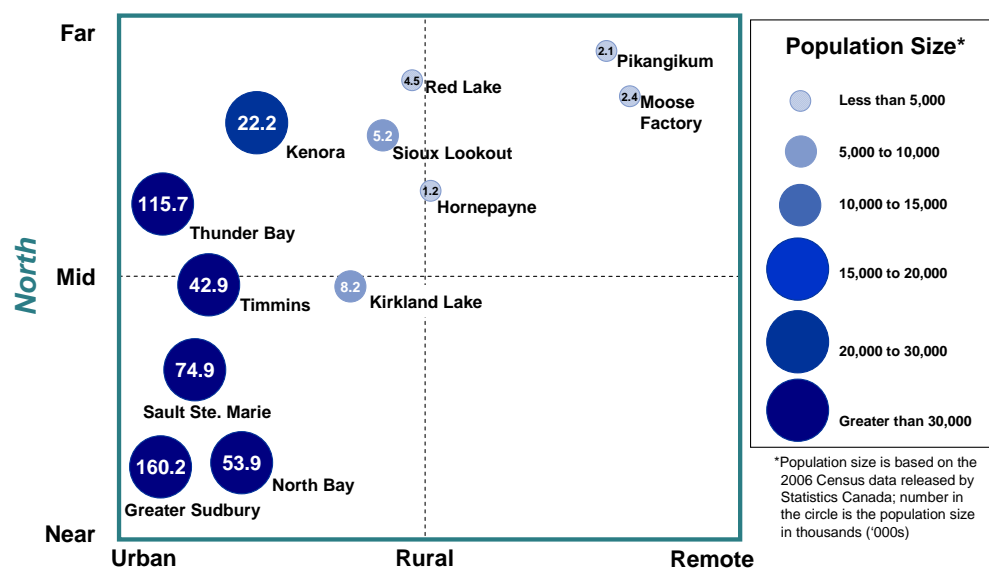
- First is the definitions used by the Panel to describe rural, remote and northern communities in Ontario.
- Second are the differences in overall health status of rural and remote vs. urban communities, and how health status is impacted more so in northern vs. southern rural communities, which signal the need for distinct access solutions to meet different population needs.
- Finally, a broad set of challenges facing rural, remote and northern communities in accessing health care services are identified, which were recognized as critical to address by all Panel members.

A summary of the Panel’s insights and perspectives on these three issues is presented below, to set the stage for the Panel’s recommendations that form this Stage 1 Rural and Northern Health Care Framework/Plan.

6. The Definitions of Rural, Northern and Remote Ontario

From the onset of the Panel’s work, it was recognized that the terms “rural”, “northern” and “remote” are difficult to define. Across Ontario the degree of each is relative. Rurality can be measured on a sliding scale, and demarcation between rural and non-rural areas may be both unclear and rapidly changing. For the north, it includes both urban and remote populations widely dispersed over vast geography.

Defining these regions in Ontario is an important step in identifying solutions that address their health care access challenges. Further, the differences among communities requires different perspectives and approaches to address their access challenges (e.g. southern rural vs. northern urban vs. northern remote areas.) To give insight into some of the deliberations among the Panel as it worked to define the terms ‘rural’, ‘remote’ and ‘northern’, the chart below depicts a sample of Ontario communities on illustrative scales of rurality and northern proximity.



6.1. Rural Definition

The purpose of developing a guiding definition for ‘rural’ is to focus recommendations and ongoing discussion on addressing access in rural communities, and to give the LHINs a working definition for planning purposes. Several definitions and considerations related to ‘rural’ and ‘rural health’ exist, however no standard definition exists. Rather, from the Panel’s research, it is clear that multiple definitions/approaches for determining the relative degrees of “rurality” between communities exist, each for different planning purposes. For example, three observed approaches to a rural definition were specifically noted by the Panel: 1. Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA) working definition⁵; 2. Rurality Index of Ontario (RIO2008_BASIC) for the MOHLTC Underserviced Area Program⁶; 3. Metropolitan Influence Zones (MIZ)⁷.

Brief descriptions of each of these three approaches to defining rural Ontario are noted below, in addition to a summary of the Panel’s deliberations on each:

OMAFRA Working Definition

The Ontario Ministry of Agriculture, Food and Rural Affairs established a working definition of rural Ontario as: areas of the province that are outside of Hamilton, Ottawa, London, Windsor, Greater Toronto Area, Niagara Region, Waterloo Region, Thunder Bay and Sudbury. Within these urban areas, municipalities with a population of less than 100,000 are also considered rural.

In reviewing this definition, the Panel felt that certain areas identified have a mix of urban and rural communities, such as the Niagara Region. Panel members also felt that using a ceiling population of 100,000 residents was too high for the purpose of this Framework/Plan, as there is significant variation in the nature of health care services available in the many communities included in this definition. Specifically, large communities close to 100,000 residents were noted to have a broader range of all health care services than the smaller communities within this definition (e.g. those under 10,000 residents).

For these reasons, the Panel decided that the OMAFRA working definition was not appropriate for defining rural Ontario in the context of access to health care services.

Rurality Index of Ontario

The Rurality Index of Ontario (RIO) is a methodology used by the MOHLTC for the Underserviced Area Program (UAP) and by the Ontario Medical Association for other applications related to physician incentives and programs (e.g. continuing medical education, physician locums and other physician compensation). For the UAP, the RIO is used to identify communities that are underserved with respect to physician services. The RIO methodology establishes an index score for each community, which is used to help define which communities require additional funding support for accessing physician services. The RIO scoring methodology uses a weighted formula, the RIO2008_BASIC, which considers three key elements: population size and density, travel time to nearest basic referral centre, and travel time to nearest advanced referral centre. Using this methodology, census subdivisions are assigned a RIO score on a continuum between 0 – 100, and those with a score of over 40 are considered for additional funding support.

⁵ Based on Statistics Canada, Census of Population, 2006 100% profile, Census Subdivision Data.

⁶ Boris Kralj, PhD. Measuring Rurality - RIO2008 BASIC: Methodology and Results. 2009

⁷ Canadian Institute for Health Information. How Healthy are Rural Canadians? An assessment of their health status and health determinants. 2006.

Panel discussion on the RIO approach was robust, and Panel members felt that the RIO is a well established methodology that serves its purpose for the UAP and other programs. In examining the mix of census subdivisions with over/under a RIO score of 40, however, Panel members felt that some communities not designated for additional physician funding support would still have elements of rurality that need to be considered from a broader health care access perspective. For this reason, the Panel decided that the RIO was not appropriate for defining rural Ontario in the context of broader access to health care services.

Metropolitan Influence Zones

This methodology was designed by Statistics Canada to better define populations living outside of the commuting zones of census metropolitan area/census agglomeration (CMA/CA). As noted by Statistics Canada:⁸

A census metropolitan area (CMA) or a census agglomeration (CA) is formed by one or more adjacent municipalities centred on a large urban area (known as the urban core). A census metropolitan area must have a total population of at least 100,000 of which 50,000 or more must live in the urban core. A census agglomeration must have an urban core population of at least 10,000. To be included in the census metropolitan area or census agglomeration, other adjacent municipalities must have a high degree of integration with the central urban area, as measured by commuting flows derived from census place of work data.

Metropolitan Influence Zones (MIZ) that lie outside of a CMA/CA are classified into four zones, depending on the proportion of employed labour workforce living in the census subdivision (CSD) in CMA/CA urban core:

- Strong – 30% or more of the employed labour workforce living in the CSD works in any CMA/CA urban core
- Moderate – 5% to 30% of the employed labour workforce living in the CSD works in any CMA/CA urban core
- Weak – 0% to 5% of the employed labour workforce living in the CSD works in any CMA/CA urban core
- No MIZ – CSDs with employed labour workforce of less than 40 as well as any CSD with no commuters to a CMA/CA urban core

In reviewing this methodology, the Panel recognizes that the strengths of the MIZ approach are that it allows for comparisons between urban areas. Concerns exist however this approach uses the Statistics Canada population definition of rural towns as being census subdivisions with less than 10,000 residents. The Panel felt that this ceiling population of 10,000 residents was too restrictive, and did not reflect many of Ontario's larger rural communities, which although over 10,000 residents in size, have rural geographies and dispersed populations that experience many of the same challenges in health care access as smaller rural communities.

For these reasons, the Panel decided that the MIZ was not appropriate for defining rural Ontario in the context of access to health care services.

⁸ Statistics Canada. Census 2006. Source: <http://www.census2006.ca/census-recensement/2011/consultation/DissDiffGuide/Appendix-Annexe-eng.cfm>

Panel members recognize the merits and appropriateness of these other methods for the purposes of the programs for which they are used. However, the Panel collectively feels that a more appropriate definition is needed for the specific purposes of the Framework/Plan, one that is more inclusive of populations with limited access to health care services. The Panel also examined populations at a census subdivision level (CSD), but felt that with the amalgamation of municipalities in Ontario over the past decade, considering the rurality of populations at a local community level is more appropriate for the purposes of the Framework/Plan.

In principle, the Panel agreed that a broader definition of rurality is needed for the Framework/Plan, which considers a continuum of several characteristics including proximity to urban centres, scope of services (e.g. community, primary, secondary, tertiary services), and population size. Based on the deliberations of the Panel, it was determined that typically:

‘Rural’ communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000.

In deriving this definition, Panel members recognized that communities with more than 30,000 residents typically have a broader scope of health care services available than smaller communities. These larger communities, of 30,000 residents or more typically have a broader range of specialty and sub-specialty inpatient hospital services, expanded community-based programs, and often serve as hubs for regional programs.

It is understood that there will be some communities that are unquestionably rural, while others may have a gradation of rurality, and further that access challenges in southern and northern rural Ontario are different – these points of differentiation are noted, and help to inform ongoing discussion about access needs in rural Ontario. The Panel believes that each LHIN will need to establish the level at which its communities are defined (i.e. by census subdivision or at a more local community level), and determine the rurality of its communities, using this definition to help guide planning discussions.

6.2. Definition of North or Northern

In defining ‘northern’, the Panel is aligned with the current government planning parameters of Parry Sound and north to be considered ‘northern’, such that the North East and North West LHINs are considered the two ‘northern’ LHINs. Further it is noted that within ‘northern’ is a set of defining subgroups that form a continuum. For example, the north includes five ‘urban’ centres: North Bay, Sault Ste. Marie, Sudbury, Timmins, and Thunder Bay. The geography of the north is also stratified into the ‘near’, ‘mid’ and ‘far’ north – as these different geographies of the north have different needs, resource availability and access to services. Specifically, the Panel accepts the current government definition of Northern Ontario (2009) as:

Northern Ontario is comprised of 10 territorial districts (145 municipalities): Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound. This area covers over 800,000 square kilometres, representing nearly 90 percent of the Province of Ontario’s land area. It extends across two time zones, from the southern boundary of the District of Parry Sound, north to Hudson Bay and James Bay, and westerly from Quebec to the Manitoba border.

6.3. Remote Definition

For the purpose of defining remote communities in the Framework/Plan, the Panel establishes that typically:

‘Remote’ communities are those without year-round road access, or which rely on a third party (e.g. train, airplane, ferry) for transportation to a larger centre.

Examples of these communities include Moose Factory and Pikangikum. It is further noted that a continuum exists across the definitions of ‘remote’ communities, and the different access challenges they face. This continuum is recognized by the Panel throughout the Framework/Plan, and as stated previously, the Panel has recommended that Government further develop a framework specific to the unique and underserved needs of those communities.

7. Health Status in Rural, Remote and Northern Communities

As stated earlier, several factors influence one's health and longevity, of which access to health care services is one. Given this, the Panel believes that understanding the current health status differences between rural and remote vs. urban populations is important to discussing the challenges and strategies to improve access to health care services, and to achieving overall equity of health outcomes.

The excerpt below from research conducted in 2006 on the health of rural Canada describes the fundamental differences in health status and the determinants of health that impact rural, remote and northern Ontario.

Health of Rural Canada

How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants, September 2006 (Centre for Rural and Northern Health Research and Public Health Agency of Canada)

In general, rural communities have different socio-economic and demographic profiles than urban communities:

- Rural populations are generally older than their urban counterparts. The aging of the population, economic difficulties and geographic isolation are among the factors that could contribute to specific health vulnerabilities in rural areas and small towns.
- In general, rural populations are less highly educated, have higher unemployment rates and have lower incomes than urban populations.
- The labour force participation and employment rates increased in both rural and urban areas between 1996 and 2000 (6% and 8%, respectively).
- Young people living in rural communities tend to migrate to more urban centres for different reasons, including better employment opportunities, and this situation is reflected by lower employment rates of rural youth
- Rural communities have a relatively high proportion of Aboriginal people compared with urban centres. In addition to the challenges of rural life, many Aboriginal communities have higher incidences of chronic disease and have the added challenges that come from living in remote communities.
- In addition northern Ontario has a higher proportion of Francophone communities, which are recognized as being typically older, having lower education, a lower employment rate, and lower overall health status.

Health Status of Rural Canadians vs. Urban Canadians

- Life expectancy at birth was generally lower in rural areas compared to urban areas for men (74.0 years versus 77.4); among women, life expectancy was at 81.3 years in rural areas and 81.5 years in urban areas.
- The all-cause mortality rates (age-standardized mortality rates) of both Canadian men and women of all ages increased with increasing remoteness of place of residence.
- Statistically higher proportions of rural residents reported having a fair/poor health status compared with urban Canadians (Urban: 12.0%; Rural: 14.4%).
- A significantly greater proportions of rural Canadians aged 20 to 64 years reported being overweight than their urban counterparts.

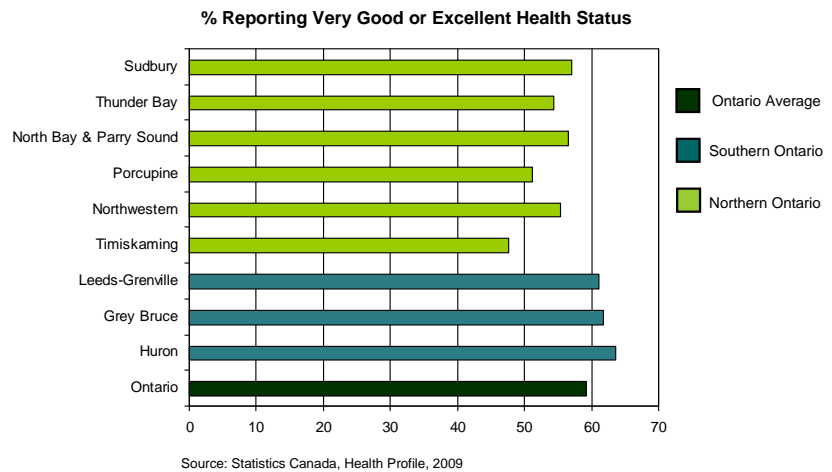
7.1. Differences of Southern Rural and Northern Rural Ontario

Building on this fundamental difference of health status between rural and urban Canadians, differences in health status are also noted between rural Ontarians and the provincial average, and more specifically between southern and northern rural Ontarians. The following charts compare a selection of health indicators for a sample of largely rural health units in southern and northern Ontario. This sample of health indicator data demonstrates that generally, these areas have a lower average life expectancy, greater proportions of overweight/obese residents, and higher infant mortality rates than the rest of Ontario residents. Overall, the northern areas are observed to have a lower proportion of residents that perceive their health to be very good or excellent compared to the provincial average; while southern rural areas have higher proportions of residents who perceive their health to be very good or excellent.

Self-Reported Health Status

Self reported health status is a high-level indicator that helps to understand the perceptions of individuals about their own health and wellness. Across Ontario, an average of 59% report very good or excellent health status. This perception varies across urban, rural and remote Ontarians. As observed in the chart below, perceived health status is higher in southern rural Ontario than in northern areas:

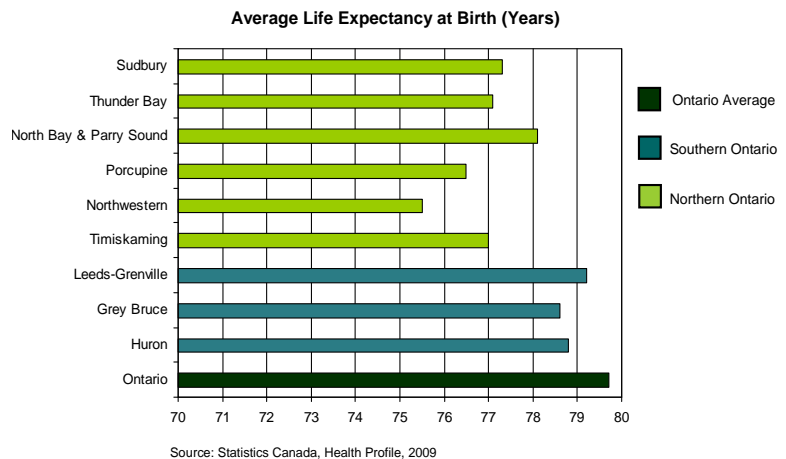
- Over 61% of southern rural residents report very good or excellent health status.
- A range of 47% - 55% of northern rural residents (Porcupine, Northwestern and Timiskaming) report very good or excellent health status
- In northern urban Ontario (Sudbury, Thunder Bay and North Bay), residents report slightly higher health status than their northern rural counterparts, but still lower than southern rural Ontario.



Life Expectancy at Birth

Life expectancy is a macro indicator that identifies the average lifespan of residents across Ontario. The chart below demonstrates the average life expectancy at birth in Ontario is 79.7 years, which is consistently higher than the average for southern rural, northern rural and northern urban residents across the province. Southern rural residents are also observed to have higher life expectancy than northern rural or urban residents:

- Average life expectancy for southern rural residents ranges from 78.6 - 79.2 years
- In northern rural Ontario, average life expectancy ranges from 75.5 – 77.0 years
- Northern urban Ontarians have an average life expectancy between 77.1 – 78.1 years

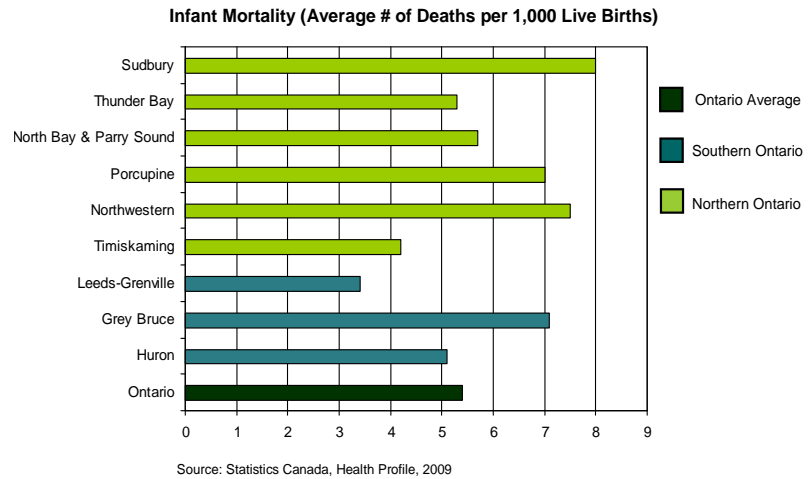


Infant Mortality

Infant mortality is an indicator that measures the average number of deaths per 1,000 live births, for infants under 1 year of age. Although a very specific measure of child health, it is considered an indicator of broader community well-being. As noted by Statistics Canada, at a macro level, the indicator “reflects the level of mortality, health status, and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health.”⁹

As demonstrated in the chart to the right, the infant mortality rates in southern rural, northern rural and northern urban communities are all higher than the provincial average. On average, northern communities have a higher infant mortality rate than southern communities, reflecting a lower overall health status:

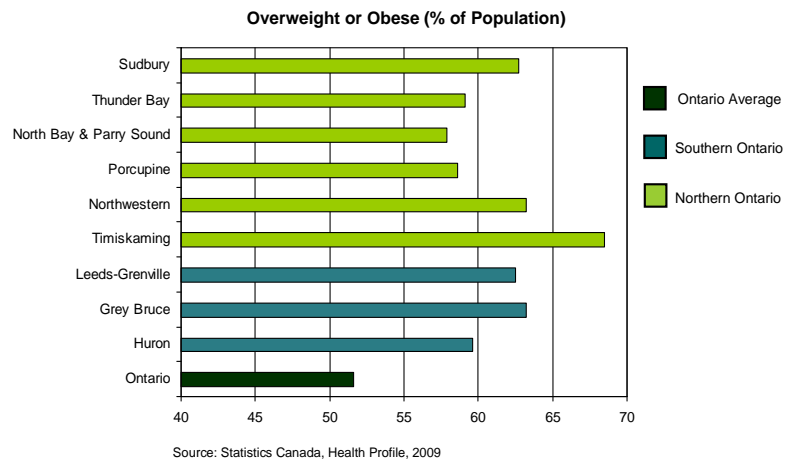
- Average infant mortality for southern rural residents ranges from 3.4 - 7.1
- In northern rural Ontario, average infant mortality ranges from 4.2 – 7.5
- Northern urban Ontarians have the highest infant mortality, ranging from 5.3 – 8.0



Overweight or Obese

The indicator for overweight or obese indicates the percentage of the population with increased health risks due to higher than recommended body mass index. Increased obesity has several related health risks, including heart disease and diabetes, which brings a corresponding increased need for health care services. The chart below demonstrates that residents of southern rural, northern rural and northern urban communities have higher rates of overweight and obesity than the provincial average. Further, the northern communities demonstrate higher rates than southern rural communities, indicating overall lower overall health status in the north:

- In southern rural Ontario, a range of 59.6 - 63.2 % of the population is overweight or obese
- In northern rural Ontario, this range is higher, with 58.6 - 68.5% of the population overweight or obese
- A range of 57.9 - 62.7% of Northern urban Ontarians are obese or overweight, higher than the provincial average, and between the southern and northern rural populations.

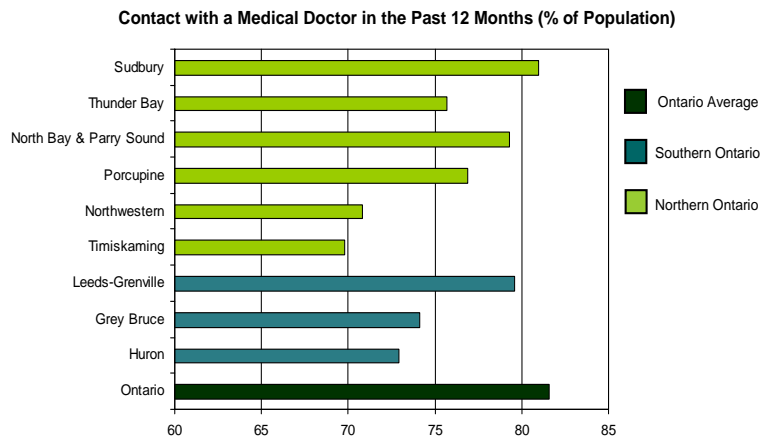


⁹ Source: Statistics Canada, Health Profile. Accessed February 2010. http://www12.statcan.gc.ca/health-sante/82-228/2009/06/details/page_Definitions.cfm?Lang=E&Geo1=HR&Code1=1202&Geo2=PR&Code2=12&Data=Rate&SearchText=&SearchType=Begins&SearchPR=01&B1=All&Custom=&LineID=7050

Contact with a Medical Doctor in the Past 12 Months

An important part of maintaining health and wellness is regular contact with a primary health practitioner. Contact with a medical doctor in the past 12 months is an indicator that tests this ongoing maintenance, reflecting both access to a medical doctor and individual behaviour in seeking out medical care. For this indicator, a 'medical doctor' includes contact with family or general practitioners, paediatricians, surgeons, allergists, orthopaedists, gynaecologists or psychiatrists. As observed in the chart below, residents of southern rural, northern rural and northern urban communities have lower rates of contact than the provincial average of 81.6%. Northern rural communities also demonstrate lower average rates of contact than southern rural communities.

- In southern rural Ontario, a range of 72.9 -79.6 % of the population had contact with a medical doctor in the past 12 months
- In northern rural Ontario, this contact rate is lower, with a range 69.8 - 76.9% of the population
- In the northern urban communities of Thunder Bay, North Bay and Parry Sound a range of 75.7 -79.3% of residents had had contact with a medical doctor in the past 12 months, below the provincial average.

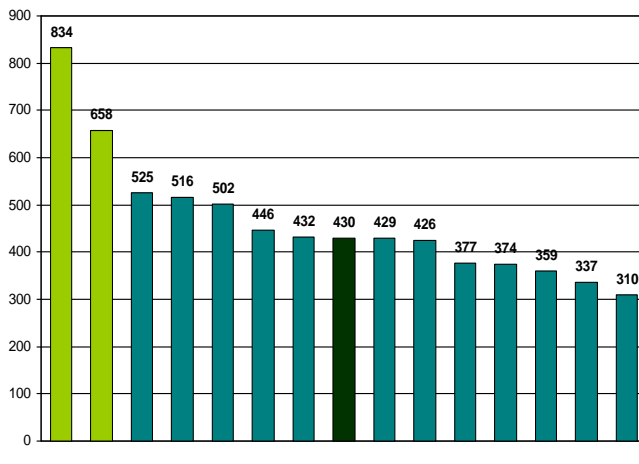


Source: Statistics Canada, Health Profile, 2009

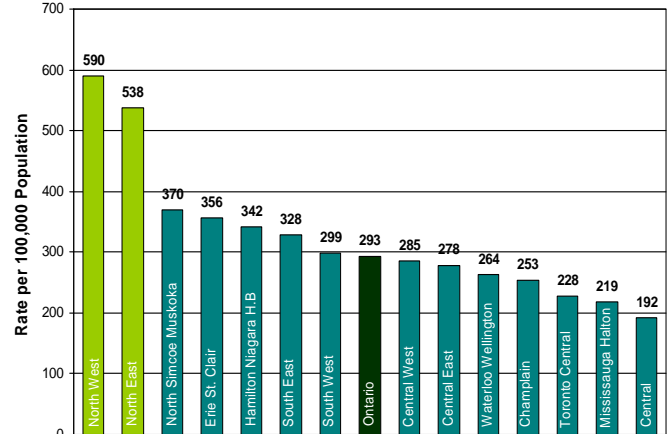
7.1.1. Differences in Health Care Access between Southern Rural and Northern Rural Ontario

In expanding the view on access-specific factors that impact northern Ontario, two additional charts below demonstrate that the North West and North East LHINs have higher rates of hospitalization due to injury, and for conditions where outpatient care could prevent or reduce the need for admission to a hospital.¹⁰ These indicators are two examples that underscore the Panel's perspective that northern Ontarians face more intense challenges in accessing health care services. Specifically, these charts point to the more dangerous work environments and lifestyles in northern Ontario that create higher access needs, and to a lower availability of non-acute health care services for northern residents.

Age-sex Standardized Hospitalization Rate Due to Injury, by LHIN



Age-sex Standardized Acute Care Hospitalization Rate for Conditions Where Outpatient Care Prevents or Reduces Need for Admission to Hospital, by LHIN



¹⁰ Health Indicators, Canadian Institute for Health Information (CIHI), 2009.

8. Key Access Challenges Facing Rural, Remote and Northern Ontario

Based on findings from all of the key inputs into this planning process, in addition to the Panel's deliberations, a summary of the broad challenges and barriers to accessing health care in rural, remote and northern Ontario is identified below, which sets the stage for the key areas of focus that must be addressed by the Framework/Plan. Through the Panel's deliberations, access challenges related to service and resources were primarily identified. Other challenges beyond these two categories were also noted by the Panel, which are considered equally important.

8.1. Service-Related Access Challenges

Service-related access challenges are issues that result in having limited access to a particular service type and/or an inconsistent level of access in a community. The key service-related access challenges identified by the Panel include:

- Access to primary care services, and the role of hospitals as the default primary care provider where other services are not available, which may explain why hospitalization rates tend to be higher in rural and northern area, even for conditions that are usually addressed within ambulatory settings in urban areas
- Access to specialized services outside of local communities, and repatriation back to the community.
- Access to public health services and education, impacting health promotion and wellness initiatives.
- Availability of health care services across local communities with similar needs varies due to health resources, infrastructure or other factors, which impacts access to a range of services (e.g. community services, primary care / family health teams, emergency medical services, public health).
- Limited availability of cultural and linguistically appropriate services (e.g. Aboriginal, Francophones), which impacts access and outcomes.

8.2. Resource-Related Access Challenges

Resource-related access challenges are issues resulting from a lack of available resources that would facilitate access to health care services. The key resource-related access challenges identified by the Panel include:

- Scarcity of resources (e.g. health human resources, infrastructures, technologies, etc.) and varied enablement of health professionals to work at the full scope of practice limit the capacity of the system to deliver care at an acceptable standard – although the Panel recognizes that many rural and northern practitioners practice to their full scope of practice, policy, infrastructure and other tools are needed to enable this more consistently in rural and northern areas
- Recruiting health care professionals is continuing to be a challenge for a number of reasons, including: limited spots opened in schools; increased timeframes for training; trend in education toward specialization vs. generalism; limited incentives to work in rural, remote and northern areas as compared to urban Ontario areas and abroad; concentration of training and education centres in urban vs. rural communities; limited family support strategies for professionals; and the need for increased mentorship.
- Demand for rural health provider organizations and professionals to take on a broader and more diverse set of care responsibilities than is required in urban settings.
- Limited capacity within local communities in rural, remote and northern Ontario to respond to health care challenges, engage in planning, pursue special grant opportunities, raise capital to support local share requirements for new infrastructure, or to support ongoing capital equipment renewal.

8.3. Inter-Sectoral and Cross-Jurisdictional Challenges

Inter-sectoral challenges to access result from a need for improved coordination across health care sectors, between health care and other sectors (e.g. health, education, social services), and across provincially and municipally funded services. Key challenges include:

- Fragmentation of the funding, management, coordination and decision-making across different components of the health system (e.g. emergency medical services, public health, primary care), with limited consideration of the impact of related changes on local community health care access.
- Varying degrees of funding transfer between health or other sectors when service changes are made, which impacts the ability of new service models to be successful.
- Political challenges in implementing strategies to improve access, which may result in sub-optimal service delivery models and access.

8.4. Cross-Jurisdictional Challenges

Cross-jurisdictional challenges to access result from a need for improved coordination across government jurisdictional levels (e.g. provincial, federal and aboriginal). Key challenges include:

- Limited coordination and clarity on the roles, accountabilities, funding and service models for health care services across federal, provincial and aboriginal governments.
- Varying alignment and success of planning and engagement by LHINs with First Nations.
- Different perspectives on the role of the LHINs in planning and service delivery for First Nations, relative to the role of the federal and provincial governments, and existing agreements between First Nations and different levels of government.

8.5. Transportation Challenges

Limited availability of appropriate transportation impacts access of rural, remote and northern Ontario residents to health care services, and the ability of providers to optimize health resource utilization. Key challenges include:

- Limited availability of non-urgent transportation in some northern, remote and rural areas, which impacts the access to physician clinics, dialysis, chemotherapy and other services. For example, public transportation options are being curtailed in many rural areas and particularly in northern Ontario (e.g., Greyhound bus services). In the north, the problem is made worse by poor roads and inclement weather conditions.
- Limited availability of emergency, inter-facility and non-urgent transportation that require a patient to be accompanied by a health professional is limited. For example, the long distances between services in the north can result in an ambulance or health professional(s) being needed for over a day for a single patient transport, limiting the availability of those services to others in the community.
- Geographic placement of service and travel distance can make access to services difficult, and influences which services individuals choose to seek – limited non-urgent transportation; inflexible travel grants (e.g. one-way trip minimum requirement versus accumulated transportation over a time period).

8.6. Planning Challenges

Traditional approaches to health care planning often do not consider the unique needs of rural, remote and northern communities, resulting in a misalignment of planning to health care access needs, and limited engagement of communities in the planning process. Key challenges for rural, remote and northern Ontario include:

- Lack of rural perspective applied in planning at the provincial or LHIN levels, and the need for increased flexibility at the local level to drive innovations related to scope of practice, funding, system integration and other aspects.
- A recognition that health care access challenges and needs in rural communities differ between southern Ontario and northern Ontario, and that challenges are typically accentuated in the north.
- The historic trend toward centralization in health system design, which limits local responsiveness and reduces access; need to create local capacity to focus on synergies across the continuum of care and sectors.

- Although shifts in the nature of health services delivered in a local community may need to occur, current planning for rural, remote and northern Ontario is insufficient with respect to: the level of community engagement in the decision-making process, examination of the impacts on health human resources and other health sectors, and consideration of the economic impact and sustainability of the community.

8.7. Other Challenges

The following are other challenges that have been identified by the Panel as impacting access to health care services in rural, remote and northern communities:

- Determinants of health and the overall lower health status. For example, the boom-and-bust economic cycles and single-industry dependency in many rural and northern communities further impacts the economic contributors to health status.
- Inconsistent implementation of potential interprofessional models across local communities, which are considered an important element of improved access to local health care (e.g. varied levels of investment in primary care models such as Family Health Teams across local communities).
- Limited sharing of health records and information across professionals within the system.
- Increasing expectations by individuals/families/communities, which are changing access demands.
- Limited availability of cultural and linguistically appropriate services (e.g. Aboriginal, Francophones), which impacts access and outcomes.

9. Services that Improve Access

Equally important to identifying challenges is identifying the current programs and strategies already in place to improve access to rural, remote and northern Ontario. As part of the Panel's work, an inventory of current programs that the MOHLTC funds to address access issues in rural, remote and northern communities was established (please refer to Appendix D). These programs, in addition to the many province-wide access strategies (e.g. Wait Times, Cancer Care, Stroke Strategy) demonstrate an ongoing commitment on the part of government to improving access, and range in the types of services funded, including:

- Diabetes Focused Programs
- Emergency Health Services
- Facilities Development
- HIV/AIDS Targeted Initiatives
- Locums
- Mobile/Virtual and Telemedicine Services
- Population-Specific Initiatives
- Physician and Health Professional Supply, Education and Training and Outreach
- Primary Health Care Initiatives (e.g. Family Health Teams, Nurse Practitioner Clinics)
- Northern Health Travel Grants

While a specific review of these programs was not conducted by the Panel, there was general acceptance of the contribution that these commitments have toward improving access in rural, remote and northern Ontario.

Example: Investments in Primary Care

Over the past five years, the MOHLTC has invested in key primary care initiatives designed to improve access to primary health care practitioners.

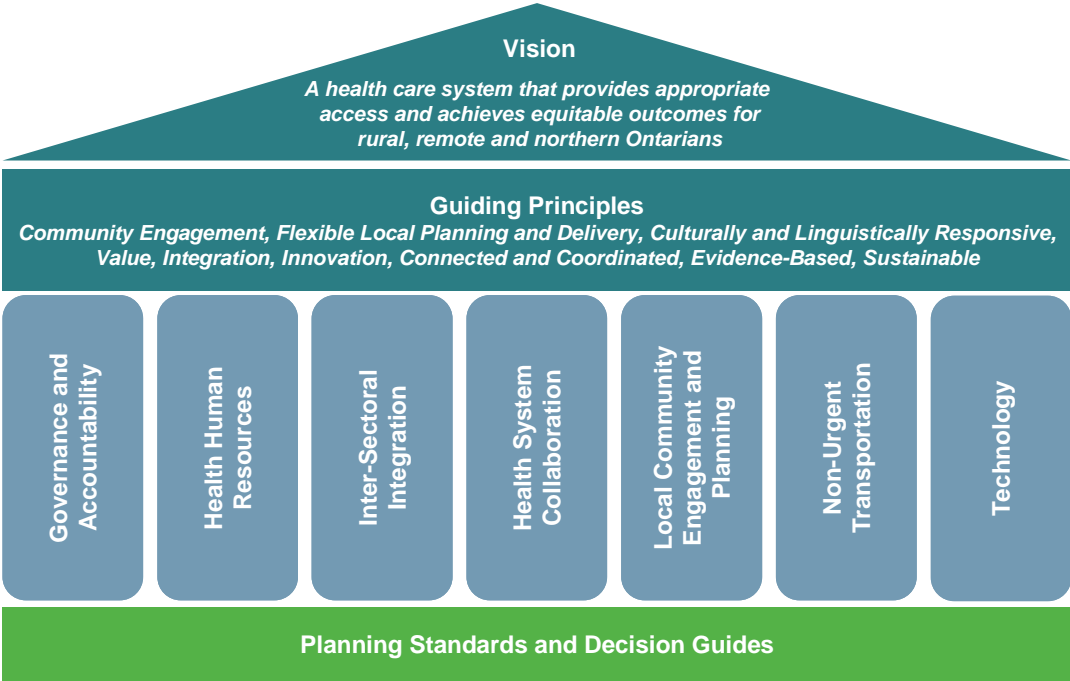
One example is the expansion of the Family Health Team model, through the current funding of 150 family health teams across the province, and announcement of an additional 69 family health teams to be created over the next three years. Family Health Teams provide better access to care closer to home and include physicians, nurse practitioners, registered nurses, social workers and dieticians

Another innovative initiative funded by the province is the recent announcement of 25 nurse practitioner-led clinics. This model optimizes the expanded scope of practice of nurse practitioners working in collaboration with physicians and other health professionals, and improves access for individuals who did not previously have access to a primary health care provider.

Section D: The Expert Panel’s Deliberations and Recommendations

The Panel is confident that access to health care will be improved by addressing the identified challenges and building on the programs already in place. To bring a renewed commitment to health care in rural, remote and northern Ontario, the Panel is proposing the following Stage 1 Framework/Plan that outlines a vision, guiding principles, planning standards and decision guides, strategies and guidelines for the MOHLTC and LHINs.

Stage 1 Rural and Northern Health Care Framework/Plan



A description of each component of this proposed Stage 1 Framework/Plan follows. It is the belief of the Panel that the implementation of this Stage 1 Framework/Plan will lessen the challenges and improve the overall access to health care in rural, remote and northern Ontario.

10. Vision and Guiding Principles

10.1. Vision

At the core of the Panel’s work is a vision designed to guide the implementation of the proposed Framework/Plan by the MOHLTC, LHINs and local communities – one which the Panel believes will appropriately direct efforts to improve access to health care for rural, remote and northern communities:

A health care system that provides appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians

The Panel feels this vision will serve rural and northern Ontario residents well, and is aligned with the province’s broader vision for health care: to help people stay healthy, deliver quality care when and where they need it and to ensure the sustainability of the health system for future generations. Critical to the achievement of this vision is the need for the MOHLTC, LHINs, local communities and front-line health providers and professionals to work together to improve health care access and outcomes for rural, remote and northern communities.

10.2. Guiding Principles

To focus planning efforts toward this vision, the following set of nine guiding principles are also identified. These guiding principles are intended to foster health care planning and delivery that is innovative, locally responsive and sustainable, as new initiatives are explored and existing programs are reviewed for their impact on improving access to rural, remote and northern health care.

Community Engagement: To encourage transparency and accountability in identifying local access issues and solutions, a community's residents, health providers and other local stakeholders should be active participants in the decision-making process.

Flexible Local Planning and Delivery: To improve access to health care, planning and delivery of services should directly involve local communities and be flexible to adapt to local needs; be responsive to different community needs; and to balance need, quality, critical mass and accessibility.

Culturally and Linguistically Responsive: To improve the accessibility and appropriateness of services, planning, and delivery of services should be responsive to the cultural and linguistic needs and differences of individuals and communities.

Value: Health facilities and the corresponding concentration of health professionals are a local base of health resources in rural and northern communities which should be viewed as **'assets'** that can improve the overall efficiency and cost-effectiveness of regionalized delivery systems, and which support local ownership and sustainability of health services.

Integration: Planning, delivery and targeted initiatives must integrate across traditional health care and inter-sectoral silos at the local level.

Innovation: Exploration of new models of care delivery, health human resource roles and integration should be supported.

Connected and Coordinated: To enable coordination of access, planning and delivery at the local level must also be connected to and across LHIN and provincial initiatives and organizations.

Evidence-Based: To ensure access is appropriate, initiatives must be evidence-based, supported by ongoing research and evaluation of standards and outcomes.

Sustainable: To maintain and improve access, new initiatives must present solutions that are sustainable with respect to financial, human and other resources.

11. Planning Standards and Decision Guides

The Panel was tasked with identifying performance metrics, standards or targets in support of its proposed Framework/Plan. Based on deliberations among Panel members, a review of available data, insights gained from the external stakeholder organizations and jurisdictional scan, the Panel is proposing the following set of ‘planning standards and decision guides’. The intent of these planning standards and decision guides is to support the province, LHINs and local communities in coordinated planning at all levels for improved access for residents in rural, remote and northern Ontario.

The planning standards and decision guides are intended as ‘visionary’ guidelines for health system planning by the Ministry and LHINs. These standards are not designed as ‘rules’ to indicate minimum or maximum access guarantees, provide decision on whether to build or close hospitals or inpatient beds, or to increase or reduce current service levels. Further, it is recognized that these standards may not be feasible for some populations in rural and remote Ontario, and that further work by the province and LHINs will be needed at the local level to engage communities to define appropriate access needs and standards, and identify alternative solutions.

- **90% of residents in a community or local hub will receive primary care within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive emergency services (24/7/52) within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive basic inpatient hospital services within one hour travel time from their place of residence**
- **90% of residents in a community or local hub will receive specialty inpatient hospital and tertiary diagnostic services within four hours travel time from their place of residence**

Travel time presumed travel by road, under normal road conditions and travel within posted speed limits.

A critical first step in using these planning standards will be for each LHIN to work with their residents to define local communities, and to then assess the degree to which local communities are served by the access levels identified.

11.1. Supporting Discussion and Definitions

In establishing these planning standards and decision guidelines, the Panel has used several definitions and parameters that are explained further below:

Planning at a 90% Threshold

The Panel recognizes that due to the geographic remoteness of some areas in Ontario, certain populations would fall outside a reasonable travel time to services. Considering effective use of limited resources and the requirement for critical mass, it is not feasible to house service provision in every possible area of the province. Due to this limitation, the Panel felt it would be appropriate to set the standards at 90% of the population. This approach is in keeping with other MOHLTC planning models, and is considered a reasonable threshold by the Panel.

As noted, the Panel recognizes that some residents and communities will fall outside of these planning standards and decision guides as stated. The Panel’s intent is not for these communities to be excluded from initiatives targeted at improving their access to health care services. Rather, the Panel recognizes that a different set of solutions will be needed for these communities, and that the MOHLTC and LHINs will need to work closely with these communities through additional planning to define appropriate access needs and standards, and identify alternative solutions. For

example, one such solution may be to enhance access to specialist services through expanded availability of telemedicine.

Emergency Services and 30-minute Travel Time

The Panel's use of the term 'emergency services' is broadly defined as facility-based emergency, urgent care or specialized primary care services that provide 24/7/52 coverage.

In discussing the appropriate access time to receive emergency services, the Panel recognizes the 'golden hour' principle of emergency care, and the supporting evidence that clinical intervention within a certain timeframe can lead to more positive health outcomes, particularly for trauma/emergency services. A shorter 30 minute travel time has been established because it is anticipated that an additional 30 minutes will be required for the patient to call for an ambulance, the ambulance to arrive at the scene within the provincial standard of 10-11 minutes, and the patient to be loaded and then unloaded from the ambulance – so that the total time fits within the 'golden hour' principle of one-hour access to service.

It is further recognized that in many circumstances, an emergency medical service (EMS) team will assess and treat a patient on-location, such that transportation to an emergency services location is not needed.

Basic Inpatient Hospital Services

For the purpose of the third planning standard, the guiding definition of 'basic inpatient hospital services' is broadly defined as having a mix of inpatient beds which may include the following core services: general internal medicine, general surgery, emergency, anaesthesia, obstetrics and gynaecology, paediatrics, psychiatry, and supporting lab and diagnostics services. It is anticipated that many small hospitals will be served by generalists vs. specialists, as is effectively done today. Further, it is not anticipated that sub-specialized services will be available, although this guiding definition is not intended to limit the availability of such services.

The location of basic inpatient hospital services and how they are defined will vary by community. Hospital services may be located in a single facility or across multiple facilities in a community. Further, the set of basic inpatient hospital services may be located across an established set of coordinated communities. These options introduce the concept of a 'local hub', which the Panel identifies as being individual communities, or clusters of multiple communities that working together form a hub of health service activity and access. This local hub model leverages the existing health facility infrastructure across the province, and need to be defined through a collaborative effort of LHINs and local communities. It is through locally defined hubs that the Panel envisions basic inpatient hospital services being organized and delivered

As the province and LHINs move forward with the implementation of these standards, an evidence-based approach that focuses on quality, patient safety and critical mass for both clinical outcomes and system sustainability will need to be at the forefront of planning to help define appropriate access for local communities. Additional consideration will need to be given to a number of factors, including: the cost and benefit of specific strategies, the impact on and availability of health human resources in local areas, and the impact on overall community sustainability. Guidelines can also be established to provide further direction on meeting the standards (e.g. prevalence of specified health care professionals in a given areas or for a given population size). The province will need to continue its work with LHINs and other sectors (e.g. EMS) to determine these factors.

12. Strategies and Guidelines

To guide achievement of the vision, guiding principles and planning standards, the Panel has also established a set of strategies and guidelines for the MOHLTC and LHINs. These strategies and guidelines are intended to support the MOHLTC and LHINs in making formal decisions, planning and when considering potential changing roles for health facilities, including sequencing of related changes.

Critical to the success of any strategies will also be the active involvement of local communities and providers. For this reason, the Panel's recommendations are identified at the provincial, LHIN and local levels. Provincial strategies are largely focused on setting policy direction, defining accountabilities, enabling integration and other key enablers to improve access. LHIN guidelines are primarily targeted toward supporting integration, funding, decision-making and planning at the LHIN level. Guidelines specific to local communities and providers are focused on how they can operationalize and support the provincial and LHIN funding, planning and service delivery models. For each recommendation, the level most responsible for achieving the identified goals and activities are identified in brackets (). Where a strategy has application to all three levels, the implications for each are identified.

Strategies and guidelines are organized across three themes:

1. **Governance and Accountability**
2. **Health Human Resources**
3. **Integration**
 - a. **Inter-sectoral Integration**
 - b. **Health System Collaboration**
 - c. **Local Community Engagement and Planning**
 - d. **Non-Urgent Transportation**
 - e. **Technology**

12.1. Governance and Accountability

Currently there is no designated point of accountability within the province to address the issues of accessing health care in rural, remote and northern Ontario. While many portfolios across the MOHLTC and other Ministries are working to improve access, without defined accountability the implementation of initiatives may be fragmented, disjointed and uncoordinated across the province and with the federal system. Lessons learned from other jurisdictions include establishing a point of accountability within government that is specific to rural and northern health and a rural and northern advisory body to provide leadership of rural and northern health care issues.

In addition, several cross-jurisdictional challenges in health care access were noted by the Panel, specifically related to the needs of Aboriginal communities. A separate process that focuses on the access needs of Aboriginal communities, in addition to the needs of other remote, isolated and distant communities is needed.

Two recommendations are proposed within this theme of governance and accountability:

12.1.1. MOHLTC Point of Accountability

The Panel believes that assigning accountability provides the potential to align initiatives across the province, leveraging lessons learned and best practices to be consistently deployed. Further, a fundamental benefit of establishing accountability is the clear articulation of roles, responsibilities and expected outcomes. Roles and responsibilities can ensure a rural perspective is applied for planning activities at the provincial level, while the implementation of effective performance management can help to assess whether the desired vision and goals have been achieved.

R1: Create a point of accountability within the MOHLTC leadership focused on rural, remote and northern health, and responsible for leading the definition and monitoring of standards for health care access (Provincial Strategy)

The sub-recommendations outlining the responsibilities of this point of accountability at the provincial level include:

- R1.1. Carrying forth the recommendations of the Panel and monitoring their implementation**
- R1.2. Leading collaborative initiatives with LHINs and local communities/providers to define and monitor performance goals and standards for access, supported by ongoing evaluation of access initiative outcomes**
- R1.3. Identifying a mechanism to stay closely engaged with the LHINs, local communities and providers in a collaborative dialogue on access to rural, remote and northern health care (e.g. through an Advisory Council or other mechanisms as deemed appropriate)**
- R1.4. Working with LHINs, local providers, universities, research centres and researchers to support research and disseminate best practices of models of care, community engagement and other knowledge**
- R1.5. Supporting provincial-health professional planning to identify the roles, expectations and accountabilities of health system-physician relationships to support health care access in rural, remote and northern Ontario**
- R1.6. Establishing clear linkages within the MOHLTC to facilitate coordination of initiatives that address health care access issues, as well as across other initiatives that impact the broad determinants of health to improve the health status of rural, remote and northern Ontarians**
- R1.7. Stewarding inter-sectoral integration of funding and policy across MOHLTC portfolios, other Ministries and provincial agencies to improve health status of rural, remote and northern Ontarians**
- R1.8. Stewarding the provincial role for coordinating policy across provincial and federal health jurisdictions to improve access**
- R1.9. Applying a ‘rural, remote and northern perspective’ to validate the appropriateness of provincial initiatives, and setting relevant targets for access in rural, remote and northern Ontario**
- R1.10. Implementing flexible funding models that support integration at the local level across existing funding silos (e.g. LHINs, primary care, EMS, Public Health, community agencies), and that are responsive and sensitive to the unique local circumstances of communities in rural, remote and northern Ontario**

12.1.2. Improving Access for Aboriginal Communities

As noted previously, Panel members feel that given the complexity of governance and funding authorities for Aboriginal communities, and the unique cultural and geographic characteristics of these populations, a separate process is needed to determine suitable recommendations to improve health care access for First Nations and Aboriginal communities. There is a recognition by Panel members that many, though not all, First Nations and Aboriginal communities are also remote communities. Given this geographic relationship, the Panel feels that this separate process should also identify suitable recommendations to improve access to care for remote communities.

R2: Establish a process to identify strategies and guidelines to improve access to health care services for First Nations and Aboriginal communities, and which also considers the needs of remote, isolated and distant communities (Provincial Strategy)

Implications for the LHINs and Local Community/Providers

Supporting the provincial implementation of this recommendation, the LHINs, local communities and providers will also have important roles to play.

LHINs and Local Communities/Providers

- Participate in initiatives targeted at implementing the recommendations
- Establish and participate in local research, monitoring and evaluation of access initiatives and outcomes
- Establish a cross-LHIN structure in parallel to the provincial point of accountability focused on rural, remote and northern health, to guide LHIN-level discussions, research, sharing of leading practices and planning
- Provide regular updates to the MOHLTC through the quarterly ‘stock-take’ meetings on the progress towards improving access in rural, remote and northern communities

12.2. Health Human Resources

The scarcity of health human resources is particularly felt by rural, remote and northern communities, which has limited the access to care in these communities. Recruiting health care professionals is continuing to be a challenge for a number of reasons, including: limited spots opened in schools; increased timeframes for training; trend in education toward specialization vs. generalism; limited incentives to work in rural, remote and northern areas as compared to urban Ontario areas and abroad; concentration of training and education centres in urban vs. rural communities; limited family support strategies for professionals; the need for increased mentorship and a need for increased leadership development. These issues, and some proposed solutions, are echoed by a recent vision brought forward by The Association of Faculties of Medicine of Canada.¹¹ There are also several existing initiatives that aim to recruit and retain physicians in these communities, such as the UAP. However, limited incentives are provided to other health care professionals, which impacts the availability of services across the care continuum.

To address these challenges, the Panel is proposing a strategy that is specific to rural, remote and northern communities and encompasses a broad array of health care professionals:

R3: Continue to establish innovative health human resource models for rural, remote and northern Ontario, and integrate this planning perspective into existing provincial health human resources strategies and programs (Provincial Strategy)

Established health human resource models specific for rural, remote and northern Ontario will help to enable the following sub-recommendations:

- R3.1. Champion inter-professional care and a focus on healthy workplace as key principles for health human resource planning (e.g. support models such as Family Health Teams, Anaesthesia teams)**
- R3.2. Further support enhanced scopes of practice for health providers working in these communities to improve access (e.g. Nurse Practitioners, Physician Assistants, Pharmacists, Paramedics, Midwives, Unregulated Workers), and eliminate policy, regulation or practice barriers that inhibit health providers from working to their full scope of practice, and enable unregulated workers to take on additional responsibilities where appropriate**
- R3.3. Provide incentives and models for working in these communities to all health professionals**
- R3.4. Invest in leadership development at all levels to lay the foundation for future leaders in rural, remote and northern communities, and provide continued momentum to improve access to health care**
- R3.5. Use appropriate recruitment strategies to attract the right individuals as health care professionals and leaders into rural, remote, and northern communities**
- R3.6. Create the required mechanisms and support to provide mentorship and development for new graduates across all health professionals that instill the requisite skills to work in rural, remote and northern communities**

Example: Expanding Scopes of Practice

The Nurse Practitioner Demonstration Project was implemented in 2002 by Nursing Secretariat to provide increased access to primary health care services in 12 small, rural and under-served communities. With funding of \$3M annually, this community-based project has placed up to 22 NPs who provide primary health care in underserved communities.

This project was implemented within the context of promoting community partnerships in the provision of primary health care and enhancing collaborative relationships between family physicians and NPs in the area. In every site, the NPs provide a broad range of primary health care services from disease prevention and health promotion to diagnosis and treatment of health-related problems. NPs work in collaboration with family physician and other health professionals. Increasing access to health services and health professionals is a priority that this project is aiming to achieve. This project also recognizes the value of NPs and MDs who collaborate to provide primary health care.

The implementation of this project is expected

¹¹ The Future of Medical Education in Canada: A Collective Vision for MD Education. The Association of Faculties of Medicine of Canada, 2010.

R3.7. Increase responsibility for all universities, colleges and training institutes across the province that train health professionals to address workforce challenges in rural, remote and northern Ontario, including:

- a. Align health professional training programs in universities, colleges and institutes to be representative of the population of rural, remote and northern Ontario (e.g. if the population represents 15-20% of Ontario, have 15-20% of learners from the population; and provide teaching/faculty support for in-community training)**
- b. Increase on-site education experiences in rural, remote and northern communities, with a linkage to ongoing mentorship and leadership development programs for new graduates**
- c. Increase the outreach of faculty to deliver education, research and clinical care in rural, remote and northern communities**

Example: Northern Ontario School of Medicine

The Northern Ontario School of Medicine (NOSM) is a joint initiative of Lakehead University and Laurentian University with main campuses in Thunder Bay and Sudbury, and multiple teaching and research sites distributed across Northern Ontario.

NOSM has a mandate to be socially accountable to the cultural diversity of the region it serves, including: Aboriginals, Francophones, remote communities, small rural towns, large rural communities and urban centres. In its student recruitment efforts, NOSM continues to follow its mandate of social accountability, and aims to have class profiles which reflect the cultural diversity of Northern Ontario.

Unique to NOSM's success is its innovative distributed learning model, in which its physician and other health receive a significant portion of their education in local communities throughout Northern Ontario, delivered by local clinical leadership who serve as faculty, linked through technology and other infrastructure.

Implications for the LHINs and Local Communities/Providers

Supporting the provincial implementation of this recommendation, the LHINs, local communities and providers also have important roles to play.

LHINs and Local Communities/Providers

- Invest in leadership development at all levels to lay the foundation for future leaders in local communities, and provide continued momentum to improve access to health care
- Develop health human resources strategies in partnership with local universities, colleges/institutes to align training and resourcing with local population health needs
- Support the creation of learning environments to support an increased capacity for student training and research being conducted in rural, remote and northern areas, including rotation of physician teachers into local communities
- Support expanded scopes of practice of other health professionals and consider different types of providers (e.g. physician assistants) to improve access in local communities
- Utilize inter-professional care models
- Provide formalized mentoring to instill the requisite skills to work as a health care professional in rural, remote, northern communities

Example: Innovative Recruitment of Rural Health Professionals

Healthkick Huron (www.healthkickhuron.ca) has been formally recognized by the Ministry of Health and Long-Term Care as an innovative rural health strategy. It is a comprehensive, community-based recruitment strategy for rural health professionals organized through a stand-alone administrative structure funded by the MOHLTC, OMAFRA, the Huron Business Development Corporation and the Huron East Community Development Trust. The strategy includes:

- *Financial support for local physician recruitment initiatives;*
- *Community Ambassador program that enables interested citizens to support health care recruitment and encourages networking of local recruitment committees;*
- *Health career exploration opportunities for rural youth (including MedQuest camp for grade 10/11 students interested in medicine; classroom visits and an annual careers symposium);*
- *Student co-op work placements in local rural health organizations (hospital, family health team, nursing home);*
- *Local training programs for residents interested in Practical Nursing (in partnership with Georgian College).*

12.3. Integration

12.3.1. Inter-sectoral Integration

Recommendations to address inter-sectoral integration are noted under several themes, to address the many examples of where limited coordination in the planning and delivery of health services impacts access in rural, remote and northern communities. Two components of the health continuum are specifically noted by the Panel as needing improved integration and alignment at a provincial and/or LHIN level to enable improved coordination and access: Emergency Medical Services and Public Health.

Two recommendations are proposed to improve the related inter-sectoral integration, as one of the mechanisms to improve access to health care in rural, remote and northern Ontario:

12.3.1.1. Emergency Medical Services

Currently, emergency medical services (EMS) are organized at a municipal level and not aligned to the LHINs. Funding and delivery models vary in different regions, and there is limited coordination between the LHINs and EMS. Further, the priorities and expectations of the role of EMS differ across LHINs, providers, EMS and the municipalities that fund EMS, and are not well-aligned to meet patient or community needs. This limits the ability to integrate services across the continuum of care, and across the existing EMS and LHIN portfolios, which creates barriers to access. As noted previously, rural and northern residents tend to require a higher level of hospitalization due to injury, and often have longer distances to available emergency services, making improved coordination with EMS critical in these areas. Panel deliberations suggest that strengthened collaboration and coordination with EMS at both the provincial and LHIN levels is required to ensure better planning and integration of these services. Further, a linkage between EMS and non-urgent transportation solutions is needed, as noted in section 12.6 of the report.

Example: Innovative Inter-Sectoral Integration

In Nova Scotia, the province worked with local communities to expand the role of their paramedics to deliver primary care, prevention and home care services within their existing skills and scope of practice – effectively integrating EMS with some public health and community care services to optimize access to health services at the local level

R4: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Emergency Medical Services (land and air) with the planning and delivery of local health services, at both the provincial and LHIN levels (Provincial and LHIN Strategy)

12.3.1.2. Public Health

For Public Health, funding and integration also varies from region to region, limiting coordination between the LHINs and Public Health, leading to fragmentation of services and limited collaboration. As noted previously, statistics demonstrate that residents in rural and northern areas tend to have poor health status, indicating the need for improved coordination and access to health promotion and disease prevention services. Panel deliberations suggest that strengthened collaboration and coordination with Public Health is needed at the LHIN level to ensure better planning and integration of health care services across the continuum.

R5: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Public Health services at both the provincial and LHIN levels, to enable integrated planning and delivery of health services (Provincial and LHIN Strategy)

Implications for the LHINs and Local Communities/Providers

Supporting the provincial implementation of this recommendation, the LHINs, local communities and providers will also have important roles to play.

LHINs and Local Communities/Providers

- Support the assessment of options to strengthen relationships, improve clarity of accountabilities and increase integration of the identified services with LHIN and local-level service planning and delivery
- Actively lead this collaboration by bringing service partners into clinical planning discussions at the LHIN or local levels

12.3.2. Health Care System Collaboration

Within and between LHINs, and across local communities, many examples of collaboration exist. In its deliberations, the Panel identified the need to formalize and expand these points of collaboration, to create a foundation for improved health system coordination that will in turn improve access for rural, remote and northern Ontario communities.

Three recommendations are proposed to enhance existing health system collaboration, aligned to two areas:

12.3.2.1. Role of Small Health Facilities

To support planning at a local community level through a collaboration of the LHINs and local communities/providers, the Panel proposes the concept of ‘local hubs’ be established around small health facilities. As noted, local hubs may be individual communities, or may be clusters of multiple communities that working together form a hub of health service activity and access. This local hub model leverages the existing health facility infrastructure across the province. Small hospitals and their surrounding catchment areas have the potential to serve as local hubs, since health care providers and supporting services congregate in these areas, however the Panel views all health facilities as potential hubs for this role.

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 (LHIN Guideline)

A local hub, decentralized approach to health planning and funding by the LHINs can facilitate the following sub-recommendations:

- R6.1. Encourage local community engagement in planning and delivery across the health continuum**
- R6.2. Leverage the role of small health care facilities and their catchment areas as potential ‘local hubs’ of integrated health care services, incorporating geographic variations of each hub to establish sub-LHIN planning areas**
- R6.3. Determine the most appropriate balance of services delivered close to home versus in local/multi-community hubs or through LHIN/provincial-level resources**

Implications for LHINs and Local Communities/Providers

Working together, LHINs, local communities and providers will need to undertake several collaborative planning activities to identify the most appropriate decentralized approach for their local areas. Key considerations for these efforts include:

- It is recognized that local and multi-community hubs will differ within and between LHINs, based on the organization of services in each area, which allows for appropriate local flexibility. This will be especially true between southern and northern rural Ontario
- ‘Local hub’ planning will need to align with overall population health and other planning parameters set by the province and LHINs, to ensure that planning requirements are met while local flexibility is also achieved
- Local hubs should integrate health services across the health continuum, to provide a physical or virtual coordinated network that improves access to health care services, which expands to include broader social services where appropriate

Example: Innovations in the Development of Integrated Rural Health Facilities

The following rural and northern hospitals are actively developing “campus of care” models in their respective communities where the hospital is the “local hub” which integrates acute care, primary care, long term care and community support services:

- *Campbellford Memorial Hospital (www.cmh.ca)*
- *Espanola General Hospital (www.esphosp.on.ca)*
- *West Parry Sound Health Centre (www.wpshc.com)*
- *Haliburton Highlands Health Services (www.hhhs.on.ca)*

- The most appropriate planning area and local hub for integrated health care services will need to be defined for each community or multi-community cluster, which balances critical mass, quality and sustainability
- Roles and responsibilities for the local hub to support other health providers, and to improve access for all residents within the planning area will also need to be defined as part of initial planning
- The role of the local hub will also need to be considered in integrated funding decisions at the LHIN and local levels
- As part of the local hubs that are established, the LHINs and local communities/providers should create learning environments that foster an increased capacity for student training and research being conducted in rural, remote and northern areas

12.3.2.2. Regional Health Facilities and Academic Health Sciences Centres

To support the creation of regional referral centres and outreach networks, the LHINs and local providers must work together to establish clear accountabilities with specified roles and responsibilities. This will support the provincial strategies of establishing accountabilities structures and enhancing networks, and will enable the creation of LHIN-wide and cross-LHIN initiatives to improve access to health care in rural, remote and northern communities.

In addition, academic health science centres (AHSCs) across the province house specialized resources that cannot be supported in regional centres or smaller communities due to the lack of critical mass. Similar to the perspectives on regional referral centres above, the Panel believes that more formalized roles and accountabilities should be established for AHSCs, to build on the many good examples of collaboration present today. This concept builds on elements of recent findings from a National Task Force on the Future of Academic Health Sciences Centres¹².

R7: Establish clear roles, responsibilities and supporting infrastructure for health providers that fosters improved collaboration, defines referral networks and pathways, and coordinates access to services (LHIN Guideline)

By establishing clear roles, responsibilities and supporting infrastructure for providers, the following sub-recommendations can be facilitated:

- R7.1. Identify and establish LHIN-based and cross-LHIN referral centres and outreach networks, with clear accountabilities that extend from an organization’s governance through to front-line professionals**
- R7.2. Establish coordinated approaches across referral centres and outreach networks to improve service coverage and facilitate patient transfers for acute services**
- R7.3. Identify telemedicine hubs, referral networks and supports needed to improve access**

Example: Innovations in Teleradiology

The NORrad Project is both a Picture Archiving and Communication System (PACS) and a teleradiology initiative that enables the production, storage and transmission of digital diagnostic images within and between hospital/clinic sites and other NORrad sites

As a result of its implementation, a patient’s diagnostic images can be shared between authorized physicians located in different communities, enabling local physicians to quickly access specialized expertise for consults on complex diagnostic imaging cases.

¹² Three Missions...One Future: Optimizing The Performance Of Canada’s Academic Health Sciences Centres. A Report from the National Task Force on the Future of Canada’s Academic Health Sciences Centres Report, Revised Draft #5, January 13, 2010

R8: Establish provincially coordinated formal referral and outreach networks between academic health sciences centres and local providers in rural, remote and northern communities, with clear roles and responsibilities (Provincial Strategy)

Through Ministry leadership, the establishment of provincially coordinated AHSC-local community networks will achieve several improvements to access as outlined by the following sub-recommendations:

R8.1. Build on the many existing referral and outreach networks established in the province in which regional referral centres and local providers in rural, remote and northern communities leverage the specialized resources of AHSCs.

R8.2. Formalize a referral and outreach relationship between AHSCs across the province so that every local community or multi-community cluster within the LHINs is formally linked with an AHSC, which establishes clear accountabilities that extend from an organization's governance through to front-line professionals

R8.3. Provide specialized expertise to local areas through in-community education, planning and service delivery.

R8.4. Improve the equity of access of rural, remote and northern Ontarians to specialized services.

R8.5. Leverage the use of electronic health records and telemedicine to enhance and expand the access to services enabled through these networks.

Example: Innovative AHSC Collaboration

To maintain their pathology and laboratory services, the hospitals in Timmins, Kirkland Lake and other neighbouring communities formed the Timmins Laboratory Cluster, and partnered as Cluster with University Health Network (UHN) in Toronto. UHN provides Laboratory Medical Director and supporting specialist services to the Cluster, enabling these communities to maintain local access to services.

Implications for LHINs and Local Communities/Providers

The implications of this recommendation are changes to the roles and traditional working relationships between providers. While these will vary depending on the different existing roles across LHINs and providers today, examples are highlighted below:

- As part of ongoing support to rural/remote communities, LHINs and providers will need to work together to create innovative planning and delivery solutions to issues of critical mass and human resource availability for some services. For example:
 - A care team in a small rural hospital could rotate into one of the urban centres to deliver service on a regular basis to maintain clinical skills, thereby also maintaining service and access in the local community
 - Clinicians in urban centres could be recruited and retained with the expectation of delivering remote or mobile services to rural/remote communities
 - Guidelines could be strengthened to ensure coordinated access for patients from rural/remote communities to access urban health services

Example: Innovative Rural-Urban Training Collaboration

The James Bay Project is a program developed by the University Health Network (UHN) to provide outreach to Moose Factory, Moosonee, Port Albany and Attawapiskat. Through the project, nurses from the northern hospitals have an opportunity to work in UHN hospitals in Toronto, providing a variety and depth of clinical skills training and experience.

The goals of the project are to recruit and retain new nurses to the communities of practice, in part by offering new opportunities for practice and learning across geographic settings.

- Guidelines could be strengthened to also support determination of when alternatives to critical mass issues are not sufficient, and quality and safety of care are at risk
- LHINs and providers could collaborate to establish enabling mechanisms that better support health professionals to work across integrated local hubs. For example, develop regional on-call protocols to ensure that rural health facilities have timely and appropriate coverage and specialist consultations, with clear responsibilities and pathways for referrals.
- Larger regional centres and AHSCs will be tasked with more formally serving as telemedicine hubs and referral networks to improve access, supported by the LHIN and local communities
- AHSCs will be tasked with establishing formal outreach networks to work with the LHINs and local communities/providers to provide in-community education, planning and service delivery to improve access to health care to residents of rural, remote and northern communities

12.3.3. Local Community Engagement and Planning

Within the LHINs are communities with unique access needs and challenges. Engagement at the local community level is required to understand these needs and challenges, and the strategies required to improve local access to health care. Moving beyond traditional community engagement, the Panel believes that more active involvement of local communities in the decision-making process for health care planning, funding and delivery is needed to improve the responsiveness of health care to local access needs, as well as to develop community understanding of the implications of health planning decisions. As noted previously, throughout this Panel report, the term ‘community’ includes residents, health providers and other local stakeholders.

One recommendation is proposed to enhance existing local community engagement in improving access to health care in rural, remote and northern Ontario:

R9: Engage local communities to actively participate in the decision-making process for health care planning, funding and delivery, to foster improved collaboration and dialogue between the public, providers and LHINs on health access needs and health system capacity (LHIN, Local Community and Provider Guideline)

By engaging local communities in the funding, planning and delivery of the health care, LHINs can achieve the following sub-recommendations:

- R9.1. Improve the assessment of community health care access needs at the local level**
- R9.2. Support, co-own, facilitate and be active participants in identifying local solutions to access challenges, support broader health status issues, and engage communities in local decision-making processes**
- R9.3. Provide leadership in seeking opportunities to integrate funding across the health and social services silos within a local community, supported by local community engagement in the decision-making process**
- R9.4. Foster local community leadership and capacity to apply for Ministry and other government funded programs that improve access to health care services (e.g. Family Health Teams, nurse practitioner clinics)**

Implications for Local Communities/Providers

To achieve success in this strategy, local communities and providers will have a critical role in the implementation of flexible local planning and delivery. By playing an active role in local planning and delivery, local communities and providers can achieve the following:

- Foster an open and honest two-way dialogue on community health needs, health system capacity and sustainability, and solutions to improve access in rural, remote and northern Ontario communities

- Provide insight on and take responsibility for community health needs
- Enable local expansion of scopes of practice and solutions to integrate provider roles across existing silos
- Engage in the decision-making process to inform the allocation of available funding and determination of services provided in the local community to support improved access
- Consider transportation needs as part of local planning, funding and delivery
- Actively promote and make services available to support improved self-care and health management among individuals, families and the community

Example: Innovations to Enhance Community Engagement

To support improved community engagement, a collaborative initiative by several Ontario health organizations has launched EPIC, a new online resource: <http://epicontario.ca>. EPIC provides several resources to help local communities, providers, LHINs and other stakeholders improve community engagement in health care planning, funding and delivery.

EPIC's key principles, originally defined by the MOHLTC, echo the Panel's perspectives on community engagement:

Principles of Effectiveness:

- *Engage early enough to make a difference*
- *Resource it properly*
- *Be prepared to pay attention to the results*
- *Monitor and evaluate its effectiveness*

Principles of Clarity:

- *Be transparent in terms of purpose and communication*
- *Be transparent about how results will be used*
- *Develop a clear but flexible project strategy*

Principles of Inclusion:

- *Build in ethnocultural diversity*
- *Eliminate physical, psychological and socioeconomic barriers to participation by all groups*

Principles of Respect:

- *Be the community's partner, not its master*
- *Use tools acceptable to the participants*
- *Hear what people say, not what you want to hear*
- *Create realistic timelines*

12.3.4. Non-Urgent Transportation

Availability of non-urgent transportation in many rural, remote and northern areas of the province is limited. As a result, residents in these communities are not able to travel to areas to receive health care services or they incur high out-of-pocket costs to travel to health service centres. Some existing travel reimbursement programs provide support to individuals travelling long distances to receive health care. However, these programs often lack flexibility related to eligibility criteria or other factors. Further, there is limited coordination between the health providers and EMS for inter-facility transfers and non-urgent transportation requiring health professional accompaniment (see section 12.3.1), leading to fragmentation and potentially ineffective use of limited non-urgent transportation resources.

To improve the availability and utilization of non-urgent transportation as a mechanism for improving access to health care in rural, remote and northern Ontario, two recommendations are proposed. The goals and implications for these two recommendations are closely connected, so are presented together:

R10: Conduct a review targeted at improving planning, coordination and funding of inter-facility transfers and transportation that may or may not require health professional accompaniment (Provincial/LHIN/Local Strategy)

R11: Conduct a review targeted at enhancing community-based non-urgent transportation solutions as part of access initiatives (Provincial/LHIN/Local Strategy)

By improving inter-facility transfers, transportation that may require health professional accompaniment, and non-urgent transportation availability and coordination, strategies should focus on the following sub-recommendations:

R10-11.1. Link to the previously identified recommendation to strengthen alignment of Emergency Medical Services with the planning and delivery of local health services, to enable coordinated service planning and delivery across urgent, inter-facility and non-urgent transportation

R10-11.2. Improve the utilization of limited health resources for inter-facility transfers and non-urgent transportation of individuals that may require accompaniment by a health professional

R10-11.3. Enable local policy and funding flexibility that establishes funding models for inter-facility transfers, transportation that may require health professional accompaniment and non-urgent transportation, to facilitate the development of solutions that meet LHIN and local community needs

R10-11.4. Review existing travel grant programs for opportunities to better align programs to the different needs of residents across rural, remote and northern Ontario

Example: Innovation in Non-Urgent Transportation Solutions

In recognition of its large rural planning area, the Champlain LHIN defined “better access to treatment” as one of its original IHSP priorities and launched the “Non Urgent Community Transportation (NUCT) Pilot Project” in 2007.

Designed to develop and implement a centralized access and coordination function related to non-urgent community transportation for discharged patients from hospitals to the community, in the small rural area of Prescott-Russell, the pilot project’s aim was to improve hospital-to-hospital transfers and transfers between hospitals and Long Term Care Homes.

Implications for the LHINs and Local Communities/Providers

To improve the availability of non-urgent transportation to residents in rural, remote and northern Ontario, LHINs, local communities and providers will need to work together to develop coordinated solutions with EMS and local transportation organizations:

- Exploration of different non-urgent transportation models should consider the role of EMS, private providers and volunteer networks, to determine the most appropriate and available resources for a local community

- Focus should be on optimizing local transportation solutions, integrating transportation funding where appropriate, and improving coordination for individuals relying on third-party non-urgent transportation to access health care services
- Solutions should provide support to existing local volunteer networks as an important contributor to the ‘spirit’ of a healthy community

12.3.5. Technology

Across rural, remote and northern Ontario, opportunities exist to improve the use of technology to enable improved information sharing, establish clinical networks, connect providers and individuals, and support ongoing health professional development. Although provincial strategies exist to invest in these technologies, the Panel believes that these efforts need to be accelerated in rural, remote and northern Ontario, and that appropriate incentives are needed to encourage the use of these emerging technologies.

One recommendation is proposed by the Panel to improve the use of technology as a tool for improved access to health care services in rural, remote and northern Ontario:

R12: Enhance provincial information management, clinical and education technology availability (e.g. eHealth, telemedicine, simulation learning), and related health professional networks and incentives to encourage use (Provincial/ LHIN/Local Strategy)

Implementation of enhanced provincial information management and technology will be facilitated by the following sub-recommendations:

- R12.1. Use should be encouraged and incented both in rural, remote and northern communities and at the larger referral centres and AHSCs to ensure effective outreach support is being delivered to rural, remote and northern Ontario**
- R12.2. Use should be supported for both clinical consultations to help improve access to specialist resources, and for education applications to improve and maintain core skills of rural, remote and northern health professionals**
- R12.3. Information and technology connections within local communities, and across local hubs and regional referral centres, should be enabled to improve access and care delivery**

Implications for LHINs and Local Communities/Providers

In parallel to provincial investments, LHINs and local communities/providers can focus local efforts on establishing technology infrastructure:

- Focus local technology investments on connecting providers and communities within local hubs, and between local hubs, regional referral centres and AHSCs, to maximize the impact of local initiatives on access

Example: Innovation in Telemedicine

To improve First Nations connectivity in north-western Ontario as well as other remote regions in Canada, the Keewaytinook Okimakanak (KO), a First Nations tribal council, established Kuhkenah Network (K-Net). K-Net provides information and communication technologies, infrastructure and application support in First Nation communities (<http://knet.ca/>).

With a focus on improving health care access, K-Net includes KO Telemedicine (KOTM), a sustainable First Nations Telemedicine Program that is holistic, community driven and culturally appropriate. KOTM delivers clinical, educational and administrative services via the telemedicine network, improving health care access for First Nation communities in Ontario.

Section E: Call to Action

The Panel has established a Stage 1 Rural and Northern Health Framework/Plan that sets forth a clear vision, guiding principles, planning standards, strategies and guidelines that, if implemented, it is confident will improve access to health care in rural, remote and northern Ontario. Implementation of this Framework/Plan will achieve several fundamental shifts in the policy and funding relationships between the Ministry, LHINs, local communities and providers. These shifts present both challenge and opportunity to all stakeholders in the health care system, but if achieved, will set the stage for significant improvement to health care access and for achievement of the broader vision set forth:

A health care system that provides appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians

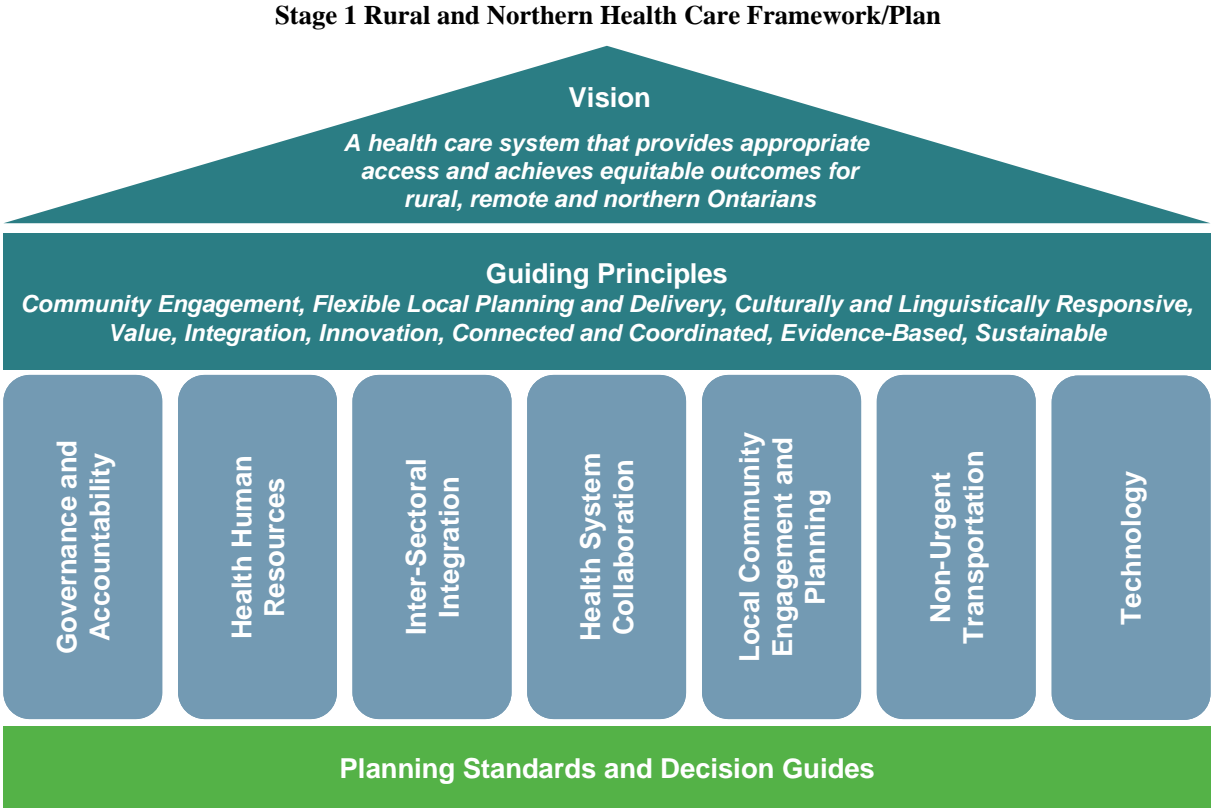
The Panel recognizes, however, that its work is only the first of three stages as the province defines its vision and framework. A critical next step to validate this Stage 1 Framework/Plan will be the planned consultation by the Ministry in Stage 2 of this planning process.

It is the Panel's recommendation that the spirit of this Stage 2 consultation be one that more directly engages the LHINs, local communities and providers, to gain further insight into the issues, challenges and strategies needed to improve access. The Panel believes that a comprehensive engagement process is necessary to not only learn key insights, but to also build momentum and buy-in to a common vision. This approach will bring both support and challenges to the recommendations proposed, but is critical to improving the Framework/Plan ultimately endorsed by the Ministry.

In parallel, the Panel recommends that the Ministry and LHINs start work immediately to collaboratively develop a process for implementing the **full** set of recommendations of this Framework. The intent of this parallel implementation planning process is to enable implementation of the Framework to proceed quickly, once the final recommendations are determined in Stage 3 of the Frameworks' development. Critical to this parallel implementation planning process is that it must consider the perspectives and revisions to recommendations identified through the Stage 2 consultations. The Panel believes this combined approach of parallel planning and consultations will best contribute to achieving the goal of this planning initiative in a timely manner: improved access to health care in rural, remote and northern Ontario.

Section F: Consolidated List of Recommendations

The recommendations proposed by the Panel are consolidated in this section of the report for ease of reference. The overall framework, vision and guiding principles are highlighted in the diagram below:



Further summary of the planning standards, strategies and guidelines are provided on the following pages. For additional information on each component of the Stage 1 Framework/Plan, please refer to Section D of this report.

Planning Standards and Decision Guides

The Panel is proposing the following set of ‘planning standards and decision guides’. The intent of these planning standards and decision guides is to support the province, LHINs and local communities in coordinated planning at all levels for improved access for residents in rural, remote and northern Ontario.

The planning standards and decision guides are intended as ‘visionary’ guidelines for health system planning by the Ministry and LHINs. These standards are not designed as ‘rules’ to indicate minimum or maximum access guarantees, provide decision on whether to build or close hospitals or inpatient beds, or to increase or reduce current service levels. Further, it is recognized that these standards may not be feasible for some populations in rural and remote Ontario, and that further work by the province and LHINs will be needed at

the local level to engage communities to define appropriate access needs and standards, and identify alternative solutions.

- **90% of residents in a community or local hub will receive primary care within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive emergency services (24/7/52) within 30 minutes travel time from their place of residence**
- **90% of residents in a community or local hub will receive basic inpatient hospital services within one hour travel time from their place of residence**
- **90% of residents in a community or local hub will receive specialty inpatient hospital and tertiary diagnostic services within four hours travel time from their place of residence**

Travel time presumed travel by road, under normal road conditions and travel within posted speed limits.

Strategies and Guidelines

Twelve recommendations on strategies and guidelines are identified by the Panel, and are organized across seven themes. The recommendations, sub-recommendations and primary responsibility for implementation are summarized within each of these themes in the table below:

Themes	Recommendations	Primary Responsibility
Governance and Accountability	<p>R1: Create a point of accountability within the MOHLTC leadership focused on rural, remote and northern health, and responsible for leading the definition and monitoring of standards for health care access</p> <p>R1.11. Carrying forth the recommendations of the Panel and monitoring their implementation</p> <p>R1.12. Leading collaborative initiatives with LHINs and local communities/providers to define and monitor performance goals and standards for access, supported by ongoing evaluation of access initiative outcomes</p> <p>R1.13. Identifying a mechanism to stay closely engaged with the LHINs, local communities and providers in a collaborative dialogue on access to rural, remote and northern health care (e.g. through an Advisory Council or other mechanisms as deemed appropriate)</p> <p>R1.14. Working with LHINs, local providers, universities, research centres and researchers to support research and disseminate best practices of models of care, community engagement and other knowledge</p> <p>R1.15. Supporting provincial-health professional planning to identify the roles, expectations and accountabilities of health system-physician relationships to support health care access in rural, remote and northern Ontario</p> <p>R1.16. Establishing clear linkages within the MOHLTC to facilitate</p>	Province

Themes	Recommendations	Primary Responsibility
	<p>and federal health jurisdictions to improve access</p> <p>R1.19. Applying a ‘rural, remote and northern perspective’ to validate the appropriateness of provincial initiatives, and setting relevant targets for access in rural, remote and northern Ontario</p> <p>R1.20. Implementing flexible funding models that support integration at the local level across existing funding silos (e.g. LHINs, primary care, EMS, Public Health, community agencies), and that are responsive and sensitive to the unique local circumstances of communities in rural, remote and northern Ontario</p> <p>R2: Establish a process to identify strategies and guidelines to improve access to health care services for First Nations and Aboriginal communities, and which also considers the needs of remote, isolated and distant communities</p>	Province
Health Human Resources	<p>R3: Continue to establish innovative health human resource models for rural, remote and northern Ontario, and integrate this planning perspective into existing provincial health human resources strategies and programs</p> <p>R3.8. Champion inter-professional care and a focus on healthy workplace as key principles for health human resource planning (e.g. support models such as Family Health Teams, Anaesthesia teams)</p> <p>R3.9. Further support enhanced scopes of practice for health providers working in these communities to improve access (e.g. Nurse Practitioners, Pharmacists, Paramedics, Midwives, Unregulated Workers), and eliminate policy, regulation or practice barriers that inhibit health providers from working to their full scope of practice, and enable unregulated workers to take on additional responsibilities where appropriate</p> <p>R3.10. Provide incentives and models for working in these communities to all health professionals</p> <p>R3.11. Invest in leadership development at all levels to lay the foundation for future leaders in rural, remote and northern communities, and provide continued momentum to improve access to health care</p> <p>R3.12. Use appropriate recruitment strategies to attract the right individuals as health care professionals and leaders into rural, remote, and northern communities</p> <p>R3.13. Create the required mechanisms and support to provide mentorship and development for new graduates across all health professionals that instill the requisite skills to work in rural, remote and northern communities</p> <p>R3.14. Increase responsibility for all universities, colleges and training institutes across the province that train health professionals to address workforce challenges in rural, remote and northern Ontario, including:</p> <ul style="list-style-type: none"> a. Align health professional training programs in universities, colleges and institutes to be representative of the population of rural, remote and northern Ontario (e.g. if the population represents 15-20% of Ontario, have 15-20% of learners from the population; and provide teaching/faculty support for in-community training) b. Increase on-site education experiences in rural, remote and northern communities, with a linkage to ongoing mentorship and leadership development programs for new graduates 	Province

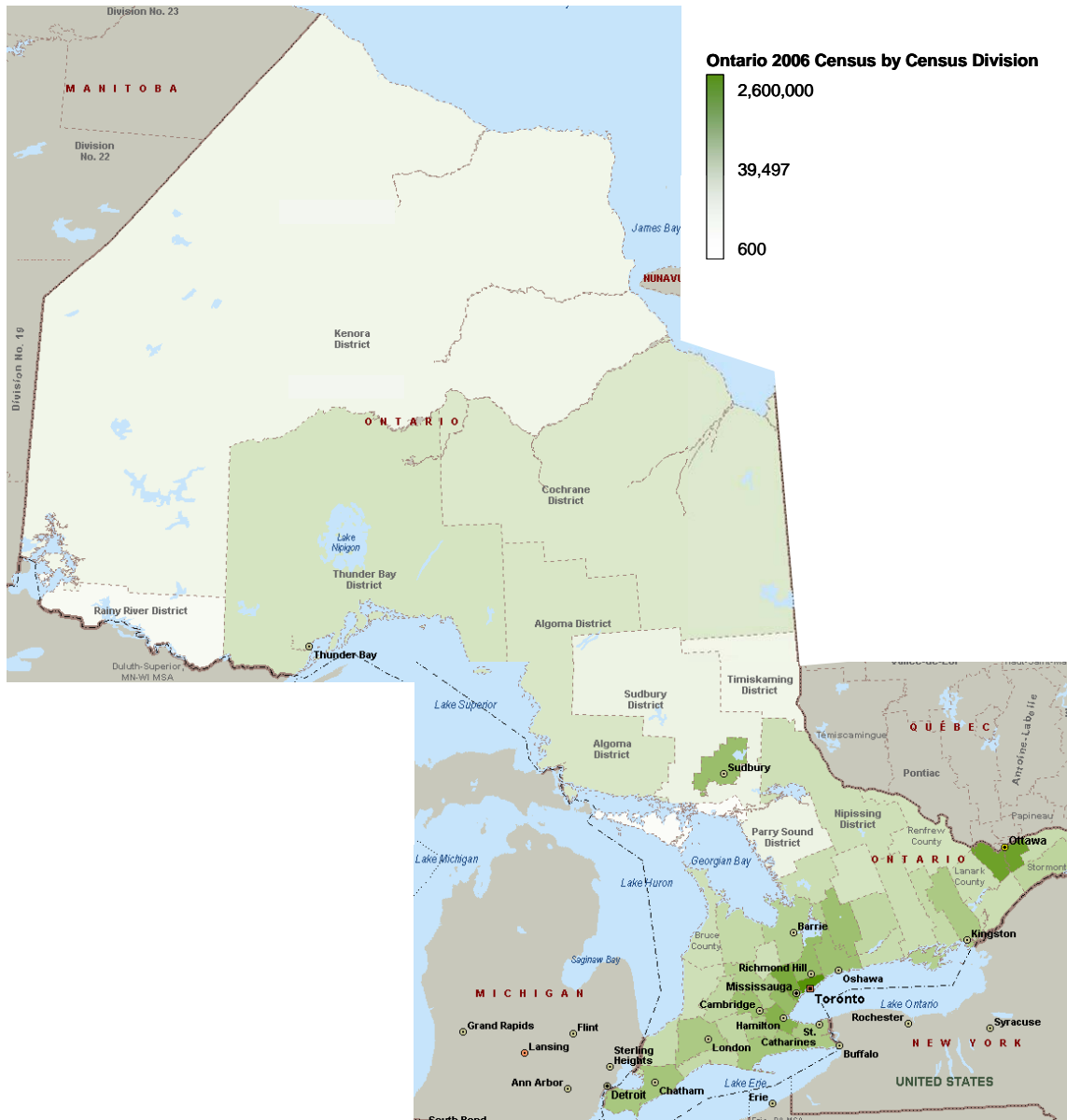
Themes	Recommendations	Primary Responsibility
	<p>c. Increase the outreach of faculty to deliver education, research and clinical care in rural, remote and northern communities</p>	
Integration: Inter-sectoral Integration	<p>R4: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Emergency Medical Services (land and air) with the planning and delivery of local health services, at both the provincial and LHIN levels</p> <p>R5: Examine and act upon options to strengthen relationships, improve clarity of accountabilities, and increase integration of Public Health services at both the provincial and LHIN levels, to enable integrated planning and delivery of health services</p>	<p>Province and LHIN</p> <p>Province and LHIN</p>
Integration: Health System Collaboration	<p>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, includes broader social services, where feasible</p> <p>R.6.1. Encourage local community engagement in planning and delivery across the health continuum</p> <p>R.6.2. Leverage the role of small health care facilities and their catchment areas as potential ‘local hubs’ of integrated health care services, incorporating geographic variations of each hub to establish sub-LHIN planning areas</p> <p>R.6.3. Determine the most appropriate balance of services delivered close to home versus in local/multi-community hubs or through LHIN/provincial-level resources</p> <p>R7: Establish clear roles, responsibilities and supporting infrastructure for health providers that fosters improved collaboration, defines referral networks and pathways, and coordinates access to services</p> <p>R7.1. Identify and establish LHIN-based and cross-LHIN referral centres and outreach networks, with clear accountabilities that extend from an organization’s governance through to front-line professionals</p> <p>R7.2. Establish coordinated approaches across referral centres and outreach networks to improve service coverage and facilitate patient transfers for acute services</p> <p>R7.3. Identify telemedicine hubs, referral networks and supports needed to improve access</p> <p>R8: Establish provincially coordinated formal referral and outreach networks between academic health sciences centres and local providers in rural, remote and northern communities, with clear roles and responsibilities</p> <p>R8.1. Build on the many existing referral and outreach networks established in the province in which regional referral centres and local providers in rural, remote and northern communities leverage the specialized resources of AHSCs.</p> <p>R8.2. Formalize a referral and outreach relationship between AHSCs across the province so that every local community or multi-community cluster within the LHINs is formally linked with an AHSC, which establishes clear accountabilities that extend from an organization’s governance through to front-line professionals</p>	<p>LHINs</p> <p>LHINs</p> <p>Province</p>

Themes	Recommendations	Primary Responsibility
	<p>R8.3. Provide specialized expertise to local areas through in-community education, planning and service delivery.</p> <p>R8.4. Improve the equity of access of rural, remote and northern Ontarians to specialized services.</p> <p>R8.5. Leverage the use of electronic health records and telemedicine to enhance and expand the access to services enabled through these networks.</p>	
<p>Integration: Local Community Engagement and Planning</p>	<p>R9: Engage local communities to actively participate in the decision-making process for health care planning, funding and delivery, to foster improved collaboration and dialogue between the public, providers and LHINs on health access needs and health system capacity</p> <p>R9.1. Improve the assessment of community health care access needs at the local level</p> <p>R9.2. Support, co-own, facilitate and be active participants in identifying local solutions to access challenges, support broader health status issues, and engage communities in local decision-making processes</p> <p>R9.3. Provide leadership in seeking opportunities to integrate funding across the health and social services silos within a local community, supported by local community engagement in the decision-making process</p> <p>R9.4. Foster local community leadership and capacity to apply for Ministry and other government funded programs that improve access to health care services (e.g. Family Health Teams, nurse practitioner clinics)</p>	<p>LHINs, Local Communities and Providers</p>
<p>Integration Non-Urgent Transportation</p>	<p>R10: Conduct a review targeted at improving planning, coordination and funding of inter-facility transfers and transportation that may or may not require health professional accompaniment</p> <p>R11: Conduct a review targeted at enhancing community-based non-urgent transportation solutions as part of access initiatives</p> <p>R10-11.1. Link to the previously identified recommendation to strengthen alignment of Emergency Medical Services with the planning and delivery of local health services, to enable coordinated service planning and delivery across urgent, inter-facility and non-urgent transportation</p> <p>R10-11.2. Improve the utilization of limited health resources for inter-facility transfers and non-urgent transportation of individuals that may require accompaniment by a health professional</p> <p>R10-11.3. Enable local policy and funding flexibility that establishes funding models for inter-facility transfers, transportation that may require health professional accompaniment and non-urgent transportation, to facilitate the development of solutions that meet LHIN and local community needs</p> <p>R10-11.4. Review existing travel grant programs for opportunities to better align programs to the different needs of residents across rural, remote and northern Ontario</p>	<p>Province, LHINs and Local Communities</p>

Themes	Recommendations	Primary Responsibility
<p>Integration Technology</p>	<p>R12: Enhance provincial information management, clinical and education technology availability (e.g. eHealth, telemedicine, simulation learning), and related health professional networks and incentives to encourage use</p> <p>R12.1. Use should be encouraged and incented both in rural, remote and northern communities and at the larger referral centres and AHSCs to ensure effective outreach support is being delivered to rural, remote and northern Ontario</p> <p>R12.2. Use should be supported for both clinical consultations to help improve access to specialist resources, and for education applications to improve and maintain core skills of rural, remote and northern health professionals</p> <p>R12.3. Information and technology connections within local communities, and across local hubs and regional referral centres, should be enabled to improve access and care delivery</p>	<p>Province, LHINs and Local Communities</p>

Appendix A: Population Density Map of Ontario

The challenges of providing appropriate access to health care in these communities stem from multiple factors: geographic remoteness, long distances, low density populations, lower availability of health providers and inclement weather conditions. The map of Ontario below demonstrates these challenges, especially for northern Ontario, which is characterized by a notably sparse population distributed across the large geography.



Appendix B: Rural and Northern Health Care Panel Terms of Reference and Membership (Stage 1)

Background/Context

The challenges facing rural and northern communities across Ontario are longstanding, difficult and complex. Health care facilities serve multiple roles relative to those in urban centres and are farther apart, with significant travel distances between locations. Health human resources are more difficult to recruit and retain and health providers are asked to carry out a wider range of medical and emergency services compared with their urban counterparts. In some cases service volumes may not achieve critical mass to maintain clinical competency or justify cost-efficient practices but need to be provided in order to ensure access. Local Health Integration Networks (LHINs) and others continue to struggle with how to effectively provide services in remote locations to meet the needs of local populations.

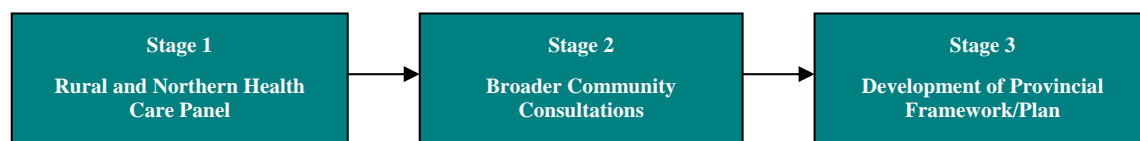
The terms “rural”, “northern” and “remote” are difficult to define. Across Ontario the degree of each can be relative. Rurality can be measured on a sliding scale, and demarcation between rural and non-rural areas may be both unclear and rapidly changing. The North includes both urban and remote populations widely dispersed over vast geography. Addressing health care challenges will require different perspectives and approaches in southern rural, Northern urban and Northern remote areas.

The government, as part of the 2007 Platform, committed to examining these issues and providing a Provincial Framework/Plan to support delivery of health care in rural/northern communities.

Now that LHINs have been well established in their roles, the government has determined that the time is right to move forward on that commitment.

Purpose

The Government is taking a three-stage approach to developing a rural/northern health care framework:



In the first stage, the government will establish a Rural and Northern Health Care Panel to collate and review current activities underway across the province. The mandate of the panel will be to identify a vision, strategic directions and principles to assist Government and LHINs in ensuring access to care as one of several dimensions of improving quality of care in rural, remote and northern communities.

Terms of reference for the second and third stages will be developed later.

Scope

The panel’s activities will review activities at a provincial, regional referral and LHIN level. The panel’s recommendations will guide LHINs in performing their statutory roles and authorities.

<i>“IN” Scope</i>	<i>“OUT” of Scope</i>
<ul style="list-style-type: none"> Programs that are intended to promote quality, safety, service, efficiency and sustainability in the delivery of health care to residents of Rural and Northern Ontario 	<ul style="list-style-type: none"> In recognition of the contemporaneous work of a select committee of the Legislative Assembly, mental health services/programs will not be reviewed. As funding decisions are the purview of the Government, the panel will not make recommendations that require new investments beyond any amount approved or planned by the Government. The panel will not review any decision made by a LHIN with the intent of overturning or questioning the decision. While identification of key issues for remote, isolated and distant communities will be in-scope for this initiative, an additional separate process will also be needed to further develop a framework specific to the unique and underserved needs of those communities. Similarly, Panel members felt that given the complexity of governance and funding authorities for Aboriginal communities, and the unique cultural and geographic characteristics of these populations, this same separate process would be more appropriate to determine suitable recommendations. The Panel has recommended the initiation of this process to Government.

Authority

Decisions about the content of the report, within the framework of the panel’s terms of reference, to be prepared by the panel will be the responsibility of the panel. Decisions about purpose, scope, roles, responsibilities, membership, duration and timelines will be made by the Executive Sponsor following consultation with the chair.

Mandate of the Panel

Role of the Rural and Northern Health Care Panel

The panel will:

- Review and examine existing historical and current work underway through community-based organizations, the Ontario Hospital Association, the Ontario Medical Association, LHINs and MOHLTC, to address rural, remote and northern health issues,
- Develop a literature review on how other jurisdictions have addressed health delivery systems issues for their rural, remote and northern communities and summarize the lessons, evidence and leading practices
- Review different approaches to defining “rural”, “northern” and “remote”
- Highlight existing programs, services and investments targeted to improving access and quality in rural, remote and northern Ontario
- Based on the current outcomes and the leading practices in Ontario, the lessons from other jurisdictions and the existing evidence, recommend key characteristics for a model of rural, remote and northern health care in Ontario

- Identify any metrics that are revealed through the work above that measure how access, quality, safety, service, efficiency and sustainability can be achieved through coordinated investments to address unique health system needs in rural/remote/northern Ontario
- Identify strategies that can be customized by LHINs for making local decisions
- Recommend guidelines for LHINs to be used when considering changing roles for health facilities, including sequencing of related changes
- Call for a plan to be developed to implement these recommendations by leveraging, coordinating, optimizing and aligning existing and available programs, opportunities and best practices.

The panel’s product will be a report to the Minister, and will include a summary of current-state, literature/experience and a framework of key guiding principles. These principles may take the form of simple rules or minimum specifications consistent with the LHINs’ mandate for local system planning, funding and integration. The objective is health service delivery policy coherency recognizing that the implementation of policy may vary widely between contexts. This work will also need to ensure that the basic features of accountability are in place including identifying the locus and scope of responsibility, common expectations, and ability to objectively measure performance.

Membership

The Minister will appoint the chair and members. The chair and members of the panel are responsible to the Minister.

The panel will be chaired by Hal Fjeldsted, CEO, Kirkland and District Hospital. The panel will consist of representatives from the following stakeholder groups:

<i>Name</i>	<i>Stakeholder Group</i>
<ul style="list-style-type: none"> • Brian Bildfell • Jocelyn Blais • Lynn Brown • Mike Brown • Margret Comack • Kathy Faries • Kelly Isfan • Carol Mitchell • Terry O’Driscoll • Raymond Pong • Doug Reycraft • Gerry Rowland • Donna Williams 	<ul style="list-style-type: none"> • Emergency Medical Services • Francophone Health • Rural/Northern Nursing • Member of Provincial Parliament • Rural/Northern FHT • Rural/Northern Nursing • Rural/Northern Hospital • Member of Provincial Parliament • Rural/Northern Family Physician • Rural/Northern Health Research • Municipalities • Emergency Department Physician • Information and Communication Technology

Accountabilities

The chair of the panel is responsible to the Minister for the timely achievement of the panel’s mandate. The Executive Sponsor is accountable for the Ministry support to the panel, consistent with its mandate. The Executive Sponsor is hiring a consulting firm who will act as Project Manager and provide the panel with logistical and project management support, review and collate current work underway, prepare materials for consideration by the panel, and assist with the writing of the panel’s final report.

The chair will work closely with the Minister’s Office and Executive Sponsor’s Office.

Linkages & Partnerships

MOHLTC will be consulting on a design of the Underserved Area Program, over the same approximate period as the work of the panel. MOHLTC staff will ensure that the recommendations of the two projects are complementary.

Capacity review

During the period that the panel is working, MOHLTC will be initiating a review of the institutional capacity in the provincial health system. Through the review, a provincial capacity planning framework will be developed which identifies service-level benchmarks from other jurisdictions, forecasts drivers of health care utilization, and proposes parameters to be considered by LHINs as they plan for their local populations. As the timeline for the capacity planning framework is approximately 12-18 months in duration, MOHLTC will be able to incorporate findings and recommendations from the panel's work, as appropriate, into the capacity planning framework.

Northern Growth Plan

The *Places to Grow Act, 2005* provides the legislative framework to develop and implement the policies of regional growth plan; it identifies the principles for growth plans applicable province-wide (e.g. sustain a robust economy and build strong communities).

The Northern Growth Plan is the second Plan being developed (2008-2010) by the province and will set out a long-term vision and goals that will guide and coordinate provincial decision-making. Key Themes have been identified (e.g. fostering research, innovation and commercialization; Increasing education and training opportunities; Retaining and attracting people and jobs; Making strategic use of infrastructure) and Health is of interest for its dual role in supporting a healthy workforce and driving the advancement of a knowledge economy.

The project is under the leadership of the Ontario Growth Secretariat. The Health System Strategy Division is linking with the Secretariat to ensure the maximum contribution of MOHLTC to the Growth Plan development.

Duration of Service

The members will submit their report to the Minister of Health and Long-Term Care in Winter 2009/10.

Role of Panel Members

The individual members of the Panel will:

- ensure the requirements of stakeholders are fully considered in arriving at the Panel's final deliverables;
- balance personal priorities and resources with those of the other members;
- be responsive to the project team and beneficiaries of the project's outputs;
- objectively consider ideas and issues raised against their contribution to the Panel's output;
- regularly monitor the progress of the project, and take initiative to ensure the project stays on track and provides a quality output; and
- promote project management standards of best practice.

Panel Logistics and Processes

Role of Chair

The chair is responsible for:

- convening and chairing scheduled meetings
- facilitating consensus building
- timely achievement of the panel's mandate
- liaison with the Executive Sponsor regarding the panel's ongoing needs

Frequency of Meetings

The panel will meet once monthly in July, September, October, November, December and January on dates to be identified by the chair in consultation with members of the panel. Meeting dates may be rescheduled by the chair in order to align with key milestones and members' availability.

Decision-Making Process

The panel will adopt a consensus model of decision-making for recommendations/advice. Deliberations of the Working group will seek to build consensus on the most acceptable advice/direction. Where consensus cannot be reached, the panel will present a summary of the deliberations to the Executive Sponsor.

Quorum Requirements

Quorum will be the chair or alternate designated by the chair, and 50% of the appointed members of the panel.

Proxies to Meetings

If a member of the panel is unable to participate in a meeting of the panel or of any sub-group, the member panel may send a proxy to participate in his or her stead, with prior notice to the appropriate chair.

Agenda Items

Agenda items may be suggested by any member of the panel, and by the Executive Sponsor. Determination of the agenda is the responsibility of the chair.

Minutes & Meeting Papers

Support will be provided by the MOHLTC for minute taking at meetings, to prepare them for the chair's approval, and distribute to all members.

Appendix C: Bibliography of Documents Reviewed

In addition to the referenced sources identified throughout this report, the following documents were reviewed by the Panel to provide insight into previous or ongoing initiatives conducted within Ontario and other jurisdictions, to improve health care access to rural, remote and northern communities.

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Appendix D: Inventory of Services Funded to Improve Health Care Access in Rural, Remote and Northern Ontario

This section presents a preliminary inventory of government-funded programs targeted to improve access to health care in rural, remote and northern Ontario. The purpose of this inventory is to provide an initial snapshot of services and initiatives focused on improving access, which the Panel hopes can serve as the start of a broader knowledge base to improve the awareness of rural, remote and northern stakeholders of the funded initiatives targeted at improving access to health care. Across this preliminary inventory of services, the Government of Ontario has invested over \$150M in one-time funding and over \$180M in ongoing operating funding, which the Panel appreciates as significant contributors to improving access in rural, remote and northern communities.

This inventory is not intended to be an exhaustive list of the many innovative services and solutions to improving access in rural, remote and northern communities across the province. It is well recognized by the Panel that the LHINs, local municipalities, aboriginal communities and other stakeholders are actively working to improve access to health care through their own innovative services and initiatives for rural, remote and northern Ontario.

Preliminary Inventory of Government-Funded Northern and Rural Health Care Programs

Program	Description/objectives
Emergency Health Services	<p>DISPATCH SERVICES</p> <ul style="list-style-type: none"> • Central Ambulance Communications Centres (CACCs) dispatch ambulances and approximately 100 fire departments, virtually all of these in rural areas. • The GPS/AVL (Global Positioning System/Automatic Vehicle Locator) system incorporated into every CACC, and the ministry funding provided to municipalities (50/50) to install the digital mapping technologies in municipal ambulances, is of particular significance in rural areas
Emergency Health Services	<p>LAND AMBULANCE SERVICES</p> <ul style="list-style-type: none"> • 100% funding for the approved costs for the provision of land ambulance services to First Nations communities – either to municipalities or to dedicated First Nations Ambulance Services. • 100% funding for the approved costs for the provision of land ambulance services within territories without municipal organization (TWOMO), all of which are in Northern Ontario. • 50% funding for municipalities for land ambulance services.
Emergency Health Services	<p>AIR AMBULANCE SERVICES 100% funding for the approved costs of providing air ambulance services</p>
Insulin pump and supplies program	<p>Some centres in Northern Ontario that provide pump therapy are unable to meet the ADP registered diabetes education program criteria because they do not have access to a physician specialist.</p> <p>To assist these centers, the ADP has made special provisions for Diabetes Education Program in Northern Ontario. This includes reviewing any additional documentation or information provided that demonstrates the health care team can fulfill the role of an ADP registered Diabetes Education Program. Family physicians that demonstrate proficiency in the care and management of type 1 diabetics through years of service will receive additional training or the ability to access and consult with Endocrinologists in larger centres.</p> <p>ADP is currently reviewing requests from 2 centres in Northern Ontario, Hearst and Kapuskasing.</p>

Program	Description/objectives
Northern Health Travel Grant	Helps to defray medical related travel costs for residents of Northern Ontario who must travel long distances within Ontario, or Manitoba to access medical specialist, or designated health care facility (e.g. hospital for MRI) services unavailable locally within 100km radius.
Northern Health Travel Grant enhancements	<p>On July 4, 2007 the Premier of Ontario announced the following enhancements to the NHTG program:</p> <ul style="list-style-type: none"> • An increase in the per kilometre reimbursement rate from 34.25 cents to 41 cents per kilometre; effective July 1, 2007 (completed); • An accommodation allowance of \$100.00 per eligible trip; effective October 1, 2007 (completed); and • Upgrades/redesign of the NHTG claims processing system; implementation scheduled for Q4 2008/09 (underway and on-track). <p>The business drivers for the NHTG Program Enhancements are to improve the delivery of this Program to Northern Residents by:</p> <ul style="list-style-type: none"> • Deferring costs for Northern Residents seeking specialty medical services not available locally; and • Assuring that applicants receive this compensation in as timely a fashion as possible in order to offset these travel costs.
Small hospital funding initiative	<p>To recognize the unique challenges small hospitals face as a result of isolation, transportation, limited efficiencies from economies of scale and lack of services in the community.</p> <p>The ministry defines hospitals as 'small' for a given funding year:</p> <p>If it had less than or equal to 2,500 equivalent weighted cases of service for that funding year. This also includes those multi-site hospitals with small sites that meet this criteria (less than or equal to 2,500 weighted cases).</p>
Northern Ontario School of Medicine	<ul style="list-style-type: none"> • Improve access to needed medical services in the North • Recruit and retain physicians in communities in rural and Northern Ontario. <p>Transitional Physician Funding to help NOSM achieve their academic mission. Full Physician funding associated with NOSM negotiated as part of the 2008 OMA Framework Agreement.</p>

Program	Description/objectives
Underserviced Area Program	<p>While the UAP has a single funding allocation, the program constitutes 18 program components. The UAP helps northern and rural underserviced communities across the province improve access to health care services by providing a variety of integrated initiatives aimed at attracting and retaining health care providers. In order to be eligible for the UAP's recruitment and retention support, a community must be designated as underserviced.</p> <p>(see Appendix for components including transfers to other programs proposed in 2009/10 RbP)</p>
Family Health Teams	<p>29 FHTs provide care to residents in North East and North West LHINs</p> <p>49 FHTs provide care to over 336,000 rural Ontarians</p> <ul style="list-style-type: none"> • Implement 50 new FHTs across Ontario to improve access to comprehensive family health care for Ontarians. • New FHTs will be located in areas of greatest unmet need (i.e. unattached patients) as identified through the Health Care Connect program. This is anticipated to include rural and northern areas of the province. • The first call for proposals is being targeted for spring 2009 with a second call targeted for winter 2010.
HIV/IDU Outreach Program	<p>The Injection Drug User Outreach Program funds community-based prevention workers in local communities to provide HIV prevention, education, support and referrals to injection drug users who are at risk of contracting HIV and HCV</p>
Community-based AIDS Education and Support Programs	<p>Community-based AIDS Education and Support Program</p> <p>Delivers HIV/AIDS prevention, education and support programs for those infected and affected by HIV/AIDS, and those most at risk of acquiring HIV/AIDS in Ontario.</p>
Community-based HIV Clinical Services	<p>Provides multi-disciplinary care for people living with HIV/AIDS.</p>

Program	Description/objectives
ED AFAs	<p>24 hour: 19 hospitals in the North</p> <p>Workload: 5 hospitals in the North</p>
ED Mentorship Program	4 hospitals in the North
ED Recruitment Program	Improve recruitment of ED resources
First Nations Agreement - Sioux Lookout	<p><u>Description</u></p> <ul style="list-style-type: none"> • Health Canada has withdrawn from directly funding physician services effective March 31, 2008 • MOH has assumed this responsibility effective April 01, 2008 by way of a Bridging Agreement that maintains status quo of physician services in the region while introducing very basic elements of a MOH funded primary care physician services funding model. Full PHC funding agreement to be negotiated in 2009/10. <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Assume funding responsibility for primary care physician services in the Sioux Lookout region in order to ensure comprehensive primary health care services available to residents of 28 isolated communities in northwestern Ontario
Ontario Telemedicine Network	<p>The Ontario Telemedicine Network (OTN) is a telemedicine networks funded by the MOHLTC. OTN provides access to care for patients in every hospital and hundreds of other health care locations across the province. Nearly 3,000 health care professionals in more than 925 sites across the province use OTN to delivery more than 90,000 patient visits.</p> <p>In addition to clinical care, OTN facilitates the delivery of distance education and meetings for health care professionals and patients.</p>

Program	Description/objectives
First Nations Agreement - Weeneebayko Health Ahtuskaywin (WHA)	<p><u>Description</u></p> <ul style="list-style-type: none"> • PHC Physician (GP) services funding model for provision of comprehensive care in isolated, mainly First Nations communities; based on RNPGEA template. • Funding elements of RNPGEA and additional funding for: clinic days in fly-in communities, anaesthesia and surgical specialist service. • Full complement : potential of having 12 full time physicians (12 currently participating) <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Ensure comprehensive primary health care services available to residents of Moose Factory and surrounding 5 fly-in communities along the coast of James Bay.
Physician APPs	<ul style="list-style-type: none"> • GP Anaesthesia (Kenora, Fort Frances, Dryden, Sioux Lookout) • Hospital for Sick Children • Kenora Psychiatry • MedOncology (Sault Ste Marie/Algoma, Sudbury, Thunder Bay) • Northern Specialist (2004 OMA agreement) • Northwestern Ontario Neurology (Thunder Bay) • Northwestern Ontario Neurosurgery (Thunder Bay) • Northwestern Regional Surgical Network (Kenora, Fort Frances, Dryden, Sioux Lookout) • Owen Sound Ob/Gyn • Physical Therapy (Breslau, Goderich, Thunder Bay) • Radiation Oncology (Sudbury, Thunder Bay) • Regional Consulting Paediatric (North Bay, Stratford, Sudbury, Chatham, Orillia, Owen Sound, Timmins, Barrie, St Thomas, Thunder Bay, Windsor NICU) • Sudbury Neurosurgery

Program	Description/objectives
<p>Group Health Centre (GHC) - Sault Ste. Marie</p>	<p><u>Description</u></p> <ul style="list-style-type: none"> • The GHC agreement funds family and specialist physicians and allied health professionals to provide an integrated health care service model to over 61,000 enrolled patients (approximately 60% of the population of Sault Ste Marie). <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • The GHC aims to provide an integrated health care service model (primary health care, health promotion, disease prevention, diagnostic services, hospital care) to over 61,000 enrolled patients (approximately 60% of the population of Sault Ste Marie).
<p>Northern Diabetes Health Network</p>	<p>The NDHN ensures that an accessible, evidence-based, standardized model of care is in place. The NDHN's funding has provided for the establishment of 39 local adult diabetes programs in large and small northern centres, including some Aboriginal communities.</p>
<p>Northern Physician Retention Initiative</p>	<p>Support recruitment and retention of physicians in Northern Ontario and to encourage physicians to maintain hospital privileges.</p> <p>Established as a three year initiative under the 2000 OMA agreement and continued under the 2004 and 2008 agreements. The NPRI provides eligible physicians in Northern Ontario with a \$7,000 retention incentive paid at the end of each year in which they continue to practice full-time in Northern Ontario. Eligible participants also have access to the Continuing Medical Education (CME) Program, for benefits up to \$2,500 in each year of eligibility.</p> <p>The NPRI is targeted to general/family practitioners and specialists who have stayed, and maintained their practices, in Northern Ontario for a minimum of four years. Northern Ontario is defined as the territorial districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Muskoka, Rainy River, Sudbury, Thunder Bay and Timiskaming.</p>
<p>Nurse Practitioner Demonstration Project (NPDP)</p>	<p>The NPDP was implemented in 2002 by Nursing Secretariat to provide increased access to primary health care services in 12 small, rural and under-serviced communities.</p> <p>Effective April 1, 2005, 19.44 FTE NP positions were transferred from the Nursing Secretariat to the PCNP program. As a result of subsequent transfers of 9.84 FTEs to other TP programs, funds have been allocated for 9.6 NP FTEs through the 2009/10 RbP.</p>

Program	Description/objectives																														
Ontario Aboriginal Diabetes Strategy	Sets out a long-term approach to diabetes prevention, care and treatment, education, research and coordination in Aboriginal communities. This is done through the Southern Ontario Aboriginal Diabetes Initiative (SOADI) and eight Aboriginal Provincial/Territorial Organizations (PTOs).																														
Anaesthesia Care Teams	Phase 1 (Sault Area Hospital) Phase 2 (North Bay General Hospital)																														
Primary Care Nurse Practitioner (PCNP) Program	<p>Implemented in 2003 to provide increased access to primary health care services in small, rural and under-serviced areas and to expand the effective use of nurse practitioners (NPs) in new clinical settings.</p> <p>The initial allocation provided funds for 115 PCNP positions of which 29 are located in the Northern regions. Effective April 1, 2009, 16 PCNP positions (including 5 PCNP positions from the Northern Regions) will be transferred to Community Health Centres.</p> <table border="1" data-bbox="537 862 1577 1211"> <thead> <tr> <th data-bbox="537 862 804 922">Northern Region</th> <th data-bbox="804 862 1226 922">2008-09 NP FTE allocation</th> <th data-bbox="1226 862 1577 922">2009-10 transfer to CHC</th> </tr> </thead> <tbody> <tr> <td data-bbox="537 922 804 954">Algoma</td> <td data-bbox="804 922 1226 954">5</td> <td data-bbox="1226 922 1577 954">1</td> </tr> <tr> <td data-bbox="537 954 804 987">Cochrane</td> <td data-bbox="804 954 1226 987">3</td> <td data-bbox="1226 954 1577 987">1</td> </tr> <tr> <td data-bbox="537 987 804 1019">Kenora</td> <td data-bbox="804 987 1226 1019">6</td> <td data-bbox="1226 987 1577 1019"></td> </tr> <tr> <td data-bbox="537 1019 804 1052">Nipissing</td> <td data-bbox="804 1019 1226 1052">2</td> <td data-bbox="1226 1019 1577 1052"></td> </tr> <tr> <td data-bbox="537 1052 804 1084">Parry Sound</td> <td data-bbox="804 1052 1226 1084">3</td> <td data-bbox="1226 1052 1577 1084"></td> </tr> <tr> <td data-bbox="537 1084 804 1117">Sudbury</td> <td data-bbox="804 1084 1226 1117">4</td> <td data-bbox="1226 1084 1577 1117">1</td> </tr> <tr> <td data-bbox="537 1117 804 1149">Thunder Bay</td> <td data-bbox="804 1117 1226 1149">3</td> <td data-bbox="1226 1117 1577 1149"></td> </tr> <tr> <td data-bbox="537 1149 804 1182">Timiskaming</td> <td data-bbox="804 1149 1226 1182">3</td> <td data-bbox="1226 1149 1577 1182">2</td> </tr> <tr> <td data-bbox="537 1182 804 1211">Total</td> <td data-bbox="804 1182 1226 1211">29</td> <td data-bbox="1226 1182 1577 1211">5</td> </tr> </tbody> </table>	Northern Region	2008-09 NP FTE allocation	2009-10 transfer to CHC	Algoma	5	1	Cochrane	3	1	Kenora	6		Nipissing	2		Parry Sound	3		Sudbury	4	1	Thunder Bay	3		Timiskaming	3	2	Total	29	5
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Algoma	5	1																													
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Parry Sound	3																														
Sudbury	4	1																													
Thunder Bay	3																														
Timiskaming	3	2																													
Total	29	5																													
Regional Consulting Paediatric Locum Program	RCP sites as required																														

Program	Description/objectives
Rural Medicine Investment Program	Recruitment and retention of physicians in Northern and Rural Areas with RIO scores of 45 or greater. (2004 OMA agreement)
Rural Northern Initiative (RNI)	<p><u>Description</u></p> <ul style="list-style-type: none"> • This program brings physicians who are teaching at the University of Toronto and a PGY-3 (final year resident) to RNPGEA communities to provide additional short term locum coverage (beyond Group's contractual locum entitlements) for RNPGEA communities with a vacancy. <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Exposes new graduates to rural medicine practice. • Provides temporary relief to RNPGEA communities in need
Rural Northern Physician Group Agreement (RNPGEA)	<p><u>Description</u></p> <ul style="list-style-type: none"> • GP services funding model for provision of comprehensive care in isolated communities. • At full complement : potential of having 114 full time physicians (approximately 99-105 currently participating) <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Ensure comprehensive primary health care services available to residents of the currently 39 identified eligible northern communities.

Program	Description/objectives
<p>Rural Northern Physician Group Agreement (RNPGA)</p> <p>Expansion</p>	<p><u>Description</u></p> <ul style="list-style-type: none"> • RNPGA physician services funding model for additional underserved communities (northern and southern) as mandated through the 2004 MOH-OMA Memorandum of Understanding. • RNPGA for southern communities is a modified version of the existing RNPGA, with main difference being PHC base remuneration tied to roster size. • Full complement : potential of having 49 full time physicians (2 currently participating) <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Expand availability of comprehensive primary health care services to residents of the 8 identified eligible northern communities and 14 southern communities.
<p>Anonymous HIV Testing Program</p>	<p>Anonymous HIV testing allows for testing to occur without revealing the identities of the individuals being tested. The goals of the anonymous HIV testing program are: to encourage high risk individuals to be tested and promote access to treatment and prevention; to provide reassurance about the confidentiality of HIV testing; to provide appropriate HIV education and counselling; to ensure referrals to appropriate medical and support services as needed; and to evaluate the program in a comprehensive manner.</p>
<p>Sudbury/Algoma Psychiatry Agreement</p>	<p>Funding support for psychiatry services</p>

Program	Description/objectives
Thunder Bay Collaborative Maternity Centre Alternate Funding Plan	<p><u>Description</u></p> <ul style="list-style-type: none"> • Interim funding for Allied Health Professionals providing maternity services pro-rated by FTE and overhead • Sessional physician services to support collaborative maternity care – currently in discussions <p><u>Objective(s)</u></p> <ul style="list-style-type: none"> • Provide integrated multidisciplinary primary maternity services to patients in Thunder Bay
Trauma Team Lead AFA — Sudbury	Provision of services by Trauma Team Leaders in regional Lead Trauma Hospital (Sudbury, Thunder Bay)
LTC homes – unorganized parts grants	To assist Algoma District municipalities in defraying the cost of establishing new LTC beds based upon the proportion of costs that are allocated to unorganized parts of the territorial districts in which the homes are established.
Northern Redevelopment Grants	Northern Redevelopment Grants represent the difference between the maximum amount that the operator can raise and a minimum project cost as determined in consultation with the Ministry. Eligibility for the Northern Redevelopment Grant is restricted to those operators who are building new awarded LTC beds or redeveloping ‘D’ LTC beds. Eligibility for the Northern Redevelopment Grant is limited to Not-for-Profit organizations that can substantiate that the cost of developing their project significantly exceeds what would be expected in more urban or southern communities, or that all avenues to access the necessary equity have been exhausted.

Program	Description/objectives
Unorganized Territories Grant	<ul style="list-style-type: none"> • The Ministry provides 100% grants to public health units for the delivery of mandatory programs in unorganized territories (territories without municipal organization). • There are eight (8) public health units which receive funding for unorganized territories: District of Algoma, North Bay Parry Sound District, Northwestern, Porcupine, Renfrew County & District, Sudbury & District, Thunder Bay District, and Timiskaming Health Units. Seven (7) of these public health units are situated in the North.
CHCs	The CHC expansion plan includes 17 Community Health Centres and 7 satellite Community Health Centres whose catchment areas include rural communities, providing access to primary health care and community health programs.

Other notes:

- Some strategies, such as Aging at Home, can benefit these communities but are not targeted to them.

APPENDIX – COMPONENTS OF UNDERSERVICED AREA PROGRAM

Incentive grants

- \$40,000 paid over four years to GP/FPs and psychiatrists who relocate to designated northern communities.
- \$15,000 paid over four years to GP/FPs who relocate to designated southern communities.
- \$20,000 paid over four years to physician specialists who relocate to designated communities in Northern Ontario plus a \$20,000 grant if the specialist provides a minimum of 12 days of outreach services per year.
- \$15,000 paid over three years to audiologists, chiropractors, occupational therapists, physiotherapists and speech-language pathologists who relocate to fill full-time, MOHLTC fully-funded positions in UAP approved vacancies in northern Ontario.

Community Assessment Visit Program

Provides reimbursement for travel and accommodation expenses within Ontario, for a physician or rehabilitation professional, and spouse, to visit ministry designated underserved communities for the purpose of exploring practice opportunities.

Rehab Outreach

To provide rehab outreach clinics in smaller and remote northern communities that have had long standing difficulties recruiting rehab professionals.

Dental Outreach

To provide regularly scheduled dental clinics, of up to three days per month, on an outreach basis to remote communities in Northern Ontario where there is no access to dental care within 80-kilometre radius.

Physician Outreach

Family physicians provide regularly scheduled primary care outreach clinics to remote communities that have UAP-funded nursing stations. This program also funds physicians for telephone back-up to the nurse/nurse practitioner working at the nursing station

Free Tuition Program

Provides up to \$40,000 (or \$10,000 per year) to final-year medical students, residents and new physician graduates, in exchange for full-time three or four-year return-of-service commitment in an eligible underserved/undersupplied community.

Visiting Specialist Clinic Program

Funds physician specialists to provide medical specialist services on an outreach basis in smaller, and remote Northern Ontario communities where the population base does not warrant a full-time specialist, or where the recruitment has proved to be difficult.

Psychiatric Outreach Program

Provides clinical service, education, and support to Northern rural or remote communities underserved in mental health care. The program emphasizes service delivery and resident training in partnership with all five Ontario university departments of psychiatry.

CNIB Mobile Eye Van

The CNIB - Ontario Medical Mobile Eye Care Unit is a fully equipped medical eye care clinic, which brings professional eye care services to remote communities in Northern Ontario. The unit has been an integral part of the "Prevention of Blindness" program for both the CNIB and the OMA section on ophthalmology. Northern communities are visited by the Eye Van between March and November of each year.

Prevention of blindness through early diagnosis of eye disease is the main goal of the program. Educating local medical communities on issues related to eye diseases and the prevention of blindness is also part of the Eye Van's goal. The CNIB also provides patient counselling and referral; vision rehabilitation; orientation career development and guidance; visual technical aids; and CNIB library services.

Specialist Locum Program

Provides temporary medical specialists services to designated underserved communities in Northern Ontario until a permanent physician can be recruited. The program also provides physicians with exposure to working in a northern community in order to assess their desirability of relocating to the north on a permanent basis. [2009/10 RbP: proposed to be transferred to HealthForceOntario - Marketing and Recruitment Agency (HFO-MRA) - (\$5.7M)]

GP Locum Program

Provides temporary GP/FP services to designated underserved communities in Northern Ontario until a permanent physician can be recruited. The program also provides physicians with exposure to working in a northern community in order to assess their desirability of relocating to the north on a permanent basis. [2009/10 RbP: proposed to be transferred to HFO-MRA (\$1.0M)]

Nursing Stations

Provides operational funding to 21 Nursing Stations in order for them to render primary care services in rural and northern communities whose population is not able to support a full-time family physician.

Nurse Practitioner

UAP funds and administers 81 NP positions across the province in order to improve access to primary health care services. [2009/10 RbP: proposed to be transferred to CHC program (\$1.56195M)]

Northern Ontario Health Professional Development

NOHP-Dev provides professional support, especially to rehabilitation practitioners working in northern underserved areas as a means of promoting retention. NOHP is a component of Northern Academic Health Science Network (NAHSN) which is designed to address northern recruitment and retention of physicians and other health professionals from high school to career practice.

Northern Ontario Virtual Library

A non-monetary practice support which provides Northern Ontario health practitioners who do not have access to biomedical information resources locally with efficient and equitable access to quality information at the point of need. Uses internet and information resources access and training which help to overcome professional isolation barriers.

Annual Health Professional Recruitment Tour

Co-sponsored by MOHLTC and MNDM, the annual tour enables underserved communities and organizations to market themselves to current and future health care professionals by providing information about practice, lifestyle and employment opportunities in their communities. This tour visits the province's five Academic health science centres for a one-week duration in September. It also includes an educational program to help communities in the recruitment and retention of physicians. The Tour is organized and administered by PAIRO.

Tuition Support for Nurses

Offers tuition reimbursement to recent nursing graduates from rural and remote communities who are new College of Nurses of Ontario registrants and who choose to do a return-of-service in an eligible underserved community. The program is open to NPs, RNs and RPNs who have recently graduated from a Canadian University or College.

Resident Placement

Funded through UAP, but coordinated in partnership with PAIRO to help medical residents better understand the career opportunities available in the province and to select those positions that best meet personal and professional needs.

