

Rural and Northern Health Care Report

Executive Summary

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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.

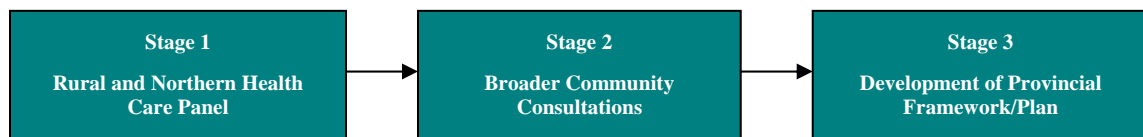
Since then the landscape of the Ontario health care system has undergone transformational changes. One of the most significant changes for Ontario's health care system has been the introduction of the Local Health Integration Networks (LHINs). The LHINs are assigned the accountability to coordinate health 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

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

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.

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

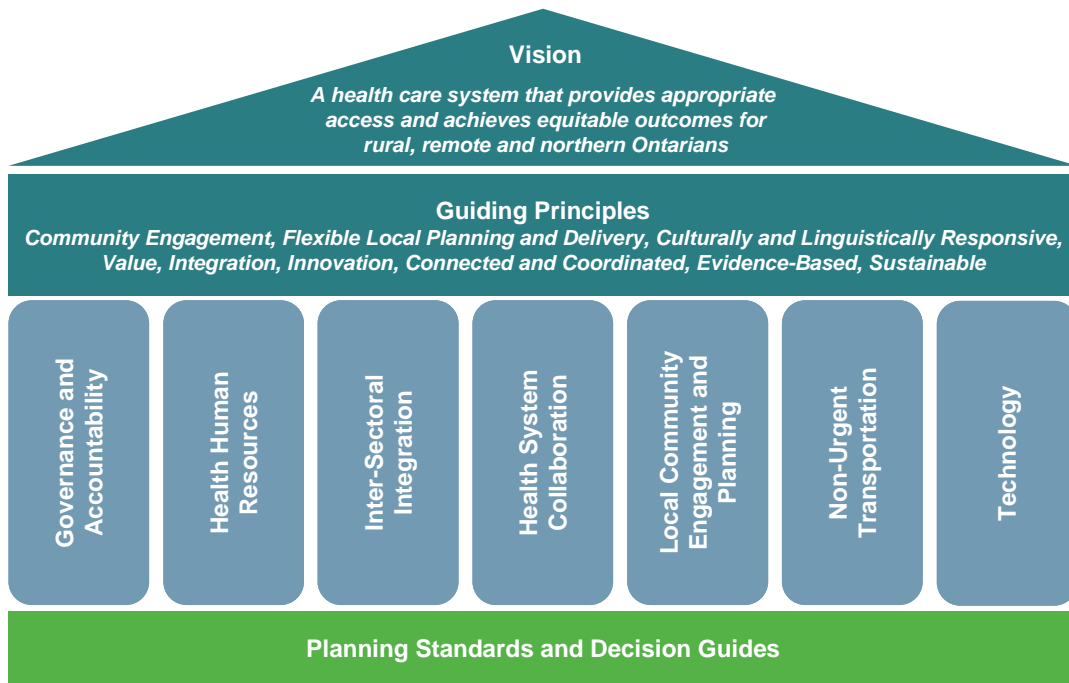
Equally important to identifying challenges is understanding the current programs and strategies already in place to improve access to rural, remote and northern Ontario. As part of the Panel's work, an inventory of current programs that the MOHLTC funds to address access issues in rural, remote and 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.

Stage 1 Rural and Northern Health Care Framework/Plan



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.