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Vision for Health Care in the Sydenham Walpole St. Clair District

V1.0

June 21, 2016

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1 INTRODUCTION

1.1 Background

The purpose of this document is to outline a Vision for health care in the Sydenham Walpole St. Clair District (SWSD). Following a description of the District and the Vision for its future health care, the document presents the contextual factors that underpin the Vision, and indeed its implementation, and identifies the key features of the model. These are followed by four strategic goals and associated priorities to expand upon the vision over the next five years.

This Report is a starting point – it provides the foundation for dialogue among health care stakeholders and will contribute to further community engagement; the result of which will be a more refined Vision for the provision of health care that will address the needs of the population in the Sydenham Walpole St. Clair District.

1.2 The Sydenham Walpole St. Clair District

The Sydenham Walpole St. Clair District (SWSD) is characterized by a widely dispersed, aging and predominantly rural population, along with a rapidly growing and comparatively much younger aboriginal population.

The Sydenham Walpole St. Clair District includes Dresden, Wallaceburg, Walpole, North Chatham-Kent, St. Clair Township and other parts of South Lambton County. It is estimated that approximately 25,000 people make up the SWSD population, with just over 10,000 residing in Wallaceburg, 2,500 in Dresden and 2,500 on Walpole Island.[1]

The growing Bkejwanong population of 5,000 is approximately half the size of Wallaceburg and approximately 20% of the Sydenham Walpole St. Clair District. Half of its 5,000 members are under the age of 25. Aboriginal peoples are the fastest growing demographic group in Canada (nationally, almost 60% is under 25 years of age), and have a disproportionate balance of health issues associated with early childhood development, maternal health, community health, mental health, and chronic disease compared to the general population.[2]

Census data show that the aboriginal population of Canada is growing at a faster rate than the general population, and is significantly younger with the average age of Aboriginal people being 27 years compared to 40 years for the non-Aboriginal population.

In contrast, there is a growing proportion of older people in the District. Eighteen percent of the population of Wallaceburg is over age 64, and 32% are between the ages 45-64. Similarly, in Dresden, 19% are over age 64 and 29% are between ages 45-64.

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[1] *Census data for 2011. Statistics Canada.*

[2] *Royal College of Physicians and Surgeons Canada (2013).*

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1.3 Vision & Mission

Vision

The Vision for health care in the District is as follows:

> *The Sydenham Walpole St. Clair District's population receives timely, coordinated, high quality care in an integrated model of service delivery that is patient/client-centred, seamless and based upon collaborative relationships among the different health professionals, service providers and sectors.*

The Vision is fully aligned with the overall direction for the future of health care in Ontario. It assumes a proactive public health dimension, recognizes the importance of broader determinants of health to the health and well-being of the population (e.g., housing, employment, environment, education, transportation), and is mindful of the unique needs of specific population groups within the District.

Mission

> *To maintain and enhance the health and well being of the population in the Sydenham Walpole St. Clair District*

The population in the Sydenham Walpole St. Clair District will be served by an integrated health care delivery system that

1. Affirms the need to improve access to the right care;
2. Provides access to a care continuum that has multiple points of access;
3. Connects and helps people navigate the health system with better coordinated and integrated care in the community and in their homes;
4. Provides patients and their families with education, information and transparency to help them make informed decisions about their health; and
5. Reflects decisions on the use of the publicly funded health care system that are transparent, accountable, and based on quality and value.

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2 THE HEALTHCARE CONTEXT

The delivery of health care is evolving from an episodic, acute care based system to a continuing care approach that focuses on health promotion, disease and illness prevention, chronic disease management, with care increasingly being provided through primary care practitioners and in the community and home settings.

Integrated models of care based on collaboration, coordination and team-based approaches are being enhanced by enabling technologies and increasing use of evidence to inform decision-making and improve processes and outcomes of care.

All this is occurring in the context of fiscal constraints, growing demands for accountability, and increased expectations and control of budgets and planning on local health integration networks (LHINs) as an aging population places continual pressure on the publicly funded health care system.

2.1 Integrated Care

Research evidence shows that successful integration reduces duplication, improves efficiency, improves clinical outcomes, improves quality of life and leads to more appropriate system utilization. There is no one model or strategy for integrated care that fits all needs of an area. The important thing is that the integrated model must be built around the needs of people. And successful integration models require team work at all levels across the health continuum. Improved quality of care that is delivered in the most cost effective way is the most important measure of integrated care systems.

The Canadian Council on Health Services Accreditation defines integration as 'services, providers and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client.' Similarly, the Canadian Health Research Services Foundation[3] observes that 'a fully integrated system means seamless integration across the public, private, and voluntary sectors, across jurisdictions and across the lifespan' (CHRSF, 2012).

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[3] *Now known as the Canadian Foundation for Healthcare Improvement (CFHI)*

KEY CHARACTERISTICS OF SUCCESSFUL INTEGRATED CARE MODELS:

- Defined populations that support relationships between health care teams and a specific population or local community. This targeted approach allows health care teams to target individuals who would most benefit from a more coordinated approach to the management of their care.
- Aligned financial incentives that support providers to work collaboratively. This includes the promotion of joint responsibility for the management of financial resources and a focus on health promotion and prevention to prevent admissions to hospitals and nursing homes.
- Shared accountability for performance through the use of data to improve quality and account to stakeholders through public reporting.
- Information technology that supports the delivery of integrated care (e.g., electronic medical records and tools to identify and target 'at risk' patients).
- The use of guidelines that promote best practice, support care coordination across care pathways and reduce gaps in care.
- Effective leadership at all levels with a focus on continuous quality improvement.
- A collaborative culture that emphasizes team work and the delivery of highly-coordinated patient-centred care.
- Multidisciplinary teams of health and social care professionals in which, for example, generalists work with specialists to deliver integrated care.
- Patient engagement in making decisions about their own care and support in enabling self-management.

Source: Kings Fund (2011), adapted from Curry and Ham (2010).

2.2 Patients First

There are a number of initiatives underway in Ontario that dovetail with the development of the proposed SWSD integrated model. First, the provincial government's framework for improving health care – *Patients First* – seeks to improve health care through:

- More effective integration of services and greater equity
- Timely access to primary care, and seamless links between primary care and other services
- More consistent and accessible home and community care.
- Stronger links between population and public health and other health services.

Indeed, the provincial government's framework document notes:

> 'We propose to truly integrate the health care system so that it provides the care patients need no matter where they live. **Our proposal is**

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> **focused on population health and integration at the local level.** It would improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health. It would also ensure that services are distributed equitably across the province and are appropriate for patients.' [emphasis added]

In addition, it notes:

> 'The health outcomes of Indigenous Peoples in Ontario — particularly those living in remote and isolated communities — are significantly poorer than those of the general population. **Improving health care and health outcomes for First Nations, Métis and Inuit peoples is a ministry priority.** This means the health care system must provide better supports and services for patients, families and caregivers, and these services must respect traditional methods and be culturally appropriate. To develop these services, we will build and maintain productive and respectful working relationships at both the provincial and local levels. We will meaningfully engage Indigenous partners through parallel bilateral processes.' [emphasis added]

2.3 Local Health Integration Networks (LHINs)

The provincial government also reasserts in *Patients First* the primacy of LHINs in leading the transformation of health care:

> In their expanded role, **LHINs would be responsible for understanding the unique needs of Indigenous peoples**, Franco-Ontarians, newcomers, **and people with mental health and addiction issues in their regions, and providing accessible, culturally appropriate services**. At the same time, the ministry would pursue discussions with these partners to determine how best to adapt system structures to provide effective person-centred care. [emphasis added]

And legislation recently introduced has given the LHINs even greater control of health care transformation with the government's decision to shift home and community care into the respective 14 LHINs across the province (formerly coordinated and managed by Community Care Access Centres).

2.4 Mental Health Strategy

In 2011, the provincial government launched *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, which is a 10-year strategy to provide mental health and addictions services to Ontarians using an integrated, coordinated approach. It is estimated that by 2017, the government will have increased its annual funding for mental health and addictions by $172 million since Open Minds strategy was launched.

2.5 Health Links

Health Links are a new way of coordinating local health care for patients who often receive uncoordinated care from several different providers, which can lead to gaps in care as well as duplication of the care provided. When there is a team of

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health providers a patient receives better, more coordinated care. The Community Health Links program was introduced by the provincial government in 2012 with the goal of providing coordinated, efficient and effective care to people with multiple complex care needs. There are considerable savings to be realized as well, as 5% of patients in Ontario account for two-thirds of health care costs.[4]

Health Links is designed to encourage greater collaboration between providers such as family care providers, specialists, hospitals, long-term care, home care and many other community organizations. Asides from receiving improved care, with better coordination and information sharing, care is provided faster with less time waiting for services.[5]

2.6 Rural Health Hubs

The provincial government is also in the process of developing the Community Hub concept. Community hubs 'provide a central access point for a range of needed health and social services, along with cultural, recreational, and green spaces to nourish community life…. Whether virtual or located in a physical building, whether located in a high-density urban neighbourhood or an isolated rural community, each hub is as unique as the community it serves and is defined by local needs, services and resources.'

The Ontario Hospital Association (OHA) has expanded upon this further with fully integrated rural health hubs. The OHA's 2010 Rural and Northern Health Care Panel report recommended support for a local hub model of health planning, funding and delivery in rural, remote and northern communities. The Hub would integrate services across health sectors at the local level, as well as broader social services.

On the basis of the report and subsequent discussions, the MOHLTC established its *Small and Rural Hospital Transformation Fund* which is designed to 'help small, rural and Northern hospitals improve patient care, operate more efficiently and work in stronger partnership with other care providers in their communities.'[6]

The hub concept for small hospitals in Ontario is not new. Several reports from the provincial government have pointed to the logic of having local area health needs met through integrated models based on partnerships among different organizations (e.g., Rural and Northern Healthcare Framework, 2011; Joint Policy and Planning Committee (JPPC) Core Services Review, 2007; Rural and Northern Health Care (RNCH) Framework, 1997). And prior to these the provincial government was developing pilot sites in the early 1990s to test five integrated models of care known as Comprehensive Health Organizations (CHOs).

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[4] Firestone and Smylie (2015) caution that data on users of Health Links will be problematic with regard to the aboriginal population as there are no Aboriginal specific data regarding emergency room use, hospitalizations and re-hospitalizations. They also point out that the 'high use' focus says nothing about unmet health care needs of persons (and populations) who are under-users of hospital services. They write: 'There is substantive evidence indicating that some Aboriginal individuals and/or populations may fall into this group.'

[5] There are 82 approved Health Links across Ontario, one of which is in the Chatham-Kent Health Link, comprised of more than 15 different providers.

[6] Established in April 2013, the Transformation Fund is a four-year, $80 million program ($20 million per year).

A number of small hospitals in Ontario that have already developed or are developing health hub models that link acute care with primary care, long-term care and other community-based services including mental health and addictions (OHA, nd).

The OHA defines a local health hub as 'a local, integrated health service delivery model where most, if not all sectors of the health system, are formally linked in order to improve patient access. It offers a number of benefits to patients such as better coordinated care, improved access to community options, better patient navigation and care closer to home.' The OHA developed a demonstration project to show the 'feasibility, patient benefit and administrative efficiency of implementing fully integrated rural health hubs (with a single funding envelope) for a number of small hospitals in Ontario' (OHA, 2015).

The advantages of the hub model identified by the small rural hospitals included:

1. Benefits to patients/clients/residents;
    a. Greater responsiveness to the needs of patients/ clients/residents
    b. Improved access and transitions of care to improve patient/client/resident experiences
    c. Reduced travel costs based on care closer to home
    d. Shared (common) client intake process so patients only have "To Tell Their Story" once
    e. More robust patient and family engagement
    f. Better system navigation and transitions of care
    g. Comprehensive supports for seniors
    h. Shared electronic patient records
2. Benefits to hub partner organizations;
3. Administrative efficiencies;
4. Local system planning and governance; and
5. Additional community partnerships.

Importantly, the OHA Local Health Hub model has four core elements:

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

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4. Mental Health and Addictions – community-based treatment and support services, access to specialty beds (when required), and traditional healing services for First Nation communities.

In addition, the Health Hub would partner with local municipalities to contract Ambulance (EMS) and Public Health Services, and could develop a range of partnerships with 'local health and human service providers (e.g., social services, recreation and fitness services, for-profit health services etc.) to ensure that local residents have access to a comprehensive range of treatment, support and prevention services.' The OHA notes that these sub-regional hub models 'are purposely smaller in scale, are in the best position to coordinate local health services and meet the unique needs of rural and northern communities.' (OHA, 2015).[7]

Finally, the Erie St. Clair LHIN[8] has specified the following four objectives for the region over the next few years, which dovetail with the provincial government's *Patients First* agenda:

- *Access:* faster access to the right care
- *Connect*: better coordinated and integrated care in the community, closer to home
- *Inform*: support people and patients by providing the education, information and transparency they need to make the right decisions about their health
- *Protect*: health care decisions based on value and quality, to sustain the system for generations to come.

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[7] The OHA Report notes that 'Based on a recent Institute for Clinical Evaluative Sciences (ICES) analysis of primary care catchment areas, LHIN recommendations and international rural health models, a Health Hub catchment population of **10,000 – 40,000 is a reasonable planning guideline for rural, southern Ontario**.' [emphasis added]

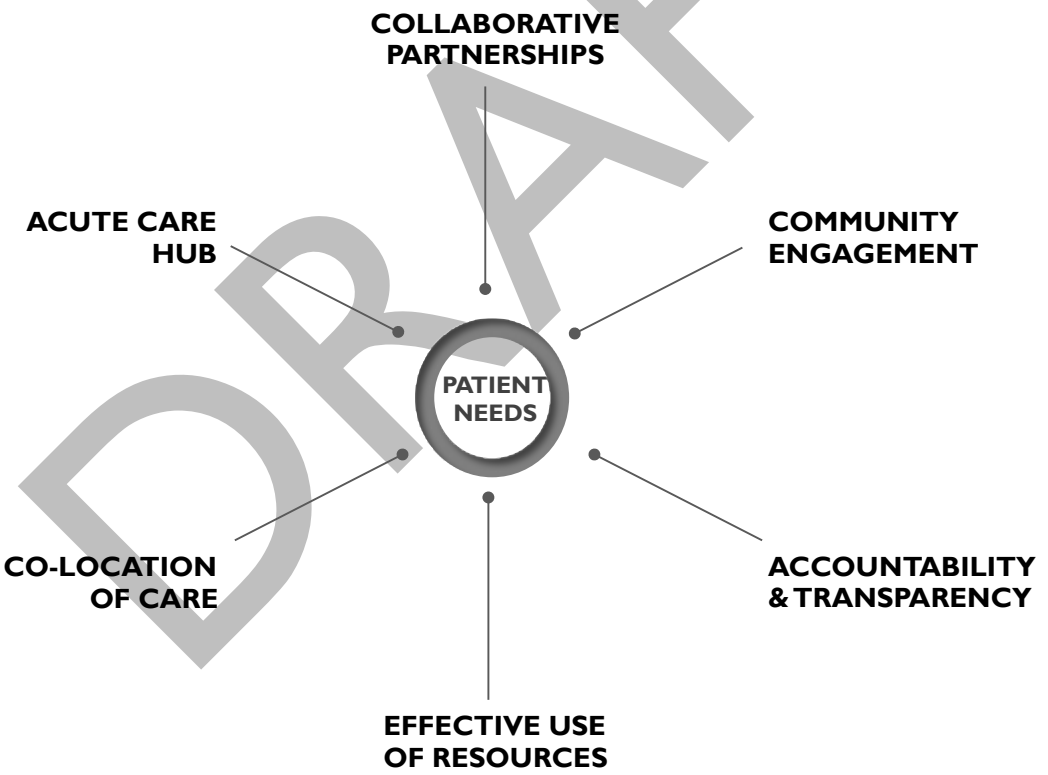
[8] *The ESC LHIN serves the communities of Chatham-Kent, Sarnia/Lambton and Windsor/Essex with a population of approximately 640,000 people and oversees a $1.14 billion budget for local health care services annually.*

3 THE VISION FOR INTEGRATED CARE IN SWSD

Given the numerous contextual factors that point to greater levels of health systems integration at the local level, along with the direction the provincial government has been taking over the past few years, it appears that the timing is right to develop a new way of supporting health and well-being in the Sydenham Walpole St. Clair District.

With the Sydenham District Hospital Board's history of governance in the district, its support from the large number of community members it represents, and its ongoing commitment and desire to improve the health of the district's population, the SDH Board would appear to be ideally positioned to take the initial lead in developing the integrated model of care in the Sydenham Walpole St. Clair District.

The integrated model spans from emergency services to hospital-based care to community-based care and support services. The integrated model must deliver on seven essential features:



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3.1 Patient/client and Family Needs

The model must emphasize and encourage individuals' dignity, autonomy and independence. It will respect the varied emotional, social, physical, mental, spiritual, cultural and developmental needs of patients/clients and their family caregivers.

There will be processes in place to facilitate the coordination and collaboration of care among patients/clients and their families and the health care providers. In addition, the model will facilitate effective communication among patients/clients, families and health care providers and will assist patients/clients and their families as they navigate the health care system.

Recognizing that the District's population must be knowledgeable about the care, services and supports available, the model will provide tools that support health literacy of the general public.

3.2 Collaborative Partnerships

Team-Based Health Care

The integrated model will be based around the provision of care and support from a mix of professional and non-professional staff, including Physicians, Family Health Teams, Nurse Practitioners, Nurses, allied health professionals, personal support workers, and others that support the promotion of social determinants of health.

The team, which will include the patient and, where appropriate, family members or other support persons, will establish shared goals that reflect patient and family priorities. These shared goals will be clearly identified and understood by all team members.

The roles of the respective team members will be based on clear expectations of each team member's functions, responsibilities, and accountabilities. This clarity will contribute to optimizing the team's efficiency and improving care for the patient.

The relationships among team members will be based on mutual trust, and centred on providing optimal care for the patient.

Central to the provision of quality care is the ongoing use of effective and efficient communication among team members. A range of communication channels will be used to ensure all team members will be fully aware of the care path of the patient at all times regardless of the care setting or stage in the continuum of care.

The model's organizational structure will promote coordination among team members across settings and levels of care.

The team will use a range of processes that support the continuity of care across providers within the integrated model.

Measurable processes and outcomes will be in place to enable the team to receive reliable and timely feedback on its functioning as a team in the integrated model.

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Inter-organizational Collaboration

The model recognizes that providing optimal quality care for patients requires healthy, efficient collaborative relationships among core its partners (as well as other providers of care). It is essential that partners in the model *want to work together*, while at the same time being able to maintain their autonomy.

Central to the successful functioning of the SWSD model are the collaborative partnerships with individuals and organizations that also provide care and services to the District's population but who may not become core partners of the integrated SWSD model.

These include at this time, for example, those providing acute care (i.e., Public General Hospital in Chatham, Bluewater Health in Sarnia and Petrolia, tertiary care hospitals in London, Windsor, Hamilton and Toronto), primary care (individual practitioners and family health teams), home and community care (i.e., CCACs/LHINs, various agencies providing direct care in the home), long term, hospice and palliative care (e.g., St. Joseph's Health in Chatham), public health (e.g., Chatham-Kent Public Health Unit), community health centres and mental health service organizations, and other community-based providers of direct services.

Inter-sectoral Collaboration

The model recognizes that the population's health and well-being is a function of more than just effective health care services. Governments, businesses and organizations in other sectors are equally important in promoting the health of the population.

The SWSD model will be based on cooperative relationships that develop and support inter-sectoral collaboration with other sectors (e.g., social services, housing).

The SWSD model will also work to ensure that the planning, access and delivery of care and services in the district is fully integrated with initiatives by other key stakeholders in the District's health and well-being (i.e., the LHIN, municipal, provincial and federal governments).

3.3 Community Engagement and Access

Accessibility

The model will aim to ensure consistent, reasonable and non-discriminatory access to quality care access to health care.

The model will enable flexibility in services that reflect the changing nature and uniqueness of some illnesses and diseases, and will ensure that /patients/clients will always be able to receive care that is physically accessible.

Patients/clients and their family caregivers will be fully informed about care options, and a dispute resolution mechanism will be put in place to address challenges to access.

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Local Aboriginal Community Engagement

Bkejwanong Band members are integral to the SWSD. The new model will aim to maximize the engagement of Band members on Walpole Island as well as those in other communities in the district using approaches that will be harmonised with local aboriginal ways of life, recognizing that cultural practices and traditions are essential to the health and well-being of Aboriginal people.

Reading and Wien (2009) in a report for the National Collaborating Centre for Aboriginal Health categorize the determinants of health into four categories:

- social determinants (e.g., political, holistic, adequacy of public health data)
- proximal determinants (e.g., health behaviours, education, food insecurity)
- intermediate determinants (e.g., systems, infrastructure, cultural support)
- distal determinants (e.g., (colonialism, racism, self-determination).

Health providers need to demonstrate 'empathy, open-mindedness, consensus and understanding of the issues facing indigenous people and the social determinants of health that contribute to their health status.' (Royal College of Physicians and Surgeons Canada, 2013).

The concept of *cultural safety* meanwhile, reflects that socio-cultural and environmental determinants continue to affect aboriginal medical disorders, ill health and well being. Principles to foster aboriginal health need to be communal, holistic, flexible and applicable to all stages of an aboriginal person's life and development through to old age. A cultural safety approach can be used to address inequities and support health professionals to improve access to health care for aboriginal patients and their communities.

Community Participation

To improve access to health care, the governance, planning and delivery of services should directly involve local communities and be flexible and responsive to different local needs.

The residents of the SWS District should be active participants in the decision-making processes regarding the provision of care and support for their health and well being.

Importantly, members of the district's population also need to take ownership for its own health and wellness of its people. Simply, if greater attention is given to lifestyle factors that support health promotion and prevent disease and illness there will be less burden placed on the local system of care.

3.4 Accountability and Transparency

Accountability is expected at all levels in the integrated model, but critically it is a fundamental responsibility at the levels of governance and management. There will

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be strong, focused, and diverse governance that reflects comprehensive membership from all key stakeholder groups.

Bkejwanong members will have representation, involvement and engagement on any Board or governance committee, where decisions are made regarding the health and well-being of its community within the SWSD model's operation and activities.

The SWSD model will be guided by the following accountability principles:

- The model will have transparent performance metrics that are used to track outcomes
- The model will have a transparent process for regularly reporting to the LHIN and the provincial government
- The model will have a transparent process for providing regular reporting to the Governing Board on specific outcomes and impacts
- The model will have a transparent process for providing regular reporting to management on specific outcomes and impacts
- The model will have a transparent process for providing regular reporting to team members on specific outcomes and impacts
- The model will have a transparent process for providing regularly reporting to the community on specific outcomes and impacts
- The model will include a project charter that defines its scope, objectives and ethical commitment to the District's population and will embrace local Aboriginal values and beliefs, including the fundamental concepts of cultural safety, holism, pluralism, autonomy, community, family and quality mental, physical, emotional and spiritual life.

3.5 Effective use of resources

The SWSD integrated model is committed to quality care that maximizes the effective use of resources. Recognizing the need to be fiscally prudent, the following resource allocation elements will be developed and sustained over the long term:

- A process to allocate financial and human resources to support care to the SWSD population
- A process to ensure and evaluate the *effective* use of resources
- A mechanism to support the *efficient* use of resources
- A process to identify and respond to the changing needs of patients and their families
- An ethical decision-making framework and process to guide the allocation of resources
- The use of new technologies to improve the delivery of care
- Support for collaborative partnerships that optimize human resources

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- A structure and processes that leverage the expertise, capacity and passion of all practitioners and partners to improve care
- Evidence-based approaches that are reflective and based on continuous quality improvement principles
- Evidence-based approaches that transfer the knowledge generated from the experiences of other areas and organizations to the SWSD model
- Evidence-based approaches that build upon research and evaluation
- Leadership committed to innovation and research
- Leadership committed to the ongoing support of innovative service delivery models

3.6 Co-location of care and services

It makes sense for patients that there is a full array of health care accessible from a single place. Having such a single location simplifies access to the provision of care for the population.

The model will be based around a single physical space that supports the co-location of a coordinated set of services and programs available from a range of health service providers, as well as enabling future expansion if required.

The site will act as a Hub so that if additional care is required that is not available from the site of care (e.g., more specific lab tests), there will be transportation available. The Site then, will also be a transit hub for patients and their families.

The single access point also makes sense for providers. The full spectrum of practitioners, from physicians to allied health professionals to community-based counsellors, will have ready access to one another, resulting in more effective communication and care for individuals.

Admission into acute care and discharge planning for home and community care meanwhile, will be enhanced by the co-location with community-based case managers. Providers can also use the transit hub for travelling to other sites of care if required. There will be mechanisms in place to support the seamless transitions between care settings, including the home.

3.7 An Acute Care Hub

The integrated model needs to include a minimum array of acute care services to the SWSD population. These would include, for example, an emergency department, day surgery, ancillary services such as lab tests and a small number of in-patient 'flex' beds. The site for the provision of this acute care can be the hub of the larger integrated model.

The provision of acute care would be centred around a 24/7 Emergency Department and a small number of acute care beds located in Wallaceburg.

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Emergency Department

The Emergency Department will provide the care typically expected of a fully functioning ED (i.e., the capacity to provide emergent and urgent care 24/7 with the requisite staffing model that includes physician and nurses and other providers, as well as ancillary services (e.g., Diagnostic and Laboratory testing). The presence of such staff will also ensure there is the 24/7 capacity to oversee and manage care for a combination of medicine and observation beds.

A fully functional Emergency Department[9] located in Wallaceburg is essential to the SWSD for several reasons:

- The rurality of the population and the associated time it takes to travel for emergencies (especially in Winter)
- The very real potential for care to be given 'too late' if greater distances to travel for an emergency are required[10]
- An aging population
- The growing proportion of younger age cohorts in the population, especially associated with the growth in the aboriginal population
- The economic significance of having an emergency department in order to attract new businesses (and thus employees) to the area
- The locational attraction for seniors from urban areas such as Windsor, London and Toronto who may be looking for a place to retire and want (and need) to be in close proximity to an emergency department.

Acute Care Hospital Beds

There is a need for a small number of acute care beds in the hospital to accommodate individuals requiring 24/7 observation (and still remain close to their home and families), day surgery, palliative care, those who may be waiting to be sent to a higher level of care at another acute care site, but who must wait for a bed in the other site to become available, or those who may be 'overflow' from other hospitals nearby that do not have beds available when needed.[11]

If there is no need for higher level tertiary care, the availability of a 'flexible' bed (i.e., multi-purpose) in close proximity to the home of the patient may assist in their own recovery, as well benefit their family caregiver, who does not have to travel large distances.

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[9] *The MOHLTC does not have an operational definition of an Emergency Department. There is work currently underway, however, to provide such a definition, as well as definitions for different types of ED's in hospitals across the province that reflect the types of specialty care they provide and the communities (e.g., urban, rural, northern) they serve.*

[10] *The current SDH Emergency Department is 15 minutes drive from the Walpole Island aboriginal community. The Chief of the Bkejwanong Territory, however, notes that for some of the Band members the drive to Chatham for emergency services can take up to an hour due to the residents being widely dispersed across Walpole Island.*

[11] *The exact number will need to be determined with the provincial government and the LHIN, but our current estimate would be approximately 15-20 beds.*

4 STRATEGIC GOALS AND PRIORITIES

Goal 1 – Develop a fully integrated system of care for the district's population

Priority 1:1 – Establish a Transitional Team to oversee the shift from the current delivery of care to the new SWSD Integrated model of care.

Priority 1:2 – Develop an open governance structure that promotes accountability, transparency and meaningful dialogue, and engages the community fully in the development of the integrated model.

Priority 1:3 – Create partnerships among key stakeholders who will be part of the integrated model and who will reflect the continuum of care, the care needs of the SWSD population, and the broader social determinants of health.

Priority 1:4 – Create collaborative operational partnerships with organizations who will be providing care as required for the district's population but will not be core partners in the integrated model Priority 1:5 – Determine the location for the physical site of the SWSD Hub.

Goal 2 – Ensure that quality care is provided in the right place at the right time

Priority 2:1 – Work with health care professionals to establish team-based processes of care

Priority 2:2 – Develop and confirm the acute care component of the integrated model, through discussions with health professionals, the LHIN and the provincial government

Priority 2:3 – Determine the transit needs to and from the Hub site that a) builds upon relationships among and beyond the integrated model partners and b) reflects the transportation requirements of the district's population that ensures they have access to the care they need

Goal 3 – Be a leader in health promotion and illness and disease prevention

Priority 3:1 – Identify and support 'Champions' of the integrated model who will promote its role in the health and well-being of the district's population

Priority 3:2 – Establish goals for the district that are in line with provincial goals and the current research on population engagement with health promotion and illness and disease prevention

Priority 3:3 – Create strategies and work-plans to lead the district as it seeks to achieve its goals (3.2)

Goal 4 – Ensure that the District's population is knowledgeable about the system of care they can use

Priority 4:1 – Create a communications strategy focused on increasing the knowledge level of the population on the system of care

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Priority 4:2 – Create support tools that can be used by providers of care to educate patients and family members on the use of the SWWD Integrated model of care

Priority 4:3 – Take promising or best practices on knowledge transfer and apply these to the SWS District.

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APPENDIX: EMERGENCY DEPARTMENT USE

Research indicates there are a variety of models for an Emergency Department (Infofinders, 2011). The two most promising models are:

> *Physician at triage:* decreased length of stay, decreased LWBS rates (leave without being seen), and increased staff satisfaction. (Approximately one third of patients can be rapidly discharged using few or no resources.) Placing a provider in triage may be a solution to expedite patient care.
>
> *Team at triage:* A dedicated physician, Registered Nurse and clerical staff work together at the bedside to triage the patient. Tasks are completed in parallel processes not in series (e.g., registration, diagnosis and completion of lab work occur simultaneously by different healthcare providers). Benefits: decreases LWBS rate, increases patient satisfaction since treatment begins immediately, patients provide information once. This system enables some patients to be discharged from triage, thus conserving rooms.'

Levels of Emergency Department Triage and Acuity

There are five levels of Emergency Department Triage and Acuity Scale that reflect different levels of seriousness of a patient's condition. These are as follows:

> Level I (Resuscitation) Conditions: Threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (e.g., cardiac arrest, major trauma or shock states).
>
> Level II (Emergent) Conditions: Potential threats to life or limb function requiring rapid medical intervention or delegated acts (e.g. head injury, chest pain, gastrointestinal bleeding, abdominal pain with visceral symptoms, neonates with hyperbilirubinemia).
>
> Level III (Urgent) Conditions: Potentially progress to serious problems requiring emergency intervention (e.g. mild moderate asthma or dyspnea, moderate trauma, vomiting and diarrhea in patients younger than age 2).
>
> Level IV (Less Urgent) Conditions: Related to patient age, distress or potential for deterioration or complications that would benefit from intervention or reassurance within 1 to 2 hours (e.g. urinary symptoms, mild abdominal pain, earache).
>
> Level V (Non-Urgent) Conditions: In which investigations or interventions could be delayed or referred to other areas of the hospital or health care system (e.g., sore throat, menses, conditions related to chronic problems, psychiatric complaints with no suicidal ideation or attempts).

CTAS levels are sometimes combined for ease of presentation and understanding into high acuity cases (levels I, II and III) and low acuity cases (levels IV and V).

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Assessment, by CTAS Level

Time to Physician Initial Assessment

	Ideal Response Time*	Actual (Median)	Actual (90th Percentile)
I (Resuscitation)	Immediate (<5 minutes)	11 minutes	47 minutes
II (Emergent)	15 minutes or less	54 minutes	190 minutes
III (Urgent)	30 minutes or less	79 minutes	229 minutes
IV (Less Urgent)	60 minutes or less	66 minutes	188 minutes
V (Non-Urgent)	120 minutes or less	53 minutes	165 minutes

Note: ** Adapted from CTAS Implementation Guidelines.* ***Source:*** *National Ambulatory Care Reporting System 2010–2011, Canadian Institute for Health Information*

Physicians in rural hospitals note that the recommended physician response times are unrealistically short for rural Emergency Departments (EDs). In urban EDs, physicians are physically present in the ED during their shift, but in rural EDs, the on-call physician may be at home in the evening, or in another care site during the day. The Canadian Association of Emergency Physicians state that the response times are 'ideals' and are not established care standards. Nonetheless, these ideals add a further nuance to understanding the importance of timely access to emergency care in the rural setting.

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REFERENCES

Canadian Health Research Services Foundation (2012). *Transformation Lessons from Disease-based Strategies: An Environmental Scan*, Canadian Health Research Services Foundation.

Curry, N. and C. Ham (2010). *Clinical and service integration. The route to improved outcomes*. London: The Kings Fund. Available from: http://www.kingsfund.org.uk/publications/clinical_andService_html

Firestone, M. and J. Smylie (2015). Aboriginal Data Report for the South West LHIN Health Links. Well Living House, Centre for Research on Inner City Health, St. Michael's Hospital. Toronto.

Infofinders (2011). *Leading Practices in Emergency Department Patient Experience*. Report commissioned by the Ontario Hospital Association (OHA) and the Emergency Room Patient Satisfaction Performance Improvement Advisory Committee (ER PIAC).

Ontario Hospital Association (nd). Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come. Discussion Paper. Small, Rural and Northern Hospitals Advisory Group, Ontario Hospital Association. Toronto.

Ontario Hospital Association (2015). The Case for Implementing Fully Integrated Rural Health Hubs on a Pilot Project Basis. OHA, Toronto.

Ontario Hospital Association (2010). Rural and Northern Health Care Report. Report from the Rural and Northern Health Care Panel, Ontario Hospital Association, Toronto.

Reading, C.L. and F. Wien (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* Prince George, British Columbia: National Collaborating Centre for Aboriginal Health.

Royal College of Physicians and Surgeons Canada (2013). *Indigenous health values and principles statement.* Prepared by The Indigenous Health Advisory Committee and the Office of Health Policy and Communications, Royal College of Physicians and Surgeons Canada, Ottawa.

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