Enhancing Access Through Integration

How small, rural and northern hospitals are innovating partnerships and building health hubs

ONTARIO HOSPITAL ASSOCIATION

On behalf of the Small Rural and Northern Provincial Leadership Council (SRN Council), we are very pleased to share with you a collection of success stories from small hospitals across Ontario.

These 19 success stories highlight the innovative work taking place at small hospitals to improve access and quality of care. These hospitals, in collaboration with their health care partners, have accomplished this by implementing local health hubs to better serve their communities' health care needs. Many of these communities have begun adopting this model in order to better link care across the continuum, namely acute care, primary care, long-term care and other community-based services such as mental health and addictions services.

You will find that each story is as unique as the community from which it originates – the different integration strategies implemented have been adjusted to fit distinct, individual circumstances.

These successes showcase the important initiatives underway in many of Ontario's small, rural and northern communities. We hope that these stories will serve as a source of inspiration for other communities that are also working to provide accessible, coordinated care to their residents, and we encourage you to share them widely.

Wade Petranik

Chair, SRN Council and CEO, Dryden Regional Health Centre

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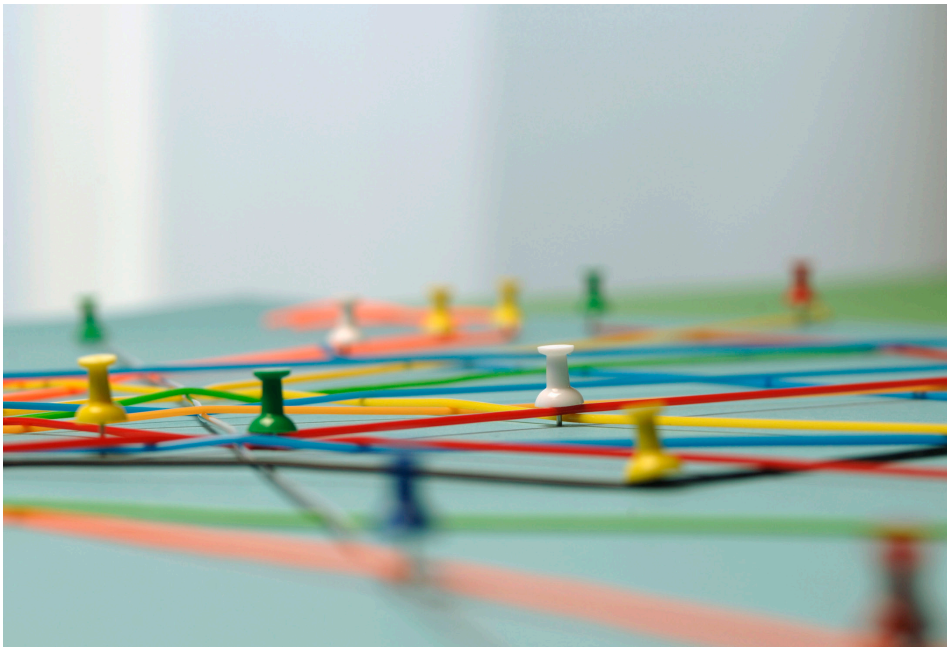
Deep River and District Hospital

Partnering with the community to bring services into the hospital space

While the Deep River and District Hospital (DRDH) has always understood its place as a vital service provider to the community, it only began specifically embracing the concept of a health hub in 2010. Today, its notion of a hub is based as much on co-location as it is on community partnerships. Its health campus includes the North Renfrew Physiotherapy Centre, the North Renfrew Family Health Team, the Four Seasons Lodge, North Renfrew Family Services, and the Deep River and Area Food Bank, and it recently launched an integrated community services council.

A significant aspect of DRDH's approach can be found in its work connecting with the wider community, where it has forged relationships with the local food bank and nearby Canadian Forces Base Petawawa. The resulting partnerships saw the food bank move into the hospital basement and the military build a helicopter landing pad (a joint project where the hospital paid for the materials and CFB Petawawa engineers designed and built it).



In a northern setting, proximity matters

DRDH sees co-location as a significant part of its role as a health hub. The health campus is located on ten acres of wooded property. It occupies approximately 50,000 square feet of that property. Currently, the health campus consists of the hospital proper and an outpatient clinic.

The hospital building houses a 16-bed medical floor and 14-bed long-term care home, a 24/7 emergency room, diagnostic imaging (including Ontario Breast Screening Program), the Eastern Ontario Regional Laboratory Association (EORLA) lab, a non-profit physiotherapy clinic, telemedicine services, administration and hospital foundation offices, laundry and support services, as well as an auxiliary gift shop. The Community Care Access Centre (CCAC) also has an office in the hospital and is staffed by a CCAC nurse who is a care coordinator, that assists with discharge planning in acute care and meets regularly with staff at the family health team.

An outpatient clinic building is physically attached to the hospital by a full-purpose walkway and ambulance entrance. It houses North Renfrew Family Services (a community-based counseling and social service agency), the North Renfrew Family Health Team and the offices of two community doctors.

DRDH's telemedicine platforms are a resource shared with others in the community whenever possible. Staff members from nursing homes share in educational events, and even the staff of the local dental office uses the equipment for learning needs. It is a regional resource that not only increases patient access to a wider community of specialists, it is also integrated with regional programs such as diabetes and stroke rehabilitation.

It is significant to note that LHIN-funded, non-LHIN-funded, and community-sponsored organizations are all located on DRDH's health campus. When these providers work together, regardless of funding sources (some from different ministries), the North Renfrew community is better served by a wider array of support services. This strategy recognizes not only the diverse needs of the area, but also the fact that socio-economic factors have an enormous impact on health.

Integrating services to leverage economies of scale

Service integration is a significant part of the health hub vision. The hospital provides information technology services to downtown doctor and dentist offices as well as to the North Renfrew Family Health Team and the North Renfrew Long-Term Care Home. It also provides laundry services to the North Renfrew Long-Term Care facility and local hotels, a massage and chiropractic office, as well as a summer science residential camp.

The hospital's sponsorship of the family health team means that the human resources and financial reporting are shared functions. This enables the family health team to recruit and retain professionals it might not have been able to attract as a stand-alone employer. Both the hospital and the family health team contract the services of a pharmacist from a tele-pharmacy company.

Expanding the health campus and its reach

DRDH plans to expand its health campus, starting with the construction of a county-funded ambulance bay that will form the northwestern boundary of the property. In keeping with the Champlain LHIN's Integrated Health Service Plan 2013-2016 ("[build] a strong foundation of integrated primary, home and community care"), the hospital is also developing its vision for a primary care facility on the grounds.

The proposed 12,000-square-foot building will be a stand-alone, single-story structure with its own mechanical and HVAC systems. It will be physically connected to the hospital by a covered walkway. Approximately 8,000 square feet will be occupied by the North Renfrew Family Health Team and the rest of the space by three community doctors.

DRDH expects to further enhance its position as a senior-friendly hospital and a primary care hub by housing these community doctors and their patients in this up-to-date facility that meets all accessibility standards and connects to ancillary services through the closed walkway. This is significant because stable primary care relationships are important for the effective management of chronic disease.

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Developing an integrated community services council

To build on its community integration, DRDH extended a public invitation to a strategic planning workshop (as part of its 2012-2013 Strategic Plan). Well attended by members of the community, strategic partners, hospital staff, and local doctors, the workshop helped develop the idea of an integrated community services council.

In the spring of 2013, a council was formed and started to build inter-agency relationships. DRDH expects the council will be able to advocate for community needs and inform regional planning projects using local data. To begin its work, it will analyze data on patients who access the services most and put a plan in place to help address any gaps in the services provided by its agencies.

Hôpital de Mattawa Hospital

Developing better health care service coverage by leveraging local integration

For the Hôpital de Mattawa Hospital (HMH), creating an integrated local health system for its catchment population has been a multi-faceted, multi-year project that aims to bring acute, long-term and primary care services together as part of a Mattawa health care campus, or health hub model.

Work on this initiative began in 2008 with the redevelopment of the hospital and the recruitment of the current CEO and senior team. This led to a multi-phased strategic plan focused on transformation so that by 2012, a new strategic plan included the key corporate value of 'system excellence'. This was defined as:

"Our ability to be a leading partner in system integration to ensure access to quality health services for our community".

As such, the key players in this work included: the hospital's president and CEO, senior management team and the board, as well as local family physicians, community and district leaders, the MOHLTC, the North East LHIN and the local nursing home. The HMH team's approach to the integration of health services has been to develop a continuum of partnerships that has culminated in a natural progression addressing the evolution of service needs over time and across diverse sectors.

Mattawa's approach is outcome-driven, rather than deadline-driven, and built on solidifying relationships of trust and common vision.

It is outcome-driven, rather than deadline-driven, and built on relationships of trust and common vision. To create a solid foundation for its success, the team adopted a strategic communication framework that encompassed many internal and external stakeholders. The messaging the hospital put out to the various stakeholders demonstrated its progress in achieving strategic goals.

Synergies can strengthen a system

While the key benefit of moving to a local health hub model is to improve access to a broader range of health services for both local and district residents, HMH found that the challenge, in the past was the lack of provincial policy and funding to support this manner of local integration for rural and northern communities.

Indeed, HMH's perspective is that while a North East LHIN agenda that is focused on regional (i.e., horizontal) hospital integration has its strengths in mitigating geographical barriers that could result in efficiencies, it does not take the opportunity to leverage local (i.e., vertical) integration between hospital and other health services. These opportunities could create synergies that may strengthen these systems – particularly in the northeast where, in some cases, regional integration is possible but the financial burden to the system may be significantly greater than the underlying benefit.

Local integration remains a key strategic priority for HMH and specific goals were written into the development of the hospital's new Strategic Plan (2012-2015) to address this. In support of these goals, the plan also includes strategic objectives such as pursuing a nursing home redevelopment project on site; bringing family physician offices on site; strengthening links to community-based health services; and, exploring opportunities to improve health promotion, enhance mental health and addiction services and work with hospital partners to coordinate care.

Building trust with local and regional stakeholders, regularly communicating the vision locally and to the North East LHIN as well as encouraging the board to champion a system of health rather than just the hospital, and promoting integration through regular updates at municipal councils are all strategies that helped HMH to build trust and develop success. But executing these tactics take time; that is why the hospital found it important to develop both long-range goals as well as short-term success stories and quick wins, to demonstrate its commitment to the community.

The integration journey has not been without barriers and challenges, which has meant that meaningful community engagement is much more than sharing 'good news' – it means creating a transparent and accountable process, both inside and outside of the boardroom, for working with the community on difficult issues and challenges.

Measuring success

The measurement of success has evolved over time as the hospital develops a consolidated, balanced scorecard. When work on integration started, it was important to create a sustainable hospital operation as the foundation of HMH's local health hub model. Financial sustainability, in terms of the hospital's operating budget and capital redevelopment project, was a key early measure of success. This helped to build the community's confidence in the hospital's commitment and leadership role. (Tracking donations has been another key financial indicator that offers a measure of community confidence.)

As HMH continued to work on integration, its focus shifted to strengthening partnerships and expanding access to a broader range of health care services, both locally and regionally. A key measure of success is the number of health care partnerships and the strength of those partnerships. While it is difficult to quantify the strength of a relationship, a good indication was the willingness of partners to enter into formal agreements with the hospital to share resources that can improve efficiency and care.

The recent accreditation results have illustrated HMH's commitment to quality and safety, and helped to strengthen the organization, not only in terms of publicly reinforcing credibility, but overall enhancement of governance and management effectiveness. Furthermore, the new Strategic Plan has allowed the board and senior management to reaffirm their commitment to building a local health hub model through integration and partnerships.

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As for benefits, the most important of these has been the improved access to services for local residents. New program and service initiatives over the last few years now include slow stream rehabilitation, a diabetes clinic, a Thorne Nursing Station, North East Ontario Network's implementation of Meditech, a diagnostic imaging initiative to reduce wait times, and work to maximize the scope of practice for Registered Practical Nurses.

Dryden Regional Health Centre

Using a steering committee to manage service mandate challenges for partnerships

As a hospital in a small, rural community, the Dryden Regional Health Centre (DRHC) has natural links between health care providers. These partnerships foster collaboration in a number of ways. Providers share financial resources and staff, and, working together, many have developed innovative approaches to resolving service challenges and reducing gaps in care.

DRHC does its planning at a community level, which helps to create seamless service transitions for its clients while enhancing the experience for both the patient and the caregiver. In small communities, the creation of a health hub model of care leverages limited resources and allows partner agencies to work to their full potential. This helps to create a system that is comprehensive and accessible.

Managing different mandates and funding

Challenges traditionally occur around service mandates and funding models. That is why DRHC initiated a System Integration Steering Committee in 2009. Comprised of members at local, district and regional levels, the committee's working group has proven to be an effective way of bringing organizational leadership to the table to plan a system for the changing demographics and care needs of the population it serves.

The partnerships formed through the System Integration Working Group resulted in the implementation of an Ontario Telehealth Network (OTN) program with formal linkages between the DRHC emergency department and Princess Court, the local long-term care facility. The program supports families and caregivers by reducing unnecessary patient transfers to the hospital. In addition, the OTN program helped to establish a formal regional caregiver support group (facilitated by the hospital's OTN coordinators through the Patricia Gardens Supportive Housing program).

Family health team and mental health successes

Under the health hub concept, the DRHC also established a unique service delivery model of care that allowed it to provide leadership and governance to the local family health team. This vision of integrated and collaborative care has permitted the family health team to expand its role in the community by supporting programs such as inpatient and home visits for individuals living with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

In addition, the family health team has expanded its role to provide off-site primary care clinics in a senior-supportive housing setting, a long-term care facility, and in First Nations communities.

Other examples of the hospital's work developing a health hub model of care include its involvement with the regional crisis response program, the mental health and addiction counseling service, the First Nations Cultural Sensitivity Committee and the local Drug Abuse Community Council. To each of these, the DRHC provides infrastructure in the form of governance, senior leadership, and back office support (e.g., human resources, payroll, finance, purchasing).

Developing a health community to build capacity

The key to the DRHC's success has been its willingness and readiness to share resources and support its partners in care. The hospital is responsive to community feedback and it demonstrates its support by submitting proposals to funders for programming such as community dialysis, end-of-life hospice beds, expanded supportive housing, and Telehealth network equipment. In a rural and northern setting, this type of community development builds capacity.

Dryden's experience with the local health hub model has resulted in positive communication between agencies. It has also reduced service duplication and addressed barriers to care. Under this model, community partners improve the patient experience by providing an environment of seamless transitions in care.

Measuring and maintaining the health hub model

Partners working together at a system level must ensure that mandates are clear and resources are effectively and efficiently used. DRHC's improvements in health outcomes are measured using client satisfaction surveys, by looking at how appropriate and timely referrals are made to agencies, by examining cost-effectiveness, and also by looking at how many clients are using alternate levels of care (e.g., using nurse practitioner clinics instead of going to the emergency department).

To maintain an effective health hub model of care and to sustain its growth, DRHC has found that organizations require acknowledgement from the province for demonstrated successes, access to resources, and a commitment from funders. It is also essential for hospital boards to maintain a vision that fosters an environment of collaborative approaches to health care. The DRHC's board has long recognized the importance of the hospital's role as a leader in the health hub model of care and Dryden stands as one of the province's more successful hub examples.

The key to Dryden's success has been its willingness and readiness to share resources and support its partners in care.

Campbellford Memorial Hospital

Using an integrated model to improve palliative care and chronic disease management

Campbellford Memorial Hospital (CMH) in Trent Hills is creating a healthy community by targeting service excellence and rethinking how it works with partners to develop a shared care model. Its need to deliver palliative care and chronic disease management, for example, depended on a number of partnerships to develop more effective care.

Starting with a group of campus partners

Serving some 30,000 Northumberland, Peterborough, and Hastings County residents, as well as a large seasonal population of cottagers and tourists in the Kawartha Lakes region and on the Trent River system, CMH is a 34-bed health care facility that provides a comprehensive array of acute care services, and its 24-hour emergency department sees 20,000 visits each year.

Given its long history of fostering and supporting partnerships with other health care providers, the local health hub as described by the OHA report is a model familiar to CMH. Some of the core service requirements cited in the report, such as emergency and inpatient care, primary care, home and community long-term care, and mental health and addictions services are already part of CMH's existing operations.

Together, CMH's group of campus partners ensures that comprehensive, coordinated, patient and family-centred care meets local needs (see sidebar). In 2012, for example, the hospital introduced two new partnerships – one a palliative care program that is still being developed, and the other, a chronic disease management initiative currently being delivered.

Palliative care partnership in development

This access to care approach includes a new palliative care initiative designed to deliver to all patients who present to CMH optimum palliative treatment based on the best practice guidelines developed by the Registered Nurses' Association of Ontario. The hospital is partnering with the Central East CCAC, Trent Hills Family Health Team, Community Care Northumberland, and Bridge Hospice to develop a 'wraparound' service that will provide the best support for people who are approaching end of life.

Patients receiving palliative care are assessed daily using a palliative performance score. This score is a way of measuring and monitoring the progressive decline of palliative patients to ensure they receive the right level of care.

The initiative is still in the early stages of development, but it is showing signs of success. The palliative group has established a strong community network with a palliative care focus. Working together, they have examined aspects of a patient's potential palliative journey to highlight the different pathways of care. As a result, the group has a better understanding of each other's services. The next step is to discuss the potential for palliative rounds and to understand the scope of palliative patients in the community.

CORE SERVICES OFFERED BY THE CAMPBELLFORD HUB

- Emergency and inpatient care is provided by CMH.
- Comprehensive primary care is provided by Trent Hills Family Health Team (focus on population health and chronic disease management).
- Home and community long-term care is provided by Campbellford Memorial Multi-care Lodge and other agencies such as the Central East CCAC and Community Care Northumberland.
- Mental health and addictions services are provided by the Campbellford and District Community Mental Health Centre (located at the hospital and delivering community-based treatment and support).

CASE STUDY: Managing chronic disease with partners

What is the program?

The integrated chronic disease management program (ICDMP) is an initiative offered in partnership with the Trent Hills Family Health Team and Community Living to area patients who are managing conditions such as chronic obstructive pulmonary disease or congestive heart failure.

The program was developed by CMH when it recognized a need for an integrated chronic disease management service that was accessible to the local community. The hospital-based interdisciplinary team includes a dietitian, physiotherapist, recreational therapist, pharmacist, and discharge planner.

How was it developed?

This interdisciplinary community outreach program was developed using the Lung Association and Heart & Stroke Foundation's guidelines. Meetings were initiated with local health care partners to establish how the different partners could build relationships and how they could provide some follow-up contacts for the clients in the community. Other partners include the Central East CCAC and Community Living Campbellford, which provides support for clients requiring additional community information, as well as Community Care Northumberland, who provide transportation services.

How does it work?

The intent of the program is to expand the role of the team beyond that of care to include education. The ICDMP is for patients who have been assessed as capable of benefitting from this five-week program, the aim of which is to:

- Improve the individual's understanding of chronic diseases;
- Provide individuals with a holistic education to enable healthy life choices and achieve self-management of their chronic diseases; and,
- Facilitate engagement with the patients in the program to establish greater confidence and education regarding the management of their chronic disease.

The program accommodates eight to 10 outpatients. It consists of a series of two-hour weekly meetings scheduled over five consecutive weeks. Participants are expected to attend all five meetings. Patients are identified for assessment for this program either by their family health team doctor or at point of discharge from CMH. They can also self-refer to be considered for this program. All patients attending the program must be medically stable to participate.

What are the benefits?

Area patients suffering from chronic disease now have access to an integrated chronic disease management program close to home. Program participants have a greater understanding of their disease and how to manage their symptoms. They feel they are being listened to by professionals who understand their disease, and they have solutions to improve their quality of life.

What contributed to its success?

Factors that have supported the success of this program include a shared governance model, having a physician champion, and having a hospital leadership team that has made partnering a strategic priority. The interdisciplinary team approach ensured that different aspects of care were addressed and that client needs were met. Patient involvement and interaction has also been invaluable as patients participating in the program support and learn from each other.

The program's success is measured through a patient survey completed before starting the program and upon its completion. Survey results show the program is having a positive impact on patient experience, satisfaction and health outcomes. Another measure that will be used to determine impact is the rate of readmission, however, it remains too early in the program's evolution to determine a direct correlation.

Patients participating in the program have shared very positive feedback about their experience. Some attending the Chronic Obstructive Pulmonary Disease (COPD) program have asked to come back every six months to refresh their knowledge. They expressed concern that as their symptoms change, new questions about care may arise. The team is arranging a regroup to accommodate this request.

Waterloo Wellington LHIN

Designing an integrated and centralized hub that balances the rural need for generalist local services

Rural health is different from urban health. There are barriers to access that exist due to socio-economic factors, isolation issues, transportation challenges, and a general lack of critical mass to ensure quality of care.

While urban settings can offer numerous community resources and hospital outreach services, there are fewer similar services in a rural setting, and those offered have less breadth. These differences often result in a need for more generalized services that are integrated and co-located. Services in rural settings should be provided close to home, where possible, and by people who live and work locally.

In July 2010, the Waterloo Wellington LHIN accepted the findings from a LHIN rural report and endorsed the creation of a Rural Health Working Group. It was a timely endorsement. The communities in rural Wellington had accepted the need for change and were working to reflect these changes in their local planning.

The current integration project underway is designed to enable area residents to optimize their health by providing efficient, responsive, high-quality health services in a manner that is not only consistent, but also resident driven, supported by providers and delivered in an inter-professional and integrated way.

The implementation process

Prior to the implementation of any integration process, it was important for partners to establish a formal organizational commitment. The team believed that a formal agreement would help ensure stability and commitment from partners even during challenging times. With this in mind, the first step was to develop the vision, mission, and model of care described above. This enabled the team to identify and agree to several high-level solutions for the challenges they were facing. These included:

Integrating services: Options for integration range from co-planning and co-location of services, to the moving of resources to have them provided by a single organization, to any other options that develop over time.

Providing services locally: Where possible, given the volumes and quality of care, services are to be provided locally and by local residents. This can decrease travel time, increase sustainability in rural communities, and increase the amount of time saved by the team of providers.

Integrating e-health: To ensure coordinated communication regarding the patient's condition and care, a common platform such as e-health is to be considered for storing and sharing this information.

Consolidating back offices: Back office services for the organizations are to be consolidated where there are opportunities to increase alignment, equity, and value for money.

Creating more general roles and services: Roles and services are to be less specialized and strong linkages made with higher specialty mentors to support the provision of local services.

Once these solutions were agreed to, a Memorandum of Understanding (MOU) was crafted, and a governor from each partner organization was asked to sign it. The Rural Wellington Health Advisory (WHA) Steering Committee was struck, comprised of each signatory to the MOU, as well as clinicians and administrators from each partner organization. The Rural WHA (pronounced 'way') has since led to the development of the health hub.

Enablers and keys to success

The continued commitment and support of the leaders of each organization has served as an important enabler of success; another was government funding. Small, rural and northern hospital funding was used to develop a strategy, to begin the development of common e-health tools, and to provide process improvement training (e.g., Lean).

Added funding is being applied to hire a change agent whose role will be to coordinate and manage the transformation process in the early stages.

Another key to the success of the implementation has been the dedication shown by all organizations towards creating trusting relationships. Building this trust began with the acknowledgement that the current system is not optimal, and that change must occur. Discussions and meetings over the last three years have helped to develop that trust, and confidence was enhanced by enabling a pace of change that allows all the people and organizations to move ahead without leaving anyone behind.

To guide the implementation of the new rural health care system, the Waterloo Wellington LHIN used four principles: creating value for residents; creating value for the system (rural health care requires a more generalist approach to create value); leveraging the local (decentralizing where possible and creating more generalist local functions linked to centralized supports); and, recognizing that change requires trust.

The impact of success and its ultimate measurement

The model adopted by the Waterloo Wellington LHIN providers was designed to improve the collaboration between small and rural hospital care and community care to create integrated networks that will:

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- Ensure patient access to core acute services;
- Ensure collaboration with community service, including family health care, home care, mental health and addiction services, and community support services;
- Respond to community needs for post-acute and palliative services, as appropriate; and,
- Improve quality and safety of services for patients, while proving to be good value for money.

This model is in the early stages of implementation and success measures have yet to be formally developed and agreed upon. However, regardless of the specifics, success will be measured by the impact on the patient population's outcomes and experience.

Arnprior Regional Health

Developing partnerships to improve care and support staff engagement

Individual small hospitals often lack the critical mass to achieve efficiency and effectiveness in the delivery of both clinical and support services. Through a variety of integration initiatives, Arnprior Regional Health (ARH) has achieved strategic goals focused on quality and finance while at the same time improving staff engagement and patient experience.

ARH is a multi-site, multi-level provider of acute and long-term health care services, as well as a provider of community-based assisted living services in eastern Ontario. It serves over 30,000 people in small towns such as Arnprior, in hamlets such as Burnstown, and in the rural country side. But over the past three years, it has moved from being a small hospital to becoming a health hub focused on providing exemplary care.

Most of these integrations and partnerships are consistent with the health hub model recently released by the OHA, but some go beyond this model by including the private sector.

Arnprior has established relationships with more than 30 organizations. The structures of these relationships range from complex and legally binding service level agreements to simple handshakes. Some, like the establishment of the Eastern Ontario Regional Laboratory Association took more than seven years to study, plan and implement, while others were established in weeks.

It attributes its success to the proactive leadership of its board. Following the development of a strategic plan in 2009, the hospital emerged with a new vision and mission statement that set the tone for its focus on integration. Its vision was to be recognized for exemplary care, which was further guided by the mission statement: "Achieving excellence through working partnerships, we deliver responsible, quality healthcare each day".

These underlying values established an organizational culture that helped the hospital assume a key role in the Champlain LHIN's local health system transformation.

Organizing partnerships into four groups

To support both vertical and horizontal integration, ARH organized its partnerships into four groups: within the corporation; with community agencies; with the private sector; and, with other health care providers.

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establishment of the Eastern Ontario Regional Laboratory Association took more than seven years to study, plan and implement, while others were established in weeks.

Adopting evidence-based leadership practices

Internally, ARH adopted evidence-based leadership practices (as per consultants, the Studer Group) to support the ongoing success of its relationships. These practices included:

- Implementing an organization-wide staff/leadership evaluation system to focus everyone on the objective and the importance of integration and partnerships.
- Creating processes to assist leaders in developing skills and leadership competencies necessary to attain desired results – i.e., learn how to build partnerships.
- Developing agreed-upon tactics and behaviours to achieve goals – i.e., foster targeted partnerships.

Externally, ARH ensured its success by seeking out partners with whom it had a strategic fit. Ideal partners were those with:

- Organizational visions and missions that are consistent with those of ARH; and,
- Where trust already existed between the leaders of the two organizations.

Obtaining feedback and measuring success

ARH sought to measure its success in terms of how well it was able to improve patient and staff rating of excellence. It used the results of third-party surveys of staff, residents, clients and patients. Among the findings were:

- The inpatient rating of excellence (5 of 5) fluctuated in the first half of the year then began to climb steadily in September 2012 from 56.3% to 73.3% in November 2012.
- The rating of excellence from residents of the Grove Nursing Home exceeded ARH's 34% target, rising to 58%.
- The rating of excellence from clients using the Assisted Living Services exceeded ARH's 34% target, rising to 70%.

Patient satisfaction information was also collected using post-discharge phone calls. The information confirmed the success of ARH's strategies and informed course corrections for various tactics deployed to improve the patient experience.

The positive feedback was also passed along to care teams as a way to acknowledge their commitment to excellence. These included comments such as: "*Your staff of nurses is exceptional. They work as a team and they are caring to the patient. I am proud to state that we have a wonderful hospital in this community.*"

Improved care supports staff engagement

ARH found that its staff greatly benefited from this change, but cautions that such work must be done carefully. Implementing organizational and health system changes, including many of the key concepts behind the health hub model, can create dissatisfaction among the staff of the organization if not done carefully.

A well-deployed change management strategy links the tactics (the 'what', in ARH's case, increased integration) of the change to the purpose of the organization (the 'why' are we doing this). Early indications are that the increased level of integration at ARH has not only improved patients' perceptions regarding the quality of care, but also supported an increase in the level of staff engagement.

St. Francis Memorial Hospital

How one of Ontario's most isolated hospitals implemented partnerships quickly and effectively

St. Francis Memorial Hospital (SFMH) in Barry's Bay is a small and rural facility but, more than most of its peers, it is challenged by its isolation. To be specific, it is the only isolated hospital in the Champlain LHIN and the only independent isolated hospital in eastern and southern Ontario.

Despite this, and perhaps because of it, the leadership at SFMH and its affiliate, the Renfrew Victoria Hospital (RVH), have implemented, in a matter of months, initiatives that usually take years to complete. What is more, they received support and buy-in from local, regional and provincial partners.

The partnership with Renfrew Victoria

A key element of this hospital's service integration is the underlying partnership – a voluntary one – with Renfrew Victoria Hospital, located in Renfrew, which is 95 kilometers to the east. The two hospitals share a CEO and information technology services, as well as radiology and picture archiving and communication systems (PACS) administration. While they are separate corporations, each with its own board and budgets, they share a number of clinical programs, including: dialysis, mammography, bone density, CT scan, as well as clinics for internal medicine, surgery, respirology and nutrition.

Developing this shared service model has given SFMH patients improved access and outcomes. For example, 10 patients now have access to dialysis locally. That means they do not have to travel three times a week, for the rest of their lives, to Renfrew or Ottawa (1 hour to 2.5 hours of driving, respectively). Improved access to mammography has allowed early breast screening for 1,200 local patients per year, and the greater number of clinics integrated within the SFMH has meant less travel for 3,700 patients who can now receive services locally.

Building a rural health care hub

One major integration project that has had a positive effect on the community has been the opening of the St. Francis Health Centre in 2003. The building provides more than 10,000 square feet of space, attached to the hospital by a tunnel.

Some of the clinical integration successes include the addition of five general practitioners to the physician group, laboratory services, the CCAC offices, dialysis, ophthalmology, optometry, orthopedics and geriatric mental health. There are also public health offices and outpatient clinics including internal medicine, audiology and addiction treatment. By fostering these partnerships, the health centre is helping to repatriate services to Barry's Bay and the surrounding area. And the measurable cost savings have helped SFMH and the RVH distinguish themselves as highly efficient small hospitals.

System integration in the last two years

The current drive to capitalize on existing partnerships has created even more coordinated services and improved access for patients through the entire continuum of care. For SFMH, many initiatives have begun, evolved and been implemented in the last two years. Some of these include the following:

- The creation of the Madawaska Communities Circle of Health, where SFMH was instrumental in developing the first full community integration working group in Champlain tasked with implementing integration opportunities in collaboration with the LHIN.

- To bring the Barry's Bay and Area Seniors' Home Support within the hospital, SFMH secured funding from the LHIN to renovate the ambulance building. This initiative saw the immediate co-location of the Seniors' Home Support service and there is a future opportunity to co-locate with mental health and Public Health. Current partnership opportunities are underway with Public Health regarding shared space at the SFMH for immunization clinics. (Renting space to these services also provides a new revenue stream for SFMH.)

- In 2010, the CCAC agreed to provide SFMH with the funding to pilot a summer CCAC clinic within the hospital that was staffed and operated by SFMH (all referrals flow through the CCAC intake). Given its success, this clinic has now received approval to continue.

- The full integration and merger of the Rainbow Valley Community Health Center in Killaloe with the SFMH (the first full integration of a community health centre with a hospital in Ontario) has provided sustainability and improved care and services. Additionally, SFMH renovated this centre to allow for more clinical space.

- A feasibility study will be completed to address the potential rebuilding and co-locating of Valley Manor Long-Term Care Home with SFMH. Preliminary plans have been completed for a three-storey facility connected to SFMH.

- Preliminary efforts are also underway to create a two-bed hospice within the hospital, and for SFMH to provide a full gamut of CCAC services in the community with the goal of increasing efficiencies, reducing duplication, and managing the local intake of referrals.

- The SFMH and the other local health service providers have successfully obtained funding to train geriatric emergency management (GEM) nurses. This initiative is consistent with the LHIN direction to create service links with community partners, standardize care and focus on improving skills and resources for the area's aging population.

- By sharing staff and integrating staff schedules with partners like the long-term care home, the community health center, the community support services and the family health team, the hospital is able to create more full-time employment, and give patients some continuum in care by the same health workers.

By fostering these partnerships, the health centre is helping to repatriate services to Barry's Bay and the surrounding area. And the measurable cost savings have helped St. Francis and Renfrew Victoria distinguish themselves as highly efficient small hospitals.

- Other integration examples include a partnership with the local pharmacy to provide medications to emergency department patients after hours, and the implementation of supportive housing, assisted living and 'going home' programs.

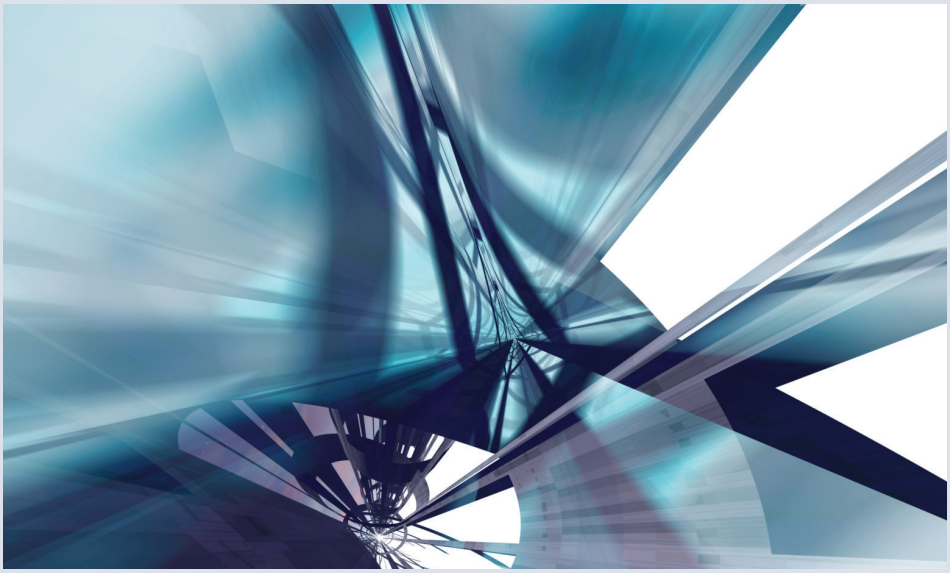
The relationship with academic and tertiary centers and regional initiatives

The hospital has created partnerships to improve its diagnostics and lab services. Diagnostics works with the Department of Diagnostic Imaging at The Ottawa Hospital, while its lab services are part of a 16-hospital partnership that makes up the Champlain-wide integrated and standardized laboratory services, where over 12 million tests are performed annually.

SFMH is part of the county-wide advisory group to the LHIN. It is a main player in the Barry's Bay and area physician recruitment and retention group, and is currently involved in a partnership with the other Champlain-area hospitals to implement a standardized clinical risk/incident reporting system and patient order sets.

Weeneebayko Area Health Authority

Remote hospital leverages technology to access qualified coding specialists and health information management professionals



The four sites of the Weeneebayko Area Health Authority (WAHA) are the most northerly hospitals in Ontario, serving the communities of Attawapiskat, Fort Albany, Moosonee and Moose Factory, along the western shores of James Bay. Accountable to the North East LHIN, the hospitals serve more than 11,500 people who are separated by hundreds of kilometres between communities, each with its own unique need for culturally appropriate health services.

Faced with the need to meet the Canadian Institute for Health Information (CIHI) and the MOHLTC's coded data submission requirements, but without access to qualified coding specialists in their community, the hospitals undertook an innovative technology project. They developed a completely outsourced remote coding and abstracting solution for all four hospitals.

How did the solution work?

The approach involved scanning the patient records locally at each of the hospitals, with local health records staff using the remote imaging technology of a southern Ontario service provider, Salumatics Inc. in

Mississauga. Following scanning, the digital images were sent electronically via a secure connection to Salumatics' Tier 2 data centre, a facility that provides uninterrupted connectivity.

Working remotely through secure Virtual Private Network (VPN) links, Salumatics' staff coders (certified by the Canadian Health Information Management Association) then viewed and coded the patient records to which they had been assigned directly into the WAHA coding and abstracting application, in real time. The records were coded and abstracted according to CIHI and MOHLTC standards, as well as all hospital-specific guidelines.

Operating remotely, each coder opened and viewed images within the secure environment. Coders did not have the ability to download or save any digital images. All patient visits were coded using ICD10-CA/CCI. At all times, coders safeguarded the confidentiality, privacy and security of patient health information according to the privacy and security policies that were in place, and as dictated by their professional code of ethics.

After coding and abstracting remotely, Salumatics conducted a data quality analysis of the coded records prior to submission to CIHI. The final CIHI material was then completed and submitted by Salumatics based on CIHI and MOHLTC requirements.

What were some of the key advantages of this solution?

In selecting a supplier for this work, WAHA was careful to engage a firm known for its integrity and accuracy. Because of its remote location, the recruitment and retention of qualified coding staff would have been a major challenge. Since all of Salumatics' remote coders are CHIMA-credentialed, WAHA was never concerned about compromising the quality of its coded data by using non-credentialed staff for the job.

WAHA has seen cost savings on two fronts as a result of using this service. First, since the coding is billed by the 'visit', instead of by the hour, WAHA can more accurately predict and budget its coding costs. The only variability in cost would be as a result of changes in patient visit volumes. Second, WAHA avoids the administrative burdens of recruiting, hiring and training certified coders, or having to find coverage for vacations and sick days.

Because of the large pool of experienced coders at Salumatics, WAHA is assured all visits are coded for a specific time period regardless of the volume and submission deadlines. Using this innovative document conversion and remote coding approach, the hospitals now have real-time statistical data to better coordinate their programs and services.

Going forward, as WAHA embarks on implementing a full electronic health record for the population it serves, the already digitized patient files will be available for loading into the system as historical data.

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Wilson Memorial General Hospital

Hospital and family health team combine efforts and e-health records to deliver comprehensive diabetes care

When Wilson Memorial General Hospital (WMGH) and the Marathon Family Health Team (MFHT) created a collaborative, integrated diabetes care system, not only did they manage to better serve their patients, they did so without seeing an increase in costs.

Located in the Thunder Bay district on the north shore of Lake Superior, WMGH and the MFHT serve a rural and remote population, a significant portion of which is afflicted with Type 2 diabetes. Historically, chronic disease management for this condition in this area has been provided by two sources: the diabetes educators associated with WMGH, and the primary care providers working with the MFHT.

Identifying the problem and building the solution

Patients would often go from an appointment with a provider in one organization to an appointment with another for the same issue, often with little time in between. Besides the redundancy in care, the lack of co-ordination and communication between the two organizations meant there was no comprehensive, integrated individual patient care.

This confused and frustrated both patients and providers. At the same time, given that the MFHT had limited physician resources, it was looking for ways to improve rationalizing care and optimizing the scopes of practice of other providers so they could take on more active roles in diabetes care.

Integrating diabetes care occurred in steps and over several years. Building the collaboration between MFHT and WMGH began with meetings between the diabetes providers of both organizations. The meetings helped to develop a mutual understanding of the individual practice realities. Commonalities were explored and shared goals established. These meetings were critical to building trust between providers and they remain a demonstration of the participants' commitment to change and willingness to devote time to nurturing relationships.

The system was built by making incremental changes beginning with increasing the scope of practice of the diabetes educators at Wilson Memorial. A nurse and a dietitian, skilled and trained in diabetes management, had their roles enhanced through medical directives.

The directives were first created to allow them to change dosages of diabetic medications and later to order diabetic lab work. When their access to patient lab results was enhanced, they had even more information for patient management. Finally, as their comfort with their enhanced scope of practice increased, they were supported in starting new medications for patients through collaboration with the providers at MFHT.

To reflect their expanded roles, these diabetes educators, as they were originally called, became diabetes clinicians. A care path was agreed upon by the organizations to share care for patients with diabetes who require regular care. Anywhere from every three to six months, depending on need, patients alternate visits with a diabetes care provider from each organization. Patients that require intensified diabetes care or extra diabetes education are referred to the diabetes clinicians who see them as frequently as needed over the short term. Once stabilized or appropriately educated, these patients are returned to the regular shared care schedule.

Sharing electronic medical records

A very important aspect of this service integration was the matter of moving both organizations to a shared electronic medical record (EMR). A patient's current provider needed to be up to date on treatment plans or the medication changes made by providers in the other organization.

At the time, both WMGH and MFHT members used EMRs for diabetes care, but the EMRs were two different systems that could not communicate or share patient information.

The two providers switched to a web-based, open source EMR (Oscar), and with patient consent, they developed an integrated EMR. Not only can providers see and add to a patient's cumulative diabetes flow sheet, they can also see the necessary lab data and message each other to enhance shared care. The hospital's move towards an IMR (integrated medical record) has received praise from its providers as it has enabled the delivery of more comprehensive care.

Benefitting from enhanced communication

Diabetes care in this community is now more patient-centred, which is enabled by clinical pathways shared by the involved organizations. As in the OHA's health hub model, these two providers have integrated quality improvement strategies to help evaluate and improve their diabetes care delivery system.

As for the benefits, providers in both organizations have been greatly pleased with the enhanced communication and information sharing that comes from using a single, web-based, EMR. Patients and providers no longer complain about redundant appointments and sharing care has freed up physician appointments to provide care for other patients.

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The former diabetes educators have embraced their enhanced role as clinicians and are able to provide care in a much more comprehensive fashion.

Ultimately, it will be patient satisfaction surveys and the accumulation and analysis of patient-oriented diabetes outcome measures that will indicate whether this delivery system is having a real impact on the patient population. The hospital is gathering this data, but for now, it remains confident that the system changes are beneficial to the providers and patients.

Leamington District Memorial Hospital

A large community hospital meets the same access challenges that plague its smaller peers

With its 65 beds, Leamington District Memorial Hospital (LDMH) falls into the same category as facilities with 100 beds or more, making it a large hospital. But LDMH essentially has the same access issues as a small, northern hospital. LDMH sees the hub or health care campus as a natural fit for its community, and likewise, the population considers the hospital the centre of its health care needs.

As part of its strategic planning process in early 2012, LDMH conducted a community-wide survey regarding the health care needs of the community, and was able to identify a thread in the responses pointing to a lack of access to community health services.

While a variety of health care services are available for county residents through various regional programs, these programs are, for the most part, housed in Windsor, some 50 kilometers away. Furthermore, transportation poses a significant challenge for this population.

The catchment area in the south shore community of Essex County serves a population of 75,000. This area is comprised primarily of seniors and other vulnerable populations such as the area's estimated 5,000 migrant workers. These groups must rely on family or friends for transportation to LDMH and sometimes to areas outside the county for services not offered locally. (There is essentially no public transportation to Windsor or Chatham.) Effectively, this is a compromised population in a rural setting.

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Core services identified by strategic planning:

- Elder care strategy (assess and restore; responsive behaviours*; end of life management*; senior-friendly care*)
- Emergency department (24/7 services)
- Medical inpatient
- Surgical inpatient
- Complex continuing care
- Obstetrics
- Diagnostics
- Outpatient programs (ambulatory care; mental health services*; peri-operative; rehabilitation*; cardiopulmonary)

* new programs planned for the hub

Building a network to service the wider region

As a result of its size classification and geographic location, LDMH must engage health care partners in order to enhance its core services. Specifically, it must engage and partner with community services that are mandated to provide the services in this region.

The hospital's robust communication strategy helped bring together several Windsor-based agencies that also acknowledged the serious gap in services for the South Essex area. At that time, the concept of a hub or health campus began to take shape.

Many stakeholders were involved during the initial planning process and several more have joined since then. Initially, the key players included LDMH's management team, its board, physicians and staff; as well as the Leamington and Area Family Health Team and Harrow Family Health Team. Several not-for-profit allied health care and social service community agencies are now also involved.

There has also been a recent announcement of a satellite hospice for Leamington, and LDMH is involved with this project. The hospital also recently embarked on a community engagement survey to assess the gaps in mental health and addiction services.

A move to centralize some services

In addition to the Leamington and Area Family Health Team, which is strategically located across the street, several agencies are planning to set up operations in the hospital itself. These include the Windsor Essex County Community Health Center, Children's Aid Society, and the Alzheimer's Society.

Several specialists such as orthopedic surgeons, urologists, psychiatrists and others from Windsor and Chatham now also provide their services at LDMH. Hôtel Dieu Grace Hospital in Windsor has recently opened a satellite dialysis unit onsite at LDMH, and it is already at full capacity.

Goals and successes

The area's shortage of physicians has been a problem for some time; it is one of the most underserviced in the province. By bringing these services to the hospital, LDMH aims to provide health care services to the high percentage of unattached patients who currently use the emergency department as their primary care provider.

The other aim of this project is to provide care close to home, especially for members of this vulnerable population, regardless of whether or not they have a family physician.

While much of the work is still in progress, the successes to date and the means of measuring these are as follows:

- The on-site satellite dialysis is at capacity (36 patients)
- There are 12 to 13 mental health clinic visits for fiscal year 2013
- The Erie St. Clair LHIN approved satellite hospice is targeted for spring 2014
- Windsor Essex County Health Centre: Satellite operations at LDMH late in 2013
- Children's Aid Society satellite services co-location is in progress
- Mental health and substance abuse survey is in progress
- A dialogue is in progress over Hiatus House Women's Shelter
- LDMH Women's Centre Enhance Diagnostics is opening late in 2013
- Alzheimer's Society's co-location is in progress
- A partnership was established with South Essex Community Council for a social services referral centre
- Fracture clinic implementation is in progress.

West Parry Sound Health Centre

An extensive network of care built on a foundation of trust and goodwill

Faced with the challenge of being located in relative isolation from larger health care providers in southern and northern Ontario, West Parry Sound Health Centre (WPSHC) became a partner in regional alliances and created internal programming solutions to improve primary and acute care service delivery throughout its catchment area and to deliver better patient- and family-centred care.

Since it was formed in 1995 as the result of an amalgamation of two distinct hospital entities, WPSHC has never limited its service integration to a single project. Its current level of service and program integration was developed over many years, and partnering has always been part of its operational culture.

To maintain this service integration, WPSHC has made manageable growth and program sustainability fundamental considerations in its fiscal management. And the organization has expanded its integrated services through the application of a thoughtful planning process that serves both the need for quality patient care and the requirement for balanced budgets.

Today, WPSHC is a highly integrated health care organization that includes: Lakeland Long Term Care, a 110-resident home co-located with WPSHC; six primary care nursing stations staffed by nurse practitioners who work in collaborative practice with a visiting physician; management of the District of Parry Sound land ambulance service and dispatch; and a full range of inpatient and outpatient programs associated with a 90-bed acute care hospital. WPSHC supports and maintains a cooperative and collegial relationship with approximately 30 health and social service provider agencies.

What are West Parry Sound Health Centre's core hub services?

Emergency and inpatient care:

- WPSHC operates the District of Parry Sound land ambulance service under contract with the Town of Parry Sound. The Parry Sound District EMS employs 72 full and part-time paramedics who work out of seven stations along with 22 full and part-time emergency services dispatch personnel located at WPSHC.
- WPSHC operates a full range of inpatient and outpatient programs associated with a 90-bed acute care hospital, including a full-time emergency department, intensive care unit, diagnostic imaging, and surgical services.

Comprehensive Primary Care:

- WPSHC nursing stations are located in Britt, Pointe au Baril, Port Loring, Rosseau, Whitestone, Argyle, and Moose Deer Point. Staffed by nurse practitioners and visiting physicians, the nursing stations provide primary health care to rural communities. Collectively, these stations delivered primary health care to approximately 25,000 patients last year.
- In partnership with family health team members and community physicians, doctors are active at WPSHC in six rotations: hospitalist, ED, anesthesia, surgical assist, obstetrics, and Lakeland Long-Term Care.

Home and Community Long-Term Care:

- Lakeland Long-Term Care is a public, non-profit corporation created by WPSHC to operate a 110-resident home co-located with WPSHC. The organizations share a CEO and many support services.

Mental Health and Addictions:

- WPSHC maintains a close working relationship with Muskoka Parry Sound Mental Health and regional addiction service providers.

First Nations communities:

- WPSHC is home to Noojimowin Bimaadziwin Gamik (First Nations Healing Centre). Three of the nursing stations serve significant First Nations populations. Support for development of a station at Wahta First Nation is also being provided.

What contributed to the success of the hub to date?

The WPSHC team says a key success factor has been maintaining the trust of the service partners along with the faith and goodwill of the community. It is important that its efforts are viewed as being in the best interests of community health, and not as self-serving or territorial. This goodwill is supported through a community engagement strategy that actively involves the hospital board, CEO, and the health centre's senior leadership. (The 2012 annual Community Engagement Report cited 82 meetings with partner organizations external to WPSHC.)

This comprehensive approach to integration has benefitted the community in a number of ways: It has created a more seamless delivery of services; improved access to primary care and telemedicine services; yielded cost savings through co-location and shared services; provided the hospital with a more direct understanding of local needs and the appropriate application of best practices; and, improved delivery of patient- and family-centred care as close to home as possible.

How is success measured?

At the individual program level, success is regularly measured in a number of ways: patient satisfaction surveys, the formal patient relations process, patient service numbers and sound financial management.

At the organizational level, success is also measured in a number of ways, including:

- Tracking manageable growth: As WPSHC has expanded its integrated services, the organization has maintained an unbroken string of balanced budgets.
- Using Accreditation Canada: During its most recent Accreditation Canada survey WPSHC scored 96.7 percent based on 1,671 quality measurements. It is currently preparing for a site visit in 2014.
- Monitoring community acceptance for integration: WPSHC's most tangible sign of community support has been the millions of dollars raised through private donations and voluntary contributions from municipal governments.
- Obtaining peer 'buy-in': Professional acceptance has come from peer organizations and other communities who routinely visit its Healing Centre and nursing stations with the intent of replicating the model. WPSHC also recognizes that the MOHLTC's HealthLink model and the OHA's health hub model closely endorse what has already started taking shape in its community.

Hospitals of the North East LHIN

Hospital buying group negotiates single contract for standardized order technology

Small hospitals and rural health care providers are doubly challenged when it comes to implementing leading practices. Not only must they deliver care, but that care must be constantly revised as teams work to keep abreast of leading practices around defined disease conditions.

Standardized order sets are one key tool that has grown in use to help providers deliver leading-edge care. Order sets are evidence-based, grouped medical checklists that help standardize diagnosis and treatment using pre-established clinical guidelines.

They include comprehensive best-practice interventions for particular populations, and are also specific in that they can present recommended interventions (e.g., specific dosing, frequencies). They are designed to make clinical ordering more efficient, present information in an organized and standardized way that reduces the

likelihood of errors, and they improve patient safety. Using order sets is a widely accepted means of promoting standardization and improving patient outcomes.

The challenge

Creating order sets is a significant undertaking. It requires research, consulting with experts and users, writing and updating as well as technology infrastructure. This precluded small hospitals from being able to develop a project like this on their own.

In 2011, however, a few small hospitals in northeastern Ontario adopted an outsourced solution.

The funding

When the MOHLTC announced a $20 million fund for Ontario's small hospitals in 2012, leadership from the North East LHIN, West Parry Sound Health Centre and Manitoulin Health Centre developed an opportunity for all hospitals across the northeast to share in a common deployment of order sets.

The integrated effort saw the negotiation of a single contract with PatientOrderSets.com for all 25 hospitals across the LHIN. (The small hospital signatories to the agreement received financial assistance for a two-year period, which came from the $20 million fund.)

The solution

These hospitals now use the company's *Entrypoint* solution, which gives users the option to enter orders electronically into a system that interfaces directly with the North Eastern Ontario Network's Meditech Health Information System.

As the province continues to implement initiatives that focus on quality and safety, such as the work of Health Quality Ontario, as well as the move to Quality Based Procedures, incorporating mechanisms that contribute to effective, cost-efficient care becomes even more important.

Hospitals in the North East LHIN participating in this initiative include:

- Blind River District Healthcentre
- Chapleau Health Services
- The Lady Minto Hospital
- St. Joseph's General Hospital
- Englehart and District Hospital
- Espanola General Hospital
- Notre Dame Hospital
- Hornepayne Community Hospital
- Anson General Hospital
- The Sensenbrenner Hospital
- Kirkland Lake and District Hospital
- Manitoulin Health Centre
- Bingham Memorial Hospital
- Mattawa General Hospital
- Weeneebayko Area Health Authority
- Temiskaming Hospital
- North Bay Regional Health Centre
- West Parry Sound Health Centre
- Sault Area Hospital
- Smooth Rock Falls Hospital
- West Nipissing General Hospital
- Sudbury Regional Hospital
- Timmins and District General Hospital
- Lady Dunn Health Centre

Manitouwadge General Hospital

Good connections between the family health team and core hospital services: one key to integration success

When it was built in 1997, the Manitouwadge Community Health Centre (MCHC) was designed using the health campus philosophy. The hospital is located in the town of Manitouwadge, which is 100 kilometers north of Lake Superior, east of Thunder Bay and west of Sault Ste. Marie.

This facility was designed as a health centre for the entire community, housing not only the hospital, but several other specialized health care services. Today, it is called a local health hub, but to the team at Manitouwadge General Hospital (MGH), it is simply the former CEO's vision reaching its full potential.

One of the keys to successful service integration has been the connection between the FHT and primary, acute, long-term care and emergency care. The recent launch of myCare home nursing services has further enhanced the hospital's ability to offer continuity of care. This joint CCAC and hospital initiative allows for the same nursing staff to provide care for patients in several contexts: within the hospital, in the FHT and also as part of a home nursing service. This means that sometimes the same nurse will work with a patient during each phase of care.

What began as a relatively unique way of offering health services is now one embraced by government, LHINs and service partners.

Building capacity by bringing services together

The hospital CEO at the time, Judith Harris, worked with the board to ensure the newly built facility would be more than just a hospital. The hospital foundation's successful fundraising allowed the hospital to build an additional wing.

This meant that beyond housing acute care, emergency, diagnostic imaging, laboratory services, long-term care and cancer treatment outreach, the hospital could also co-locate more than a dozen health services (from mental health and addictions to a mobile CNIB clinic). Furthermore, a primary care clinic for all local physicians, a dental clinic and an emergency medical services station are also located on the same property in buildings owned by the hospital.

The health campus concept was first introduced to the health sector in the late 1980s. When the MCHC built its facility in the mid-1990s, it was not a new idea, but one that suited the operational context; the community lacked infrastructure and many service providers tended to be small, often less than one full-time employee.

By co-locating all services onto one site, patients could have all their needs met in a single location. Since most programs are so small, evolving

to a centralized model made more sense to MCHC. As it moves more completely toward a structured health hub, it has been careful to address concerns its communities have over losing staff or resources.

Leadership's vision now a blueprint for health service in small communities

The vision that all health services should be in one location and integrated as much as possible has long been established in the community. The former CEO and board built the infrastructure and used local fundraising to do it. Today it is held as an example of how small communities should proceed. There are many enablers that have contributed to this process. The initial board and CEO vision have been the foundation, but the recent decision by the MGH board to insist on a hospital-governed family health team (FHT) model has created the synergy to achieve the level of success it currently enjoys.

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Service integration offers the hospital other benefits such as the economies that come from shared facilities and staff, as well as shared back office and standardized procedures. Also, since MGH provides information technology services for the medical centre, FHT and hospital, all patient records can be accessed from any location.

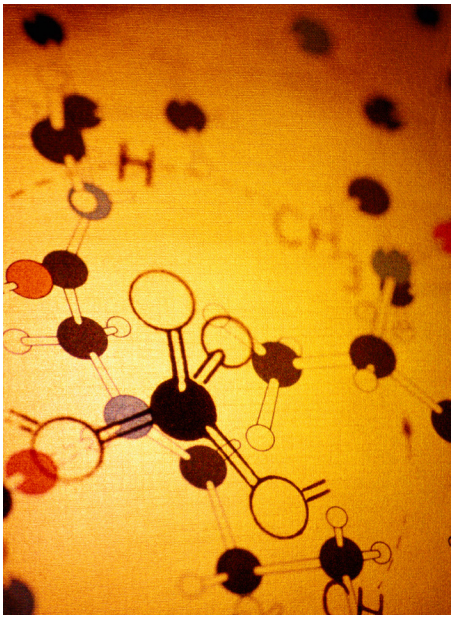
Measuring success by monitoring community health

Strong leadership from the board, the CEO and the FHT director, along with a solid community focus, helped to make this integration a success – and the results are measurable.

The FHT's collaboration with the hospital on wound care has established procedures for wound care referrals that have led to a 50% decrease in visits to the emergency department since the introduction of the program in 2010/2011. The implementation of the foot care program has eliminated approximately 100 foot care visits a year from the ED and the diabetes program, which has been expanded to include advance diabetes foot care, and has reduced diabetic foot ulcer ED visits by 90%.

Programming to proactively reduce ED visits

The Chronic Obstructive Pulmonary Disorder (COPD) program is developing an action plan so that patients enrolled in an FHT program who are educated on their condition and able to monitor triggers can access care differently. When their



COPD is exacerbated, a medical directive will provide a prescription available for pick up at the pharmacy for early intervention. This will mitigate the number of non-urgent visits to ED for treatment.

The implementation of an urgent care clinic has also increased access to primary care and reduced the number of non-urgent visits to the ED.

Patient satisfaction surveys confirm the community's support for this integrated style of health service delivery. In fact, given the length of time the centre has been in place, older residents assume all communities have health hubs. The MCHC has been operating in an integrated fashion for some time, and there is still more work to be done before it is complete, but it is well on its way to building a local health hub that will meet the changing needs of its population by working well together.

Riverside Health Care

Adopting a partnership strategy to promote integration

For many years, Riverside Health Care (RHC) has been working to create an integrated local health system for the central western portion of the Rainy River District in northwestern Ontario, and it has made significant progress.

Today, RHC is a fully-accredited, multi-site and multi-sector health care corporation operating three hospital sites (La Verendrye General Hospital in Fort Frances, the Emo Health Centre and the Rainy River Health Centre). It also includes a long-term care home (Rainycrest) a non-profit supportive housing corporation; a district-wide diabetes care and education program; and offers a range of community support services for seniors and for individuals requiring mental health, addictions and family violence treatment services.

The hospital's acute care sites represent close to two-thirds of its consolidated operating budget, with the remainder supporting the long-term care home and community-based programs. The acute care sites have had a single corporate structure for the last 30 years. The management and assets of the Rainycrest Long-Term Care Home were transferred to RHC in 2006.

RHC's previous health system board members and administration served an important role in helping to establish the current integrated health care model. Health and social service integration has been viewed as ongoing and while there are no project deadlines, the implementation of the North West LHIN's blueprint has introduced some timeframes.

The current state of RHC's integration

The hospital's current integrated care model is very similar to the local health hub model described by the OHA. This model is based on the local integration of four service sectors: (1) emergency, acute and post-acute hospital care; (2) primary care and health promotion; (3) long-term care (facility-based and community-based); and, (4) mental health and addictions.

RHC's commitment to local integration was further reinforced when this was made a key strategic priority in the corporation's new strategic plan (2013-2016), where 'partnerships' was listed as one of the three strategic pillars for the corporation (quality and organizational health serve as the other two). In support of this pillar, the new strategic plan lays out the following goals and objectives for strengthening local and regional partnerships:

To develop cooperative partnerships within its communities, RHC will:

- Increase awareness of programs/services in the community and across the Rainy River District.
- Evaluate current relationships with local partners.
- Strengthen existing partnerships and pursue new partnerships consistent with RHC priorities.

To further develop its relationships with regional partners, RHC will:

- Continue to explore collaborative opportunities that can be supported by existing resources.
- Champion and support the development of a new regional collaborative structure (e.g., information technology enterprise).
- Work with regional partners to ensure adoption and maintenance of new programs and services.

The benefits and challenges of the health hub model

The key benefit of moving to an integrated health hub model has always been to provide local residents with improved access to a broader range of health services. This was driven by a key part of the RHC mission that sought to respond to

community needs in collaboration with health system partners. One of the key goals in RHC's 2007 strategic plan was in fact to expand services to the district, and now, this integration strategy is more fully developed in its 2013-2016 strategic plan.

In the past, the lack of enabling provincial policy and funding to support local integration for rural and northern communities in a manner that is consistent with RHC's direction has proven to be a challenge. Despite this, the health system's leaders and board of directors have continued to make progress.

Working with the LHIN's blueprint

RHC's ongoing integration strategy, including its new strategic plan, is consistent with the North West LHIN's 10-year Health Services Blueprint plan released in 2012. This blueprint calls for the development of local health hubs across northwestern Ontario. According to this plan, RHC's La Verendrye General Hospital site is considered the district health campus for Rainy River with local health hubs recommended for the communities of Fort Frances, Emo, Rainy River and Atikokan. RHC is working with the LHIN and key health care partners to determine the appropriate service requirements and appropriate care pathways.

In addition to the implementation of the blueprint, RHC is engaged with the North West LHIN in the development of Health Links. This emerging provincial and regional focus on high-needs individuals with complex care requirements should provide RHC with another strategy for patient-centred integration.

Determining factors for success

Successful integration is best accomplished by bringing stakeholders around the table to better understand what everyone does, to discuss and evaluate new strategies for working smarter together, and to maintain a strong focus on the patient. Partnership-building has not always been part of RHC's corporate culture. It is working hard to broaden its stakeholder engagement strategies and to seek ongoing feedback from current and prospective partners about what can be done better.

There is a significant aboriginal population in the catchment area, which necessitates an important, multi-faceted relationship-building process and the continuous development of significant cultural competency. RHC is still learning how best to work more closely with its First Nations communities and how to provide culturally competent care.

Better partnerships for better care

RHC is also in the process of building mutually supportive relationships with its partners, which is as much a current accomplishment as an ongoing goal. This benefits patients by preserving their access to a range of emergency, acute, primary, and long-term care services in each of RHC's communities.

Riverside is focused on thinking regionally and acting locally. There will always be specialized services outside of its district to which it must refer patients. It remains committed to supporting those patients when they are prepared to return to the community.

Efforts to work with the North West CCAC to smooth and simplify transition into communities continue in earnest. RHC is also working to improve access to selected secondary and tertiary care at Thunder Bay Regional Health Sciences Centre and St. Joseph's Care Group by strengthening the working relationships between clinicians and telemedicine support. (This would not have been possible over time if the individual sites and programs had been separately governed and managed.)

As a small rural and northern health hub, RHC understands that it cannot be all things to all people. As such, it is focused on thinking regionally and acting locally. There will always be specialized services outside of its district to which it must refer patients. RHC remains committed to supporting those patients when they are prepared to return to the community.

Winchester District Memorial Hospital

Local collaborative develops a rural health and education centre to coordinate services

The Centre of Excellence (The Centre) for Rural Health and Education is a collaborative that brings the Winchester District Memorial Hospital (WDMH), Dundas Manor Long-Term Care Home, physicians, community care providers, educators and researchers together in one place, to coordinate services that will benefit local communities.

The concept of a 'centre of excellence' was first introduced during WDMH's strategic planning process in 2010 when the board recognized the hospital's role in serving a population with unique needs. Rather than focus on just treating the sick, WDMH wanted to help address a number of the determinants of health including access, social challenges and education. This led to the hospital expanding its mandate and taking a larger role within its regional system.

The hospital works with many organizations to build partnerships that support healthy rural communities. The Centre, which leverages the substantial investments made by the province and WDMH donors in infrastructure, technology, clinical services, education and research, is a natural extension of these partnerships.

For example, WDMH works with The Ottawa Hospital as a satellite site offering dialysis and chemotherapy services to provide timely and supportive care in Winchester. As a rural teaching hospital, WDMH has affiliation agreements with more than a dozen universities and colleges. And a new on-site Community Care Building houses the Champlain CCAC, the Eastern Ontario Health Unit, a Job Zone office and an Ontario Early Years program.

Being a Centre partner is a shared responsibility

The successful development of the Centre is a shared responsibility, with all partners working together to identify opportunities and strategies to deliver better care. For instance, the Community Care Building 'tenants' agreed at the outset to be more than just tenants. They embrace

the Centre concept for the benefit of the communities served, and actively seek opportunities to collaborate.

A multi-faceted communication effort helped to explain the model to external stakeholders. The plan included extensive local media coverage, community newsletters, WDMH Community Ambassador Breakfasts, and presentations to the LHIN, the Ministry of Health and Long-Term Care, community groups, service clubs, municipal councils and chambers of commerce.

How do the partners measure success?

Each of the Centre's partners has developed its own means of measuring success. For example, WDMH has just completed a strategic planning process that recognizes the hospital's role as part of the Centre.

The initial measures of success were simply to track the progress as various pieces came into place, such as enabling Dundas Manor Long-Term Care Home to secure new non-profit ownership. As well, it ensured that the Community Care Building was constructed with the fourth and final partner arriving in April 2013.

There were also additional process and structural components that advanced the collaborative. For example, joint management positions were established between Dundas Manor and WDMH, and the hospital broadened its educational opportunities at Dundas Manor (for the first time, a social work master's student placement was arranged).

Another measure of success is the development of a relatively new joint role at WDMH and Dundas Manor: a vice president of Seniors' Services. This role seeks to develop local seniors' services, including the co-ordination of seniors' services in hospital, long-term care and the community (both on site and in the broader community).

What are the benefits to users and the community?

As the Centre expands, so do its benefits. With the Eastern Ontario Health Unit located in the Community Care Building, for example, WDMH has had easier access to vaccines, and all partners have been able to easily refer clients/patients to the unit's immunization clinics as these are 'right next door'.

Having the Early Years program onsite means clients of any other on-site community service can have their children supervised by the program. As well, clients of the Early Years program have an increased awareness of, and access to, children's programs offered by the Health Unit and the CCAC.

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Another benefit relates to training the next generation of rural health care professionals. The WDMH's unique full-time medical residency program offers future family physicians access to all aspects of the Centre during their two years of study in Winchester.

Moving forward, the collective hopes to broaden educational and research efforts among all its partners. And it hopes to build another Community Care Building, and a new multi-purpose, multi-agency, long-term care home. It also hopes to align its work with HealthLink efforts and initiatives.

Mental Health Grey Bruce

Five teams from three partners provide mental health services to a 9,000-square-kilometer region

PATIENT PROFILE: How a multi-pronged approach helped "John"

'John' is in his 50s. He recently moved to this area, didn't know anyone here and had no support network. John has diabetes, a bi-polar disorder, a history of narcotics use, and suffers from chronic pain due to a physical injury. He has been unable to work, but would like to find employment.

John visited a drop-in centre operated by the Canadian Mental Health Association and, during an assessment by a Nurse Practitioner (NP) from Grey Bruce Health Services, it became evident that he would also benefit from addiction counseling provided by HopeGreyBruce.

John was suffering from isolation and anxiety, was at risk of returning to narcotic use, and expressed fears of suicide. His NP connected him to a case manager with the MHGB team serving the area. John's situation was complex, but not unique. As a member of his MHGB team, John's case manager provided additional counseling, accompanied John to a diabetes education session, and arranged for medical treatment of his chronic pain. The case manager also connected him to an employment program, to help him learn skills that will allow him to re-enter the workforce.

Established to improve access and care, Mental Health Grey Bruce's partnership of three organizations works to coordinate the delivery of mental health services in the region. It uses five community mental health teams made up of members from each agency working under the direction of a team leader drawn from one of the partner organizations. Each team is assigned a specific geographic area where they help residents access the full range of mental health services offered by the various partners.

The partners and what they do

The partnership between Grey Bruce Health Services (six hospitals, including a withdrawal management program), HopeGreyBruce Mental Health and Addictions Services, and the regional branch of the Canadian Mental Health Association, observe many of the same principles described by the local health hub model proposed by the OHA. Each of the partner organizations has a specific focus and skill set related to mental health treatment, support and prevention. These include case management, counseling, leisure and recreation, and housing support services.

Mental Health Grey Bruce (MHGB) and its teams enable families and patients dealing with serious mental illness or those who have acute mental health needs to access effective, coordinated mental health services as close to home as possible.

In a rural setting that covers about 8,850 square kilometres, with virtually no access to public transportation, this partnership model is particularly effective. Many of the patients are vulnerable and improving access to service reduces their need to travel throughout the two counties to see multiple service providers.

The region's medical community has also benefitted from having support for the high number of mental health patients. In fact, MHGB has been developing relationships with family doctors in the area since the partnership was formed in 1999.

Being able to readily access support services gives patients stability. As the case study (see sidebar on page 31) illustrates, some patients can find themselves frequently in and out of hospitals. Receiving support in Grey Bruce allows them to stabilize themselves and remain in the community, with fewer trips to emergency departments.

How it works

The two psychiatrists who support the five teams practice at Grey Bruce Health Services (GBHS) Owen Sound Hospital. This hospital has a general psychiatric unit, a psychogeriatric program as well as the region's only psychiatric intensive care unit. And due to the rising demand for mental health services, GBHS has recently recruited two more psychiatrists. While the psychiatrists sometimes travel, the hospital is currently examining options for maximizing their reach through the Ontario Telemedicine Network.

As for structure and governance, the three organizations that make up MHGB are each managed and governed independently. A formal partnership agreement exists among them and there are regular meetings among administrative staff, and quarterly meetings for the partnership's governance group, which consists of two board members from each organization and the executive directors from each of the partners. MHGB measures its performance and tracks service gaps using scorecards it developed. The partnership is currently in the process of hiring a consultant to review its model of service delivery and to implement further quality improvement processes.

Training and efficiency

The partnership has provided increased access to training, as well as standardized training by pooling educational resources, enabling team members to train together locally. This results in more consistent care, and means they are required to travel to a larger urban centre for continuing education less often. Reducing travel also allows the teams to work more efficiently. With five teams spread out across the two counties; staff no long need to travel from Wiarton to Kincardine to see a patient, they can send a team member who works closest to that patient.

Feedback to date has been positive. Patients, family members, and community providers have expressed that working together has improved access and quality of care for those in need.

What patients are saying...

"I live on the border of a county that was not necessarily a place that the team covers. Thankfully, I was able to get the care I needed. It has been very beneficial. The care has been excellent and I would not be where I am today if not for the understanding and knowledgeable staff and care team. I could not have made it without this program."

"Thank you for making a difference in my life. My aftercare worker is very capable, skilled and supportive and understanding. Thank you for the services and great company."

Espanola Regional Hospital and Health Centre

Building a health hub whose parts are owned and operated by a single corporate entity

Espanola Regional Hospital and Health Centre (ERHHC) started looking at integrating services 25 years ago. Today, it is a 79-bed facility that stands at the centre of a health care hub consisting of an acute care hospital, a 62-bed long-term care facility, a family health team (FHT), an outpatient lab and diagnostic imaging, a cardiac lab, a physiotherapy service centre, a sleep lab, a 19-bed assisted living complex, a 30-unit seniors' apartment complex, and a CCAC area office. With the exception of the CCAC, the hospital either owns or operates under agreement all of these services through a single corporate entity governed by a single board of directors.

The notion of operating a hub here was initiated in 1988 by the hospital board and senior management. With the support of the MOHLTC and the Ministry of Municipal Affairs and Housing, the team started to create a health campus that integrated acute care, long-term care, assisted living and seniors' affordable housing. Fast forward to today, the hospital has since established new programs and services on the campus site and now it includes additional nursing home beds, an FHT, a sleep lab, a private pharmacy and a CCAC area office.

The FHT and the seniors' non-profit housing have their own governance structures, but the hospital provides day-to-day oversight of both. As such, the hospital board has both direct and indirect control of the complete health care system in this catchment area. In terms of comprehensiveness, ERHHC has achieved a full range of health hub services, with the exception of home care.

How did the idea of a health campus take shape?

In the mid-1980s, ERHHC was developing a new approach to offering care for patients in its catchment area, which includes a population of 14,000 spread among four municipalities and two First Nations communities. The board's vision was to build a 'one stop shop' that would offer all the health services patients need under one roof.

As the board planned its move to a new site, opportunities arose to work with other organizations such as Espanola's non-profit housing agency to create a health campus that would include housing for seniors as well as a nursing home and a hospital. Seeing the immediate benefits of this model, the board pursued other opportunities over the years which have resulted in strategic additions to its campus.

Evolving and developing a model such as this requires the ongoing investment of operational and capital funding. Fortunately, ERHHC received support from various government agencies, the MOHLTC, North East LHIN, volunteers, and community fundraising.

This model of care offered a number of advantages. It was used to attract

and retain the services of health professionals and doctors who would be interested in being able to provide care to patients in multiple settings without ever having to leave the facility. Centralizing these services also helped to alleviate the transportation challenges faced by many area seniors.

What are some of the organizational benefits?

By integrating all these services under one administration, the hospital has been able to create teams that have successfully and effectively implemented better discharge planning, service coordination across the continuum of care and improved patient navigation. This has resulted in a reduction of patients 'falling through the cracks' and has been instrumental in helping the facility lower its occupancy rates, readmission rates, and average length of stay. By exceeding provincial averages in these key performance indicators, ERHHC was able to reinvest cost savings in other areas of its system to address a variety of other pressures.

The board's quality committee continues to see performance improvements in many areas and attributes much of this to employing a health hub model. By having responsibility and oversight in all aspects of local health care, the board has found that it is able to efficiently implement leading practices across the continuum of care. It uses an integrated group of providers to oversee quality improvement planning in the hospital, long-term care and the family health team.

The hospital has also been able to achieve cost savings and efficiencies using this health hub model that would be more difficult to accomplish in single focus organizations. With one board overseeing several organizations, there is less duplication and more efficiency in areas of board training and knowledge development. Also, staff members on an integrated campus are able to work in various parts of the system. Besides the advantage of cross-pollination, this staffing arrangement also offers economies of scale that would not exist in a smaller organization with a single focus. By sharing clinical and management functions across the hub, ERHHC has reduced its staffing and management needs relative to the number of organizations under its model.

How has this hub model been accepted?

To date, ERHHC has received very positive and favourable feedback from patients, families, visitors, staff, physicians and volunteers. According to their survey results, patients and families, whether local residents or vacationers, have continually commented on how "great" the facility is and how they would recommend it to other family members. This support (or validation) of the hub model has been key to influencing the board's determination to explore further opportunities for enhancing this model.

As for staff, the hospital reports that morale has been positively affected by this model. While pressures in health care delivery are unavoidable (due in part to increased volume and acuity, fiscal constraint, achieving a work-life balance), ERHHC has found anecdotal evidence to suggest this model provides a positive environment. This contentment leads to greater job satisfaction and greater staffing stability.

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There is also an element of knowledge sharing that occurs across departments. In this way, staff members can access training they would not normally be exposed to if they did not work in a certain sector. One quality indicator measuring the hospital's ability to attract and retain staff has been the drop in the time it takes to replace vacant, full-time equivalent positions.

What are some lessons learned?

Creating a health hub model is not a static event. Rather, it is a journey that continually evolves and adapts to changes in the health status and needs of patients. For example, in the past five years, ERHHC has had to renovate existing space to make alterations for new or expanded services. The board, through its strategic planning process, continually looks for ways of reinventing the hub to ensure its model is aligned with health system transformation, while at the same time meeting the immediate needs of its patients and residents.

Manitoulin Health Services

Integrating care delivery on an island with diverse populations and dispersed residents

Manitoulin Island's 2,766 square kilometers of rural landscape has a population of 13,000 that doubles in the summer with cottagers and campers. About 40% of the permanent population are members of First Nations and there are seven separate reserves distributed across the island. The remaining 60% of its residents are spread out among the small towns and villages that dot the island.

This is the context in which myriad health care providers, both provincially and federally funded, attempt to provide much needed services. Manitoulin Health Centre (MHC) is the island's hospital. It is a two-site organization with one location on the north shore in Little Current and another towards the island's geographic centre in Mindemoya.

The population is serviced by a number of providers: three family health teams, three nursing homes, four physician practice groups, seven First Nations on-reserve clinics, three First Nations home care provider groups, an Aboriginal Health Access Centre, CCAC providers, as well as mental health services, withdrawal management, diabetes clinics, and other social and support services.

Almost all of these providers function as independent entities with their own streams of funding and accountability. The challenge, as the MHC team saw it, was to find a way to improve service by linking and coordinating these organizations into a single group.

How did the providers first come together?

Under the guidance and leadership of MHC, a core of seven providers came together in 2008 to form the Manitoulin Health Services Group – initially focused on improving discharge planning. To accomplish this, the group determined its terms of reference and agreed to focus on care transitions, information exchanges and hand-offs, then began

to meet quarterly. Today, the group includes 17 member organizations and has an expanded range of interests.

With its expanded scope, the group's terms of reference now state that it must seek to provide seamless comprehensive care for clients transitioning between health care settings; to openly communicate issues that impact client care and problem solve as a group to ensure the best possible solutions; and, to disseminate information between federally and provincially funded health care agencies.

What are some of the group's successes?

Among some of its successes, the MHC group is seeing better problem solving through these established relationships. And gaps in service have been identified so that further problem solving and lobbying, as a team, can ensure that patients' needs are met across the island (by implementing an assisted living program, for example).

Another success is better discharge planning. Once fragmented and problematic, this has been much improved as a result of agreed-upon standardized processes. MHC found further success with the use of an area-wide hospital electronic medical record (EMR) that provides clinical information exchanges and has enabled the delivery of more comprehensive care. For example, medication information is readily exchanged, with reconciliation being shared across all interfaces of care. The hospital also successfully developed shared protocols and standardized equipment and supplies for services such as wound care.

MHC is also working with the Union of Ontario Indians in an effort to break down barriers for First Nations agencies and provide timely in-home IV medication therapies. It is also piloting the First Nations and Inuit Health Branch palliative care formulary, providing rapid access to palliative care medications on-reserve.

The group integration also offers collaboration on educational opportunities for staff and clients, such as an island-wide palliative care session, a workshop incorporating western and traditional First Nations therapies, and sharing of program information on initiatives like diabetes education, being senior-friendly, falls prevention, and medication management.

How will this group change in the future?

The membership is growing, as is the sense of what can be accomplished. The North East LHIN regularly attends the group's meetings to more easily interface with the island's many providers. MHC has become a venue for common strategic discussions.

For example, one investigation is examining the feasibility of adopting a Health Link project across Manitoulin, and there is an early discussion of what a rural health hub might look like in this setting.

The cooperative model adopted on Manitoulin makes sense in the context of its setting. It is not a town, but rather a vast community with a diverse and distributed population. Consolidation and co-location of some services has occurred where it makes sense between some providers. However, the complexities of the many different streams of funding, accountability and politics, both federally and provincially, coupled with the geographical challenges, have necessitated this unique approach.

Focusing on the patients and enhancing their experience is at the core of these collective efforts. The building of trust through respectful open communication coupled with a sense of common purpose, are driving this effort forward. As it matures, MHC looks forward to further success.

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Hanover and District Hospital

Building a solid network while reinforcing its core strengths

Hanover and District Hospital (HDH) is considered a small, independent hospital corporation, but its staff and partners have helped to ensure that it achieves the benefits of belonging to a larger system.

A rural leader in health care, HDH strives to meet the needs of the surrounding population by providing a full range of primary-care hospital services and selected secondary-care services to the population of Hanover and the surrounding rural townships. It does so by leveraging service opportunities through integration and coordination between acute, primary care and community care, and by partnering with other health care facilities to improve the services for its surrounding communities.

Hanover's activities are organized around and within the hospital to be a one-stop, local access health care service destination. It has a busy emergency department, a strong surgical program with a skilled in-house surgeon and several itinerant surgeons, excellent administrative support, and dedicated staff.

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How is HDH developing its partnerships?

The organization has been able to afford and maintain the necessary services for quality care as well as improve service delivery by creating partnerships and developing proactive initiatives with other hospitals or organizations in the following ways:

- **Strengthening its local offerings:** Local residents who need care within or close to the hospital can access the following services: emergency department, CCAC, acute inpatient care, surgical services, specialty clinics, cardiac rehabilitation, physiotherapy, the family health team, the medical clinic, family-centred obstetrical care, mental health, diabetic counseling, home and community support services, hemodialysis (using a satellite service out of London), palliative care, the Victorian Order of Nurses (VON) and pastoral services.

- **Partnering with regional health providers:** HDH is also a member of the Grey Bruce Health Network (GBHN), which is a network of five corporations: Grey Bruce Health Services (GBHS), HDH, South

Bruce Grey Health Centre, Grey Bruce Public Health Unit, and the South West CCAC. Providing local, accessible health care for the Grey Bruce region, its projects include the integration of the information system (Cerner) through the creation of the Grey Bruce Information Network (GBIN); a shared pictorial archive communication system, which is now linked to London; an evidence-based care program that creates clinical care pathways and order sets; diabetic education; an electronic common credentialing process for physicians throughout Grey-Bruce; common pharmacy policies and procedures, standards and pharmacist; and a shared data analyst.

- **Committing to innovative services:** HDH is a long-standing member of the Inter-hospital Laboratory Partnership, a partnership with eight other area hospitals in Huron Perth and Wellington counties. The labs of each hospital share a pathologist, benefit from the bulk purchase of equipment and have reduced lab unit costs.

- **Using shared service arrangements:** The hospital's partnerships with GBHS include several shared arrangements. Among these are: a shared bed board to assist with repatriation and overflow/surge management; a shared contract for nursing education sessions; a network with physicians in Owen Sound and surrounding cities that provide specialist services (e.g., outpatient clinics are provided at HDH for a Guelph urologist, GBHS pediatrician, endocrinologist and orthopedics); and operating room time, which is also provided for orthopedics and oculoplastic surgery. Also, a link with the Grey Bruce Religious and Spiritual Health Care Council-Owen Sound provides staff and patients counseling and services, and the Grey Bruce Public Health Unit provides speech pathology services in-house.

- **Working with partners in London:** HDH provides a full and self-care hemodialysis satellite unit in-house through London Health Sciences University Hospital. It also participates with the perinatal outreach program in London for the family-centred obstetrical program. It also works with the regional stroke strategy program with GBHS through London and participates in the Southwestern Ontario London project for digital imaging and shared storage of pictorial archive communication system. HDH is also linked to London X-Ray Associates for 24/7, year-round radiology coverage.

How is it organized?

The hub does not have a formal link with all partners, nor is it centrally funded. However, partners are recruited based on HDH's population need and space availability within the facility, or proximity to the hospital and/or the medical clinic.

As the inpatient census declined and surgical processes changed to outpatient surgeries, more specialists were recruited to bring care closer to home. Empty rooms and units are now used for other services such as a satellite hemodialysis unit or offices for the family health team, surgeon, psychologists, psychiatrist, VON, CCAC, chaplaincy program and palliative care.

The hub has evolved naturally based on local leadership and through trusting partnerships. HDH cites being open and engaged with its partners to establish trust as a key enabler in growing the hub. Over the years, 'buy-in' has evolved through its positive reputation and its focus on meeting the needs of the patient population.

The entire process is reinforced with support from engaged board directors, physicians and communities, all of whom have expressed a shared vision and shared goals. These are, in turn, based on the

existing local demographics and local assets. HDH also points to consistent messaging and 'equal bragging rights' as elements that have helped create trust between organizations and dispel fears of amalgamations.

What are the benefits and how does it measure success?

Measures of success have been based on standards of care and practice agreed upon by hub providers. Quality-based procedures (QBP) and scorecards are used to promote better health care processes and outcomes, which are achieved through internal quality improvement activities, public recognition, incentives (e.g., pay for performance), integration partnerships and informed consumer decisions.

Patients are surveyed to assist in evaluating how well HDH is achieving its goals of improving health outcomes and information flow. To date, data and testimonials have been very positive.

The care and information provided within the patient's 'circle of care' is organized through various personnel and professional staff as well as other resources. This is often managed by the exchange of information among participants responsible for different aspects of the care. Sharing surveys and data trending will continue through the use of scorecard measures such as quality-based procedure (QBP) and quality integrated plan (QIP), as well as measuring against strategic planning goals and objectives.

Partnering resources and linking services through the continuum of care provides a wide variety of unique benefits to local communities:

- Training for health care professionals who serve communities throughout Grey Bruce;
- Access to high-quality health care services, especially for HDH's elderly and most vulnerable patients;
- Accessible services to residents through the partners within the hub such as the family health team, VON, CCAC, and specialist services, some of whom might not otherwise have access to important health information and services;
- Care is monitored and evaluated through various services, for example: the cardiac rehab physiotherapy service was developed through the collaborative effort of HDH, cardiac rehab at St. Mary's General Hospital, the Hanover Family Health Team and Diabetes Grey Bruce program, and is offered within the facility.

What challenges remain?

The evolution and development of its hub has not been without challenges. HDH strives to meet the mental health and addictions treatment needs of its community. It has an informal link with the local community-based treatment and support services, Hope Grey Bruce Mental Health and Addictions Services, and a formal agreement with the Canadian Mental Health Association Grey-Bruce. However, there remains limited access to specialty Schedule 1 beds and youth mental health services.

As the inpatient census declined and surgical processes changed to outpatient surgeries, more specialists were recruited to bring care closer to home. Empty rooms and units at Hanover are now used for other services such as a satellite hemodialysis unit or offices for the family health team, surgeon, psychologists, psychiatrist, VON, CCAC, chaplaincy program and palliative care.

Other challenges beyond mental health include limitations in offering rehab services and dealing with staff shortages. There are also transportation challenges typical of serving patient populations in a rural area (e.g., non-urgent transfers, distances between regional and tertiary sites). However, the hub of services has been able to bring care closer to home. Individuals requiring care are receiving it, thus reducing visits to the emergency department and hospital readmissions.

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