Access to Quality Health Care
In
Rural and Northern Ontario

The Rural and Northern Health Care Framework

Ministry of Health
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The Rural and Northern Health Care Framework

Vision

Our vision is a fully integrated and co-ordinated network that provides access to a range of programs and services which put the patient first while using resources more effectively and efficiently - the right care, in the right place, at the right time. Small hospitals in rural and northern communities will have new opportunities to evolve in their role in health care while rural and northern health care providers will be supported in addressing the needs of these communities. The rural and northern health system will use new and emerging health care and communications technology to support physicians and health care professionals in the provision of 24 hour access to care, and appropriate linkages to more specialized services when required.

Access to Quality Health Care in Rural and Northern Ontario

The Rural and Northern Health Care Framework

Quality health care and access to the services people need is a priority for all Ontarians, in rural, northern and urban areas. Putting the needs of patients first and ensuring access to services are priorities of this government.

In February 1997, Health Minister Jim Wilson announced plans to establish a comprehensive framework for rural and northern health care in Ontario.

This framework recognizes that there is no cookie-cutter approach to health care in Ontario and that the unique circumstances and conditions of rural and northern Ontario must be addressed in the delivery of health care. These unique needs were highlighted recently with the work of the Health Services Restructuring Commission (HSRC) which is reviewing the delivery of health care and making decisions and recommendations to improve services to patients. Earlier this year, the Commission indicated that it did not have a framework, guidelines or policy from the government regarding rural health care to guide its work.

In addition, a pilot project local hospital restructuring study by the Grey-Bruce District Health Council, which used planning tools more applicable to urban areas (planning tools provided by the former government), indicated clearly to this government the need for a framework specific to the needs of rural and northern hospitals.

This government is the first to recognize this need and address these issues with the *Rural and Northern Health Care Framework*.

Created with the advice from a panel of experts composed of doctors, nurses and health care specialists from rural and northern Ontario, the framework does not exempt rural and northern hospitals from hospital restructuring. Nor does it represent the status quo.

The framework provides guidelines to District Health Councils (DHCs), the HSRC and local hospitals for the restructuring of local health care services. It indicates that all rural and northern hospitals should provide, at a minimum 24 hour access to basic emergency services. Small rural hospitals will be formally linked to at least one designated larger hospital with a fully staffed, 24 hour emergency department. This larger facility will also be designated to provide specialty services and ongoing clinical support.

In addition, the framework requires that rural and northern hospitals located close together form regional networks to share administrative and support services and to explore options for a common medical staff and governance.

The *Rural and Northern Health Care Framework* is an integral and important part of the Government's ongoing efforts to improve Ontario's health care system. Health care restructuring is not about saving money. Instead, it will put patients first by taking the money that is now being wasted on duplicate services, buildings and administration, and reinvesting it to direct, front-line health care services.

Issues Affecting the Delivery of Health Care in Rural and Northern Ontario

In recent years, the delivery of health care services has changed greatly, and the challenges facing, rural and northern communities in the delivery of health care are especially difficult and complex.

Health care facilities in rural and northern areas are fewer and farther apart than those in urban centres. Travel distances to and from such facilities, especially during winter months, often makes around-the-clock access to health care and emergency services in particular, extremely difficult.

Rural and northern communities generally find it harder to recruit and retain health care professionals. Rural physicians are expected to meet a wide range of medical and emergency needs, and nurses have to act much more independently than their urban counterparts to serve their patients. Concerns about heavy workloads, being isolated, or having reduced access to clinical and educational supports, discourages many doctors and other health care providers from moving to rural and remote areas.

Since most rural and northern hospitals operate independently of one another, many of them find it difficult to acquire sophisticated equipment or achieve clinical and administrative efficiencies that allow them to keep pace with new technologies and provide the access and level of care that their patients need and deserve.

Reinvestments in Rural and Northern Health

Since taking office in 1995, this government has recognized that the health care needs of residents in rural and northern Ontario differ from those in urban areas. And we have made significant reinvestments, which recognize this. Reinvestments such as:

- the $70 per hour sessional fee for physicians who cover emergency rooms in small, rural and northern hospitals. This reinvestment of $13 million means that 70 emergency rooms, which were in danger of closing, have stayed open in these hospitals providing needed services;
- $14 million for growth funding for northern hospitals;
- $ 6.7 million for Northern Community Contracts for physicians;
- $4.4 million to equip ambulances with defibrillators and symptom relief for patients;
- $45.5 million to recruit physicians to underserviced areas.

These reinvestments have been made to help ensure that residents in rural and northern Ontario have access to care when they need it. And that's what the *Rural and Northern Health Care Framework* is all about.

Developing the Framework

This government recognized that, while reinvestment would help address some of the issues facing rural and northern communities, a comprehensive framework would still be needed to address the key issue of access to services.

In September 1995, the Minister of Health asked the Grey-Bruce District Health Council to carry out a pilot study that would determine the best way of meeting rural health care needs.

Interim advice from Grey-Bruce, together with recommendations from a number of other groups and individuals, contributed to the development of the *Rural and Northern Health Care Framework*.

Work on this initiative was coordinated by a Ministry of Health Steering Committee. Valuable input and advice was obtained from an expert panel which included the following prominent members:

- *Robert Muir* of the Ontario Hospital Association and former Chief Executive Officer of Lake of the Woods General Hospital, Kenora;
- *Dr. Ray Dawes*, President of the Rural Physicians Group, Ontario Medical Association;
- *Dr. Michael Murray*, Emergency Physician and Medical Director, Base Hospital, Royal Victoria Hospital, Barrie;
- *Willis A. Rudy*, Past Vice-President, Small Hospitals, Ontario Hospital Association and former Executive Director, Wilson Memorial Hospital, Marathon;
- *Dr. Jim Rourke*, Rural Family Physician, Goderich, and Director, Southwestern Ontario Rural Medicine Education, Research and Development Unit, University of Western Ontario;
- *Charlotte Clay-Ireland*, past President of the Rural Ontario Municipal Association;
- *J.P. Aube,* Member, Cochrane District Health Council, and former hospital board member;
- *Louise LeBlanc*, President, Emergency Nurses Association of Ontario;
- *Susan Shaw*, Emergency Unit Staff Nurse, North Hastings District Hospital, Bancroft; and
- *Dr. Dennis Psutka*, Emergency Physician, Hamilton Health Sciences Corporation, and Assistant Professor, Department of Family Medicine, McMaster University, Hamilton.

The Ministry also consulted with other ministries, selected District Health Councils, and representatives of organizations such as the Ontario Nurses Association, the Ontario Hospital Association and the Ontario Medical Association. The framework brings together the advice and findings of the participants.

The framework provides a series of recommendations, guidelines and approaches to ensure access to health care in rural and northern areas.

Re-Inventing Rural and Northern Hospitals

The framework re-invents rural and northern hospitals to ensure that they continue to meet the needs of Ontarians. It recognizes that these hospitals will continue to play an important part in their communities but that their role will change.

Hospitals will no longer operate in isolation, but will link with larger hospitals in the area, developing networks of care and sharing resources with other small hospitals near by. By working together, hospitals within these networks will, for the first time, be able to offer a comprehensive range of programs and assure residents access to quality health care services as close to home as possible.

The *Rural and Northern Health Care Framework* will encourage the development of flexible and innovative approaches to service delivery, improve the ability of small communities to recruit and retain physicians and other health care professionals, and lead to closer ties between small hospitals and community based services.

Five basic types of hospitals serve rural and remote communities and each fulfils a different but vital role in the delivery of health care services:

- small hospitals located within about 40 kilometres of a larger hospital;
- hospitals more than 40 kilometres from a larger hospital, but not distant enough to be considered remote;
- northern remote hospitals;
- larger secondary hospitals with full service emergency departments; and
- specialized hospitals and Academic Health Science Centres.

Although most rural hospitals have some inpatient beds and offer services such as outpatient clinics, day surgery and rehabilitation, they differ greatly in their ability to provide complete 24 hour emergency care. Many factors, such as the availability of general practitioners, specialists, diagnostic equipment and trained technicians have a direct impact on the level of emergency care that hospitals are able to provide.

The *Rural and Northern Health Care Framework* will address this problem by establishing a co-ordinated emergency care system as an integral component of Rural and Northern Health Care Networks. The framework distinguishes among four categories of emergency care which are consistent with the recommendations of the Canadian Association of Emergency Physicians.

In the future, all rural and northern hospitals will be specifically designated as Level A, B, or C facilities and will be linked to at least one designated D-level facility. Each hospital's designation will be based on the services it offers and the resulting level of emergency care that it is able to provide, as outlined below.

Level A Hospitals

These hospitals will provide access to 24 hour emergency triage, i.e., assessment, resuscitation and stabilization usually provided by an on-duty Registered Nurse with access to a physician for advice and direction, as well as necessary medical transportation services. Level A hospitals may or may not have inpatient beds and may have one or more 24-hour observation beds.

Level B Hospitals

Level B hospitals will use on-call physicians (up to approximately 15 minutes away, as is now the case) to provide 24 hour care. These hospitals will provide some secondary services (e.g., general surgery, internal medicine, anaesthesia, some diagnostic and other support services). They will have some acute care beds and will operate emergency units that, in addition to Level A emergency care, will provide some physician emergency services such as suturing wounds and setting simple fractures.

Level C Hospitals

These full-service emergency hospitals will offer 24 hour a day coverage by on-site or on-call physicians, have more advanced technological and diagnostic capabilities, and offer additional specially services such as orthopaedics, cardiac care, obstetrics, gynaecology, paediatrics, and psychiatry. Level C hospitals will have acute care and specialty care beds. Their services will vary according to community needs, service volumes, and the availability of health care providers. Each Rural and Northern Health Care Network will contain at least one designated Level C hospital.

Level D Hospitals

Rural and Northern Health Care Networks will be linked to highly specialized hospitals, such as Toronto's Hospital for Sick Children and the Academic Health Science Centres in Ottawa, Kingston, Toronto, Hamilton and London. These Level D facilities will work with Rural Health Care Networks to

improve access to specialty services, consultation, and the most current medical information, training and continuing physician education resources available in Ontario.

Developing Rural and Northern Health Care Networks

Many small rural and northern hospitals already realize they cannot survive in isolation and that they must work with other small hospitals and larger secondary centres to move successfully into the future. They also recognize the need to join with other health care providers and agencies to provide better access to health care, provide new services, and operate more efficiently.

As a result, a number of such hospitals have already formed partnerships or are in the process of merging or forming alliances that will strengthen and improve access to necessary services and achieve efficiencies through joint administration, shared support and clinical services, and a common medical staff.

The Ministry of Health strongly supports these initiatives, but recognizes that a clear, consistent and comprehensive approach is needed to ensure that such changes take place in all areas of the province. When the Rural and Northern Health Care Networks become operational, all hospitals within a network will be formally linked. The progress that rural hospitals make toward achieving these objectives will be considered when the Ministry makes future funding decisions.

District Health Councils, hospitals and other rural health care providers and agencies will work together to develop the Rural and Northern Health Care Networks. Hospitals within about 40 kilometres of each other will be expected to form clusters with shared administrative, support, and clinical functions. They will also be encouraged to explore opportunities for common governance.

If a hospital cluster is more than about 40 kilometres away from a full service emergency hospital, at least one of the hospitals within the network will have enough secondary resources to provide Level B emergency services. The remainder will provide Level A access, triage and transportation.

In some areas of the province there may be a need to establish more than one hospital cluster, within the same network.

If there is more than one hospital in a rural community, they will be expected to work with their community to consolidate services and to share a single site. Doing so will allow them to maintain access to services and to realize savings that can be reinvested in front line services.

Rural hospitals which are the only hospital in their community, will provide 24 hour access to care unless it is determined that a nearby hospital is better equipped to provide such services through the network planning process. They will also be expected to carefully examine how health care resources can be coordinated with neighbouring facilities and services. Sharing administrative and clinical services with other small hospitals in the area, and moving to a common medical staff, can bring new opportunities for clinical management, quality of care and innovative approaches to health care delivery.

It may be feasible to have all hospitals and potentially other health care services within a network report to a single Chief Executive Officer. The Ministry of Health will support the movement toward single governance structures.

Opportunities for Rural and Northern Hospitals

When Rural and Northern Health Care Networks are established, some hospitals may provide different types of services than they have in the past. For example, they might have beds for patients who received highly specialized services in an Academic Health Science Centre, but need some convalescent/recovery care before returning home. These types of changes will allow rural residents to receive the right care in the right place at the right time, and to get this care as close to home as possible.

Some small hospitals may also have the opportunity to assume new responsibilities. For example, small hospitals could make space available for other services such as those provided by community workers, physician and dentistry offices, visiting clinics, day programs and Community Care Access Centres. Rural and northern hospitals could also provide programs and services such as:

- physiotherapy, occupational therapy, speech therapy and audiology;
- aftercare or convalescent care for patients who have had major surgery or received acute care in a more specialized setting;
- dialysis services;
- mental health programs;
- palliative care;
- geriatric programs including assessment and rehabilitation;
- seniors' day programs; and
- visiting specialty clinics, including well baby clinics.

All rural and northern hospitals will be encouraged to increase patient access to health care by making office space available to physicians and other health care providers at reasonable cost. This will allow administrative services and equipment to be shared in order to reduce overhead and redirect funds to patient services.

Rural and northern hospitals will also be encouraged to establish formal linkages with other health care facilities, such as those which provide long term care. This will give patients easy access to a variety of services and ensure a smooth transition between these services.

Requirements to Support Implementation

Implementation of the *Rural and Northern Health Care Framework* will require:

- the development of new benchmarks to address issues such as the size and service capabilities of rural and northern hospitals, their proximity to other hospitals, and the range of services they provide;
- the allocation of dollars to ensure that nurses are able to expand their roles and enhance their skills to meet rural needs;
- the development of protocols that allow highly trained and expanded-role emergency nurses to function more effectively in rural and northern hospitals;
- further expansion of the province's Paramedic Program and the introduction of new methods of providing advanced level pre-hospital emergency care, such as using Registered Nurses to provide pre-hospital services;

- the gradual phasing in of new technologies such as the installation of equipment that will allow all rural ambulances and helicopters to transmit up-to-the minute information about a patient's vital signs to emergency departments or urban trauma centres;
- improved strategies for training, recruiting, retaining and supporting rural health care providers, including physicians, specialists and specially-trained nurses;
- arrangements that enable physicians and other health care providers to work together in local and regional teams and to use non-traditional methods, such as telemedicine consultations, to deliver care more effectively;
- facilitating education and training of an adequate number of "rural physicians";
- mechanisms that make it possible for specialists in teaching centres to provide backup to rural physicians; and
- education programs that give rural communities a better understanding of how rural and northern health care networks work and how services can be accessed.

The Ministry of Health will support these initiatives which are important to the implementation of the *Rural and Northern Health Care Framework.*

Next Steps

It is hoped that communities will move forward quickly, with their local District Health Councils, hospitals and other health care providers, to implement the requirements of the *Rural and Northern Health Care Framework*. Networks will not be confined to current DHC boundaries. The Ministry anticipates that rural and northern communities will work together to voluntarily establish networks to provide care to residents of their communities.

The Health Services Restructuring Commission will also be provided with the government's *Rural and Northern Health Care Framework* to guide its decision-making processes.

The *Rural and Northern Health Care Framework* puts the needs of patients first by providing direction and guidelines on ensuring access to 24 hour quality health care to residents of rural and northern Ontario. This government's vision for health care means patients getting the right care, in the right place, at the right time. This government's *Rural and Northern Health Care Framework* realizes this objective for all Ontarians.

Appendix 1

Rural and Northern Health Care Scenarios

In Rural and Northern Health Care Networks, all parts of the system will work together so that the patients have access to the right care, at the right time, in the right place.

Listed below are some scenarios showing how the Rural and Northern Health Care Networks could respond to various health care needs:

- Three-year-old boy has an asthma attack late at night and the closest hospital is in an A level

    - on arrival he is assessed by a nurse
    - the nurse consults with on-call physician by phone
    - medication is ordered by physician and administered by the nurse
    - the boy is kept overnight for observation and his condition improves
    - he is released next morning, and parents are instructed to follow up with family physician

- 19-year-old tourist injures his ankle while skiing and arrives at an A level emergency facility

    - on arrival he is assessed by the nurse who suspects a fracture and consults with a physician by phone or follows previously agreed treatment protocols
    - the nurse immobilizes the ankle and the man is sent to a nearby rural hospital that provides (B level) emergency services
    - the physician at the rural emergency unit orders an x-ray
    - once the fracture is confirmed, the physician applies a cast
    - the man is discharged with medication and instructions for care and observation in his home town and is told to follow up with his family physician

- 24-year-old mother with severe abdominal pain presents at an A level facility

    - on arrival she is assessed by the nurse who suspects appendicitis
    - the nurse contacts the on-call physician by phone and describes symptoms
    - the physician orders the woman transferred to the nearest secondary hospital with full emergency services (C level)
    - the nurse orders an ambulance and the woman is transferred
    - on arrival, the on-duty physician assesses the case, calls in a specialist, diagnostic procedures are carried out that confirm acute appendicitis and she is moved immediately to the operating room for surgery
    - following surgery, the woman is kept at the secondary hospital for acute care then transferred to her home for follow-up by her family physician

- A 78 year old man arrives at an A level facility with chest pain

    - while being assessed by the nurse he stops breathing
    - the heart monitor shows that the patient's heart is fibrillating
    - the nurse immediately calls for an ambulance and, using standard treatment protocols, resuscitates the patient and administers needed medication

- when the ambulance arrives the paramedics transfer the patient to the nearby B level facility where a doctor meets them
- once the patient is stabilized, he is admitted to the Coronary Care Unit for monitoring and treatment
- after several days in CCU he is transferred to a hospital closer to his home for convalescence and rehabilitation
- after discharge from hospital his condition is monitored by his family physician in consultation with home care

- 84-year-old woman has hip replacement at a large urban hospital

  - after spending several days in acute care, she is transferred to a hospital closer to her home for convalescence and rehabilitation
  - during convalescence, rural hospital staff consult with staff at large urban hospital as necessary
  - as soon as she is able, she is sent home with support from a home care provider and follow-up by her family physician
  - rehabilitation continues with the help of outreach and transportation services

- 63-year-old male cottager has sudden severe chest pain with shortness of breath

  - wife realizes no 911 service available, does not know local ambulance number, so calls local hospital
  - nurse asks specific questions and, according to previously approved protocols, immediately calls ambulance and arranges transportation to level C facility
  - paramedics assess and stabilize, start I.V. in ambulance and consult with physician at level C facility
  - cardiologist is contacted by hospital and is at level C awaiting arrival of ambulance
  - the man is assessed and admitted to the coronary care unit
  - several days later he is discharged to the care of his family physician elsewhere in the province

- a 19 year old is severely injured in a snowmobiling accident

  - other snowmobilers contact police
  - police and ambulance attendants arrive to find the youth unconscious and bleeding from his ear
  - ambulance services immediately carry out emergency procedures and contact the base hospital for direction
  - under the direction of the base hospital physician, the ambulance attendants immediately transport the youth directly to the nearest level D facility

Appendix II

GLOSSARY OF TERMS

Academic Health Sciences Centre (AHSC)

- an affiliation or working relationship between universities that have health profession schools, including a medical school, and teaching hospitals that are involved in education, research and patient care and are responsible for providing the complex or specialized care (i.e. tertiary and quaternary care) required for their communities, districts, regions, and in some cases, other parts of the province and the country

Access

- to get at - in a health care system, it is the ability to make contact and to receive care

Advanced Trauma Life Support (ATLS)

- a specific set of skills and procedures used in the emergency treatment of patients who have sustained major injuries

Assessment

- the evaluation of a patient in order to determine an appropriate course of action

Benchmarks

- the term benchmarks is often interchangeable with targets. Benchmarks are used as assessments of performance. They are established for various categories of hospital activity such as average length of stay, outpatient surgery, and occupancy by adopting a 'best practice" approach. Benchmarks serve to highlight areas where there may be opportunities for improvement in operating efficiency and effectiveness

Defibrillation

- artificial stimulation (usually electrical) of the heart muscle when it is not beating properly (i.e., is "fibrillating") in order to try and restore a normal heart beat. Fibrillation is a life-threatening condition. In the pre-hospital environment, defibrillation is accomplished by paramedics and fire-fighter first responders who, using a portable electric defibrillator, act on standing orders from a physician

Dialysis

- end stage renal disease (ESRD) is the final stage of chronic kidney failure which is fatal if untreated. The only treatments for patients with ESRD are kidney transplant or renal dialysis. There are two types of dialysis: hemodialysis and peritoneal dialysis.

- Hemodialysis is a process that cleans the blood by taking it from the body and passing it through an artificial kidney machine (3 times per week). Peritoneal dialysis uses the person's abdominal cavity to clean his or her blood by cycling fluid through a tube into the body (4 to 5 times per day)

Health Services Restructuring Commission (HSRC)

- an arms-length body created as a statutory corporation under the Ministry of Health Act by Bill 26. It has the power to issue directions to public hospitals. Its broad mandate is to advise the minister on all matters relating to the health care system and restructuring

Nurse Practitioner (NP)

- a nurse registered in the College of Nurses Extended Class with an expanded scope of practice that includes the additional controlled acts of: communicating a diagnosis; prescribing certain drugs; ordering diagnostic ultra sound; ordering selected X-rays and lab tests

Paramedic

- an Emergency Medical Care Attendant who has been certified by a base hospital physician to perform one or more delegated medical acts within a Ministry of Health approved advanced life support-ambulance program

Pre-hospital care

- (in this context) patient care provided by ambulance workers and tiered responders

Primary care

- the first contact between the patient and the health care system, and the link with diagnostic and hospital services. Primary care providers include family physicians, nurses, chiropractors, psychologists and other regulated health practitioners

Protocols

- systematically developed statements to assist practitioners and patients with decisions about appropriate health care for specific clinical circumstances

Quaternary care

- the provision of highly complex sub-specialty services. Centres delivering quaternary care may act as provincial, national, and international resources, e.g. Hospital for Sick Children

Resuscitate

- the attempt to prevent the death of a patient who has lost or is losing some vital function such as breathing or a heart beat

Secondary care

- care provided by a specialist health care professional, such as a surgeon, psychiatrist or opthalmologist

Stabilize

- the attempt to restore a patient's vital signs to a more normal state and/or prevent vital signs from deteriorating further below normal values

Symptom relief program

- a specific group of medications which have been approved for administration by ambulance crews in Ontario and are aimed at providing some immediate relief to a patient. Examples would be the administration of nitro-glycerine to patients suffering angina or the administration of epinepherine to patients experiencing severe allergic reactions

Telemedicine/Telehealth

- the use of information technology to deliver medical services and information from one location to another

Tertiary care

- care that requires highly specialized skills, technology and support services, usually provided in facilities serving a large region or the province as a whole

Triage

- the sorting of patients according to criteria which ensures that the most seriously ill or injured patient is treated before patients with less serious problems

Vital signs

- functions of the body which can be used to assess a patient's condition such as blood pressure, pulse, and respiration