North West Regional Integrated Care Working Group
Summary of Preliminary Recommendations

Purpose of this document

To provide details of the North West Regional Integrated Care Working Group discussions and draft recommendations to date, so that it can be shared with stakeholders (Working Group member networks and organizations) for discussion and validation.

*NOTE: all content should be considered **draft and for discussion**.*

Engagement Questions

As you review and discuss the draft concepts within this document, please consider whether they will support improved care for our population, and the following questions:

1. What questions come to mind that need to be addressed in the next phase of work?
2. What will be important to consider as we move ahead with this work? *Critical success factors, challenges, etc.*
3. Understanding this is a starting point, is there anything you can't live – and why? *How can it be addressed?*

Background

The 'North West Regional Integrated Care Working Group' – consisting of approximately 30 cross-sectoral and cross-geography system partners – have developed recommendations on:

- A local Ontario Health Team (or other more culturally appropriate model of care) coverage model for the North West;
- A coordinated approach to planning for regional specialized services; and,
- What regional-level resources/supports may be required going forward.

Why are we doing this work?

First and foremost, to improve care for the people within our region!

With some Ontario Health Teams approved in the North West region, there is some confusion or question regarding what the rest of the region looks like related to integrated models – there is opportunity for a coordinated approach to guide partners.

A coordinated approach will ensure equity across the region; ensure patient care and experience is not unduly impacted (rather, will be improved); allow efficiencies to be realized; and, leverage lessons learned and common work.

Additionally,

- To align efforts with Ministry directions, and leverage funding and strategic opportunities.
- To propose a 'coordinated' way for Ontario Health Teams and other integrated models to engage in planning with 'regional specialized services'; we also need to ensure that peoples' experiences with regional/specialized services are not negatively impacted, for instance through funding disruptions, additional administrative burden or unintended fragmentation that affects access and quality of care.
- To continue to collaborate across the North West region – locally and regionally!

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Ontario Health Team/Integrated Local Model Coverage:

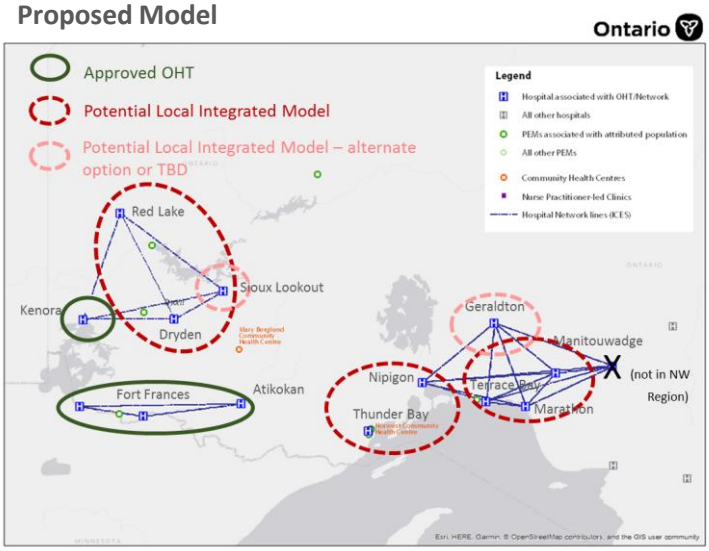
What has been (or still needs to be) considered in informing potential models?

1. **Where people currently access care** – guided by 'attributed population' data provided by the Ministry of Health and select service utilization and referral data (pulled from hospital-based data sets)
2. **Where providers/organizations currently provide care** – to be further validated by a list of providers/organizations and which communities they serve (being provided by OH North) as a well as factors related to existing 'working relationships'
3. **How care should be organized in the future**
4. **How care should be organized to support and work with the Health Transformation taking place in Treaty #3, Treaty #5 and Treaty #9 led by Grand Council Treaty #3 and Nishnawbe Aski Nation**

In formulating recommendations, the following **principles for organizing OHTs/Models of Integrated Care**, were considered**:**

1. Status quo is not an option – we must move beyond the current state to improve care for our population
2. Any models we pursue must support: integrated delivery of care at the local community level; what is already working well locally; and, improved connection to the broader regional system
3. Our models need to be supported by a reasonable level of data – however, it's not only about existing referral or utilization patterns – it's also about:
   - Safe, timely, effective, efficient, equitable and patient-centred care
   - Economies of scale
   - Readiness and willingness of partners
4. We need to start somewhere – we won't get it perfect, and we may not even get it right at the start – we need to move forward, so let's pick a place to start and evolve

Proposed Model



The map above shows initial community groupings as proposed/provided by the Ministry (shown by blue lines connecting hospitals). Through the work described in this document, a model for OHT coverage is proposed – this model falls somewhere between the Ministry proposed OHT 'hubs' and traditional 'sub-regions' or 'Integrated District Networks'. The proposed model (green and red circles on the map) considers 5-6 OHTs/models, including partners organized around the following geographies:

1. Kenora (All Nations Health Partners) – approved OHT
2. Atikokan/Rainy River/Emo/Fort Frances (Rainy River District) – approved OHT
3. Dryden/Red Lake
4. Thunder Bay/Nipigon
5. Marathon/Terrace Bay/Manitouwadge
6. Sioux Lookout/Far North Communities**requires further discussion (may align with Dryden/Red Lake, or different model respecting NAN transformation)*

* Geraldton **requires further discussion (may align with Marathon/Terrace Bay/Manitouwadge or Thunder Bay/Nipigon or other)*

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Regional Services Model:

A *working definition* is proposed as a starting point for what we consider a regional specialized service:

A specialized service is a service that ensures access to care to a population within a defined geographical area, and which requires specific expertise and resources in order to provide high-quality care promoting positive population health outcomes and care experiences. A specialized service is inextricably linked to other services and requires broader planning at the district, regional or provincial level.

Regional specialized services should be defined based on:

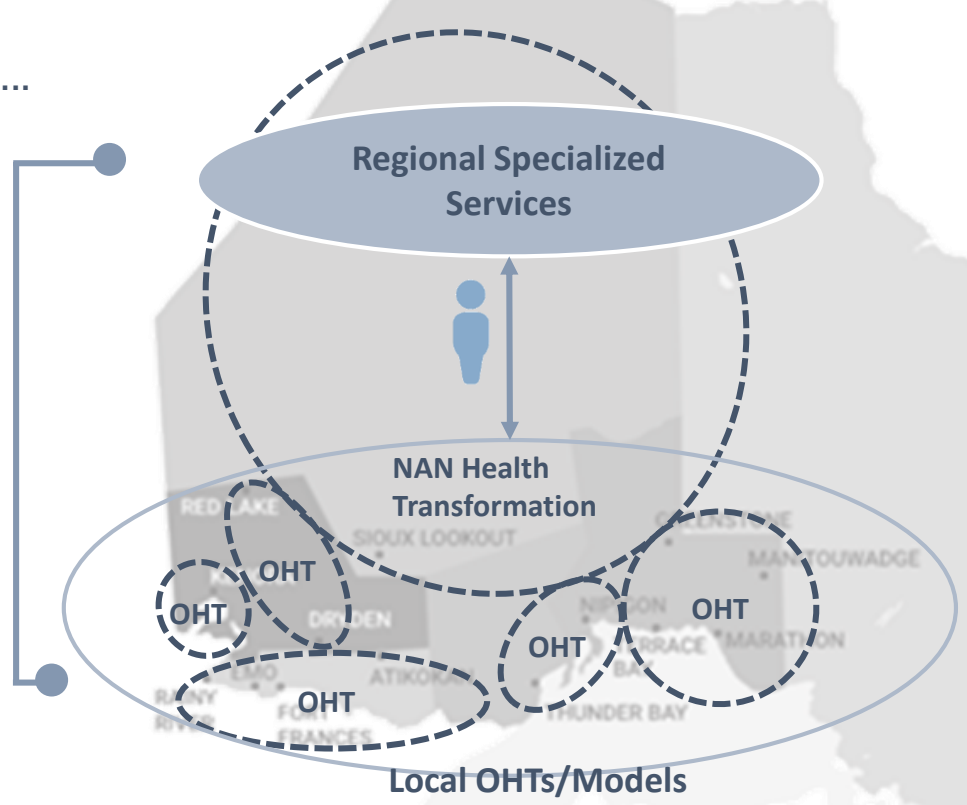
- Expertise – interprofessional team, specialized teams, clinical coherence and interdependencies;
- Resources – extensive requirements for capital and/or operating, planning at a regional and/or provincial level.

To facilitate a coordinated approach to specialized services the following is recommended:

1. Leverage existing networks to advance the goals of local integrated care systems (i.e. OHTs)
   - A. Complete a mapping of existing networks/structures to help visualize what local/district/regional structures exist so OHTs/local integrated models can effectively use them to plan services across the care continuum
   - B. Complete a mapping of current services and referral/access patterns to inform improvements in care, both regionally and locally
2. Continue to utilize the Regional Integrated Care Working Group to advance discussions that require regional coordination
   - A. Evolve and sustain Regional Integrated Care Working Group; meet on regular (quarterly or twice a year) basis
   - B. Focus on practical things that will enable local integrated models to deliver the full continuum of services to their population and our collective region. Focus on 'transitions in care' as a priority.
   - C. Use a structured process improvement methodology (such as the 'Design Events' we have hosted) to develop practical improvements and action plans

How it all fits together….

Coordinated approach for planning 'Regional Specialized Services'



A formalized network of locally integrated systems (Local Health Hubs, SLFNHA and OHTs)