ROMA
Rural Ontario Municipal Association

Fill the Gaps Closer to Home
Improving Access to Health Services for Rural Ontario

Proposals from
Rural Ontario Municipal Association

January 21, 2024

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1. Executive Summary

In early 2023, the Rural Ontario Municipal Association (ROMA) began a detailed examination of the challenges associated with improving access to health services in Rural Ontario. The preceding four years, coinciding with COVID-19 pandemic, devastated an already challenging situation for residents of Rural Ontario, and amplified trends of the past several decades --- a situation that existed well before the current provincial government took office. From ROMA's perspective, it appears that no one at the provincial level has been paying attention to geographic disparities in *accessibility* of health services for quite some time.

Despite the health services catastrophe now facing Rural Ontario, all is not lost. The current provincial government has an unprecedented opportunity to turn back from the brink and set a new course that will be more effective at implementing the integrated healthcare system that Ontario seeks and deserves. More importantly, pursuing the recommendations in this report will ensure that residents of Rural Ontario have *equitable* access to the health services as envisaged by the Canada Health Act. This is not the case today.

In this report, ROMA explains why a different approach to health service design, delivery and funding must be taken in Rural Ontario, and offers 22 recommendations for immediate action. Developed through extensive consultations with both rural municipalities and experts from across the health service spectrum, the recommendations convey the palpable sense of desperation shared by many residents, and local leaders in healthcare, community services and municipal government. It is time to answer the call.

The full report is available at https://www.roma.on.ca/advocacy.

1.1 Rural Ontario is Different

The effects of geography and lower population densities in Rural Ontario make health services delivery difficult, but not impossible, especially if decision-makers are prepared to think --- and act --- creatively. Yet ROMA is not convinced that the Province is even aware of the extent of the health services catastrophe unfolding in Rural Ontario.

Executive Summary… continued

The deteriorating state of access to health services to residents of Rural Ontario is driven by four factors:

1. **Access to primary care is declining far more rapidly in Rural Ontario than in urban areas**. The number of residents of Rural Ontario without access to a family physician or a family health team is increasing four times as fast as in urban areas.

Geographic Classification (using Rurality Index of Ontario to classify as rural)	Uncertainly Attached; Not Receiving Primary Care (September 2022)	Percentage Change in Residents Not Receiving Primary Care; March to September 2022 (Six Months)
Urban	1,152,086	1.53
Small town	257,392	6.15
Rural	118,866	6.06
Missing/unable to classify	43,193	2.05
TOTAL	1,571,539	

Note: As defined by ROMA, "Rural Ontario" includes municipalities in both the "small town" and "rural" categories used in this analysis, based on data compiled by Inspire-PHA.

2. **Hospitals in Rural Ontario were disproportionately affected by the temporary Emergency Department closures in 2022 and 2023.** Rural residents without primary care are more vulnerable to other health risks. When the nearest Emergency Department is closed, they have nowhere close to home to get help.

3. **Communities in Rural Ontario do not have the capacity in their network of community services that could absorb demand from hospital Emergency Departments**. Valuable supports that were put in place during the pandemic have now receded. The health crisis has not.

4. **Travel Burden --- both time and money --- is much higher in Rural Ontario.** Even before the onslaught of temporary Emergency Department closures, residents in large portions of Rural Ontario lived more than 30 minutes from the nearest Emergency Department. This simple indicator signals increased travel costs, time commitments, and potentially worse health outcomes for Rural Ontario residents.

1.2 Accessible Health Services Means Delivery Closer to Home

If residents of Rural Ontario are to achieve equitable access to health services, there must be *direct and immediate access* to a full range of services closer to home. This means having primary care in residents' own communities or close by. It means clinics, Emergency Departments and Emergency Services all able to provide service in a timely way. It means specialty health consultations, mental health counselling, and addiction supports without having to travel far from home or extraordinary wait list times.

Across Rural Ontario, the availability of these services is deteriorating by the day. Provincial support for services to support communities during the pandemic has now fallen away, leaving Rural Ontario ill-prepared for both everyday health needs as well as the next crisis. In addition, this is not the time to reorganize Public Health --- a program that is vital to Rural Ontarians --- unless it is to expand local capacity. Instead, **the Province must refocus on building out the robust set of services needed to meet needs *locally* across Rural Ontario**.

1.3 It's Time to Upload the $481 Million in Annual Health Costs Now Borne by Rural Ontario Property Taxpayers

Delivering health services is a provincial responsibility, yet Rural Ontario municipalities foot a significant share of the bill: nearly $481 million in 2022. This is unsustainable and egregious. Health services must be funded from provincial and federal income tax revenues, not residential property taxes --- the only revenue source for Rural Ontario municipalities. ROMA is giving the Province a failing grade when evaluating its performance in living up to the principles of the Canada Health Act. **The Province must act to remove health costs from property taxes.**

1.4 The Only Way Out of Labour Shortages: Utilizing Health Professionals in New Roles

From doctors and nurses to nurse practitioners, paramedics and personal support workers, the current labour force shortages were predictable --- if only on the basis of demographics. Despite provincial initiatives to increase enrolments in specific healthcare professions and to attract internationally-trained professionals to Ontario, the current and projected shortages will not be resolved in any meaningful way in less than a decade --- at least not by using conventional approaches. There is another way out of this morass: utilizing existing and near-term additions to the provincial pool of health professionals in new roles.

> ***"The definition of insanity is doing the same thing over and over and expecting different results"***
> attributed to Albert Einstein

In discussions with knowledgeable stakeholders across Rural Ontario, ROMA has identified more than a dozen ways to improve access to health services by capitalizing on the considerable skills and expertise of healthcare professionals in new ways.

Using the Province's traditional top-down approaches, implementation of new ideas will fail. The Province must defy convention and use the policy, regulatory and fiscal tools at its disposal in new ways. Only then will Rural Ontarians see an integrated healthcare system that delivers real access to health services.

The required transformation should start today.

Executive Summary… continued

1.5 Rural Municipalities Must Have a Seat at Their Ontario Health Team Table

Rural municipalities fund a significant share of Ontario's health system, and often spearhead local efforts to find innovative ways to close systemic gaps. They must be part of its governing structures. The Province must *require* Ontario Health Teams to provide a seat at their table for rural municipal government.

Through this paper, ROMA has demonstrated that vital health services are not equitably available and accessible to residents of Rural Ontario. A serious evidence-based policy response from the Province to the current catastrophe is long overdue. The recommendations that follow are intended to galvanize provincial decision-makers into action to create the integrated health care system that Rural Ontarians deserve. There is no time to waste.

Acknowledgements

On behalf of ROMA, I extend our heartfelt thanks to the hundreds of people and organizations who contributed to this study. Each person who turned their mind to this important issue is helping to lay the foundations of a much stronger health system for Rural Ontario. We heard your anger, fear and frustrations and captured this in our recommendations.

ROMA also extends our thanks to the Association of Municipalities of Ontario (AMO) for its keen interest and contributions. The support of AMO staff, particularly Ms. Petra Wolfbeiss, Director of Membership Centre, was key to this policy work.

And finally, ROMA wants to recognize our consultant, Ms. Kathryn Wood, President and CEO of Pivotal Momentum Inc by expressing our sincere thanks for her collaboration and support. Kathryn's expertise, teamwork and dedication to ROMA's *Fill the Gaps Closer to Home* research were instrumental to providing the research and data to support the recommendations to improve access to health services in Rural Ontario.

Mayor Robin Jones, Village of Westport
Chair, ROMA

Executive Summary… continued

1.6 Recommendations:

ROMA offers 22 recommendations for the attention of the Province of Ontario, as well as other stakeholders eager to put the shoulder to the wheel to ensure that residents of Rural Ontario do indeed have equitable access to healthcare and related services. These recommendations are organized by theme with the evidence to support each theme being presented in later sections in this report. The eight themes are:

- Ensure that rural municipalities have a seat at their Ontario Health Teams' table
- Fix Primary Care
- Reconfigure the Deployment of Health Human Resources
- Shift Demand from Emergency Departments to More Appropriate Forms of Care
- Complete the Full Range of Community Care
- Implement Inter-professional Team Approaches
- Support Community-Focused Innovation in Rural Ontario, and
- Preserve Public Health Emergency Response and Prevention Programs.

In section 5, each recommendation is presented along with a distillation of the background to its formulation.

Theme One: Fully Engage Rural Municipalities in Ontario Health Teams

Recommendation 5.1
That the Province require Ontario Health Teams (OHTs) to ensure that rural municipalities have a seat at the table, even as the OHT organizations evolve and grow.

Theme Two: Fix Primary Care

Recommendation 5.2A
That the Province maximize opportunities to increase medical school enrollment at Ontario universities and concomitantly, seize the opportunity to implement additional strategies that maximize primary care physicians' capacity for direct service to patients.

Recommendation 5.2B
That the Province work with Ontario Health Teams and other stakeholders to understand the forces that drive family physicians into or out of this specialization, and
Further that the Province develop specific strategies to reduce barriers to the practice of family medicine, and
Further, that the Province improve the provincially-funded program to attract family physicians to all areas of Rural Ontario.

Executive Summary…continued

Recommendation 5.2C
That as part of its efforts to reduce barriers to being a family doctor in Ontario, the Province call upon its Digital and Data Strategy secretariat to identify and develop solutions to reduce the amount of administrative work for which Family Physicians are currently responsible.

Theme Three: Reconfigure the Deployment of Health Human Resources

Recommendation 5.3A:
That the Province increase funding for walk-in clinics and urgent care services to enable those services to expand hours of operation, and
Further, continue to explore and introduce scope of practice measures for nurse practitioners and nurses that would enable these professionals to expand their roles in primary care, and outside of physicians' offices and walk-in clinics.

Recommendation 5.3B
That Ontario Health Teams be required to bring paramedic services into local discussions about how to serve homeless populations as well as those with mental health and addictions challenges.

Recommendation 5.3C
That Ontario Health atHome explicitly include Community Paramedicine programs as one of the options available to care coordinators, and that they be considered along with the other 14 existing organizations, and
Further that the choice of options be based on both medical and health expertise (in relation to patients' needs) and proximity/capacity to respond in a timely fashion, fulfilling the promise of "seamless transitions", and
Further that utilization of Community Paramedicine programs be fully-funded by the Province, with no requirement for municipal contributions.

Recommendation 5.3D:
That the Province consider expanding the scope of practice of Paramedics and Community Paramedics so they can take on new healthcare roles with specific populations, and support primary care, and
Further, that the Province develop the medical directives and assessment skills associated with these new roles, and
Further that utilization and expansion of Community Paramedicine programs be fully-funded by the Province, with no requirement for municipal contributions.

Recommendation 5.3E

That the Province consider legislative changes that would allow Emergency Medical Attendants (EMAs) and volunteer drivers to work with paramedics in ambulances, including driving and assisting paramedics under their direction.

Recommendation 5.3F

That the Province expand the types of patient transports for which patient transfer services could be utilized, beyond their current roles (e.g. inter-facility movement of patients such as long-term care to a hospital or imaging lab appointment). Their roles could be expanded to include any transports that do not require an ambulance. Paramedic Services, including Community Paramedics, would be well-positioned to determine the most appropriate form of transport.

Recommendation 5.3G

That the Province develop and implement medical protocols and procedures, particularly for water-based transports, including ferry services, to allow first responders other than paramedics, with appropriate training, to transport patients to the mainland for transfer to an ambulance.

Recommendation 5.3H

That the Province consider the announced plan for increasing the number of nurse practitioners in Ontario as "phase one" and that as universities are able to do so, the numbers of graduating nurse practitioners be further increased, with a continued emphasis on service to Rural Ontario, and

Further that the Province consider the opportunity for nurse practitioner specialization in managing in-scope health services such as chronic diseases, and services offered at clinics --- whether walk-in or appointment-based, and

Further, that the Province further encourage the development of nurse practitioner-led clinics especially in Rural Ontario, where recruitment of family physicians is especially challenging.

Theme Four: Shift Demand from Emergency Departments to More Appropriate Forms of Care

Recommendation 5.4

That the Province develop a multi-pronged strategy for addressing staffing shortages in Emergency Departments in Rural Ontario, first by seeking to train, attract and retain health human resources (primarily physicians and nurses) to ensure reasonable access to Emergency Departments, and

Further, to fill gaps and expand capacity in other healthcare and related services to be able to receive and provide community care to those who would otherwise visit Emergency Departments, and

Further, to develop and implement measures to reduce Emergency Department closures, prioritizing investments based on access to services considerations such as impact on health outcomes and travel burden, and

Further, introduce education programs for primary care, long term care and home care about the most appropriate alternatives to Emergency Departments.

Theme Five: Complete the Full Range of Community Care

Recommendation 5.5A

That the Province require Ontario Health Teams to complete --- or fill the gaps --- in the range of services available closer to home for residents of Rural Ontario, and

Further, provide multi-year/ongoing funding to rural municipalities for community services that provide health and social services such as mental health and addictions services, housing services, income support, and local mental health crisis intervention, and

Further, ensure that paramedic services are engaged in OHTs' work as service delivery partners, especially in strategies that reduce demand on Emergency Departments, complete the range of community care services available to residents, and address specific populations such as the homeless.

Recommendation 5.5B

That the Province provide funding support for implementation of community-based Mental Health Crisis Intervention Teams (as part of Community Safety and Well-being Plans), and

Further, that this funding support be directed to and through municipalities that have been mandated to implement CSWB plans, and

Further, that this funding be available to municipalities whether they have a municipal police force or use the Ontario Provincial Police.

Recommendation 5.5C

That the Province and Ontario Health Teams incorporate the concept of "complete communities", as articulated by the Ministry of Municipal Affairs and Housing, in any community-focused planning or program development and implementation related to Ontario's health care system.

Theme Six: Implement Inter-professional Team Approaches

Recommendation 5.6A

That the Province engage the Ontario Health Teams, and through them, the community-based organizations that are needed to enhance prospects for success for provincial initiatives in Rural Ontario and,

Further, that services such as Ontario Health atHome and the Ontario Structured Psychotherapy Program work with the Ontario Health Teams and other local stakeholders to develop a network of service access points that recognize the distinctive challenges and opportunities for service delivery in Rural Ontario.

Recommendation 5.6B

That the Province work with local housing service providers, Ontario Health Teams and other local stakeholders to develop ways to integrate social determinants of health into homelessness programs.

Recommendation 5.6C

That ROMA engage in a review of the City of Toronto integrated approach to homelessness, now funded by the Province, and

Further that Ontario Health develop a targeted funding program to which municipalities in Rural Ontario could apply to secure the resources that will support implementation in their communities, and

Further that Ontario Health work with the Ministry of Municipal Affairs and Housing and the Ministry of Community and Social Services to support wrap-around programs for transitional housing that recognize determinants of health not directly related to access to health care.

Theme Seven: Support Community-Focused Innovation in Rural Ontario

Recommendation 5.7

That the Province establish a community-focused funding stream that could flow through the Ontario Health Teams, with the express purpose of devising more innovative, cost-effective ways to address the needs of under-serviced communities in Rural Ontario, and
Further, that funding priority be given to rural areas for which current services are not meeting provincial standards and/or guidelines similar to those proposed in the Rural and Northern Health Care Report (2010) (Ontario), and
Further, this could include rural areas that are part of an urban municipality, and
Further, that funding priority be given to pilot projects that propose to test models of care that increase or improve access to services in Rural Ontario.

Theme Eight: Preserve Public Health Emergency Response and Prevention Programs

Recommendation 5.8A

That the Province review with ROMA the business case that predicts $200 million a year in savings from the consolidation of 35 public health units into 10, and
Further, that the Province describe how rural municipalities that currently pay 25 per cent of the costs for public health units operating in their municipalities will have input into public health program development and delivery in their areas, and
Further, that the Province confirm that regardless of future governance models for public health, the services traditionally within the mandate of Public Health will be delivered 'closer to home' in Rural Ontario.

Recommendation 5.8B

That the Province continue its funding support for prevention programs currently delivered by public health units, so that Rural Ontario residents can capitalize on opportunities to protect and strengthen their health for decades to come, as well as contributing to better control of health care costs in the years ahead, and
Further, that the Province continue its funding support for emergency services and public health emergency planning and response, so that Rural Ontario residents can take appropriate measures to protect their health, and build resilient communities.

2 Background/Purpose of the Project and Report

This report is the second intensive exploration of ways to pursue Opportunities for Rural Ontario in a Post-COVID World, the landmark study and action plan released by ROMA in January of 2022. Focused on rural growth and resiliency, the report outlines nearly two dozen ways to rethink rural communities' role in the economic and social vitality of the province. It has attracted considerable attention from within the municipal government sector and was explicitly referenced by Dr. Thomas Homer-Dixon in his end-of-conference address at ROMA 2023.

By ROMA's definition, Rural Ontario includes 375 of Ontario's 444 municipalities (84% of Ontario's total municipalities) and includes Districts in Northern Ontario. It is home to 2.8 million residents and an estimated 965,000 households. Its labour force is 1.1 million workers' strong. In 2021, Rural Ontario produced $321 billion in goods and services annually, of which $150 billion is from the manufacturing and agriculture sectors. These two sectors employ 178,500 people whose work generates $102.6 billion in exports out of Rural Ontario.

2.1 Improved Access to Services --- One of Five Interlocking Issues

In the *Opportunities* paper, ROMA identified five interlocking issues that require detailed attention and offered recommendations on:

- **Improving Digital Connectivity:** High-Speed Internet and Mobile Broadband/Cellular Coverage since many rural and remote communities do not enjoy the connectivity that is commonplace is more densely populated areas.
- **Developing, Attracting and Retaining the Labour Force of the Future**, on which business and economic growth depend and is deeply linked to housing.
- **Addressing the "Full Spectrum" of Housing Needs**, given the dramatic impact of COVID-19 on housing supply, demand and costs.
- **Growth and Development Planning,** especially re-imagining the Provincial Policy Statement, and giving rural areas the latitude to make choices based on local needs and preferences.
- **Improving Access to Services**, particularly applying the ecosystem concept to local healthcare and social services at a community or regional level and reducing the need for rural residents to travel long distances to access services.

First Action Priority Was Attainable Housing and Purpose-Built Rentals

Following the release of the Opportunities paper, the ROMA Board chose Affordable and Attainable Housing as its first priority for advocacy and action. Within weeks of launching its Opportunities paper, ROMA formed an Attainable Housing Task Force, comprised of housing industry experts, municipal staff, and ROMA Board members. In August 2022, the Task Force delivered its report: a set of proposals designed to address barriers to attainable housing and purpose-built rentals. In the fall of 2022, ROMA also reviewed and responded to the proposed new Provincial Policy Statement. ROMA is now awaiting the release of the new Statement and remains an active participant in housing-related events such as the Housing Summit held in November of 2023 by the Ontario Ministry of Municipal Affairs and Housing.

Second Action Priority Is Improving Access to Services

In early 2023, the ROMA Board chose its second priority: Improving Access to Services. The *Opportunities* paper established a specific goal for ROMA and Rural Ontario on this front:

To ensure that vital services, particularly health care and social services, are available and accessible to residents of Rural Ontario on the same basis as in urban areas.

Rural is Different

The disparity in service accessibility between rural and urban areas is well-documented and is summarized in this report. Accessibility challenges were known well before the pandemic but COVID-19 certainly accentuated them. Both the historical disparities and their amplification were confirmed by a survey of ROMA members in mid-2023, and a survey of paramedic chiefs later in the same year.

The implications of the disparity for rural residents are profound and are reflected in explicit gaps in service availability, resident-specific travel burden, extra costs to access services in often distant locations, severe strains on existing services that are already overloaded, and reduced levels of community well-being.

What is it Costing Us to Leave These Service Disparities Unaddressed?

- Increased costs for municipal services, especially related to emergency response
- Inability to respond effectively to mental health challenges in our communities
- Increased cost to residents to access "public" services (travel burden)
- Increased time and inconvenience to residents when travelling to appointments or receiving service (including impacts on caregivers or family members)
- Increased stress for caregivers and family members
- Reduced community well-being.

Taken together, these aspects of the prevailing service delivery system raise serious questions about the degree to which health care and related services are truly accessible to residents of Rural Ontario.

2.2 Call to Action on Improving Access to Services for Rural Ontario

ROMA's *Opportunities* paper contained two very specific recommendations that provide the foundation for this in-depth report.

Improving Access to Services:

Recommendation 20: Collaborative networks to deliver services locally

That ROMA advocate with the Province for the development of healthcare and social service ecosystems in rural areas to serve as base stations for rapid response to community needs as they evolve over time. In particular, ROMA seeks discussions with the Province to determine how best to ensure that sufficient levels of mental health and substance abuse/addictions services are available "on the ground" in Rural Ontario. [for details see P.64]

Recommendation 21:

That ROMA work with the Province as well as Paramedic Services serving Rural Ontario, to support the expansion of Community Paramedicine into rural areas, serving seniors and/or other residents with similar health and mobility issues. [for details see P.65]

2.3 Solutions Require Acknowledgement of the Challenges of Health Service Delivery in Rural Ontario

Assuring real access to services in Rural Ontario[1] requires an appreciation and acknowledgement of the challenges of service delivery in areas of relatively low population density over large geographic areas. Per capita costs of service delivery will be higher than in densely populated areas.

[1] For the purposes of this plan, the definition of "Rural Ontario" is based on membership in ROMA with some adjustments made to exclude urban areas where there are urban and rural areas within the same city or regional government if data specific to the rural area was not available. For that reason, the cities of Ottawa, Hamilton, and the regions of Niagara, Halton and Peel could not be included in the analysis. Representatives from their zones, which include cities and regions, sit at the ROMA table and participate actively in discussions about rural matters.

Planning and delivering health service in Rural Ontario must include acknowledgement that digital services requiring high-speed internet and/or cellular telephone services are not yet available across Rural Ontario. Even in circumstance where "virtual" services will work, on-the-ground follow-up and support is usually required. At the moment, there is limited capacity in Rural Ontario to provide these services.

For example, the travel burden for Rural Ontario residents --- derived from the distance between residents' homes and healthcare or other services --- is often well beyond 30 minutes drive time. This imposes extra travel time and costs, as well as time away from work for patients and family. These same factors stretch primary care, paramedic and hospital Emergency Department resources thin.

These challenges are compounded by generally lower household incomes across Rural Ontario, and a Baby Boom-driven demographic bulge of older residents --- who have now become patients requiring primary care and emergency services.

These physical facts of life make planning and delivery of services especially complex, drawing attention to transportation, housing, and labour force considerations in both planning and delivery of health services in Rural Ontario. A different approach is needed in Rural Ontario.

2.4 Research Reveals Serious Gaps in Accessibility of Services

In the course of interviews with "on the ground" organizations across Rural Ontario in 2023, it is clear that we are falling short on at least four[2] of the key determinants of health. Therefore, it ought not to be surprising to see unprecedented levels of stress among healthcare professionals, social services personnel, families and caregivers; residents unable to access basic health services; increasing homelessness; and demand for mental health services and supports to address substance abuse.

> ***"The front lines of health care and the front lines and location of service delivery have totally changed"***
> Comment from consultation participant, fall 2023

2.5 Province Must Step Up

As front-line observers of the deterioration of residents' lives, rural municipalities are doing all they can to address challenges in services mandated to them: housing and homelessness, emergency services, long-term care. Local tax dollars also support a share of the costs in other areas such as public health, policing and fund-raising campaigns for hospitals.

[2] Social determinants of health, as defined by the World Health Organization include: *income and social protection*; education; unemployment and job security; working life conditions; food insecurity; *housing*, basic amenities and the environment; *early childhood development*; social inclusion and non-discrimination; structural conflict; and *access to affordable health services of decent quality.* [italics added for emphasis]

Rural municipalities often lead local efforts to find solutions to service delivery challenges. However, the municipal levy --- drawing almost exclusively from property taxes --- cannot and should not be expected to fund health services that are, under the Canada Health Act, a provincial responsibility.

It is time for the Province of Ontario to deliver on the unmet health services needs of Rural Ontario residents, and to do so closer to home.

2.6 What Role(s) Should ROMA Play in Implementing Solutions?

While identifying Improved Access to Services as a ROMA priority, the Board has not viewed itself as leading the entire initiative or the push for change but rather to partner with other organizations with much deeper understanding of policy, operational realities and subject matter expertise (whether medical or mental health).

For the Improved Access to Services theme, the Opportunities Plan[3] laid out ROMA's proposed role as a partner in:

- Recognizing and developing local healthcare ecosystems;
- Expanding the availability/use of community paramedicine; and
- Stimulating the development of transportation services to connect people and services.

The Plan also noted that ROMA expected to play a significant role in helping service providers understand and remain engaged in processes designed to address access challenges. Appreciating the complexity of healthcare and related services, additional roles were identified for related themes such as Addressing the Full Spectrum of Housing Needs.

2.7 Project Scope: What's In? What's Out?

In framing the *Improving Access to Services* project, ROMA established that its analysis would focus on the following aspects of health care:

- Primary care
- Specialist physician services
- Emergency Departments
- Paramedicine and Community Paramedicine
- Clinics (walk-in or appointment-based)
- Home-based services (home care, community paramedicine)
- Mental health and substance abuse services, and
- Public health.

[3] See page 10 of the Opportunities for Rural Ontario in a Post-COVID World report.

Other services, such as pharmacies, were expected to come up in the course of discussions but were not a primary focus of this report. Because there is so much work already under way on matters related to long-term care (e.g. constructing new beds[4], addressing labour force shortages), ROMA set this service area aside in order to concentrate on the preceding list.

2.8 ROMA's Process … So Far

ROMA's work on Improving Access to Services has included:

- **An initial ROMA Board theme session** entitled "What is it Costing Us?" to have access to services issues unaddressed. The Board has received regular reports on this initiative throughout 2023, culminating in the review and approval of recommendations in December 2023.
- **Three types of consultations** that, taken together, represent input from more than 250 elected officials, service providers and other knowledgeable stakeholders:
  - **A survey of ROMA members** to establish "most significant pain points" related to access to services, establish priorities for ROMA's general advocacy and specific aspects of the access to services issue, and to seek out proactive measures taking place at the local level. Representatives from 186 of 375 ROMA member municipalities responded to the survey for a 50 per cent response rate.
  - **A survey of Paramedic Chiefs** to better understand the impact of access to services issues on paramedics and other service providers in the community, as well as understanding the degree to which access to services might be improving or declining (on key measures). Chiefs from 24 of 56 paramedic services across Ontario responded to the survey for a 43 per cent response rate.
  - **Interviews with organizations from across the province**, operating "on the front lines" to ensure that ROMA understands the issues, identify those who are already working on them, and gather suggestions for proposals to address them. Several of these interviews were group discussions, that invited input from people from a diverse set of communities that make up Rural Ontario.
- **A review of public domain *data*** on the highest priority services that are at the centre of "improved access to services", with a particular focus on data specific to Rural Ontario.
- **A review of public domain *reports*** --- including provincial or federal or special purpose bodies tasked with examining health care and related service issues).

[4] The Ministry of Municipal Affairs and Housing has recently indicated that long-term care beds are considered housing. The sector is also working to meet a new expected standard of care (minimum four hours of direct care per day per resident by a registered nurse) by 2024.

Background/Purpose of the Project and Report…continued

- **A profile of the availability of highly-qualified labour force** required to address improved access to services (e.g. multiple occupational groups in health care, housing/skilled trades, transportation).
- **Distillation of preceding work into a formal strategy** with associated workplan.
- **Further consultations/presentations to ROMA Board** for additional feedback and to obtain sign-off.
- **Formal unveiling and launch of the strategy** at the 2024 ROMA Conference.

3 The State of Access to Services in Rural Ontario Today

Access to vital healthcare, mental health and related services in Rural Ontario was challenging before the COVID-19 pandemic; it is now a full-blown catastrophe. Whether it is the growing number of residents who do not have a family doctor, the all-too-frequent closures of rural hospital emergency departments, the upsurge in opioid overdoses, or increased numbers of Rural Ontarians who are homeless, the healthcare and social safety net is falling apart.

3.1 Rural is Different

For more than a decade, a multitude of reports --- both federal and provincial --- have highlighted systemic challenges, repeatedly noting the differential access to services and the implications for health and social outcomes for residents of rural parts of the province ---or the entire country. These reports have come from the front lines of the service delivery system as well as from commissioned analyses undertaken by third party experts.

In these reports, there is a remarkable degree of consistency in both system diagnoses and prescribed solutions. Yet the situation "on the ground" in Rural Ontario has not changed markedly. In fact, in many places it has gotten worse.[5]

Two-thirds (67.9%) of ROMA members responding to a survey in mid-2023 described access to services in their communities as either "fair"[6] or "poor"[7]. Less than five (5) percent of respondents described access to services as "very good"[8].

RURAL ONTARIO's HEALTH CARE CHALLENGES TODAY

- **525,000** Rural Ontario residents without access to primary care --- similar to the estimate for the City of Toronto (415,000)
- **Rural Ontarians are losing access to primary care four times faster than urban residents**
- **+1,500** unfilled primary care physician positions, many in Rural Ontario
- **65%** of Rural Ontario municipalities do not have access to walk-in clinics
- **60%** of Rural Ontario municipalities do not have access to mental health and addictions services
- **600+** Emergency Department Temporary Closures in Rural Ontario in 2023

[5] New data released in April of 2023 by INSPIRE Primary Health Care found that the number of people in Ontario without a family physician has risen to more than 2.2 million, and projected a further increase to more than three million by 2025. Source: https://www.ontariofamilyphysicians.ca/news/more-than-2-2-million-ontarians-left-without-a-family-doctor/

[6] "Fair was defined as: "some essential services are available 'close to home' but other services are only accessible in other municipalities, incurring significant travel and other costs in order to access them."

[7] "Poor" was defined as: "very few services are available 'close to home' with most residents having to travel significant distances or perhaps not having access to services at all".

[8] "Very good" was defined as: "a wide range of services is available 'close to home' for residents of our municipality with no significant gaps in service.

"In 2009, Andre Picard wrote: "The reality is that there is two-tiered medicine, but it's not a private-public split, it's an urban-rural split."

*Thirteen years later (2022), the reality is even worse --- **access to primary care** in many small communities is difficult or lacking altogether; announcements of **emergency department closures** occur almost daily; adult mental health care, If available at all, is **distant in both time and place**; mental health-care **access for children** is worse; increased **surgical disruptions** creating further issues for those who have traveled from afar; women forced to travel farther and farther to birth their babies. The list goes on."*

*"But what if we got it right for rural Canada… Pediatric, mental health, surgical and cancer care would be provided locally, regionally and in large urban centres based on urgency and complexity, with the goal of providing high-quality care as **close to home** as possible."*

[Underlining added for emphasis]

***Excerpt from** Rural health care: how to get it right*

Article by Dr. Sarah Newbery, Dr. James Rourke and Dr. Ruth Wilson (2022)

3.2 At Least 525,000 Rural Ontario Residents Are Likely Without Primary Care

Multiple research studies have been published since 2020 detailing the number of Canadians or Ontarians without a family physician. Data on what proportions of those Ontarians that live in rural or remote areas are difficult to find or even estimate, and definitions are not applied consistently across health programs and policies.

"Strong primary care is fundamental to effective, efficient and equitable health care systems"

Source: Trends in attachment to a primary care provider in Ontario, 2008-2018: an interrupted time-series analysis, Canadian Medical Association Journal, September 2023

Even before the pandemic, it was clear that in Ontario, "*attachment… was lower among people with low comorbidity, high residential instability, material deprivation, rural residence and recent immigrants*."[9] [underline added]

Inspire-PHC publishes primary care data reports for all Ontario Health Teams online, including data on having a consistent source of ongoing primary care (attachment). For all OHTs taken together, 1.5 million Ontarians apparently did not have access to primary care in September of 2022 (see following chart). Roughly a quarter of them were in Rural Ontario.

[9] Source: https://www.cmajopen.ca/content/11/5/E809

When rural and small town "unattached" residents are combined, these reports show that in September of 2022, there were at least 376,000 residents of Rural Ontario who do not have access to primary care.[10]

Geographic Classification (using RIO index to classify as rural or not)	Uncertainly Attached; Not Receiving Primary Care (September 2022)
Urban	1,152,086
Small town	257,392
Rural	118,866
Missing/unable to classify	43,193
TOTAL	1,571,539

Figure 1 – Number of Ontario residents without access to primary care in September of 2022. Source: complied from primary care data reports compiled by Inspire PHA and available at www.inspire-phc.org/primary-care-data-reports

RIO (Rurality Index of Ontario) refers to more than 200 communities (municipalities and indigenous communities including First Nations, Metis or Inuit) that are not part of a census metropolitan area. Use of this index means that the number of communities considered "rural" is significantly fewer than the number of communities (census subdivisions) that are part of rural local governments (ex. municipalities that are part of a county). This is a concern to ROMA because the RIO score is used as an eligibility factor for incentive programs offered to rural physicians.

When the data is analysed over a six-month period in 2022, it becomes clear that residents of rural and small-town Ontario are losing access to primary care at four times[11] the rate of urban residents. In other words, Rural Ontario is hemorrhaging access to primary care.

Uncertainly Attached; Not Receiving Primary Care, by Geographic Setting	Percentage Change in Residents Not Receiving Primary Care; March to September 2022 (Six Months)
Urban	1.53
Small Town	6.15
Rural	6.06
Missing	2.05

Figure 2 – Percentage change in Ontario residents not receiving primary care between March and September of 2022. Source: calculations based on primary care data reports compiled by Inspire PHA and available at www.inspire-phc.org/primary-care-data-reports.

[10] Please note that "attachment" is not always clearly established; there are large numbers of other residents who "might" (or might not) be receiving primary care.

[11] 1.53 x 4 = 6.12

The dramatic increase in the number of Rural Ontario residents without primary care is the result of the aging of the existing physician pool, and the larger patient rosters they typically carry. Replacing these physicians in Rural Ontario is particularly challenging due to the preference of recent medical students for specialties other than family medicine upon their graduation, combined with the modest incentives offered by the Province to encourage family physicians to locate in rural and remote areas.

How Bad Was the Situation in 2023?

Applying ROMA's definition of Rural Ontario to job postings for family physicians[12] reveals that of the total 1,528 active postings across Ontario in November 2023, 442 (28%) were from Rural Ontario. These postings were roughly evenly spilt between "rural" communities (241) and small towns and cities (201).

If each physician were able to serve 1,000 patients, this would suggest there are at least 440,000 rural and small-town residents without a family physician. The analysis in this report suggests that the reality is likely much worse. If attachment rates in rural and small-town Ontario continued to decline through 2023 at the same pace as in mid-2022, the number of Rural Ontario residents without a family doctor would have reached **525,000** by the end of December 2023.

Since many retiring family physicians in Rural Ontario may have patient loads of 3,000 to 4,000 each, each job posting may indicate demand for services for as many as 4,000 residents. In this case, the number of Rural Ontario residents without a family doctor may now be well above the 525,000 estimate.

In a ROMA survey of members in mid-2023, nearly a third of respondents (29.7%) said that residents of their municipality "mostly did *not* have access to primary care either in person or virtually". Given that ROMA estimates the number of residents in Rural Ontario to be approximately 2.8 million, it is conceivable that as many as 831,600 residents may be with a family doctor already.

The truth is no one knows.

[12] These postings include physicians with family medicine specialization and could be for clinics, locums, taking over an independent practice or to join a family health team. This data comes from the HealthForce Ontario platform as of November 2023. November 2023 data from Lightcast, an online labour force data and analytics service, showed that job posting intensity was 4:1, double the provincial average for all occupations.

The Situation is Getting Worse

Two thirds (67.6%) of respondents to ROMA's 2023 survey of members said that access to primary care had gotten "somewhat worse", "significantly worse or was a crisis" over the past 12 months. Virtually all Paramedic Chiefs surveyed by ROMA in 2023 reported significant increases in the number of residents without a family physician.

> ***"People who live in rural and disadvantaged areas experience a higher burden of ambulatory-care-sensitive conditions, such as asthma, chronic obstructive pulmonary disease, diabetes, high blood pressure and heart disease."***
> Canadian Institute for Health Information (2012)

Physician retirements are a major reason for the deterioration in access to primary care in Rural Ontario. The age profile of family physicians suggests that Rural Ontario residents will be deeply affected by ongoing retirements[13]. ***The number of residents without access to primary care will easily climb to at least 880,000 by 2028***.

3.3 The Number of New Physicians Needed in Rural Ontario Will Double in Five Years

The number of family physicians required to fill the void left by retiring doctors is stunning. Using the rule of thumb that three new family physicians will be required to replace each family physician retiring from practice in Rural Ontario, ***the number of new physician hires will easily be in the 800 to 900 range by 2028.*** This might be considered a conservative estimate.

Taking into account that other parts of Ontario also need primary care physicians, the competition for family physicians will be intense. Rural Ontario does not have the resources to compete with larger centres for these doctors. ***A significant upgrade to Ontario's Northern and Rural Recruitment and Retention Initiative[14] is urgently required.***

Given the disappearance of primary care physicians and the unprecedented number of Emergency Department closures in Rural Ontario over the past two years, ***the Rurality Index for Ontario (RIO) that establishes both community eligibility and the degree of financial support for physicians must be reviewed and updated immediately.[15]***

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[13] By September 2022, nearly 2.3 million Ontarians were estimated to be without a family doctor. A survey by INPSIRE-Primary Health Care showed that 1.74 million Ontarians have a family doctor over the age of 65. In addition, a recent survey of family doctors by the Ontario College of Family Physicians suggested that almost two-thirds (65%) of family doctors are planning to change (reduce hours) or leave their practice (comprehensive family medicine) by 2028.

[14] The NRRR Initiative offers taxable financial incentives to each eligible physician who establishes a full-time practice in an eligible community. The grants range between $80,00 and $117,600 paid over a four-year period.

[15] Community eligibility is based on three factors: a) population count and density; b) travel time to a basic referral centre; and c) travel time to an advanced referral centre. If travel time to either of these types of facilities has increased due to loss of primary care or hospital Emergency Department closures, a community's RIO score would presumably change.

The State of Access to Services in Rural Ontario Today… continued

> ***"The shortage of family physicians and other primary care providers is a complex Canada-wide problem related to aging of physicians and patients, increasing patient and system complexity, declining interest in family medicine among medical school graduates, and misdistribution of the workforce, especially affecting rural areas. These pre-existing factors have been exacerbated by the pandemic and call for fundamental changes in how we are organized, paid, supported, and deliver care."***
>
> Dr. Rick Glazier, co-author of the study, family physician at St. Michael's Hospital, and a scientist at the MAP Centre for Urban Health Solutions at St. Michael's Hospital and a senior scientist at ICES. As quoted in article on Unity Health Toronto website regarding a study on family medicine, September 2022

Rural Ontario Residents Do Not Have Access to Other Primary Care Services

Two thirds of respondents to ROMA's survey of members (65.6%) said their residents "mostly did not" have access to walk-in clinics. These results suggest that this form of primary care is even less accessible in Rural Ontario than primary care through independent physicians' offices and Family Health Teams.

Pressure Growing for In-Home, Walk-in and Specialist Referrals:

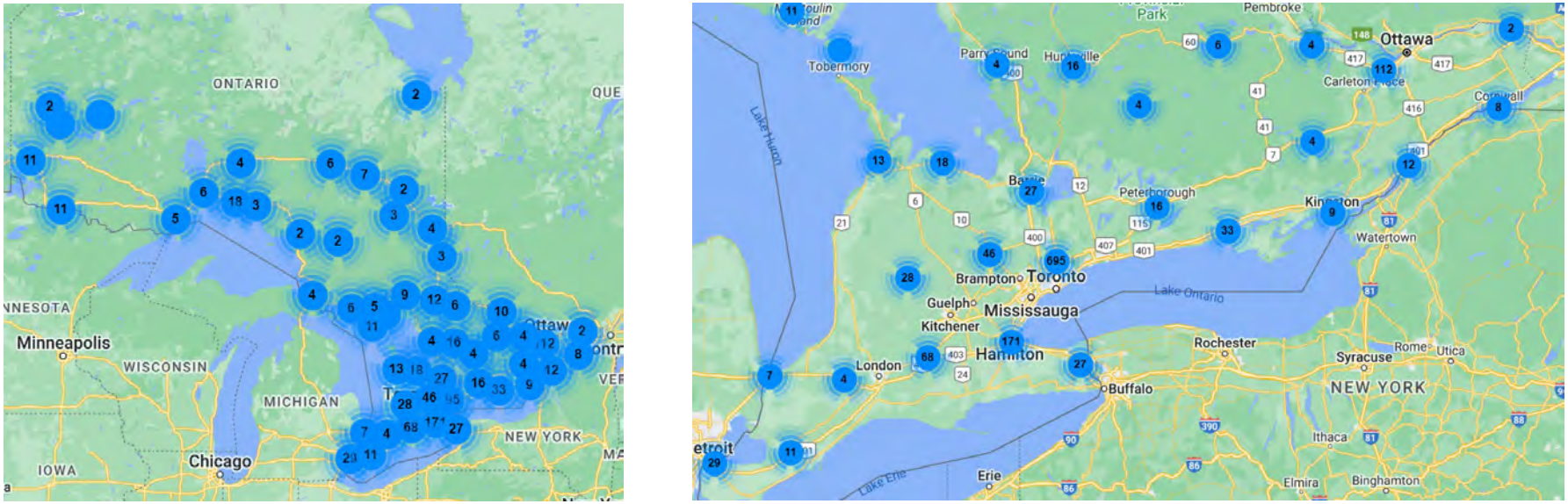
Virtually all (96%) Paramedic Chiefs that responded to ROMA's 2023 survey are seeing increased demand for in-home services such as Community Paramedicine, and one in four (25%) indicate that walk-in clinics are moving to appointment-based operations as a result of increased demand. A significant number of Chiefs (58%) reported an increased number of residents that cannot get a referral to a specialist physician.

Shortage of Family Doctors Puts Significant Pressure on Emergency Departments

ROMA's survey of Ontario's Paramedic Chiefs found that virtually all responding Paramedic Services are seeing increased numbers of residents "without a family doctor at all" (95.8%) As a result, there is an upsurge in 911 calls from residents whose only option for receiving service is to go to an Emergency Department (87.5% of Chiefs report this phenomenon). Nearly four in five responding Chiefs (79.2%) also reported increased numbers of persons who are homeless and without a primary care service option. Presumably, the Emergency Department is their only care option as well.

3.4 Massive Need for Physicians with Family Medicine Specialization: +1,500 Positions Posted Online (Fall 2023)

Aggregated data from HealthForce Ontario employer postings in mid-November of 2023 showed that Ontario needs 1,500 additional family physicians. In Rural Ontario, there were postings from 16 communities in Northern Ontario and 94 in rural areas of Southern Ontario. Note that each posting may represent demand for more than one family physician. Given the extraordinarily competitive environment for health professionals generally and the limited availability of financial supports for physician attraction, the prospects for Rural Ontario to fill these positions is limited.



Geographic distribution of job postings for **Physician positions in Family Medicine**, for the Province of Ontario (left), Northern Ontario (16 communities) and Southern Ontario (right; 94 communities). Note that the numbers in the blue circles represent the number of postings in each community, often from different employers.

Source https://hfojobs.healthforceontario.ca/en/ November 14, 2023

137 postings in total representing 1,532 positions

Additional detail on which communities are seeking physicians with Family Medicine specialization, zoom in on the map found at the URL shown above.

3.4 An Unprecedented Phenomenon in Rural Ontario: Emergency Department Closures

In addition to the catastrophic loss of primary care physicians in Rural Ontario, 2022 and 2023 saw another unprecedented phenomenon: the temporary closure of hospital Emergency Departments (EDs). In 2022 alone, the total number of *days of closure* of hospital EDs in Rural Ontario was 583. Taken together, these closures were equivalent to one hospital ED being closed continuously for 18 months.

In its review of budget allocations to Emergency Departments in Ontario hospitals in March of 2023, the Financial Accountability Office of Ontario (FAO) noted that "*Prior to the emergency department closures in 2022, the FAO is aware of only one unplanned emergency department closure since 2006 due to a lack of doctors.*"[16] The FAO noted that ED closures **"*are primarily an issue in smaller population centres, while the longest ED wait times are more commonly found in hospitals in urban areas*."** In other words, urban hospital EDs were able to stay open.

NOSM Research Project Has Tracked Closures in Northern and Southern Ontario

A research project[17] conducted by the Northern Ontario School of Medicine (NOSM) collected and analyzed data[18] on ED closures across Ontario in 2022 and continued this analysis in 2023. Using social media, mainstream media and hospital website announcements, all known ED closures for the year were collected and analyzed for hospital location, distance to next closest ED and cause of closure (Figure 2). Hospitals' capabilities (critical care, cardiac care, stroke care, trauma care, general surgery and ICUs) were also mapped across the province (Figure 3).

NOSM has continued to track closures throughout 2023, with an eye to understanding what the implications of diverting patients to other Emergency Departments are for treatment and longer-term health outcomes. The closure phenomenon continued into 2023. In the January to November 2023 period (inclusive), there had been 867[19] temporary closures of EDs --- a virtually identical number to 2022: 848. The proportion of closures in Rural Ontario is likely similar to 2022. In other words, ***actions taken by the Province to address ED closures in 2022 were either insufficient or ineffective or both.***

[16] https://www.fao-on.org/en/Blog/Publications/health-2023

[17] Data from *Analyzing emergency department closures in Ontario* in 2022, a presentation by David Savage, MD, PhD, CCFP (EM); study co-authors: Ray Jewett, Peash Saha, Robert Ohle, Bradley Jacobson and Salimur Choudhury at INFORMS Healthcare, Toronto Ontario July 27, 2023

[18] Note that information used to prepare the NOSM report was culled from hospital websites and social media channels so all possible reasons for closures may not be represented in this analysis.

[19] Note that only closures of at least 12 hours in duration were tracked.

NOSM's analysis for 2022 shows that 22 different hospitals were affected by closures (a total of 846), with the overwhelming majority being in southern Ontario. Where a reason for closure was given, *shortages of nurses* was cited in all but one case. In a majority of cases however (58%) no reason was given for the closures (489 of 846).

In its March 2023 report, the Financial Accountability Office for Ontario surmised the reasons for the closures in their March report, noting that the Province's plan to address ED closures *"focuses on measures targeted to increase physician coverage in northern and rural emergency departments*", thereby inferring the reason for closures and the disproportionate impact on rural/small town hospitals. ***Given the catastrophic impact on health services in Rural Ontario, the Province must undertake the analysis necessary to ensure that its measures are responding to all of the factors prompting closures.***

	North	South
Number of closures	2	846
Number of hospitals closed	2	20
Closure length (days)		
Total	1.4	583.1
Mean	0.7	0.7
Minimum	0.4	0.3
Maximum	1.0	58.6
Reason for closure		
Physician shortage	1	1
Nursing shortage	1	353
Physician and Nurse Shortage	0	1
Not specified	0	489
Other	0	2
Distance between EDs (km)	149.7	22.3

Figure 4 - Data from presentation by David Savage, MD, PhD, CCFP (EM); study co-authors: Ray Jewett, Peash Saha, Robert Ohle, Bradley Jacobson and Salimur Choudhury at INFORMS Healthcare, Toronto Ontario July 27, 2023

The State of Access to Services in Rural Ontario Today… continued

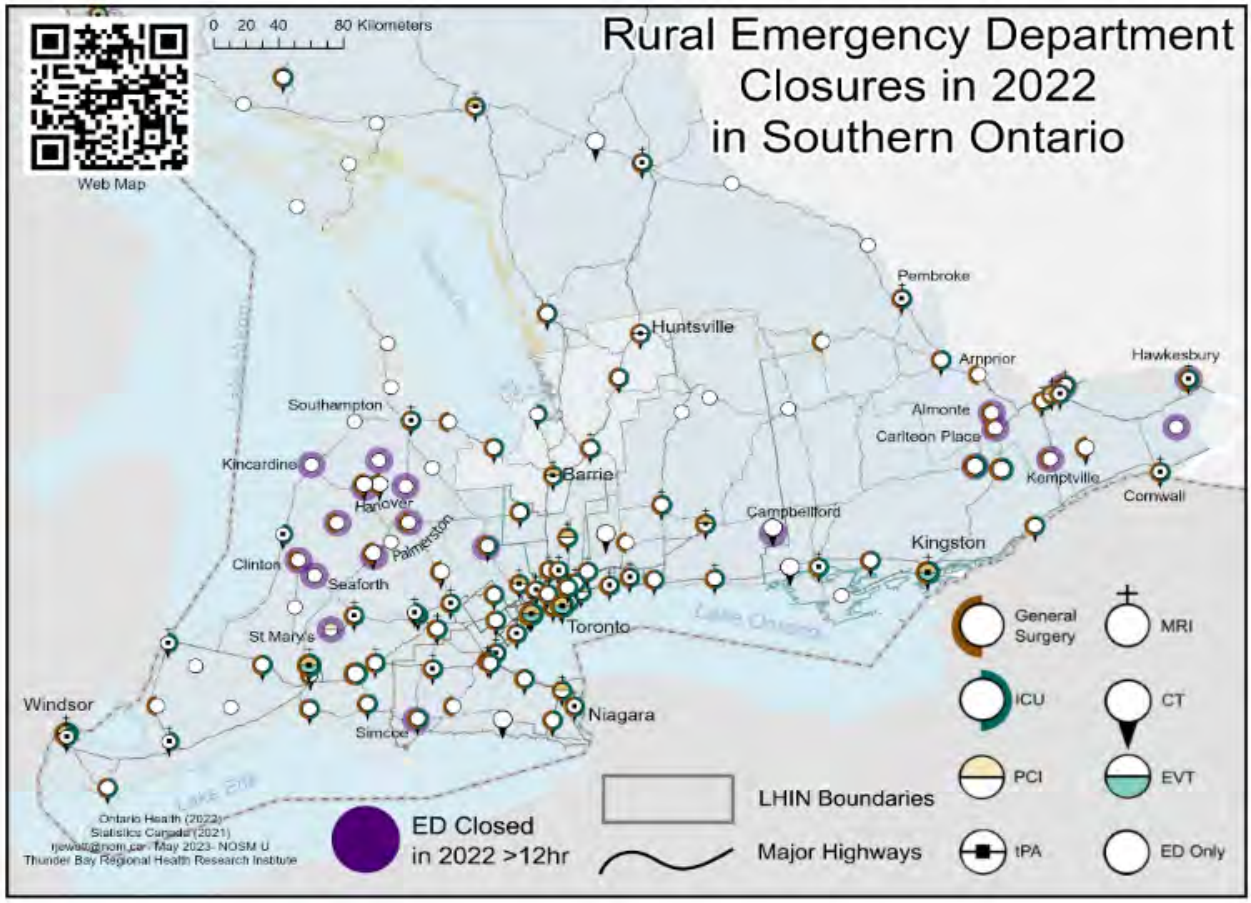


Figure 5 - - Map from presentation by David Savage, MD, PhD, CCFP (EM) with co-authors Ray Jewett, Peash Saha, Robert Ohle, Bradley Jacobson, Salimur Choudhury to Northern Ontario Research Conference, June2, 2023. A map of hospitals in Northern Ontario is presented on a following page.

It is not entirely clear what all the factors were that prompted closures at these particular hospitals but as can be seen in the preceding map, the hospitals that suffered closures were almost all outside of major urban centres. ***ROMA believes this pattern of withdrawal of service deserves a careful and comprehensive review, as the first step in designing a strategy to ensure that rural EDs can provide the 24/7 service that Rural Ontario residents need.*** If the reason for these closures is truly staff shortages (physicians and nurses), this issue will take five to 10 years to address. The current approach is inadequate. In Section 5, ROMA offers multiple recommendations to address staffing shortages and take the pressure off hospital emergency departments.

Figure 6 - Map from presentation by David Savage, MD, PhD, CCFP (EM) with co-authors Ray Jewett, Peash Saha, Robert Ohle, Bradley Jacobson, Salimur Choudrury, Northern Ontario Research Conference, June2, 2023

Beyond distance to another Emergency Department, another observation is that Emergency Departments in southern Ontario close at a much higher rate than in the north. In 2022, only two Northern Ontario hospitals experienced closures; in the same timeframe there were 19 hospitals in Southern Ontario closing their EDs at least once. ***Virtually all of these hospitals are rural/small town hospitals with no diagnostic or emergency services beyond basic ED services***[20].

[20] As noted in the map legend, these services are: general surgery, Magnetic resonance imaging (MRI), Intensive Care Unit (ICU), Computed Tomography (CT), Percutaneous coronary intervention (PCI for coronary artery blockage), Endovascular thrombectomy (EVT: stroke procedure), Ventricular tachycardia (VT: abnormal heart rhythm) , and tPA (clot dissolving medicine used in strokes).

The State of Access to Services in Rural Ontario Today… continued

Hospitals in Rural Ontario typically do not offer the range of ED-related services available to residents of urban areas. Rural hospitals with Emergency Departments rarely have MRI, CT, ICUs and trauma units. This means that vital diagnostic tools and aftercare are not available without delays or transfer to other facilities. In fact, the availability of these services may determine the hospital to which an ambulance is directed when transporting a patient. When directed to a more distant hospital, transport time is increased as well as time to return from that trip. This puts additional stress on paramedic services that are responsible for these transports.

More than a third of respondents (39%) of ROMA's 2023 survey of members said that Emergency Services (ex. Emergency Departments; Paramedics/Ambulances) had "gotten worse" in the past year. This is not surprising given data on Emergency Department closures (temporary or permanent) in 2022 and 2023.

A Deeper Look at Closures across the Province: Beyond the 867 highly visible temporary closures of Emergency Departments, 2023 saw many other temporary closures[21] across Ontario:

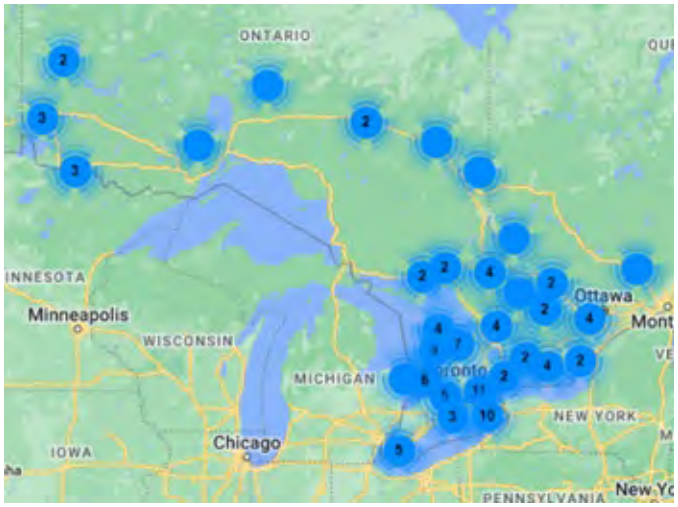
- 316 urgent care centres
- 11 obstetric units
- 1 Intensive care unit
- 2 outpatient laboratories
- 1 labour and delivery unit (long-term closure).

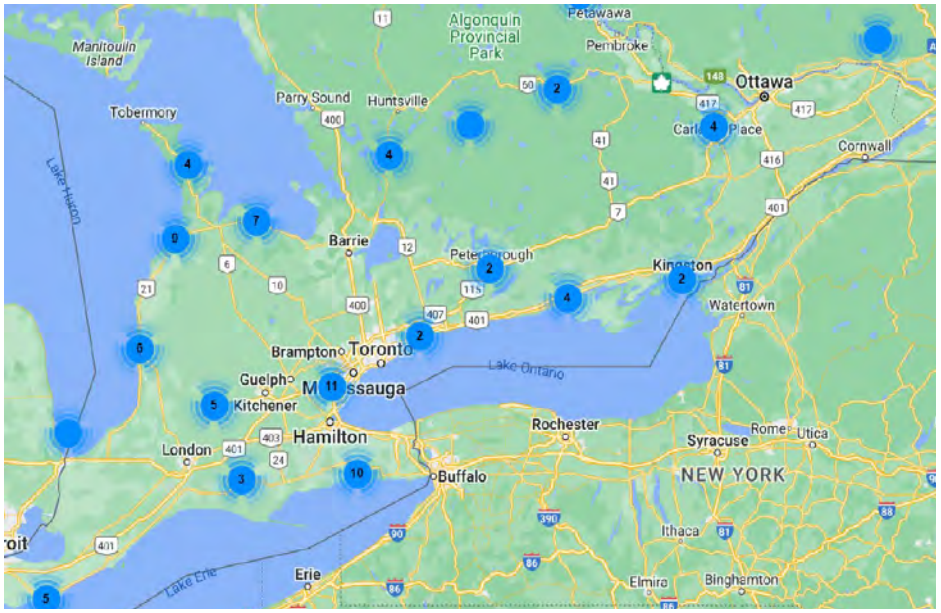
Virtually all types of patients saw a reduction in hospital-based service in 2023, including pregnant women and parents. In the absence of strong primary care, access to services would impose a significant travel burden.

[21] https://www.ontariohealthcoalition.ca/index.php/report-release-unprecedented-and-worsening-ontarios-local-hospital-closures-2023/#:~:text=In%20its%20report%20released%20today,closures%20(one%20is%20permanent)%3B

Pervasive Need for Physicians with Emergency Medicine Speciality: +100 Positions Posted Online

Aggregated data from HealthForce Ontario employer postings in mid-November of 2023 showed that Ontario needs at least 100 additional physicians with Emergency Medicine specialization. In Rural Ontario, there were postings from 12 communities in Northern Ontario and 35 in rural areas of Southern Ontario. Note that each posting may represent demand for more than one emergency medicine physician. Given the extraordinarily competitive environment for health professionals generally and the apparent shortage of physicians with this specialization, the prospects for Rural Ontario to fill these positions is limited.





Geographic distribution of job postings for **Physician positions in Emergency Medicine**, for the Province of Ontario (upper left) Northern Ontario (12 communities) and Southern Ontario (right; 35 communities). Note that the numbers in the blue circles represent the number of postings in each community, often from different employers.

Source: https://hfojobs.healthforceontario.ca/en/ November 14, 2023

108 postings in total

Additional detail on which communities are seeking physicians with Emergency Medicine specialization, zoom in on the map found at the URL shown above.

Emergency Department Closures Reduce Access to Service in Rural Ontario

There is some evidence of negative impact on patient outcomes as a result of delays in receiving emergency care (see inset box). This could happen as a result of an ED closure that required ambulance transport to another more distant hospital or a combination of transport time and wait time at an ED. Therefore, drive time or transport time becomes a critical component of ensuring access to service.

A 30-minute drive or transport time is considered a reasonable standard[22] for emergency departments[23], based on medical assessment as well as travel times used in other jurisdictions. Figure 5 on the following page shows the geographic areas of Ontario whose residents are within 30 minutes drive time of a hospital ED, as well as those that are outside of that drive time. This depiction is based on the assumption that the hospital EDs shown on the map are, in fact, open. As we have seen over the last two years, this is often not the case.

An analysis[24] conducted in 2023 in Ontario compared access to Emergency Department services with and without ED closures. The study compared access based on three different travel times and 14 actual hospital ED closures. The analysis found that 35,808 residents in 29 municipalities[25] would potentially lose access to ED care with a 30 minute travel time.

"Short delays have been associated with increased mortality for severely injured patients or effect patient eligibility for specialized stroke and cardiac interventions. Therefore, although not examined in this study, our results suggest these ED closures may result in patient harm. Additionally, extended transport times for both land and air ambulances increases time to definitive care for patients and reduces the paramedic crew's ability to respond to further emergent transports in that community. Not surprisingly, when one ED closes, the nearest ED then sees an increase in their patient volume, putting further strain on that hospital."

Source: A system in crisis…. K. Larsen, B. Nolan and D. Gomez, National Library of Medicine, March, 2023

[22] A Provincial Framework and Plan created by the Ontario Ministry of Health to support improved access to health care in rural communities included a reference to ensuring that 90% of residents in a community could receive emergency services within 30 minute travel time from their place of residence. The justification of this timeframe was in recognition that an additional 30 minutes would be required for patients to call an ambulance and for paramedics to arrive, assess, begin treatment and load the patient into an ambulance. ED closures in rural communities significantly impair or may make it impossible to meet these Ministry targets.

[23] This includes the Rural and Northern Health Care Report (2010)

[24] Source: A system in crisis: exploring how recent emergency department closures influence potential access to emergency care in Ontario.

[25] Census sub-division, which aligns with lower or single tier municipalities as well as districts in Northern Ontario.

The State of Access to Services in Rural Ontario Today… continued

The analysis concluded that "ED closures have led to decreases in potential access to emergency care for predominantly rural populations" and that "Health Human resource recovery strategies must focus on (geographic) areas where lack of overlap exists."

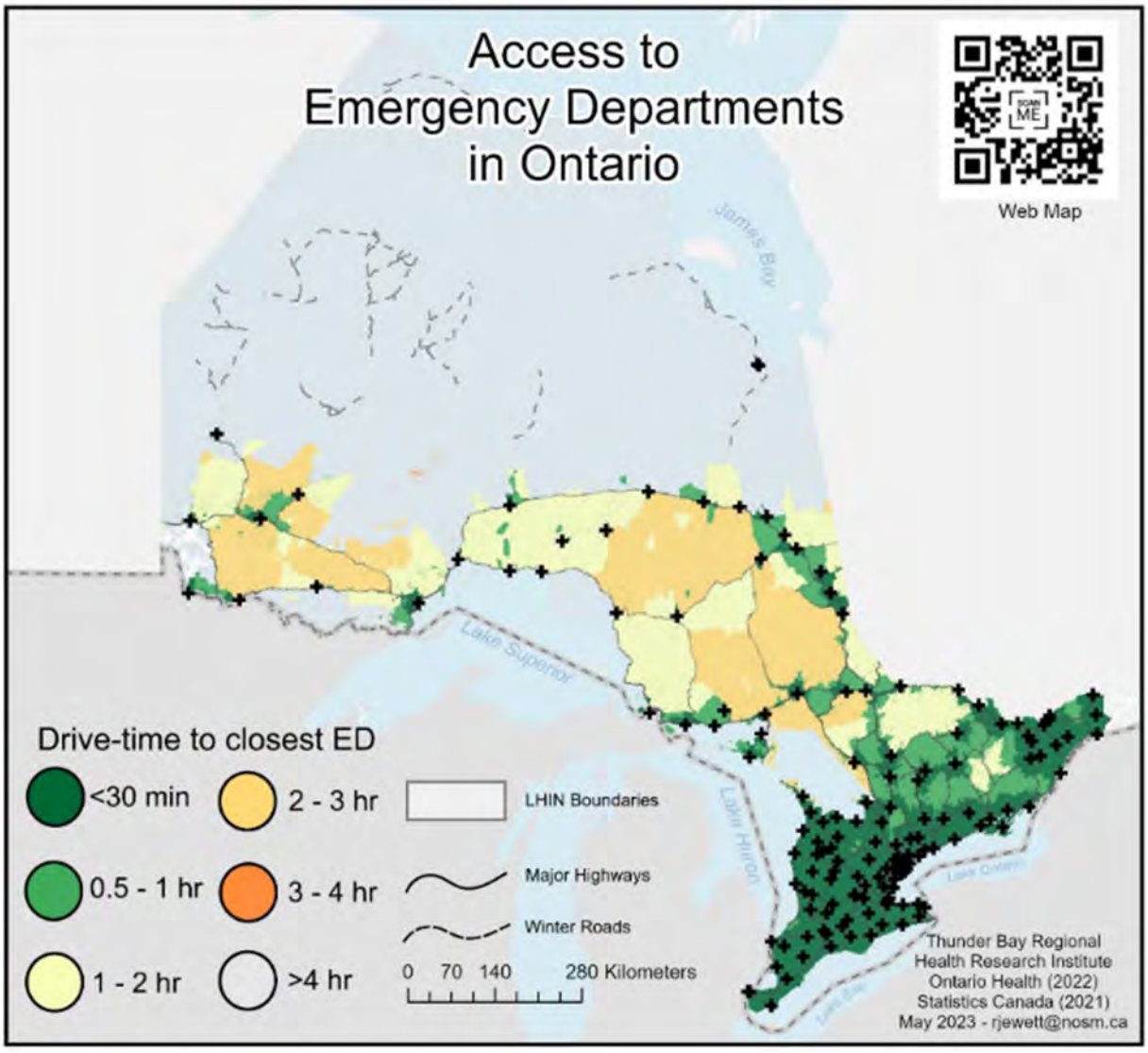


Figure 7 – Map from presentation by David Savage, MD, PhD, CCFP (EM) with co-authors Ray Jewett, Peash Saha, Robert Ohle, Bradley Jacobson, Salimur Choudhury to Northern Ontario Research Conference, June2, 2023

"While our own hospitals have not experienced closure (all large tertiary care centres), the outlying rural hospitals that feed into our system have. This has resulted in our service providing coverage to outlying areas as their own services are challenged by coverage requirement, longer patient transport times, and increasing delays on arrival to the more distant destinations."

Comment by Paramedic Chief in 2023 ROMA Survey

Figure 7 (preceding page) shows the drive-time to the closest ED for all geographies of the province. This map demonstrates that residents in multiple parts of Rural Ontario are not within a 30-minute drive of the nearest Emergency Department[26]. Any colour other than dark green means that residents in those areas are at least a half hour away from an Emergency Department. ***Note that this map assumes that the closest Emergency Department is actually open at the time of need as well as offering the services that a patient requires. Given pervasive ED closures, these criteria have come into question over the last two years, at least for hospitals in Rural Ontario.***

Because there were more closures in late 2022 and 2023 than were assumed in the 2022 "System in Crisis…" analysis, the number of residents of Rural Ontario who are outside the 30-minute boundary as well as the number of residents that were pushed outside the 30-minute boundary over the last two years must be quantified in order to understand the real impact of rural hospital ED closures on access to emergency services.

Travel Burden Falls More Heavily on Shoulders of Residents of Rural Ontario

Travel Burden[27] refers to the *distance* or *time* that a patient must travel, whether by ambulance, by family or friends, or by self-transport. Regardless of travel mode, longer distances or times mean greater costs and inconvenience. This means that travel burden is a key factor in assessing "real-world' access to health services for residents of Rural Ontario. If the Emergency Department a resident would normally go to is closed, the travel burden increases. This means that the hundreds of ED closures in Rural Ontario hospitals in 2022 and 2023 have increased travel burden for these residents.

Residents in large portions of Rural Ontario live more than 30 minutes from the nearest Emergency Department. With the unprecedented and pervasive wave of temporary closures of Emergency Departments over the last two years, drive times to get service are even longer. These increases in travel time disproportionately affects Rural Ontario residents, increasing travel costs[28], caregiver time commitments, and potentially health outcomes.

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[26] More than a decade ago, the Rural and Northern Health Care Report (2010) suggested that a good guideline for assessing adequacy of emergency services was: 90% of residents in a community or local hub will receive emergency services (24/7/52) within 30 minutes travel time from their place of residence.

[27] Multiple researchers have examined this issue, defined by most as trips that lasted either 30 minutes or 30 miles. https://www.ruralhealthinfo.org/podcast/travel-burden-may-2022. A 2021 study conducted in British Columbia, Canada, The rural tax: comprehensive out-of-pocket costs associated with patient travel in British Columbia, estimated the out-of-pocket costs for rural patients to be $856 per respondent for transportation, and another $674 for accommodation. Note that these estimates covered all forms of health care, not just travel to Emergency Departments..

[28] Example: https://www.timminstoday.com/local-news/northerners-still-need-help-with-health-travel-costs-mpp-says-6935264

The data presented in Figure 6 and in map form in Figure 7 show that, as a matter of course, patients in northern Ontario experience a much higher travel burden than in the south. The Northern Ontario School of Medicine analysis shows that the distance *between Emergency Departments,* which may be seen as an indicator of increased travel distance when an ED is closed, averaged 149.7 kms in the north and 22.3 kms in the south.

ROMA has not seen any quantitative analysis that would determine the additional travel burden placed upon paramedic services or patients as a result of redirection from a temporarily closed Emergency Department. However, in a 2023 ROMA survey of Paramedic Chiefs, nearly two-thirds (62.5%) of respondents reported significantly longer distance to transport patients.

Although there are relatively few Canadian studies of the relationship between travel burden and access to health services, a recent study of overall access to health services in British Columbia has highlighted "the existing inequities between rural and urban patient access to health care and how these inequities are exacerbated by a patient's overall travel-distance and financial status."[29] [Underlining added] The same study noted that the research uncovered "physical and psychosocial impacts of travel as well as delayed or diminished care seeking." [Underlining added]

Given the dramatic increase in Emergency Department closures, and the concomitant decline in availability of primary care, ROMA is especially concerned about the as-yet unexamined impact of travel burden on residents' health. For example, the first 60 minutes after stroke onset (the golden hour) is the period of greatest opportunity to save threatened brain tissue[30]. A study of trauma cases in Norway[31] found that pre-hospital time (emergency services response time plus on-scene time plus transport time) increased significantly from urban to remote areas[32],

The Province must undertake analyses to understand the impact of travel burden --- both the financial and health outcome aspects --- on accessibility of health care in Rural Ontario.

[29] Source: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06833-2

[30] Source: https://www.uclahealth.org/news/more-than-a-quarter-of-stroke-patients-arrive-at-get-with-the-guidelines-hospitals-within-the-golden-hour#:~:text=%22The%20'golden%20hour'%20refers,at%20the%20UCLA%20Stroke%20Center.

[31] Whie the medical importance of the golden hour has been questioned by some in recent years, there is some recent evidence that long transport distances from injury sites affect mortality. https://pubmed.ncbi.nlm.nih.gov/37798724/. In this study, prolonged on-scene time --- rather than remoteness itself --- was found to be associated with higher odds of mortality. Note that Norway has a single-payer form of health care with universal coverage.

[32] The study found a correlation between higher on-scene time and the rate of morbidity.

Emergency Department Closures Have Significant Ripple Effects on Other Services

Emergency Department closures affect other health services, especially paramedic services, and walk-in clinics, primary care and community care services that are part of the health services supports for a specific patient.

Because a paramedic service is directed to deliver a patient to the hospital Emergency Department, that can best meet that patient's health service needs, not necessarily the closest one, an ED closure may dramatically increase the travel distance and time associated with ambulance transport. This increases the time that will elapse before the ambulance will be available to respond to new emergency calls. When rural hospital ED closures are occurring at the frequency witnessed in 2022 and 2023, paramedic services must adjust their services, in some cases by adding more ambulances and crews.

Two-thirds of Paramedic Chiefs responding to ROMA's 2023 survey said that the ED closures had led to "significantly longer distances to transport patients" and "increased overtime costs".

One in four (25%) of Paramedic Chiefs responding to the 2023 ROMA survey described the impact of Emergency Department closures on their operations as either "major", requiring a *large and probably permanent reconfiguration of their service*, or "moderate" requiring a *significant/extended reconfiguration of their service*. Another 20% described the impact as modest requiring a *time-limited/short-term reconfiguration of service.* The most common adjustments to paramedic services were increasing a) the number of ambulances available for calls (46%) and b) the number of paramedics on staff to ensure coverage (42%)

With advance planning, services like the Renfrew County Virtual Triage and Assessment Centre (RCVTAC) may be able to take some of the pressure off hospital EDs --- and paramedic services --- by supporting primary care and community paramedicine services delivered at patients' homes.

Increased Offload Delays at Emergency Departments Cause Increased Overtime Costs

Offload delays are situations in which paramedics transporting patients to hospitals are delayed in transferring patients into the care of hospital staff. This can happen because of high volumes of patients already at the hospital or insufficient staffing or other resources to handle a surge. A delay of more than 30 minutes is especially serious because it means the paramedic service cannot reassign the ambulance and its crew to another emergency that may have arisen during the initial transport.

Offload delays have been a challenge for ambulance services for years, but they exploded in prevalence and cost to the healthcare system both during and after the pandemic. Nearly one in three responding Paramedic Chiefs (29%) said that ED closures resulted in a much higher incidence of trips with offload interval delays (above 30 minutes) at other hospitals.

Permanent Closure of Rural Emergency Department in 2023

In June of 2023, the Emergency Department at the Minden site of Haliburton Highlands Health Services closed permanently due to staff shortages and all emergency services were transferred to the Haliburton site, roughly 25 kilometres away. This is the only permanent closure in Ontario since the pandemic but many EDs (especially in the north) are struggling to remain open. The Province is now funding an urgent care centre at the Minden site, operated by Kawartha North Family Health Team. The service is treating patients with "unexpected but non-life-threatening" conditions through walk-ins and booked appointments. The Minden hospital still offers out-patient X-ray, Bone Densitometry and Physiotherapy by appointment. In addition to a 62-bed long-term care facility, program offices for supportive housing and diabetes education are on-site, the Geriatric Assessment and Intervention Network (GAIN) offices are next door.

> ***"There is no playbook anymore"***
> Comment from front-line healthcare staff member

Opportunities to Redirect a Significant Number of Visits from Hospital Emergency Departments

The 2009 report of the Office of the Auditor General of Ontario[33] questioned whether a significant share of visits to the Emergency Department of hospitals could be avoided, and undertook audit work to understand the degree to which EDs are being used inappropriately by some citizens. Whie the audit report is more than a decade old, its conclusion may still be valuable in understanding patterns of ED use today.

"The opinion of the 2006 expert panel on Improving Access to Emergency Care was that diverting low-acuity patients would only minimally reduce the demand for emergency departments and only minimally impact wait times. However, we noted that, province-wide, about half of emergency department visits were made by patients with less urgent and non-urgent needs, who could have been supported by other alternatives such as walk-in clinics, family doctors, and urgent care centres. We estimated that such patients took up 30% of emergency department physician time, which could have been spent on patients with more urgent conditions". [Underline added]

In encouraging redirection of less urgent ED visitors to other services, the Auditor General may have assumed that the alternatives (walk-in clinics, family doctors, and urgent care centres) were available for those patients. ***For much of Rural Ontario, these alternatives may not be available at all let alone in reasonably close proximity***.

[33] The Auditor General's office undertook audit work at three hospitals (Hamilton, Scarborough General and Southlake Regional Health Centre), as well as a survey of 40 hospitals of varying sizes,

Creating or expanding these services in Rural Ontario to divert a significant proportion of inappropriate visits from rural hospitals' EDs, and free up ED physicians' and nurses' time, is a strategy worth serious consideration. And given, the long wait times in Ontario's emergency departments, both health outcomes and patient satisfaction might be improved as well.

Overall, Health Services in Rural Ontario Are Deteriorating Rapidly

Paramedic Chiefs identified major impacts in their service areas from shortages of doctors and/or primary care services or strains on walk-in clinics. Beyond these impacts, Paramedic Chiefs are seeing significant increases in calls related to other health issues, such as mental health (12.5%), addictions and substance abuse (8.3%).

Impact of ongoing shortage of doctors and/or primary care services or the strain on walk-in clinics	Percentage of Responding Paramedic Chiefs Citing This Impact	Number of Responding Paramedic Chiefs Reporting This Impact
Increased number of residents without a family doctor at all	95.8	23 of 24
Increased demand for in-home services including Community Paramedicine	95.8	23 of 24
More 911 calls from residents who don't have a family doctor; their only option is to go to the Emergency Department	87.5	21 of 24
Increased incidence of calls related to mental health and/or substance abuse	87.5	21 of 24
Increased numbers of persons who are homeless and without a primary care service option	79.2	19 of 24
Increased number of residents that cannot get a referral to a specialist	58.3	14 of 24
Walk-in clinics moving to appointment-based services due to increased demand	25.0	6
Other impacts (no walk-in clinic; ambulance offload delay increases; increased pressure on hospital EDs)	25.0	6

Figure 8 – Results from ROMA's 2023 Survey of Paramedic Chiefs

Addressing Health Service Challenges is More Difficult in Rural Ontario

More than 80% of responding Paramedic Chiefs[34] said that addressing health system challenges is more challenging in rural and remote areas than in urban areas. A third of these respondents (33%) said that it is "significantly more challenging to address" these issues in rural and remote areas --- so much so that a ***very different strategy/approach is required.***

3.5 Across-the-Board Labour Shortages in Health Care

In addition to physician shortages, whether in primary care or in Emergency Departments, there are also significant shortages of other healthcare professionals, as measured by job postings. While physician job postings are focused on the HealthForce Ontario portal than generic digital job boards, the opposite appears to be true for nursing jobs. In this case, it appears that postings are more frequently made on conventional digital job boards (ex. Indeed), on employers' websites or at association websites (ex. www.rncareers.ca) than through HealthForce Ontario's portal. Personal Support Worker (PSW) jobs are also posted on the RNAO site.

Position Type	Total Jobs – HealthForce Ontario (Ontario-wide)	Total Jobs – Other Digital Job Boards
Physicians – All types	2,707	
Physicians – Family Medicine	1,532	
Physicians - Psychiatry	136	
Physicians – Emergency Medicine	108	
Nurse Practitioners – All Types	83	261
Registered Nurses – All Types	306	3,278
Registered Practical Nurses – All Types	190	

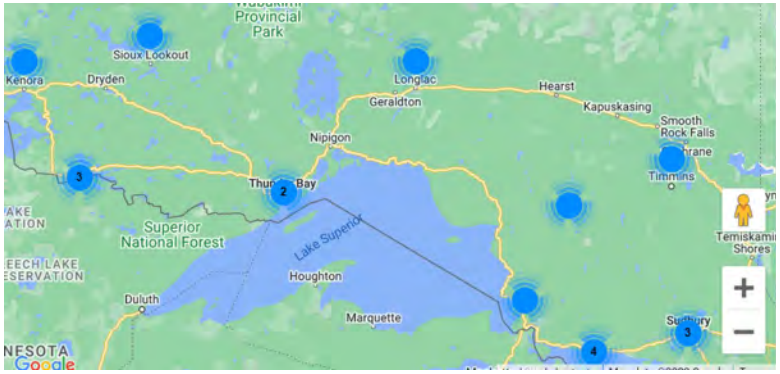
Figure 9 - As at December 1, 2023 Source: https://hfojobs.healthforceontario.ca/en/map/?p=10

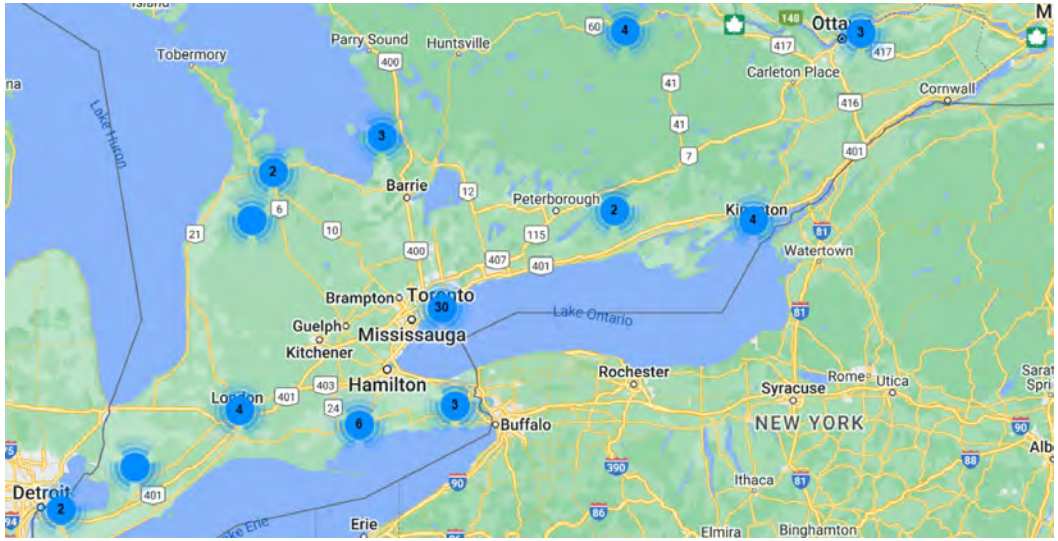
[34] There are 56 paramedic services in Ontario; 24 chiefs responded to the ROMA survey. Most responses were from chiefs of services with significant rural areas of service.

Nurse Practitioners Are Needed Everywhere

As a professional group, there were relatively few nurse practitioners in Ontario: 3,912 compared to 162,000 nurses (2021). There were only 83 job postings on the HealthForce Ontario site (shown in map form below). Posting distribution appears to be well-distributed across Northern Ontario (16) and Southern Ontario (67) and were from employers in 25 communities. These maps underestimate actual demand; in the fall of 2023, there were 260 job postings for nurse practitioners on other digital job boards.

Note that demand for nurse practitioners in 2023, as measured by total postings is twice as high as the increased number of spaces being opened up at Ontario universities (121) in 2024. In other words, there will likely be a significant shortage even after the first cohort of additional students graduate. Given that the Province has an existing program for nurse practitioner-led clinics with an expectation that these will be especially useful in rural and remote communities, Rural Ontario is unlikely to be able to address much of its primary care challenge without a significant acceleration/further expansion of education and training opportunities.



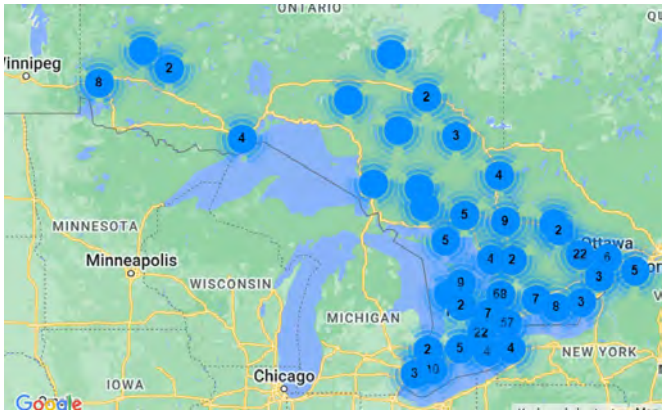


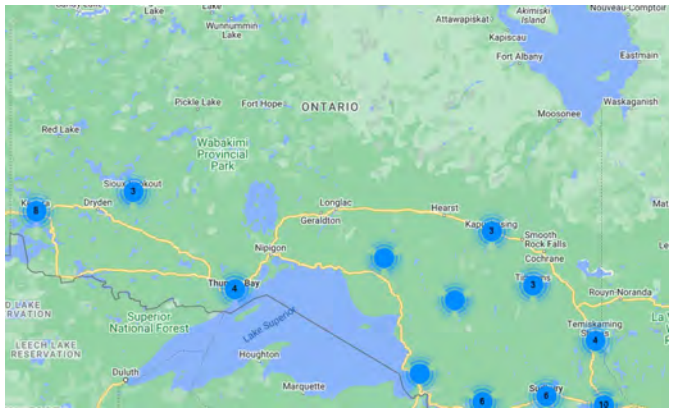
Geographic distribution of job postings for **Nurse Practitioners**, for the Province of Ontario (left) and Southern Ontario (right)
Source https://hfojobs.healthforceontario.ca/en/ December 1, 2023
Postings totaled 83 and were split between Southern Ontario (67) (across 15 different communities) with 16 in Northern Ontario (across 10 different communities). Note that the numbers in the blue circles represent the number of postings in each community, often from different employers.

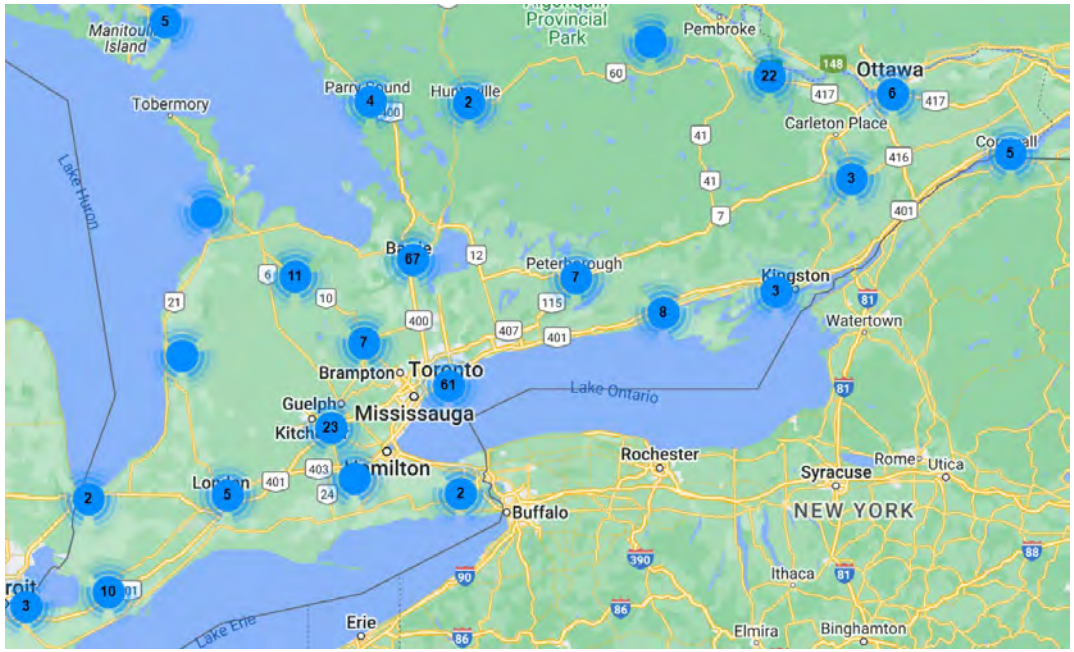
Additional detail on which communities are seeking nurse practitioners, zoom in on the map found at the URL shown above

Very Strong Demand for Registered Nurses: +3,000 Positions Posted Online in Fall 2023

As a professional group, there were 162,000 nurses – all types, in Ontario in 2021. In the fall of 2023, there only 306 job postings on the HealthForce Ontario site (shown below) and 10 times as many on generic digital job boards (3,200). In other words, most job postings for nurses were not on the HealthForce Ontario site. ROMA is flagging this issue to ensure that if the Province is using HealthForce Ontario postings data to assess or forecast demand for nurses, HealthForce Ontario will not provide an accurate picture of the situation. HealthForce Ontario reflects demand from only 44 Northern and Southern Ontario employers. The Province will need to use every tool at its disposal if Ontario's healthcare system is to be able to staff nursing positions in the entire range of health service settings. Accurate estimates of demand for nurses, especially in Rural Ontario, would be a good place to start.







Geographic distribution of job postings for **Registered Nurse** positions – All Types of Practice
for Province as a whole (upper left: 306 postings); Northern Ontario (lower left; 12 41communities) and Southern Ontario (right; 32 communities)
Note that the numbers in the blue circles represent the number of postings in each community, often from different employers.
Source https://hfojobs.healthforceontario.ca/en/ December 1, 2023

Both during and since the COVID-19 pandemic, it is clear that Ontario had not predicted nor developed solutions for the health professional shortages now evident. There is no reason why Rural Ontario should be facing current and projected shortages other than not being understood by successive provincial governments stretching back several decades.

Despite some provincial initiatives to increase enrolments in healthcare professions and to fast-track international professionals attracted to Ontario, this catastrophe will not be resolved in any meaningful way in much less than a decade. This does not mean that nothing can be done. In this report, ROMA suggests multiple ways of redeploying healthcare professionals for maximum benefit to the healthcare system and the Rural Ontario patients that rely on it.

There is no time to waste in responding to the health human resource catastrophe in Rural Ontario. The Province must begin immediately to evaluate, refine and implement the recommendations contained in this report.

3.6 Capacity Required to Address the Mental Health Challenges in Rural Ontario

One of the most challenging healthcare issues for rural and northern communities to address is the upsurge in demand for mental health services, both during and following the pandemic. While this issue affected both urban and rural communities, addressing it in Rural Ontario is made more difficult by other factors ranging from the relatively weak system of healthcare and social services supports, to lower than average incomes, social isolation, and the absence of easy-to-access transportation systems.

> ***"I hear a lot of talk about health team restructuring, and policing. Those things don't necessarily make that difference when doctors, nurses and allied health care professionals just aren't here/available. I want it to work, I want it to make sense of the mental health landscape, but alas, it seems we are to wait, and leadership feels uncertain."***
>
> *Comment from respondent to ROMA member survey 2023*

In ROMA's 2023 survey of members, 60 per cent of respondents said that residents of their communities did not have access to mental health and addictions services. They also said the service situation in their communities was deteriorating: half of respondents said the availability of these services was now "somewhat worse" (31%) or "significantly worse or a crisis" (18%).

Rural communities --- and certainly rural hospitals --- pay a heavy price for inadequate availability of mental health supports. A 2019 analysis showed that **"…the use of emergency departments (EDs) for psychiatric reasons is two-fold higher in rural versus urban Ontario…"**[35] The same report noted that due to the lack of psychiatrists in rural communities, rural populations often rely more heavily on psychologists, nurses, primary care physicians, and emergency physicians as well as informal supports such as family and friends.

For **psychiatry**, the only publicly-available estimates of wait time for accessing psychiatric services suggests that, across Canada, this process takes four months, with children and youth waiting up to 2.5 years[36]. In Ontario, wait times appear to range between four months and a year[37]. Of the 1,900 registered psychiatrists in Ontario, the majority practice in mostly urban areas.

> *"The economic costs of **mental health and addiction** have been estimated at $39 billion annually, three-quarters of those from productivity losses. **Ripple effects** are felt in the justice, educational and social services sectors."*
> *Source: Commission on the Reform of Ontario's Public Services, 2012*

The recent announcement of continued rollout of the **Ontario Structured Psychotherapy Program**[38] is intended to improve the availability of mental health services, However, the effectiveness of this service will be limited unless there is a conscious effort to put in place the follow-up and community support services once patients access the the OSP program. ROMA has seen no evidence that the development and funding of these services has been considered as part of the implementation of the OSP program in Rural Ontario.

[35] Source: The Landscape of Mental Health Services in Rural Canada, article in University of Toronto medical journal, Erik Loewen Friesen, Department of Medicine, University of Toronto, March 2019

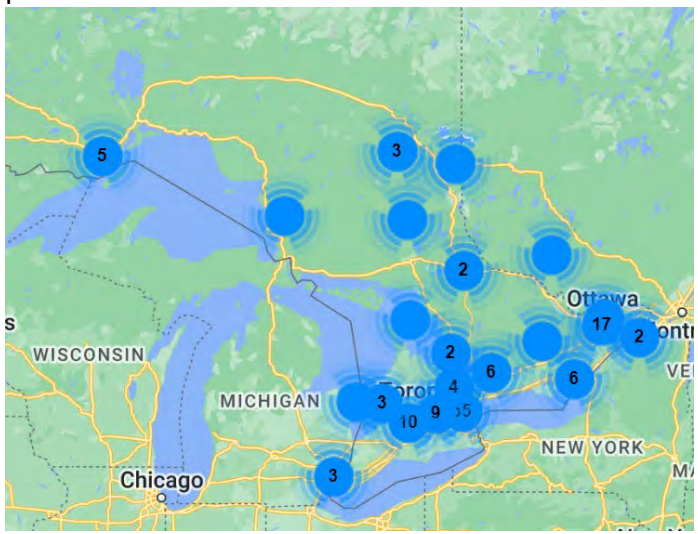
[36] https://resolvve.ca/blog/psychiatry-wait-times-in-ontario#:~:text=But%20in%20Ontario%2C%20it%20takes,2.5%20years%20for%20psychiatric%20services.

[37] https://resolvve.ca/blog/psychiatry-wait-times-in-ontario#:~:text=Psychiatrists%2C%20unlike%20psychotherapists%2C%20can%20diagnose,year%2C%20to%20see%20a%20psychiatrist.

[38] Source: https://www.ontariohealth.ca/getting-health-care/mental-health-addictions/depression-anxiety-ontario-structured-psychotherapy

Demand for Psychiatrists Equals that for Emergency Department Physicians: +130 Positions Posted Online

In the fall of 2023, there were more than 130 job postings for Psychiatrists in Ontario. Six communities in Northern Ontario and 21 communities in Southern Ontario were seeking psychiatrists. The number and distribution of postings is similar to that of Emergency Department physicians. Given that there are fewer than 2,000 psychiatrists practising in Ontario now[39], that half of them are nearing retirement, and the education and training period for psychiatrists is 10 to 12 years, Rural Ontario is not likely to see its needs met for some time. As a result, there is a need for creative thinking about how to ensure that psychiatric services are available across the entire province.



Geographic distribution of job postings for **Physicians – Psychiatry**
for Province as a whole (left: 136 postings); Northern Ontario (6 communities) and Southern Ontario (right) (21 communities)
Source: **https://hfojobs.healthforceontario.ca/en/** December 1, 2023
Note that the numbers in the blue circles represent the number of postings in each community, often from different employers.

[39]https://ontario.cmha.ca/news/how-should-ontario-tackle-the-psychiatrist-shortage/#:~:text=A%20new%20report%20highlights%20the,over%20half%20are%20approaching%20retirement.

Data released by the Canadian Institute of Health Information (CIHI) in November of 2023 indicates that half of *Canadians* **wait** about a month for ongoing **mental health counselling** services in the community. However, 1 in 10 wait nearly five months.[40] While CIHI provides wait times to access these services by province, data for Ontario is not yet available. ***The Province must make data on wait times for mental health counselling in Rural Ontario available to support program and service delivery planning and implementation.***

CIHI has also released data indicating that 1 in 10 Canadians who **visit the Emergency Departments with help with mental health and substance use** do so at least four times a year and that nearly half of them (47%) go to the ED for help with both mental health and substance abuse issues. In 2019, ED visitors to Ontario EDs for these reasons visited four or more times a year (slightly above the national average). By 2020-2021, this percentage had risen to 10.6% and then declined slightly to 10.4% in 2021-2022 (Source: Ontario Health Annual Report.). ***The Province must take the needs of this population into account when planning and funding rural hospital ED services as well as community care services.***

Time to Revisit the Local Health Hub Concept? A decade ago, the Ontario Hospital Association developed a concept[41] referred to as Local Health Hubs, with the specific intent to support small, rural and northern communities. The goal of local health hubs was to "improve access and delivery of the entire healthcare system to rural communities by integrating most or all healthcare sectors at a single rural hospital or healthcare centre". [Underlining added]

Mental health care was proposed as one of the services to be available at the hub[42]. The expectation was that the concentration of services would facilitate better communication between healthcare sectors and help rural patients to access a full complement of healthcare services at a single location.

The local health hub model would also capitalize on health human resources already present in the community (e.g. primary care physicians) and support the delivery of telepsychiatry services to rural residents.

[40] Average wait times for children and youth is 67 days for counselling and therapy and 92 days for intensive treatment. Source: Kids Can Wait report by the Canadian Mental Health Association, 2020. The same report notes that "There are significant inequities in wait times based on where you live, how old you are, who you are and what type of treatment you need".

[41] The concept is described in: Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come, Jim Whaley, 2013

[42] Other services could have included improved screening and treatment of mental illness, primary care in and potentially traditional healing services for First Nations patients.

The OHA concept is somewhat similar to ROMA's ecosystem proposal in its *Opportunities* paper although recognizing that not every community has a hospital, ROMA envisaged a diverse set of physical site locations including but not limited to hospitals or healthcare centres.

> ***"Mental health care, however, is not solely the responsibility of psychiatrists. It is also provided by other mental health practitioners such as psychologists, nurses, primary care physicians, and emergency physicians as well as informal supports such as friends and family. Due to the lack of psychiatrists in rural communities, rural populations often rely more heavily on these alternative sources of mental health support. Indeed, the use of emergency departments (EDs) for psychiatric reasons is twofold higher in rural versus urban Ontario, and strategies to improve mental health support in the primary care setting have been proposed and implemented in rural Ontario and across Canada."***
>
> Source: The Landscape of Mental Health Services in Rural Canada, article in University of Toronto medical journal, Erik Loewen Friesen, Department of Medicine, University of Toronto, March 2019

Mental Health and Material Deprivation Closely Linked

Ontario Health has reported that 47% of frequent visitors to Ontario's hospital Emergency Departments were from the most materially deprived quintile[43]. This suggests that better availability of community services, combined with services to address deprivation (ex. housing, food insecurity, financial resources) will be required to reduce certain types of ED visits In Rural Ontario.

Despite the understanding that support services are vital to patients experiencing mental health challenges, ROMA notes that the Ontario Structured Psychotherapy Program does not offer any of the following supports. ROMA has seen no evidence that this gap in service planning is being addressed in Rural Ontario.

Services that are not part of the OSPP are:

- Dialectic behavioural therapy (DBT)
- Crisis management
- Housing support
- Case management
- Chronic pain management
- Medication management
- Financial support
- Substance use counselling
- Relationship counselling
- Legal services.

[43] This measure assesses the "material deprivation" dimension of the Ontario Marginalization Index, developed by Public Health Ontario, in collaboration with St. Michael's Hospital, using data from the 2021 Canadian census. The index is related to poverty and measures the inability of individuals and communities to access and attain basic material needs. The Index can be used for: planning and needs assessments, resource allocation, monitoring of inequities, and research. It is not clear if the Index has been applied to neighbourhoods outside the Greater Toronto Area, but it could be.

The State of Access to Services in Rural Ontario Today… continued

Prospects for success in addressing the mental health needs of Rural Ontarians and diverting related visits to rural Emergency Departments requires a strategy to fill the gaps --- from psychiatry and psychotherapy to counselling and other community supports.

Increased Visits to EDs, Hospitalizations and Deaths Due to Opioid Use

Along with many expressions of deep concern from individuals participating in ROMA's project interviews, there is also some quantitative evidence of a dramatic rise in ED visits by individuals with opioid challenges, starting in 2015-2016 and escalating through the pandemic.[44] Nonetheless, the longitudinal patterns vary markedly across health units and it is not clear --- other than anecdotally --- what factors are driving opioid-related morbidity and mortality, especially in Rural Ontario.

Public Health Ontario's Interactive Opioid Tool shows the relationship between opioid cases and ED visits, hospitalizations and deaths across Ontario. Hospital EDs closures in Rural Ontario reduce response capacity and potentially health outcomes. These data should be analyzed to support local addictions and substance abuse program planning.

In what is referred to as "the shadow epidemic", researchers are now beginning to focus on understanding the "context within which overdoses take place in smaller regions."[45] A report from one health unit in Ontario, with both urban and rural areas, noted the disproportionate presence of the following factors in opioid-related deaths: a history of incarceration, use of opioids while alone, not accessing opioid substitution therapy treatment, and mental health diagnoses or chronic pain. The report calls for a "robust approach to decreasing opioid-related harm integrating telehealth, technology and progressive policies including providing a safe supply…".

A separate report, undertaken by Toronto Public Health, compares accidental opioid deaths in the City of Toronto to the rest of Ontario. The report notes that in the "rest of Ontario", attempts to resuscitate the deceased individuals were made in 48% of cases, most often by emergency responders. Sixteen (16) % of those dying from overdoses in the "rest of Ontario" were homeless at the time of their death but shelter status was unknown for 5% of deceased individuals. The "rest of Ontario" clearly includes both urban and rural areas; all of Rural Ontario would fall into that category.

[44] Source Public Health Ontario

[45] Source: Opioid Deaths in the Kingston, Frontenac, Lennox and Addington Health Unit, Authors, Stephanie Parent, Samantha Buttemer, Jane Philpott, and Kieran Moore in Health Promotion and Chronic Disease Prevention in Canada, February 2023

If data related to health, mortality and use of health services by opioid users is available for the entire province, it should be released in support of service planning. If not, ROMA challenges the Province to fund, either directly or through Public Health Ontario, a study for the rest of Ontario, similar to that carried out by Toronto Public Health.

Community Safety and Well-being Plans Not Bearing Fruit

Of ROMA member survey respondents, only 14 per cent of ROMA member survey respondents said that implementing the Community Safety and Well-being Plan had improved access to health services for their residents. Forty per cent respondents (40.3%) said the plans had not improved access, and the balance of respondents (45.9%) chose the "don't know/can't say" option.

Comments made as part of the survey suggested there are a few good initiatives arising from these plans (example: not-for-profit Board application to the Ministry of Health for a Primary Care Nurse Practitioner-led clinic) but overall, the implementation process may not yet have begun or is proceeding slowly. The lack of staff across various services, as well as lack of operational funding, are major contributors to the slow rollout.

If the Province expects to see significant progress on this front in Rural Ontario, there will need to be financial support directed to municipalities and community groups for implementation and operations. This support must be provided regardless of detachment size or the structure of law enforcement in those communities (e.g. Ontario Provincial Police or municipal force).

Mental Health Crisis Intervention Teams Not Comprehensively in Place Across Ontario

A recent survey of Ontario Paramedic Chiefs[46] found that only a third (33%) of the communities they served "mostly had access" to mental health crisis intervention teams, with 20% "working on this issue now". Where the teams exist, respondents offered observations on service limitations (e.g. the service is only available on weekdays; demand outstrips available teams; there is a need for better coordination and multidisciplinary team composition).

3.9 Access to Community Services: Home Care, Mental Health Counselling and Substance Abuse

Data released by the Canadian Institute of Health Information (CIHI) in November of 2023 indicates that the median wait time for Canadians to receive **home care** services that are paid for by government is four (4) days. This means that 50 per cent of Canadians wait longer than four days. **Ontario's median wait time is also 4 days.**

[46] The survey was distributed to all 56 Paramedic Chiefs in the fall of 2023; 24 responded with most respondents being from services with significant rural and/or remote areas. The overall response rate was 42 per cent.

ROMA calls upon the Province to be transparent about the distribution of wait times, including what percentage of Rural Ontarians receive home care immediately after hospital discharge and what percentage wait more than a month.

Regardless of service type --- mental health counselling or substance abuse or home care, community services in Rural Ontario do not have the financial or staff resources to serve the many residents who are using Emergency Departments unnecessarily. And yet, funding the development and expansion of these services is one of the most cost-effective health service policies the Province could adopt. The most prominent examples of populations that could be served through a more robust network of community care services are populations who are experiencing mental health challenges, those who are mobility-challenged and without family doctors**,** and those who are homeless.

3.10 Homelessness is a Challenge in Rural Ontario Too!

It is often assumed that homelessness is an urban problem, exacerbated by migrants from rural areas that go to cities in search of employment, shelter and supportive services. However, a research study undertaken by the Rural Ontario Institute in 2017 found that:

- Homeless was just as prevalent in rural areas/small population centres that are not part of a Census Metropolitan Area as in large urban centres. Homelessness had been experienced by 2.1% of rural populations (about 22,545 people) as compared to 2.0 % of urban residents (204,422 people)
- Residents of rural areas were more likely to have experienced hidden homelessness than residents of urban areas (9.7% compared to 7.5%; only residents 15 and over included)
- Women were more likely to be homeless in rural areas rather than in urban centres.
- Younger people (aged 15-34) were more likely to be homeless in rural areas than in urban centres.
- Persons with aboriginal identity were more likely to be homeless in urban centres than in rural areas.
- Access to services was highly variable by service and by region (north as compared to rural southern Ontario). Health and social services were viewed as being most accessible by those who are homeless while shelter services, and legal/court services are least likely to be accessible.

Table 10: Estimated percentage of rural/northern people who are homeless and deemed able to access services

Services	80+%	60-79%	40-59%	20-39%	<20%	Don't know
	%	%	%	%	%	%
Health services	24	15	15	13	13	20
Social services	26	19	14	13	11	17
Shelter services	10	8	10	12	43	17
Legal/court services	13	9	17	14	22	25

Figure 10 - Excerpt from Homelessness and Hidden Homelessness in Rural and Northern Ontario, 2017

While homelessness has been a challenge prior to the pandemic, the upheaval to the housing sector as well as the extraordinary service demands placed on healthcare organizations, social service and public health organizations across Ontario has likely led to a significant increase in homelessness and precarious housing. Before offering recommendations for solutions, It will be important to search out information to either validate or discount this assumption.

For the purposes of this report, ROMA's focus is on looking for ways to ensure that health and social services are, in fact accessible to homeless populations in rural and remote areas. This will mean advocacy to expand the availability of these services as part of "filling the gaps' in the array of community services for the entire population of Rural Ontario, whether homeless or not.

3.11 Transparency Required in Restructuring Public Health

In August of 2023, the Province of Ontario offered funding to public health units that merge voluntarily. This restructuring is described as an effort to clarify public health roles and responsibilities to reduce overlap and ensure public health care is aligned with provincial priorities as outlined by Ontario's Chief Medical Officer of Health. Provincial announcements have also clarified that the funding formula for public health units will return to the 2019 version, in which the Province pays 75 per cent and municipalities pay 25 per cent.

ROMA's consultations with Public Health officials generated strong recommendations to ensure that as Public Health governance and structures change, ROMA continues to highlight the importance of a "rural voice" in what will be much larger, urban-based organizations. Often, the impact of policy, program or service changes on rural populations is not studied to any degree. An example is Public Health's ability to support Healthy Babies Programs in areas

where new mothers may not have transportation and Health Unit nurses can cover less ground each day than they can in densely-populated areas. These factors could essentially make an important health program inaccessible to new or young mothers. Overall, reduced emphasis on prevention programs as a result of health unit consolidation and associated budget reductions could incur a very heavy long-term cost.

There is a "return on investment" from Public Health. The North Wales Local Public Health Team (UK) conducted a systematic review of studies that calculated an ROI or cost-benefit ratio (CBR) for public health interventions in high income countries. The review found that the *median* Return on Investment from a range of existing public health interventions was 14.3 to 1. In other words, every dollar of investment in prevention generated $14.30 in healthcare savings. In this study, ROIs ranged from -21.27 for influenza vaccinations of healthy workers to 221 for lead paint control. In other words, the return on investment from reducing exposure to toxic chemicals is far greater than for some types of vaccinations given to otherwise healthy people.

This study also calculated a cost-benefit ratio (CBR) with which to evaluate the economics of investments in public health. The CBR is the benefit divided by the cost. On this evaluation, CBRs reported ranged from 0.66 (reduced speed limits in specific areas) to 167 for single measles vaccinations. In other words, measles vaccinations had a much higher benefit to cost ratio than did some other measures.

As is noted in this study, many public health interventions with high ROI are not funded. This may well be the case in Ontario where other "immediate" priorities have taken precedence. When undertaking long-term planning for Ontario's healthcare system, particularly in Rural Ontario, reducing commitments to public health is short-sighted.

3.12 Transportation Is Seen as Part of A Multi-Pronged Approach To Improved Access

Nearly two-thirds (60.8%) of ROMA member survey respondents agreed strongly with this statement: *"Success in improving access to health services in Rural Ontario requires additional investment in other supports for our citizens (ex. transportation*)." Another 32% agreed with this statement "somewhat". Taken together, these results suggest that virtually all municipal leaders in Rural Ontario see the need for a multi-pronged access-to-service strategy, of which transportation is part.

Additional comments included in survey response mentioned transportation --- whether by land or water, as well as the impact of isolation, the resulting increased frustration and family violence, mental health, addictions, homelessness, and food insecurity. Rural communities see the many factors that affect their health and their ability to access health services.

3.13 Rural Ontario Municipalities Pay Too Much of Health Costs in Property Taxes

In Canada, funding and delivering healthcare services is a provincial responsibility, undertaken under the framework set out in The Canada Health Act. The Act sets out the primary objective of Canadian health care policy:

"to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

In March of 2023, the federal Minister of Health, Jean-Yves Duclos[47] reiterated that "no matter where in the country Canadians live or how they receive medically necessary care, they must be able to access these services without having to pay out of pocket." The Minister also referred to shared principles enshrined in the Canada Health Act:

- Public administration
- Comprehensiveness
- Universality
- Portability
- Accessibility

ROMA's review suggests that Rural Ontario's access to healthcare services falls short of fulfilling at least three of these principles: comprehensiveness, universality, and accessibility.

Despite the fact that healthcare is a provincial responsibility, Rural Ontario municipalities are footing a significant share of the bill: **$481 million in 2022[48]**. This is both unsustainable and egregious. Rural municipalities rely exclusively on the residential property tax as their only revenue source. Yet rural municipalities pay a significant share of specific services such as emergency services (paramedics) (50%), long-term Care (50%), and public health (25%).

Health services must be funded from provincial and federal income tax revenues, not property taxes.

[47] The Minister may have been referring to compliance with a relatively new (2018) Diagnostic Services Policy "aimed at eliminating patient charges for medically necessary diagnostic services (such as MRI and CT scans)". The federal government noted that the "federal position has always been that patients should not face charges for medically necessary hospital and physician services --- including diagnostic services --- regardless of where the service is provided."

[48] This number was generated from data in the Financial Information Returns of Rural Ontario municipalities. It is a net number (total expenditures less contributions from the Province of Ontario).

ROMA must now openly question the degree to which the Province of Ontario is fulfilling the principles[49] of the Canada Health Act, as articulated in its primary objective:

"to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." *[underlining added for emphasis]*

Municipalities and Community Groups are Actively Seeking Better Solutions

When surveyed about their response to residents' challenges in accessing health services, 38 percent of respondents to the ROMA member survey said that their municipality had funded projects or programs "*designed to improve access to health or related services for residents of your municipality*". Regrettably, when asked if the Ontario Ministry of Health (and Long-Term Care) had provided any financial support, only one in three said yes.

Setting Priorities for Action on Increasing Access to Services

The ROMA member survey identified specific health issues as being of greatest concern in Rural Ontario, and echoed the concerns shared at the ROMA Board table. This information is summarized at right. These sentiments, as well as review of other reports and available data on Ontario's healthcare system, has guided the process of setting priorities and formulating related recommendations.

"Top two or three" Priorities for ROMA's Attention
from member survey (2023)

- Lack of access to primary Care (75%)
- Insufficient mental health supports (61%)
- Wait times to see a specialist (48%)
- Closure of hospital ERs (38%)
- Persistent and increasing homelessness (38%)

These priorities were also echoed in the sentiments of the responses to the Paramedic Chiefs survey. Those respondents traced very clear lines of impact from the lack of primary care and mental health supports to homelessness and substance abuse. Responses from both surveys also flagged wait times to see specialists, and hospital emergency department closures.

[49] The five principles set out in the Canada Health Act are: 1. Public administration. 2. Comprehensiveness. 3. Universality. 4. Portability. 5. Accessibility.

3.14 ROMA Has Chosen to Address Six Priority Issues

Based on the preceding assessment of the state of access to services in Rural Ontario in 2023, as well as clear direction from its members in a recent survey, ROMA has chosen to focus opportunities in six areas:

- Primary care
- Mental health supports
- Community care/home-based Services
- Homelessness
- Emergency departments
- Transportation.

It is highly likely there will be a need for inter-ministerial collaboration on several of these issues.

In carrying out its research and analysis, identifying opportunities for positive change (see Section 4), and in framing its recommendations (See Section 5), ROMA has probed these priorities deeply, and sought innovative approaches to addressing the access to health services catastrophe that Rural Ontario residents are now experiencing every day. There is no time to lose.

4 Opportunities for Improved Access to Services

Through its surveys and consultation in 2023, ROMA received many suggestions for concrete action that would help to improve access to services for residents of Rural Ontario. In undertaking this work, ROMA was well aware of four widely-shared perspectives on healthcare and related services:

1. There is no comprehensive, integrated plan for health services in Rural Ontario.
2. There is an urgent need for a focus on health services in Rural Ontario
3. There is virtually unlimited demand for additional funding.
4. There are many ideas about how we might collectively do a better job in delivering services, building on the resources we already have.

The ideas that emerged from ROMA's consultations, many of which have been incorporated directly into this report, can be categorized as:

- Expanding the **health human resources/labour force available** to support residents of Rural Ontario *where they live* (examples: primary care, paramedics, mental health supports and crisis intervention teams)
- Ensuring that the **right work** is being done by the **right people, individually and in teams** (examples: changes to scope of practice for multiple types of healthcare professionals; delegation of lower-risk tasks to appropriately-trained staff)
- Putting services in place to **divert inappropriate utilization** of high-cost services (example: emphasize home visits and low-barrier community services such as walk-in clinics; design services to reduce the need for low-access residents to go to an Emergency Department)
- **Leverage existing infrastructure**, no matter who owns it (examples: use hospital campuses as physical service hubs; municipalities, schools or community groups could provide space for visiting professionals such as counsellors; accelerate roll out Medical Priority Dispatch System to improve paramedic resource deployment; develop transportation systems; work with food banks)
- Align the **regulatory environment** with proposed service delivery systems (examples: scope of practice changes; use of Emergency Medical Attendants, patient transfer services, other first responders)
- Make **service-related decisions based on evidence,** especially applied research (examples: use data on local healthcare needs to shape service design; changes to Public Health structures/governance).
- **Use good ideas from others** including those outside the conventional healthcare system (example: "complete community concept" from MMAH; broaden stakeholder organizations that are eligible for one-time funding; introduce an explicit plan to roll out good ideas from pilots across the province).

5 Recommendations for Action

Introduction

In reviewing the current state of rural residents' access to healthcare and related services, as well as many suggestions for improvement emerging from consultations, ROMA envisages a different approach to the provision of healthcare and related services across Rural Ontario: one based on filling service gaps and working collaboratively in networks rather than silos. The following 22 recommendations are grouped under **eight themes** intended to:

- Require that Rural Ontario municipalities have a seat at their Ontario Health Teams' table
- Fix primary care
- Reconfigure the deployment of health human resources
- Shift demand from Emergency Departments to more appropriate forms of care
- Complete the full range of community care
- Implement inter-professional teams
- Support community innovation
- Preserve capacity for long-term investments and emergency response.

> ***"Where people live impacts their health status and health care needs. Significant differences exist between urban and rural populations in terms of health status, health behaviours, health service use, costs and outcomes. In general, rural residents have direct access to a much smaller number and scope of health services and providers than urban residents. Decision-makers and planners frequently face challenges regarding the availability, capacity, sustainability and performance of rural health systems."***
>
> *Canadian Institute for Health Information*

A consistent message across these themes is to envisage, plan, design and deliver services as part of a *system* --- or a network of services --- rather than as a series of isolated programs or "silos".

The evidence presented earlier in this report makes it clear that services are intertwined: when one service changes, it almost always affects one or more other services. And not necessarily in positive ways.

While almost certainly applicable in urban Ontario, this approach is essential in Rural Ontario where geography, population density, demography, lack of transportation and other factors challenge conventional approaches to accessibility of services.

5.1 Require that Rural Municipalities Have a Seat at Ontario Health Team Tables

Recommendation 5.1
That the Province require Ontario Health Teams to ensure that rural municipalities have a seat at the table, even as the OHT organizations evolve and grow.

Background: Rural municipalities play a significant role in funding *and operating* specific health services such as paramedic services and other emergency services, as well as long-term care. They also pay a portion of the budget for Public Health and support hospital fund-raising campaigns. As Ontario Health Teams reshape the way vital services are delivered across the province --- including Rural Ontario, rural municipalities must be at the table.

Responses to the 2023 ROMA member survey indicate that only half of respondents (48%) have had some form of interaction/engagement at this point in the Ontario Health Teams' evolution. Less than a quarter of respondents (24.2%) said that their municipality was not involved at this time.

While Ontario Health Teams are working to develop and implement team-based plans for service delivery in their areas, participation of rural municipal partners must not be delayed until the OHTs' evolution is complete. It must happen now.

> "***There are too many levels/groups and it is very confusing. LHINs, Family Health Teams, Hospital networks, Hospital Boards, physician recruitment personnel and I'm not sure if any of the levels understand the needs/wants of today's doctors, nurse practitioners and nurses. They don't reach out to the rural municipalities to understand the needs and the challenges."***
> Comment from ROMA Member Survey Respondent
> (2023)

The rationale for engaging rural municipalities goes beyond acknowledgement of its funding and operating role. Rural municipalities are also advocates for equitable access to services for their residents, and can often suggest strategies, as well as physical and human resources that can be brought into our collective efforts to improve services in their communities.

The time act is now: A recent ROMA survey revealed that leaders in rural municipalities are divided on the likelihood that Ontario Health Teams in their municipalities will "*address service needs in rural or remote areas*". Only 15% were "extremely confident" or "very confident" in this outcome. By contrast, more than half (53%) of municipal representatives were "not particularly confident" or "not confident at all".

ROMA members want the Ontario Health Teams to succeed. It is time to get around the same table.

5.2 Fix Primary Care

Recommendation 5.2A
That the Province maximize opportunities to increase medical school enrollment at Ontario universities and concomitantly, seize the opportunity to implement additional strategies that maximize primary care physicians' capacity for direct service to patients.

Background: Family physicians that work in rural family health teams or independent practices are key to delivering healthcare and related services in Rural Ontario. They are the first point of contact for patients, the first to diagnose emerging health concerns and manage chronic conditions, and to refer their patients for other health or related services, including referrals to specialty physician services.

ROMA's analysis shows that roughly 525,000 residents of Rural Ontario are now without a family physician. This number will grow dramatically over the next few years as rural doctors with 2,000 to 4,000 patients retire. In many cases, three new family physicians, with 1,000 patients each, will be required to place one retiring doctor. This will be a massive undertaking.

Rural residents' access to healthcare services is heavily dependent on their family physician's ability to refer them to specialist services, often located in other communities. As a result, a physician's retirement also means that referrals to specialists may be much more difficult to obtain. Both rural municipal leaders and paramedic chiefs are observing the emergence of this challenge in the communities they serve.

In most rural communities, there is often just a few physicians. Sometimes there is only one doctor, practicing alone. This means that when a rural family doctor retires, the loss of expertise and skills is felt not just by individual patients but also by other agencies and organizations in that community. A physician's retirement may create gaps in service that need to be filled.

In parts of the province where the spectrum of community services often has significant gaps or where specialty physicians may not be present at all, patients may have to travel long distances to access these services. The absence of sufficient numbers of family physicians means more than a half million residents lack access to the same level of healthcare services as exists in urban areas. As a result, the continuing deterioration of primary care is an equity issue.

The Province must continue to work with universities to maximize the number of spaces available to candidates seeking to become a family physician. Given the time it takes to educate and train physicians, this is a decade-long assignment. In the meantime, it is important to *retain* as many family physicians as possible. Other recommendations in this report address this issue.

Recommendation 5.2B
That the Province work with Ontario Health Teams and other stakeholders to understand the forces that drive family physicians into or out of this specialization, and
Further that the Province develop specific strategies to reduce barriers to the practice of family medicine, and
Further, that the Province improve the provincially-funded program to attract family physicians to all areas of Rural Ontario.

Background: According to both quantitative and qualitative measures, Rural Ontario has an insufficient supply of family doctors. In two separate surveys in 2023 (of ROMA members and Paramedic Chiefs), lack of access to primary care emerged as a major concern. Three-quarters (75%) of ROMA member survey respondents named the inability of residents to find a family doctor/primary care physician as one of the "top two or three" challenges on which ROMA should focus in the next few years.

ROMA's perspective on addressing the challenges of family medicine aligns with two aspects of the Ontario College of Family Physicians' advice to the Province[50]. The OCFP has recommended:

- Emphasizing access to family doctors *working in teams* with other healthcare providers (nurses, pharmacists, dietitians, social workers and more). The COFP has stated that currently "70 per cent of family doctors and their patients do not have access to team-based support."
- Ensuring that family doctors are spending their time *caring for patients* rather than undertaking administrative tasks such as writing sick notes and filling out insurance forms. Surely these tasks could be delegated, safely, to another member of a family health team.

[50] https://www.ontariofamilyphysicians.ca/news/more-than-four-million-ontarians-will-be-without-a-family-doctor-by-2026/#:~:text=As%20of%20September%202022%2C%20nearly,over%20age%2065%2C%20nearing%20retirement.

Recommendations for Action… continued

In Rural Ontario, fixing primary care also requires attention to improved strategies to recruit more family physicians to fill vacancies and respond to population growth. In recent years, communities in Rural Ontario that are desperate for family physicians put together recruitment campaigns including significant financial incentives such as providing a building for a clinic or office. This practice puts rural communities at a disadvantage due to the heavy dependence of their tax base on residential property taxes. And so they lose out. ROMA's position is that funding healthcare is a provincial responsibility. It is also the Province's responsibility to ensure that residents of Rural Ontario have reasonable access to healthcare services. Given the scale and breadth of the shortage of family physicians in Ontario, a robust provincial response to this challenge is required.

Recommendation 5.2C
That as part of its efforts to reduce barriers to being a family doctor in Ontario, the Province call upon its Digital and Data Strategy[51] secretariat to identify and develop solutions to reduce the amount of administrative work for which Family Physicians are currently responsible.

Background: As with physicians across the province, family doctors carrying on practices in Rural Ontario are experiencing increased stress from unmet demand for primary care. These doctors often have responsibilities to support or work in local hospital Emergency Departments or in long-term care. In all of these venues, physicians are likely to face significant administrative workloads:

- A survey of family doctors conducted for the Ontario College of Family Physicians INSIGHT Primary Health Care (May, 2023) has calculated the administrative burden for physicians to be 19 hours of paper work per week. This burden has been identified as one of the factors behind the high burnout rate for family physicians.
- Canadian Medical Association, MD Financial Management and Scotiabank have teamed up to provide $10 million in grants (October 2023) to help reduce the administrative burden facing physicians. Health Care Unburdened Grants are expected to lead to "system-wide changes that improve inefficient processes and reduce the time physicians spend completing administrative tasks", thereby enabling physicians to provide better patient care and supporting their own well-being.

  To prevent burnout or to reduce the increasing number of family physicians who are reducing the time they can devote to seeing patients to get the paperwork done, the Province must dedicate significant attention to ways to convert administrative time back into patient care time. Activating Ontario's digital and data strategy in support of better utilization of family doctors' time is a major opportunity.

[51] https://www.ontario.ca/page/building-digital-ontario

5.3 Reconfigure the Deployment of Health Human Resources

Recommendation 5.3A:
That the Province increase funding for walk-in clinics and urgent care services to enable those services to expand hours of operation, and
Further, continue to explore and introduce scope of practice measures for nurse practitioners and nurses that would enable these professionals to expand their roles in primary care, and outside of physicians' offices and walk-in clinics.

Background: Addressing the challenges of insufficient primary care providers, as well as overwhelmed Emergency Departments calls for active consideration of expanded opportunities for other health professionals and greater use of different service models.

The scope of practice changes announced for nurse practitioners in the fall of 2023 are a good step forward in better deployment of the full array of health care professionals available for serving residents. In addition to these measures, the Province also announced that in January 2024, nurses who achieve additional education requirements will "provide more care and administer the medications they prescribe." The stated objective is to further reduce wait times at community clinics and hospitals. The educational training programs that will be offered at certain colleges and universities are being developed and require approval from the Council of the College of Nurses of Ontario.

As deployment of the full range of health human resources evolves, the Province and the Ontario Health Teams must implement strong education programs to ensure that the entire network of healthcare services understands that the physician's office and the local hospital may not be the only --- or the most appropriate--- care alternative at any point in time.

These measures are likely to be successful in connecting "unattached" rural residents to primary care. This is, however, only the beginning. The Province must work with all types of healthcare professionals to maximize their contribution to the health and well-being of all Ontarians.

Recommendations for Action… continued

Recommendation 5.3B
That Ontario Health Teams be required to bring paramedic services into local discussions about how to serve rural homeless populations as well as those with mental health and addictions challenges.

Background: To date, the Province has been silent on its long-term commitment to Community Paramedicine, a program with great potential to serve residents in their own homes. Both paramedics (for emergency services) and community paramedicine (for community services) have significant potential to reduce visits to rural Emergency Departments.

Because they are naturally mobile, paramedics can support homeless persons as well as those with mental health and addictions challenges. Both of these groups are known to be relatively heavy users of Emergency Departments, often because they do not have access to a primary care physician. Paramedics can also support the implementation of Community Safety and Well-being plans since they are likely to be the first called, along with law enforcement personnel, in the event of a serious medical risk or trauma.

> ***"Increasingly, community paramedicine programs are demonstrating their considerable capability to redirect 9-1-1 calls, reduce emergency department visits, decrease hospitalizations and avoid revisitations."***
> Report on the Status of Community Paramedicine in Ontario, November 2019
> {underlining added for emphasis]

As Ontario seeks new ways to make the most effective use of the full range of healthcare professionals, several new models of care for paramedics and community paramedics warrant consideration.

For example, community paramedicine programs could[52]:

- Help address transport issues by arranging or providing transportation of patients to treatment locations other than emergency departments
- Provide on-site diagnoses and treatment, and if necessary, refer patients to other healthcare providers
- Refer certain patients to the most appropriate care options, at any stage of a 9-1-1 call
- Treat and release patients from their care on-site,
- Provide 'on-demand' assistance or consultation, in person or over the phone, in coordination with primary care providers or other health system partners.

[52] Source: Report on the Status of Community Paramedicine in Ontario, November 2019

Recommendations for Action… continued

Recommendation 5.3C
That Ontario Health atHome explicitly include Community Paramedicine programs as one of the options available to care coordinators, and that they be considered along with the other 14 existing organizations, and
Further that the choice of options be based on both medical and health expertise (in relation to patients' needs) and proximity/capacity to respond in a timely fashion, fulfilling the promise of "seamless transitions", and
Further that utilization of Community Paramedicine programs be fully-funded by the Province, with no requirement for municipal contributions.

Background: In October of 2023, the Province of Ontario introduced the *Convenient Care at Home Act*, 2023, to make Ontario Health Teams responsible for connecting people to home care services, starting in 2025 with 12 "accelerated" Ontario Health Teams. Ontario Health atHome is a new, single organization that will see care coordinators working alongside doctors and nurses, and directly with patients while in the hospital or in other care settings, to facilitate seamless transition for people from hospital or primary care to home care services. Each Ontario Health Team is expected to receive $2.2 million over three years to "better coordinate people's care". Ontario Health atHome represents a consolidation of 14 existing Home and Community Care Services organizations.

ROMA strongly supports the proposed improvements to the delivery of home care services, with special emphasis on improving transitions from hospital and/or primary care. It is not clear however how Ontario Health atHome intends to improve upon the earlier efforts to accomplish the same ends (e.g. Community Care Access Centres). Ongoing shortages of nurses, personal support workers and other healthcare professionals in clinics, hospitals and other institutional settings must prompt consideration of any and all options for meeting the needs of patients when they are returning to or are continuing to receive care at home.

Innovation at Work in Rural Ontario

Renfrew County's health service providers recently received a provincial award from the Association of Family Health Teams of Ontario for its Virtual Triage and Assessment Centre (VTAC) service that provides comprehensive, integrated care to patients who do not have access to a family physician or a Family Health Team.

Patients access in-person care at home, and virtually depending on their individual needs and preferences.

RCVTAC is a collaboration between family doctors, the County of Renfrew Paramedic Service, primary care teams, Renfrew County Hospitals and the Renfrew County and District Health Unit. It is now permanently funded by the Province of Ontario.

Recommendations for Action… continued

As "a consolidation of 14 existing Home and Community Care Services organizations", Ontario Health atHome should consider the inclusion of Community Paramedics as one of the service provider options, particularly for patients transitioning from hospital or needing help with chronic health conditions.

Community Paramedicine Is Already Working in Resident Homes Across the Province:
In 2019, a report on community paramedicine programs reported that of the 143 programs operating in Ontario at that time, significant percentages were already providing a variety of services helpful not just to their patients but to the local healthcare network as well as reducing non-emergency visits to EDs.

Program Classification	Percentage of Community Paramedicine Programs Offering…
Community Assessment and Referrals Programs	31.4
Community Paramedic-Led Clinics	16.1
Home Visit Programs	24.5
Remote Patient Monitoring Programs	16.1
Community Paramedic-Specialist Response	7.0
Other Programs	4.9

Figure 11 – Source: Report on the Status of Community Paramedicine in Ontario, November 2019
Note: in 2018-2019, Community Paramedicine Programs served 56,640 individuals and patients.

This research[53] has demonstrated the clear potential for Community Paramedicine to play a role in *increasing rural residents' access to services*, especially at a local level[54].

Recommendation 5.3D:
That the Province consider expanding the scope of practice of Paramedics and Community Paramedics so they can take on new healthcare roles with specific populations, and support primary care, and
Further, that the Province develop the medical directives and assessment skills associated with these new roles, and
Further that utilization and expansion of Community Paramedicine programs be fully-funded by the Province, with no requirement for municipal contributions.

[53] Source: Report on the Status of Community Paramedicine in Ontario, November 2019

[54] For example, the County of Simcoe Paramedic Service found that 60% of referrals made through their Assessment and Referral program resulted in new or increased home care and community services for their patients. Community Paramedicine in the Champlain LHIN has delivered influenza vaccination, and treated patients with influenza-like illness in retirement homes or long-term care facilities, thereby addressing seasonal surges in 9-1-1 calls and influenza-related transports to emergency departments.

Recommendations for Action… continued

Background: As highly-mobile professionals, paramedics and community paramedics could perform vital sign checks, and administering tests to confirm diagnoses for common health conditions (e.g. testing glucose levels; prescribing antibiotics and GERD medications.) Consideration might also be given to permitting paramedics and community paramedics to treat and prescribe medications for a limited set of common medical ailments, as pharmacists are now allowed to do.[55]

This change would help fill gaps in primary care service, for patients with personal mobility limitations or without a mode of transportation to get to the pharmacy. Paramedics or community paramedics could provide a home-based or other accessible community-based location option to meet the same need. As highly-mobile professionals, paramedics and community paramedics could provide this service.

The Renfrew County Virtual Triage and Assessment Centre is an excellent example of the innovative approach that health service providers in Rural Ontario have taken to ensure that residents have access to comprehensive, integrated care…. *at home and virtually*.

Ontario Health Teams and the organizations providing home care case coordination must embrace new approaches, engaging the full suite of health service professionals in home-based services.

Recommendation 5.3E
That the Province consider legislative changes that would allow Emergency Medical Attendants (EMAs) and volunteer drivers in Rural Ontario to work with paramedics in ambulances, including driving and assisting paramedics under their direction.

Background: Years ago, the Ontario Ministry of Health moved away from staffing configurations in ambulances that had allowed certain personnel to assist/support Paramedics in their work while on a call. The need to have two paramedics in each ambulance is limiting the number of ambulances that can be deployed at any time. This is especially challenging when offload delays at hospitals are increasing and Emergency Department closures extend the distances patients must be transported in Rural Ontario. An alternative staffing configuration for ambulances, that was previously used in Ontario, could be considered.[56]

[55] On October 1, 2023, the Province announced that pharmacists would be allowed to treat and prescribe medications for an additional six common medical ailments (adding to the 13 common ailments that they have been prescribing for since the beginning of 2023). Pharmacists are also able to administer certain injection and inhalation treatments for people who need help with, for example, insulin, vitamin B12 or osteoporosis treatment. Patients will pay a fee for these services, "similar to fees to receive travel vaccines".

[56] See the Ambulance Service Patient Care and Transportation Standards document (Ministry of Health and Long-Term Care, Emergency Health Services Branch, 2007) for details on this approach.

Recommendations for Action… continued

Recommendation 5.3F

That the Province expand the types of patient transports for which patient transfer services could be utilized, beyond their current roles (e.g. inter-facility movement of patients, for example: long-term care to a hospital or imaging lab appointment). Their roles could be expanded to include any transports that do not require an ambulance. Paramedic Services, including Community Paramedics, would be well-positioned to determine the most appropriate form of transport.

Background: Currently Ontario's healthcare system relies on two forms of patient transport (beyond patient or family members' own vehicles): an ambulance or a designated patient transfer service[57]. Until recently, this system worked reasonably well in most circumstances. By 2019, however, some observers were recommending that more attention needed to be paid to how patients are transferred (and repatriated) from a range of medical/health-related appointments[58] --- and concluding that there might be better alternatives.

With Emergency Department visits up sharply through the pandemic, regular paramedic services are now under increasing stress and Code Black alerts[59] have become more common. In addition to introducing measures to divert unnecessary transports to hospital Emergency Departments generally, there is also merit in asking if other transport arrangements are appropriate in certain circumstances.[60] Designated patient transfer services, already part of the healthcare service network, is one such option.

Recommendation 5.3G

That the Province develop and implement medical protocols and procedures, particularly for water-based transports, including ferry services, to allow first responders other than paramedics, with appropriate training, to transport patients to the mainland for transfer to an ambulance.

[57] https://patienttransferontario.ca/

[58] In 2019, the Rural Road Map Implementation Committee (RRMIC) established three key priorities for action: a) rural patient transfer and repatriation, b) rural and indigenous health competencies, and c) rural health research.

[59] Code Black refers to lack of availability of an ambulance to respond to a call. There are several reasons for increased instances of these alerts. Sometimes ambulances are being used for calls that are not emergencies and could be dealt with in ways other than transport to a hospital Emergency Department. Often though, ambulances are waiting to off-load patients at overloaded Emergency Departments; this is referred to as off-load delays. https://www.cbc.ca/news/canada/windsor/windsor-code-black-incidents-increaingly-frequent-reality-1.6615220

[60] Need to include a reference to paramedics now having the authority to refuse to transport to hospital and suggesting that a lower-cost alternative, to take the patient to the right type of care, would be advisable.

Recommendations for Action… continued

Background: In November of 2023, the Province of Ontario announced $108 million investment in Ornge Air Ambulance's fixed wing service (replacement plus additional aircraft), to provide Ontarians, especially those living in remote locations, with consistent access to high-quality urgent care.

There is also value in considering what improvements might be made to transports, where transport partly or wholly by water is required. Consideration might be given to allowing other appropriately-trained emergency services personnel to undertake transport, for example by ferry, to reduce the amount of time required to get a patient to an ambulance waiting on the mainland. In these situations, the paramount consideration is whether the requirement to use a regular ambulance service would so delay the patient receiving of medical care that their health outcome would be negatively affected. These alternative arrangements would be especially helpful in northern and rural Ontario where transport times are already challenging.

Recommendation 5.3H
That the Province consider the announced plan for increasing the number of nurse practitioners in Ontario as "phase one" and that as universities are able to do so, the numbers of graduating nurse practitioners be further increased, with a continued emphasis on service to Rural Ontario, and
Further, that the Province consider the opportunity for nurse practitioner specialization in managing in-scope health services such as chronic diseases, and services offered at clinics --- whether walk-in or appointment-based, and
Further, that the Province further encourage the development of nurse practitioner-led clinics especially in Rural Ontario, where recruitment of family physicians is especially challenging[61].

Background: In November, 2023, Minister of Health Sylvia Jones announced that 121 additional training spots[62] would be opened up for students to become nurse practitioners. The announcement positioned the move as a way to make it "faster and easier for people to connect to primary care, especially in northern and rural areas".

[61]See Article in the Canadian Journal of Family Physician **Progress made on access to rural health care in Canada,** by Ruth Wilson, James Rourke, Ivy F. Oandasan (Director of Education, College of Family Physicians and Surgeons, Mississauga; also Full Professor at University of Toronto) and Carmela Bosco (Secretariat Support for the Rural Road Map Implementation Committee supported by College of Family Physicians of Canada and the Society of Rural Physicians of Canada). January 2020

[62] The new training opportunities will be at the following universities: Windsor (24), Toronto (20), Toronto Metropolitan (17), Western (16), Queen's (15), York (11), McMaster (8), Laurentian (6), Lakehead (6).

The Province's target is 350 positions; the latest announcement would bring the total to 321 --- still short of the target but moving in the right direction. The Ontario government invests $46 million annually to fund nurse practitioner-led clinics, with twenty-five of these clinics now supporting 100,000 people who might otherwise face challenges accessing primary care. This ratio of patients to clinics means that each clinic is serving 4,000 patients. It is not unusual in Rural Ontario for a single physician to have 3,000 to 4,000 patients, often serving multiple generations of the same family.

While ROMA welcomes this announcement as one way to begin to address serious challenges in primary care in Rural Ontario, it is not nearly enough. At present, there are fewer than 4,000 nurse practitioners in Ontario, as compared to 34,000 physicians and 104,000 registered nurses.[63] The Province must maximize deployment of nurse practitioners in other roles in the healthcare system, especially in clinic and institutional settings. With proper protocols in place, nurse practitioners could play an even larger role in shifting a share of physicians' workloads to other capable hands. Also, the Province should consider whether nurse practitioners, with appropriate medical directives, protocols and processes in place, could manage small, rural hospital Emergency Departments, with physician backup from a regional Emergency Department.

5.4 Shift Demand from Emergency Departments to More Appropriate Forms of Care

Recommendation 5.4
That the Province develop a multi-pronged strategy for addressing staffing shortages in Emergency Departments in Rural Ontario, first by seeking to train, attract and retain health human resources (primarily physicians and nurses) to ensure reasonable access to Emergency Departments, and
Further, to fill gaps and expand capacity in other healthcare and related services to be able to receive and provide community care to those who would otherwise visit Emergency Departments, and
Further, to develop and implement measures to reduce Emergency Department closures, prioritizing investments based on access to services considerations such as impact on health outcomes and travel burden.
and
Further, introduce education programs for primary care, long term care and home care about the most appropriate alternatives to Emergency Departments.

[63] In 2021, there were three (3) nurse practitioners per 10,000 population compared to 12 family physicians per 10,000 population, and 112 nurses (all types) per 10,000 population.

Background: Over the past two years, Ontario has seen unprecedented numbers of temporary closures of hospital Emergency Departments. On the surface, the challenge appears to be staffing shortages, especially of physicians and nurses. Ass detailed elsewhere in this report, these closures have been predominantly in Rural Ontario. In addition to the direct impact on patients expecting to be able to access Emergency Department services, the ripple effects on other health care services, patients and families are significant:

- When primary care is unavailable, patients naturally turn to Emergency Departments. In Rural Ontario, it is often the only alternative. This is particularly true for those who are homeless and those with mental health or addiction challenges. Alternative services for these populations are significantly underdeveloped in Rural Ontario.
- Community services (home care, community paramedicine), that could be a triage point and provide appropriate care, do not have the capacity to help, or may not be present in the community at all.
- Paramedic services see increased demand for patient transport to Emergency Departments, increasing service times and offload delays at other hospitals. Ambulances and staff are therefore unavailable for other calls. Overtime costs shared by the province and municipalities rise.

Through Ontario Health Teams and Ministry community program funding streams, there is an opportunity to develop a more robust network of services that can support patients with less urgent health concerns, reduce demands on Emergency Department staff. The positive impact on Emergency Departments in rural hospitals, as well as on paramedic services, will be greater because the opportunities for integrated care would be expanded, and the travel burden for patients as well as family and friends would be reduced. In other words, investments in community care would pay much higher dividends in Rural Ontario.

5.5 Complete the Full Range of Community Care

Recommendation 5.5A
That the Province require Ontario Health Teams to complete --- or fill the gaps --- in the range of services available closer to home for residents of Rural Ontario, and
Further, provide multi-year/ongoing funding to rural municipalities for community services that provide health and social services such as mental health and addictions services, housing services, income support, and local mental health crisis intervention, and
Further, ensure that paramedic services are engaged in OHTs' work as service delivery partners, especially in strategies that reduce demand on Emergency Departments, complete the range of community care services available to residents, and address specific populations such as the homeless.

Recommendations for Action… continued

Background: Consultations undertaken by ROMA with front-line organizations across Rural Ontario have demonstrated that many communities do not have the range or depth of service/capacity in community services to make healthcare services truly accessible to local residents. Beyond basic hospital services, including Emergency Departments with long distances to travel and long wait times, and increasingly scarce primary care, residents of Rural Ontario have few community care options close at hand.

Not-for-profit organizations are constantly searching for funding to sustain their organizations "next year", a phenomenon that limits their ability to attract staff and offer sustained services. This is an unproductive approach to developing the full range of community services required in an integrated health care system, especially when both municipalities and community partners have strong collaborative capabilities. Many report that they already have a strong track record for doing this and may have already undertaken projects designed to address local health challenges in innovative ways. ***The Province must provide sustained funding to these organizations if they are to fill the gaps in the local healthcare system.***

Specific populations have specific health challenges that require collaboration across multiple service providers. Residents with mental health and addictions challenges are especially at risk and are often dealing with multiple challenges, such as unemployment and homelessness at the same time. Because they are a mobile service provider, paramedics could play an invaluable role in ensuring that high-risk residents are able to access the care they need.

Recommendation 5.5B
That the Province provide funding support for implementation of community-based Mental Health Crisis Intervention Teams (as part of Community Safety and Well-being Plans), and
Further, that this funding support be directed to and through municipalities that have been mandated to implement CSWB plans, and
Further, that this funding be available to municipalities whether they have a municipal police force or use the Ontario Provincial Police.

Background: The formation of Mental Health Crisis Intervention teams is part of Community Safety and Well-being Plans, as mandated by the *Police Services Act (2019).* The deadline for municipalities to prepare and adopt the plan was July 1, 2021.

These teams are especially critical in Rural Ontario where crisis services are scarce. In Rural Ontario, law enforcement officers, paramedics, and emergency department staff that are already stretched thin, are expected to handle these crises without specialized support or additional resources to backfill their regular services when other emergencies arise.

> ***"The Community Safety and Well-being plan legislation is a huge failure. No ministries have committed any real funding to these plans and municipalities struggle to gain any kind of effectiveness from them."***
> Comment from ROMA member survey respondent (2023)

Creation and implementation of a Community Safety and Well-being Plan, and the ongoing operation of Mental Health Crisis Intervention Teams requires significant financial and human resources. In most of Rural Ontario the agencies and organizations responsible for delivering on the Plan do not have these resources. It is hard to imagine how CSWB plans in Rural Ontario will be successful without recognition by the Province and the Ontario Ministry of the Solicitor-General that they must make a *significant, ongoing financial contribution to non-policing services*. At minimum, the Ontario Ministry of Health and the Ontario Ministry of Community and Social Services must direct *ongoing* funding to these services. The emphasis on ongoing funding recognizes that attracting, training and retaining staff who can build trust in our communities, as well as with their colleagues in other services, is essential.

Recommendation 5.5C
That the Province and Ontario Health Teams incorporate the concept of "complete communities"[64] , as articulated by the Ministry of Municipal Affairs and Housing, in any community-focused planning or program development and implementation related to Ontario's health care system.

Background: In its August 2023 issuance of a revised Provincial Policy Statement, the Ontario Ministry of Municipal Affairs and Housing introduced the concept of "complete communities", meaning places such as mixed-use neighbourhoods or other areas within cities, towns and settlement areas that offer and support opportunities for equitable access to many necessities for daily living for people of all ages and abilities. Assuming that this concept is retained in an approved Statement, municipalities will be considering land use and development decisions at least in part, with an eye to contributions to "complete communities.".

[64] As articulated by the Ontario Ministry of Municipal Affairs and Housing in its August 2023 version of the revised Provincial Policy Statement, "complete communities" means places such as mixed-use neighbourhoods or other areas within cities, towns and settlement areas that offer and support opportunities for equitable access to many necessities for daily living for people of all ages and abilities, including an appropriate mix of all ages and abilities, including an appropriate mix of jobs, a full-range of housing, transportation options, public service facilities, local stores and services. Complete communities are inclusive and may take different shapes and forms appropriate to their contexts to meet the needs of their populations. [Underlining added for emphasis]

Recommendations for Action… continued

As healthcare services are modified or created anew, the Province and Ontario Health Teams must explicitly consider how "complete communities" might include considerations related to social determinants of health.

5.6 Implement Inter-professional Team Approaches

Recommendation 5.6A
That the Province engage the Ontario Health Teams, and through them, the community-based organizations that are needed to enhance prospects for success for provincial initiatives in Rural Ontario and,
Further, that services such as Ontario Health atHome and the Ontario Structured Psychotherapy Program work with the Ontario Health Teams and other local stakeholders to develop a network of service access points that recognize the distinctive challenges and opportunities for service delivery in Rural Ontario.

Background: Health care professionals with particular expertise in delivering health care and related services in Rural Ontario have been clear that the preferred organizational model in these areas is "**networks of care**". In this model, different types of service providers can come together in a collaborative model to improve access to services and support rural communities in attracting and retaining the highly-qualified personnel required to fulfill the promise of a publicly-funded health care system.

Networks of care are more likely to access the full breadth of local capacity, including service clubs, volunteers and retirees. As ROMA heard often in its consultations for this report, these hidden assets were strongly leveraged in the COVID-19 pandemic and communities are eager to see these "crisis collaborations" morph into ongoing systems of care.

Despite expectations that Ontario Health Teams will embrace and implement network of care models, it not clear that other initiatives undertaken by the Province are aligned with this approach. For example, in October of 2023, the Province announced expansions to the Ontario Structured Psychotherapy Program (OSP) that would complete service availability to all regions in the province[65]. The OSP is intended to ensure that "all Ontarians… can now have more convenient access to mental health care, close to home."

[65] The October 2023 expansion brings the OSP program to Mississauga as well as Northwest and Northeast Ontario.

Recommendations for Action… continued

The Province is reporting that the OSP is now offered at more than 100 locations across Ontario and is "delivered through nine regional networks of mental health providers that include local hospitals, community organizations and health care providers at different service delivery site locations."

ROMA acknowledges the Province's effort to expand psychotherapy service availability across the entire province and encourages the Province and its contracted OSP service providers to use this program rollout as an opportunity to engage with both Ontario Health Teams and Rural Ontario municipalities in the implementation phase.

> ***"All of our residents have to travel outside the municipality for health care. We have limited control over what services are available in the neighbouring urban center. Most of the partners in the community safety and well-being plan are located in the neighbouring urban center. Providing improved services to their rural neighbours is not always a top priority."***
> Comment from ROMA member survey respondent (2023)

This is particularly important for identifying the best distribution of the 100 service locations so that Rural Ontarians have access to this service close to home, and in creating/expanding the community supports needed to ensure that those Rural Ontario residents receiving OSP services are successful once the initial psychotherapy service is delivered.

ROMA believes that through engagement with municipal government and inter-professional collaboration, there are opportunities for bringing these types of services even closer to home. Examples that might work well in Rural Ontario are:

- Identification of multi-use "satellite" offices that might be used on by a range of service providers. Municipalities may be able to help with this.
- Development of highly-localized networks of service providers that can provide "wrap-around" services tailored to particular patients and populations. These networks would bring together primary care, hospital staff, social workers, food bank staff, mental health counselors, housing service providers and others in addressing the needs of patients in their own communities. Municipalities may be able to provide local leadership in building these collaborations, especially for services that are delivered through municipalities.

> ***"…relationships can be strengthened between rural family physicians, other specialists, and other health care providers and rural communities through the creation of networks of care that improve access and positively influence physician retention. "***
> **Progress made on access to rural health care in Canada**, by Ruth Wilson, James Rourke, Ivy F. Oandasan Carmela Bosco, January 2020

Recommendations for Action… continued

Recommendation 5.6B

That the Province work with local housing service providers, Ontario Health Teams and other local stakeholders to develop ways to integrate social determinants of health into homelessness programs.

Background: It is well understood that homelessness is part of a web of challenges faced by some members of our communities. Provision of shelter is a necessary but often not sufficient community response. Homelessness may have its roots in unemployment, low incomes, a shortage of affordable housing, rising shelter costs, lack of access to health services, mental health and addictions, or lack of access to transportation. But homelessness also takes its toll on the health and well-being of those who experience it.

ROMA believes that an integrated approach to homelessness, one that uses a social determinants of health "lens", would be the effective way of preventing deterioration and restoring health in the most disadvantaged members of our communities.

Recommendation 5.6C

That ROMA engage in a review of the City of Toronto integrated approach to homelessness, now funded by the Province, and

Further that Ontario Health develop a targeted funding program to which municipalities in Rural Ontario could apply to secure the resources that will support implementation in their communities, and

Further that Ontario Health work with the Ministry of Municipal Affairs and Housing and the Ministry of Community and Social Services to support wrap-around programs for transitional housing that recognize determinants of health that are not directly related to access to health care.

Background: In November, 2023 the Province of Ontario announced a $15 million investment in the City of Toronto to make it easier for people experiencing homelessness to connect to primary health care, mental health and the other supports they need. This suggests that the Ministry and Ontario Health, along with community partners, recognize the need for an integrated approach to provide access to:

- interprofessional primary care and psychiatric services,
- mobile and community-embedded teams of healthcare workers (for overdose prevention and mental health services), and

> *"The health care system is only part of the picture:* ***Only 25 per cent of the population's health outcomes can be attributed to the health care system****. Yet amazingly, the three-quarters of environmental factors that account for health outcomes, such as education and income, barely register in the health care debate."*
>
> Commission on the Reform of Ontario's Public Services
> Public Services for Ontarians: A Path to Sustainability and Excellence
> 2012

- a peer worker support program to deploy teams comprised of previously-homeless persons to make initial contact with those reluctant to access services.

ROMA believes the approach, as being implemented in Toronto, is likely to be an effective strategy, and should be developed, adapted and expanded to Rural Ontario.

5.7 Support Community-Focused Innovation in Rural Ontario

Recommendation 5.7
That the Province establish a community-focused funding stream that could flow through the Ontario Health Teams, with the express purpose of devising more innovative, cost-effective ways to address the needs of under-serviced communities in Rural Ontario, and
Further, that funding priority be given to rural areas for which current services are not meeting provincial standards and/or guidelines similar to those proposed in the Rural and Northern Health Care Report (2010) (Ontario), and
Further, this could include rural areas that are part of an urban municipality, and
Further, that funding priority be given to pilot projects that propose to test models of care that increase or improve access to services in Rural Ontario.

Background: ROMA's member survey (undertaken in mid-2023) revealed that stakeholders in a third (33%) of respondent municipalities have developed and tested new ways to improve access to services in Rural Ontario. Yet only one in three of those innovation projects has had the support of the Ministry of Health. This lack of support means that solutions that meet the specific needs of Rural Ontario are not being pursued, and opportunities to improve access to services lie dormant. If Ontario is to fulfill the expectations of the "accessibility" principle embodied in the Canada Health Act, this must change.

ROMA notes that the Ministry's "Models of Care Innovation Fund" funding call was posted on the Ontario Health website in July of 2023 with applications closing on August 31 --- peak season for vacations when most organizations would already be short-staffed. Further, the organizations eligible to apply seem to have been limited to organizations and facilities that are already part of the healthcare system.

In ROMA's view, pilot projects as described above must:

- Ensure that the Ministry of Health has a seat at the table for evaluation purposes
- Provide an opportunity for direct involvement by the appropriate OHT
- Provide an opportunity for direct involvement by ROMA for advocacy and information dissemination purposes
- Treat the pilot project as a rigorous research project, ensuring that academic and other qualified evaluators are also engaged.

Recommendations for Action… continued

If successful in delivering targeted outcomes, the Ministry of Health and Ontario Health Teams would be expected to diffuse learnings (e.g. with case studies) and the Ministry must fund these innovative services on an ongoing basis, above and beyond funding envelopes provided to the Ontario Health Teams for existing services and models. ROMA is keenly interested in supporting the development and diffusion of good ideas that meet the health needs of residents of Rural Ontario.

> Recommendation calling for *"implementing flexible funding models that support integration at the local level across existing funding silos (e.g. LHINs, primary care, EMS, Public Health, community agencies) and that are responsive to the unique local circumstances of communities in rural, remote and northern Ontario."*
> [Underlining added for emphasis]
> Source: Rural and Northern Health Care Report (2010) (Ontario)

5.8 Preserve Public Health Emergency Response and Prevention Programs

Recommendation 5.8A

That the Province review with ROMA the business case that predicts $200 million a year in savings from the consolidation of 35 public health units into 10, and

Further, that the Province describe how rural municipalities that currently pay 25 per cent of the costs for public health units operating in their municipalities will have input into public health program development and delivery in their areas, and

Further, that the Province confirm that regardless of future governance models for public health, the services traditionally within the mandate of Public Health will be delivered 'closer to home' in Rural Ontario.

Background: In 2019, the Province announced plans to save $200 million a year by consolidating Ontario's public health units from 35 to 10. Because Rural Ontario does not have the breadth and depth of healthcare services that are present in larger centres, Public Health Units have been an effective partner in promoting public health, and most recently supporting rural municipal governments in responding to the COVID-19 pandemic.

> ***"If we'd had to manage the pandemic with only 10 public health unit offices, it would have been a complete disaster…. The current consolidation plan is false economy. The long-term cost will far exceed the proposed savings."***
> Comment from consultation participant, fall 2023

Given rural municipalities' experience with municipal restructuring in 1998, ROMA questions the wisdom of consolidating public health units into new governance structures responsible for 500,000 people. Typically, these kinds of consolidations mean either that there will be health units with very large geographic areas to support, or rural populations will be added to much larger urban centres. In either case, ***the result is a diminished "rural voice" and reduced levels of service.***

Recommendations for Action… continued

The Province must demonstrate transparency in its work by providing ROMA with an opportunity to review the business case that predicts $200 million a year in savings, including where the $200 million will come from, how it will be reinvested, and how the proposed new governance structure will ensure that Rural Ontario is not left out in the cold.

ROMA anticipates that as part of that review, the Province will share case studies from within or outside of Ontario that demonstrate a high probability that the proposed savings will be achieved. In ROMA's experience, consolidations and/or amalgamations rarely generate the savings predicted. Certainly, Ontario's municipal restructuring in 1998 did not.

Given that municipalities pay 25% of public health units' annual budget, ROMA requests that rural municipalities be consulted on this change before it is implemented.

Recommendation 5.8B
That the Province continue its funding support for prevention programs currently delivered by public health units, so that Rural Ontario residents can capitalize on opportunities to protect and strengthen their health for decades to come, as well as contributing to better control of health care costs in the years ahead, and
Further, that the Province continue its funding support for emergency services and public health emergency planning and response, so that Rural Ontario residents can take appropriate measures to protect their health, and build resilient communities.

Background: The Financial Accountability Office of Ontario recently published projections for health spending by program area through to 2027-2028 (see table below). The projections project significant increases in most program areas, with one exception: "Other Programs". This category includes both public health and emergency services.

Table 2
FAO projected health sector spending by program area to 2027-28, $ billions

Program Area	2021-22 Actual Spending ($ billions)	2027-28 Projected Spending ($ billions)	Average Annual Growth Rate 2021-22 to 2027-28 (%)	Average Annual Growth Rate 2019-20 to 2027-28 (%)
Hospitals	26.4	32.6	3.6	4.5
OHIP (physicians and practitioners)	16.6	21.3	4.3	3.8
Ontario public drug programs	5.3	7.2	5.1	5.2
Community programs	5.2	7.1	5.1	5.7
Mental health and addictions programs	2.0	2.6	4.6	4.5
Long-term care	6.8	11.6	9.2	12.9
Other programs	11.2	10.1	-1.7	3.8
Health capital	2.2	2.6	3.2	4.3
Total Health Sector	**75.7**	**95.1**	**3.9**	**5.1**

Source: 2019-20 and 2021-22 Public Accounts of Ontario and FAO.

Figure 12 – Source: Financial Accountability Office of Ontario; Ontario Health Sector: 2023 Budget Spending Plan Review May 2023

Recommendations for Action… continued

ROMA is deeply concerned that this budget plan --- especially the $1.7 billion reduction in spending in "other programs" will gut Ontario's fiscal capacity to maintain infrastructure, materials and supplies, and emergency services personnel required to respond to public health emergencies[66]. ROMA expects the opportunity to work with the Province to ensure that these essential public health services remain funded by the Province and accessible 'closer to home' across Rural Ontario.

ROMA also strongly recommends that the Province preserve capacity for long-term investments in research and program/services for which the financial and health-related "return on investment" may be at least a decade off. In ROMA's view, this is essential to achieving one element of Ontario Health's mandate to "reduce per capita cost of health care."[67]

[66] These emergencies include future epidemics and pandemics, major power outages and natural disasters.

[67] https://www.ontario.ca/document/healthy-ontario-building-sustainable-health-care-system/chapter-2-vision-health-care

6 Next Steps and Conclusion

Nearly five years have passed since the Province introduced The People's Health Care Act, 2019 (Bill 74), creating Ontario Health from a consolidation of multiple provincial health agencies and authorizing the creation of new integrated delivery systems called Ontario Health Teams[68]. Less than a year later, the COVID-19 pandemic exposed the weaknesses in the provincial healthcare system that demand transformation. Ontario Health's current business plan reflects the Province's approach to implementing that transformation.

Ontario Health's business plan covers several themes that are also prominent in ROMA's report. For instance, it refers to "addressing "the distinct needs of individuals and communities across the province", "partnering to take action to make improvements", and "contributing to upstream social determinants of health and preventative care." The provincial plan also refers to "working with Ontario ministries, funded and non-funded partners including municipalities and social services to support and enable more connected and coordinated care" and "challenging the status quo and embracing transformation in order to continuously strengthen our organization and the health system." [underlining added for emphasis].

Immediately upon releasing the *Fill the Gaps Closer to Home* report, ROMA intends to press the Province to ensure understanding of the catastrophic state of health services in Rural Ontario and to review the recommendations with an eye to finding ways to achieve --- *for Rural Ontario* --- the "equitable outcomes and experiences" the Province is promising from a transformed healthcare system.

ROMA notes that "rural" Ontario is mentioned only four times in Ontario Health's plan:

- In the "Reduce Health Equities" section of Ontario Health's 2023/24 business plan, in which the focus on "equity-deserving, high-priority and communities with geographic disparities in access to care". However, the only strategy for achieving this reduction in inequity for "rural, remote and geographically isolated populations", appears to be via "**secure virtual care solutions**". *Filling gaps solely with virtual care is not equitable access to health services.*

[68] At maturity, OHTs are expected to exhibit 10 characteristics including: operating within a single clinical accountability framework system with a *single integrated funding envelope*, providing a *full and coordinated continuum of care* to a defined population, and offer *24/7 navigation support* through virtual care and patient access to information.

Next Steps and Conclusion… continued

- "**preventing ED closures by deploying capacity balancing techniques** within and across hospitals and implementing locum programs to ensure clinicians are deployed, particularly in rural and northern settings," *As previously noted in this report, ROMA recommends a careful and comprehensive review, as the first step in designing a strategy to ensure that rural EDs can provide the 24/7 service that Rural Ontario residents need.*

- **implementing an ED peer-to-peer program** to provide "on-demand, real-time support and coaching from experienced emergency physicians 24/7 for patients of all ages and levels of need." This plan states that this program started with six early adopter rural EDs in October of 2022 and expanded to 27 additional sites in December of that year. *Given that rural EDs closed with the same frequency in 2023 as in the previous year, the current version of this program is an insufficient response.*

- **stabilizing and transforming health human resources** including "supporting crisis response, stabilization, recruitment and retention in rural and Northern communities." The near-term strategy appears to be one of using locums and internationally educated health professionals. *In this paper, ROMA offers multiple recommendations on how to deploy health professionals differently, not just in the near-term but in a transformed system.*

Other references in Ontario Health's plan are on ROMA's radar for early attention:

- "supporting the **integration of primary care** in OHTs, which includes providing guidance for the implementation of **local networks of primary care** and the involvement of primary care leadership in OHT decision-making". *ROMA will be pressing for action to increase the number of primary care physicians in Rural Ontario, overhaul the Province's physician attraction and retention program, and deploy other health professions in ways that increase access to primary care in Rural Ontario.*

- "completing a **community services review and providing recommendations on optimal ways for community agencies to participate** as part of OHTs (**beginning with community support services and community mental health and addictions services**)". *ROMA will be pressing the OHTs and the Province to increase and expand the capacity of community agencies to deliver services in Rural Ontario, including but not limited to mental health and addictions services.*

Next Steps and Conclusion… continued

- "Developing a provincial approach to **social determinants of health**, providing clear actionable support for OHTs to integrate care that will address the non-medical factors that influence health outcomes*". ROMA will be pressing the Province to ensure that the proposed actionable support takes into account that "Rural is Different" and that it includes firm commitments from other Ministries as well as the Ministry of Health and the Ministry of Long-Term Care.*

In ROMA's view, if residents of Rural Ontario are to achieve equitable access to healthcare services, the rural municipalities that represent and deliver many other services to them locally must be at the Ontario Health Team table. ROMA will be pressing the province to require OHTs to include municipal participation in the current fiscal year as these initiatives move forward.

Rural Municipalities Can Help Ontario Health Teams in Other Ways: In addition to ensuring that rural residents' healthcare interests are considered in planning and service delivery discussions, rural municipalities can help in other ways:

- Identifying resources (physical/space, human and technical) that might be accessed to support rural service delivery.
- Bringing local stakeholders together, within or in addition to OHT deliberation, to accelerate integrated care, and address health human resource shortages.
- Share innovative local projects that can help OHTs achieve their goals for both rural and urban parts of their service areas.
- Share information with residents and ROMA's own networks about how governments, service providers and community groups are working to make the healthcare system in Rural Ontario better.

ROMA will **accelerate its existing advocacy role** in direct discussions with both provincial and federal governments to ensure that their decisions and actions focus on filling the gaps in access to health services in Rural Ontario. ***For example, at the first opportunity, ROMA will meet with the Province to review the proposed restructuring of Public Health to review projected cost savings, ensure that its importance to Rural Ontario is not lost in centralized corporate processes, that emergency response capacity is preserved, and that the longer-term role of prevention programs is understood and retained.***

There is no time to waste. Let's fill the gaps closer to home, starting today.