Integrated Health Services Plan
IHSP2

Draft August 2009

“Reaching for Excellence”
Executive Summary

Ontario’s provincial health-care system is large and complex. It is experiencing a number of challenges such as: an aging population, changing consumer expectations, scarce health human resources, more unhealthy lifestyles and escalating costs. In order to address these challenges, our health-care system must become more adaptable and less fragmented. It must demonstrate evidence of integration of programs and services, and be more effective and efficient. In short, it must undergo a transformation that will focus on results, outcomes, operational efficiency, clinical excellence and long-term sustainability.

The current provincial health plan for Ontario sets out a vision and strategic direction to guide this transformation of our health-care system. It builds upon existing strengths and responds to emerging priorities.

The transformation is underway, led locally by each of the 14 Local Health Integration Networks (LHINs) in Ontario. Each LHIN is required to develop an Integrated Health Services Plan (IHSP) every three years to direct improvement of local health care services within its region.

This is the second Integrated Health Services Plan (IHSP2) for the South East LHIN. It builds upon the progress made to improve local health care since IHSP1 was approved in October 2006.

This report outlines how the plan was developed, and defines the alignment with the priorities set and agreed to by the Ministry of Health and Long-Term Care (MOHLTC). It describes the themes heard through community engagement and consultation processes, sets out the specific priorities the South East LHIN will focus on, and explains how the LHIN will demonstrate and measure success. In addition, there is an expectation that all health service providers will respond to local needs, measure their performance, incorporate best practices and support meaningful community participation to ensure accountability to the South East LHIN.

The plan is entitled, Reaching for Excellence and has been formulated around six strategic pillars of excellence, including:

- Quality of Care
- Patients/People
- Integrated Service Delivery

- Effective Programs/Services
- Community Engagement
- Financial Health and Sustainability

Reaching for Excellence supports the LHIN in pursuit of its vision: Achieving better health through proactive, integrated and responsive health care in partnership with an informed community.

The IHSP2 focuses on strengthening primary care, integrating mental health and addictions services, providing supportive care and delivering specialized and emergency care. Improvement in these areas will be demonstrated through enhanced access to health-care services, improved overall system efficiency and better services for individuals with mental health and addictions needs. Improvement will also be achieved in part by support for health promotion and engagement of consumers in all aspects of their health-care delivery. There will be more emphasis on helping people stay healthy and better manage their long term health.

In all, there are 10 priorities set out in IHSP2 to assist the South East LHIN in creating an accessible and sustainable system for care. In turn, these priorities will also position care so that it is provided in the right place at the right time. These system improvements will enable the acute care system to be better able to focus on its role. The IHSP2 priorities include:

- Developing a System of Primary Health Care (page 19)
- Enhancing a Culture of Patient-Centred Care (page 20)
- Improving Mental Health and Addictions Services Capacity (page 21)
- Developing Regional Program Management (page 22)
- Improving Access in Emergency Room Care (page 23)
- Reducing the Incidence of Alternate Level of Care (page 24)
- Implementing the Ontario Diabetes Strategy (page 25)
- Furthering Access Through E-health (page 26)
- Expanding cultural and linguistic health care services (page 27)
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2. Achievements from IHSP1
3. ReCAP Findings 2009
4. ENGAGE 2009: A qualitative analysis
5. Programs & Services: A listing of existing resources in the South East LHIN July 2009
6. Companion documentation – not part of the approved IHSP: Strategic Health Plan of the Mohawks of the Bay of Quinte
1. Introduction

The Integrated Health Services Plan (IHSP) is the three-year strategic plan for our local health-care system. All of the 14 Local Health Integration Networks (LHINs) in Ontario are required to develop strategic plans for their communities to guide the development of local health care in their area, as laid out in the Local Health System Integration Act, 2006. This plan is aligned with the strategic direction of the Ministry of Health and Long-Term Care to achieve coordination and integration of health services.

In partnership with health-care consumers, community members and health-care providers, the South East LHIN has developed this three-year plan, which responds directly to health-care service needs within our communities. This plan builds upon the progress that has been made to improve local health care since 2006.

This is the South East LHIN’s second IHSP. It is more specific and detailed than the IHSP1 that was approved in October 2006. IHSP2 articulates the results the LHIN wishes to see as it enters into the next three-year journey with specific deliverables related to local needs identified through community engagement, data analysis, local demographics and utilization of services. The IHSP establishes an inventory of the region, analyzes our present state of services, establishes benchmarks to be achieved and sets standards for evaluation.

The plan sets out the key steps to be taken locally to address needs within the south east region, such as: reducing waiting times in emergency rooms; lowering the number of alternate level of care patients in hospitals; implementing the Ontario diabetes strategy; addressing the needs of individuals with mental health and addictions challenges; and moving forward with Ontario’s e-health strategy.

Reaching for Excellence challenges health-care providers across the South East LHIN to explore possibilities for integration and improvements in the delivery of care, to meet goals and to measure results. Engaging our South East LHIN stakeholders regarding the future of health care is the foundation for the Reaching for Excellence strategy.

In designing a system of quality care that puts patients first, the South East LHIN is building upon six key principles, or “pillars of excellence” (See Figure 1) that provide the foundation for all activities within the South East LHIN. These pillars assist the LHIN in aligning and prioritizing operational goals by serving as the roadmap to help health-care providers navigate the journey to developing an excellence-based culture for patient care. These pillars provide the foundation for a high performing health-care system and thereby make a significant contribution to the overall improvement of population health. Each of these pillars is explained below:
Quality of care involves provision of safe quality health care that is defined and measured. There is a commitment to improving community health status and access to care.

Focus on patients/people means patients and staff are engaged in care delivery. Patients are satisfied with the quality of care experience. The focus is on the patient, not the provider. The patient is the ultimate decision maker about his/her care. Staff are engaged and satisfied with their work environment. There is equity and diversity within the system, with recognition of needs of specialized groups such as French language communities and Aboriginal populations.

Integrated service delivery recognizes efficiencies through elimination of duplication of services and focuses on enhancements to care delivery through regionalizing services. There is a commitment to providing excellent and compassionate service to all.

Effective programs/services lead to more efficient delivery of sustainable programs, maximizing the value of available funding to support patient care.

Community engagement involves consultation with community residents, health-care providers and stakeholders to learn of needs and to be responsive.

Financial health and sustainability are evidenced through our stewardship and commitment to be fiscally responsible to meet the health-care needs of the region.
2. A VISION for Integrated Health Care

Canadians have grown to have high expectations for their health-care system. Oftentimes, they speak of five principles related to the Canadian Health Act: accessibility, administration, portability, comprehensiveness and universality. They demand the right care at the right time from the right provider. In 2004, the First Ministers’ Health Accord was created to help build the nation’s health-care system, with additional long-term federal funding provided and provinces and territories agreeing to improve reporting to taxpayers on the performance of health-care services.

The government of Ontario is positioning the provincial health-care system to deliver high quality services, ensuring patient needs are available in the right place at the right time and ensuring services are cost effective. In Ontario, the health-care system should work to prevent sickness and improve the health of the people of Ontario (source: Ontario Health Quality Council, 2009).

Provincial Vision

The Ministry of Health and Long-Term Care is a large and complex ministry and has divided the province into 14 local units or LHINs. The Ministry’s provincial vision, as stated by former Minister of Health and Long-Term Care The Hon. George Smitherman in 2004, is “a health-care system that helps people stay healthy, delivers good care to them when they need it, and will be there for their children and grandchildren.”

South East LHIN Vision

The South East LHIN vision fits under the umbrella of the broader provincial health vision. In turn, health service providers within the South East LHIN each need to align their focus to assist the South East in moving towards its vision for a regional integrated health system. Further, the South East LHIN expects all of its providers to ensure their own visions fit within the South East vision.

The South East LHIN vision was created by nearly 100 citizens from across the region who took part in an innovative panel on health. They collectively wrote the vision after participating in dialogue about the IHSP1 priorities and learning about the complexity of the south east health system, demographics, capacity and future estimates of demand for services.

The vision for the South East LHIN health system is:

“Achieving better health through proactive, integrated and responsive health care in partnership with an informed community.”

The vision statement is a commitment to improvement in individual and population health status. It commits to focus on needs before they become problematic and to provide for integrated or seamless care within the continuum of care, in partnership with internal and external stakeholders. It also refers to an informed community that understands how to access the system and can maintain optimal health.

Integration

In order for the South East LHIN to move forward with better delivery of services and programs in a more sustainable way, there must be integration of care delivery. But what does integration really mean? Integration is simply more effective management through alignment of independent and interdependent organizations with unique goals and objectives. The purpose of health system integration is to achieve seamless care: improving the match between single and multiple services; and enabling effective and efficient use of the resources available.

Integration of health services will assist patients and clients in accessing the various components of care they require at the right time and in the right place. It will also support the quality of patient care by ensuring the right health information is available to enable the right health service providers to deliver the most appropriate care at the optimal time.
Furthermore, integration of health resources will allow the system to maximize the value of services delivered from our available health-care funds.

Two types of integration should be evident under the LHIN model: horizontal and vertical integration. Horizontal integration involves similar organizations providing similar services across a region to develop standards for consistent quality care – i.e., hospitals providing hip and knee surgery. Vertical integration occurs across sectors – i.e., hospitals, long term care, mental health and other sectors/providers, often in smaller geographic areas within a LHIN region.

Integrated health systems demonstrate well developed performance monitoring systems including indicators/performance measures that enable close monitoring of outcomes. There is growing evidence that implementing an integrated health system requires leadership with vision and an organizational culture congruent with the vision. This leadership is particularly important when working across the continuum of care where differing organizational cultures are brought together.

Barriers to successful integration may be different cultures, acute care mindsets, lack of engagement and weak governance. In order to successfully integrate services within the South East LHIN, the following need to be in place: integration of leadership; coordination of patient-centred care; system level strategic planning, and accountability measures. Integration of health systems requires much planning; redirection of resources; and interactive, interdependent relationships among the organizations involved. An integrated health system in the South East will lead to sustainable high quality of care and better health outcomes.
3. Overview of the Current Local Health-care System

The South East LHIN covers 19,473 square kilometers of land mass and is the largest rural health region in southern Ontario.

**Key facts about the South East LHIN**

- Population of approximately 482,100 - represents 3.7% of Ontario’s total population
- Extends from Brighton in the west to Prescott and Cardinal in the East, north to Perth, Smiths Falls and Bancroft and south to the USA border
- Receives 4.5% of the total funding to all LHINs
- Half of region’s residents live in rural areas scattered across the region; the other half lives in more densely populated areas along the Highway 401 corridor, including Kingston, Belleville and Brockville

The July 2009 Listing of Programs/Services has a more detailed portrayal of the services provided by each of the organizations within the South East LHIN (see Appendix 5).

LHINs are responsible for funding and accountability for hospitals, community care access centres, community support services, mental health and addictions agencies, long-term care homes and community health centres. The South East LHIN’s budget in 2009/2010 is approximately $920 million. Funding allocations are seen in Figure 3.
LHIN Funding Allocations by Sector 2007-2008

- Hospitals: 68%
- Long-Term Care Homes: 15%
- Community Care Access Centre: 10%
- Community Mental Health & Addictions: 4%
- Community Support Services: 2%
- Community Health Centres: 1%
4. Framework for Planning

The IHSP2 was built from an understanding of five main bases for our local health-care system planning. These include:

- Regional Capacity Assessment and Projections (ReCAP), a significant quantitative analysis of the current health status and services available in the South East and projections for the future
- ENGAGE 2009, an extensive qualitative community engagement program
- Achievements and implementation of priorities identified in IHSP1, and an understanding of what remains to be accomplished
- Current provincial Ministry of Health and Long-Term Care priorities being furthered by all LHINs
- Lessons learned from literature about high performing health-care systems.

Regional Capacity Assessment and Projections (ReCAP)

ReCAP (see Appendix 2) represents a systematic analysis of data to determine current utilization of health-care services and forecasts for the future based on population growth. It is an advanced analysis of current and projected demand for health care in the South East. Part of the work involved a review of information describing our population and how it uses current health-care services. The analysis involved what services are now delivered in the LHIN and how they are configured. The analysis also projected what people will need from the health-care system until 2012 if no changes are made in how we deliver care (i.e. status quo).

ReCAP provided an analysis of:

- Where we are now
- Where we are going if the demand for health care grows and nothing changes
- What the impact will be on health-care providers and whether they have the capacity to be more efficient.

Emerging themes

Demographic and Health Status

- In fiscal 2007, the population of the South East LHIN was 481,000 with over 17% of people aged 65+. Overall, the South East has a higher percentage of elderly individuals than the rest of the province (13%).
- Data projections suggest that most of the population growth in the region will occur in the 45-64 and 65-74 age groups. Growth in the older age groups is not expected to be substantial between fiscal 2007 and 2012. Consequently, the aging of the population is not likely to be a major cost driver of health care in the short term.

- Chronic diseases such as cardiovascular disease (primarily heart disease and stroke), cancer and diabetes are among the most prevalent, costly and preventable of all health problems.
- Compared to the Ontario population, the South East LHIN has a higher frequency of chronic diseases (arthritis/rheumatism, diabetes, asthma, heart disease, cancer and high blood pressure). Prevalence of chronic disease has been increasing between fiscal 2001 and 2005. These diseases account for slightly less than 90% of all deaths. Health Canada predicts deaths from chronic disease will likely increase – most markedly, deaths from diabetes will increase by 44%.
IHSP2 - Reaching for Excellence

- A large percentage of the South East LHIN’s population lives in rural areas scattered across the region, with limited transportation options to access care.

Health Service Demand

- Most of the smaller hospitals have less than 5 visits to their Emergency Department (ED) between midnight and 6 a.m. Some of these hospitals have more than 15% of emergency room visits that could be managed elsewhere.

- South East LHIN hospitals provide acute care for a range of chronic and other conditions, the most frequent being circulatory, pregnancy-related, digestive or injuries – see Figure 5.

- Cardiology (13.3%), obstetrics (11.8%), neonatology (11.0%) and orthopedics (7.9%) accounted for the majority of acute inpatient separations in the South East LHIN.

- To meet the South East LHIN’s 2009 target of alternate level of care days (13% or less of total acute inpatients days) requires a reduction of 25% in the current 45,000 ALC days.

- The highest percentage (47%) of alternate level of care days was to patients waiting for transfer to continuing care institutions followed by those waiting for home care (with 23% of ALC days).

- For individuals aged 65+, utilization rates for inpatient rehabilitation is lower in the South East LHIN than the rest of the province.

- Between fiscal 2006 and 2007, there was a 5% increase in the number of adult inpatient mental health admissions, but a drop of 4% in the number of bed days (most of which was as a result of divestment of cases at Providence Care into the community).

- In fiscal 2007, the majority of visits to South East LHIN Community Health Centres (CHCs) were for nurses followed by physicians and nurse practitioners. Other types of visits were made to social workers, nutritionists, health counsellors, chiropodists and therapists.

Figure 5: Most Responsible Diagnosis for Acute Inpatients in the South East LHIN Hospitals, Fiscal 2007
- South East Community Care Access Centre (SE CCAC) admission rates for individuals 75+ are slightly higher than those in the province.

- Although meals on wheels, transportation and congregate dining are provided as part of the Community Support Services (CSS) to all regions in the South East LHIN, there are some areas that receive proportionally less service.

- The number of referrals for attendant outreach services in the South East LHIN is continuing to increase with time.

- After fiscal 2007, modest increases are expected in rehabilitation, radiation, complex continuing care and acute medical care while only marginally or negative growth is likely be demanded in the other services – see Table 1.

**Health Service Supply**

- Between fiscal 2003 and 2007 while the number of family physicians in the LHIN remained relatively constant, there was a slight increase in the number of specialist physicians.

- The number of registered nurses and registered practical nurses also did not notably change during the period.

- Volunteers are a major resource component of the workforce among community health service providers; there are at least 4,800 volunteers within the 33 community health service providers.

With small populations spread across a large area, a coordinated model of integrated care delivery is required to ensure equal access to health-care services. Overall, ReCAP demonstrated that the current health-care system capacity is sufficient to meet the needs of our population over the course of IHSP2, but reallocations will be required.

### Table 1: Reported and Projected Volumes for Key Health Services, 2007 / 2012

<table>
<thead>
<tr>
<th>Sector</th>
<th>Service</th>
<th>Unit</th>
<th>2007</th>
<th>2012</th>
<th>Annual % Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Department</td>
<td>Visit</td>
<td>284,400</td>
<td>290,100</td>
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<td></td>
<td>Acute-Medical Separation</td>
<td>Visit</td>
<td>17,110</td>
<td>17,200</td>
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<tr>
<td></td>
<td>Acute-Surgical Separation</td>
<td>Visit</td>
<td>11,530</td>
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<td></td>
<td>Acute-Pediatrics Separation</td>
<td>Visit</td>
<td>1,920</td>
<td>1,890</td>
<td>-0.3</td>
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<td></td>
<td>Acute-Newborn Separation</td>
<td>Visit</td>
<td>4,450</td>
<td>4,290</td>
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<td></td>
<td>Acute-Obstetrics Separation</td>
<td>Visit</td>
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<td>-1.6</td>
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<td></td>
<td>Rehabilitation Separation</td>
<td>Visit</td>
<td>560</td>
<td>750</td>
<td>6.1</td>
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<tr>
<td></td>
<td>Complex Continuing Care Separation</td>
<td>Visit</td>
<td>960</td>
<td>1,110</td>
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<tr>
<td></td>
<td>Mental Health Separation</td>
<td>Visit</td>
<td>2,260</td>
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<td><strong>Hospital-Inpatients</strong></td>
<td>Surgical/Post Anesthetic Recovery Room</td>
<td>Visit</td>
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<td>58,390</td>
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<td></td>
<td>Oncology</td>
<td>Visit</td>
<td>17,070</td>
<td>16,350</td>
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<td></td>
<td>Dialysis</td>
<td>Visit</td>
<td>43,540</td>
<td>47,340</td>
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<td>Cardiac Catheterization</td>
<td>Visit</td>
<td>2,100</td>
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<td></td>
<td>Radiation Treatment</td>
<td>Visit</td>
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<td><strong>CCAC</strong></td>
<td>Home Care</td>
<td>Referral</td>
<td>29,950</td>
<td>32,800</td>
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<td>Assessment</td>
<td>Visit</td>
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<td></td>
<td>Admission</td>
<td>Visit</td>
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<td><strong>Community Support Services</strong></td>
<td>Meals on Wheels</td>
<td>1 meal delivered</td>
<td>2,730</td>
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<td>Transportation</td>
<td>1 way trip</td>
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<td></td>
<td>Congregate Dining</td>
<td>1 attendance</td>
<td>8,960</td>
<td>7,814</td>
<td>-2.7</td>
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</table>
ENGAGE 2009 - Community Engagement

An extensive community consultation series of events was held in early 2009, designed to allow the LHIN to listen to a variety of its stakeholders. While community engagement is one of the South East LHIN’s pillars of excellence, there is also a statutory obligation to engage stakeholders in decision-making. The *Local Health System Integration Act, 2006* states “health needs and priorities are best developed when the community has input that informs the making of decisions.”

The community engagement phase of IHSP2 represents a qualitative analysis of thoughts, ideas and perceptions from across the region (For full report, see Appendix 5). There were five phases in obtaining public input: a health care providers’ workshop, a citizens’ panel and community open houses; focused discussions, and finally, a public review and response to the draft IHSP2.

The South East LHIN used a five question survey that was available to everyone on the website. In all, there were 268 responses. The same survey was used with all ENGAGE event participants.

**Four key stakeholder groups engaged**

- A two-day health service providers’ workshop allowed providers to receive information from ReCAP and participate in developing possible future states, as well as to participate in crafting future roles among health service providers and health service sectors.

- A citizens’ reference panel on health priorities and integration engaged 36 people who were randomly-selected and spent three Saturdays learning about the health-care system, and who made recommendations for the future. The panel also hosted a town hall meeting in Kingston that further engaged more members of the public in the health-care dialogue.

- Community open houses and public consultation were held in 15 communities throughout the region. These drop-in style meetings gave front line health-care workers, municipal officials, business people and members of the public an opportunity to talk to a LHIN board member or staff about their experiences, beliefs and ideas for health care in the South East.

- There were also focused discussions: Open houses and consultations with Francophone, Aboriginal, Métis populations, and physicians (hosted jointly with the Ontario Medical Association) provided focused discussions on the needs of the constituents of our population. The labour councils in Belleville, Kingston and Brockville, as well as the Quinte Labour Council, also met with LHIN representatives.

**Emerging themes**

- There are significant pressures recruiting and retaining health care professionals within the South East.
- There is a desire for more funding for health-care services and health-care professionals.
- There is need for a sound plan.
- Access to care is still a concern for many.
- People described a shortage of primary care physicians even in communities where physicians described a lack of patients.
- More long-term care beds are thought to be needed for our seniors.
- There is no supportive housing available for the elderly in the South East.
- Gaps are perceived in delivery services between youth and adult programming (particularly around mental health).
- People want walk-in clinics for primary health care and non-urgent care.
- Rural health service delivery faces transportation challenges.
- End of life care needs to be more accessible and coordinated.
Achievements and Implementation of IHSP1

In October 2006, the South East LHIN released its inaugural IHSP based on the most pressing needs of its communities, the priorities of the province and opportunities for new and emerging trends in health-care delivery.

Seven priorities for change were identified and have since driven planning for delivery of health services in the region. The priorities included:

- Improving Access to Care
- Improving Availability of Long-Term Care Services
- Integrating Services Along the Continuum of Care
- Engaging Aboriginal Communities
- Ensuring French Language Services
- Integrating E-Health
- Creating a Regional Health Human Resources Plan

A significant amount of work has been carried out in each of these areas (see Appendix 2). Since creation of IHSP1, the South East LHIN has further refined the priorities into four major areas upon which planning efforts are focused. They include:

A. Strengthening Primary Health Care
B. Providing Supportive Care
C. Integrating Mental Health and Addictions Service
D. Delivering Specialized and Emergency Care

Following are some highlights of successes in the South East LHIN to date in each of those key areas. Recognizing that some work currently underway still needs to be completed, there is also an outline of work that is planned to continue.

Primary Health Care

Developing a system of primary health care supports the South East LHIN’s goal of ensuring everyone who wants access to primary health care gets access to primary health care.

Primary care is the point where most people first seek health-care assistance. This is usually through a visit to a family doctor or nurse practitioner, a family health team, or community health centre. Having access to a primary health-care provider allows patients coordinated access to information, screening, diagnostics and early treatment, proper management of their chronic condition, referrals to specialists, and access to other resources available in the community.

Primary care involves a holistic approach that is built on a foundation of patients being informed and knowing how to self manage their health. It includes disease prevention and early intervention to reduce the frequency of disease, the severity of chronic conditions, and the need for emergency room visits and/or hospitalization.

The South East LHIN helped create a Primary Health Care Council to advise the LHIN of ways that primary care services can be better coordinated and delivered. While the LHIN is responsible for only a limited amount of primary health care, it works with family health teams and other primary health-care providers. The South East LHIN also led the development of the provincial Health Care Connect registry which matches unattached patients to primary health-care providers. From the time it was launched in February 2009 and July 31, 2009, 2,545 unattached patients in the South East LHIN have gained access to primary health care.

The South East LHIN will continue to develop primary health care as a system of care and increase its accessibility to our population.

Supportive Care

Supportive care provides community-based services to people who need help in order to live independently and remain as healthy as possible. A first-of-its-kind approach to providing supported living assistance through the Seniors Managing Independent Living Easily (SMILE) program was launched in the South East LHIN and evaluation of results continues. SMILE is an innovative program that offers individualized care plans and budgets to address the needs of seniors who are admitted to the program and caregivers who support them in their instrumental activities of daily living.
Many patients who utilize supportive care are impacted by one or more chronic health conditions or are recovering from an acute illness or injury. Chronic conditions such as cancer, disabilities from stroke, chronic respiratory disease, diabetes and heart disease are leading causes for death (source: World Health Organization). Patients with these chronic conditions may benefit from supportive services. Supportive care agencies deliver the services required by patients to maintain activities of daily living such as personal care, essential housekeeping, assistance with meals, bathing, medication administration and assisting with medical appointments. The South East LHIN will continue to build the supportive care component of the health-care system in an effort to provide individuals with more options and to decrease demand on acute care resources.

**Mental Health and Addictions Services**

Improving access to services for any individuals afflicted with mental health or addictions challenges means moving care from hospital and institutional environments to a specialized community model. This improvement will require a realignment of fiscal resources to support community providers in delivery of care. In addition, maximizing the efficient use of psychiatry services will be required to ensure equitable access to services across the region.

In the past two years, consumer survivor initiatives in the South East LHIN have been integrated, with one consolidated agency providing oversight and streamlining services. Further, three points of entry are being developed among mental health agencies across the region. Finally, divestment of mental health services continues at Providence Care in Kingston and Royal Ottawa Health Care Group in the Brockville area, resulting in a significant focus on mental health services planning for the South East LHIN.

We need to continue to build a system of community mental health care to support consumer survivors and their families.

**Specialized and Emergency Care**

Development of specialized and emergency care means that patients will have improved access to emergency care, spend less time in the emergency room waiting to be seen, have good health-care outcomes, and be satisfied with the level of care received. In addition, waiting times for laboratory tests and other procedures will be reduced so that patients can be diagnosed and treated sooner.

By reducing the number of alternate level of care (ALC) patients in hospitals, acute care hospital beds will be freed up for people who need the bed; this in turn will lower emergency room wait times by improving the flow of patients throughout the health-care system.

Integrating access to medical specialists across the region, not just at each hospital, will mean better matching of medical skills to special patient needs, better health outcomes, and improved work life for health-care providers.

More specifically, the South East LHIN has been focusing its support in several key areas, including:

- Supporting the Cancer Centre of Southeastern Ontario to improve the diagnosis of cancer, reducing the impact on society through effective and early screening detection and improved patient satisfaction.
- Ensuring timely, safe, effective and appropriate critical care by integrating critical care units across the region and establishing protocols to provide critical care surge capacity.
- Working to improve the heart health of residents by ensuring timely access to quality cardiac care through regional collaboration.
- Streamlining surgical care across the region by standardizing referrals for surgery, and improving access for diagnostic imaging services and laboratory work prior to surgery.

As we build community services such as primary care, supportive care, and mental health and addictions services, we will strengthen the ability of our hospitals to provide acute care.

With the designation of Kingston under the French Language Services Act in 2009, significant work continues with identified French language health service providers as they implement plans for French service designation. Further, the South East LHIN itself continues to work towards its designation under the Act.
Over the course of the past few years, the South East LHIN Board and staff have been dedicated to fostering stronger relations with Aboriginal communities in the region in order to ensure we work together to best meet needs for health-care services. The LHIN looks forward to furthering these important relationships.

**Provincial Priorities**

The Ministry is developing a strategic plan for the health-care system. The 10-year plan will include a vision, priorities and strategic directions for Ontario. It will reflect a patient focused approach, be results driven, illustrate integration and be sustainable. The Ministry goal is to “modernize the health-care system.”

As we await the 10-year strategic plan for Ontario’s health-care system, the LHINs have agreed to focus on improving access to care in five provincial priorities:

- Reducing wait times in emergency departments
- Reducing the time patients spend in alternate level of care in hospitals
- Supporting the roll out of Ontario’s diabetes strategy
- Enhancing mental health and addictions services
- Building on an e-health framework.

**Reducing Wait Times in Emergency Rooms**

Ontarians are entitled to safe, reliable, appropriate and high quality care when they visit an emergency room. With decreased waiting times come improvements in the patient’s experience.

To achieve shorter emergency room wait times, LHINs must improve performance across the entire health-care system. Bottlenecks in one area often impact other areas of the hospital.

Patients with non-urgent needs account for almost half of all emergency room visits. Thus, the LHINs are building health service capacity within their communities so people can access appropriate care outside the emergency room.

The Ministry has set provincial targets and requires LHINs to report wait times to the public.

**Reducing Time in Alternate Level of Care**

Close to 19% of patients currently in Ontario acute care hospital beds are considered ALC. They may be waiting for additional services to support them in returning home, placement in a long-term care facility or rehabilitation care beds. This may potentially prevent another patient in the emergency room from being admitted to an acute care bed, thus creating a backlog leading to longer wait times, and causing longer emergency room wait times.

The LHINs are working with the Ontario government on a variety of initiatives that will help patients get the care they need – whether that is in a hospital, in a long-term care home or rehabilitation care facility, in the community or at home.

**Supporting Ontario’s Diabetes Strategy**

Ontario’s diabetes strategy will help tackle a growing – and expensive – health-care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province’s population). The number of Ontarians with diabetes has increased by 69% over the last 10 years, and is projected to grow from 900,000 to 1.2 million by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year.

The diabetes strategy will improve access to prevention programs and team-based care. It includes an online registry that will give patients access to information and educational tools so they can better manage their disease. The registry will also enable health-care providers to check patient records, access diagnostic information and send patient alerts. The registry will result in faster diagnosis, better treatment and improved management for Ontarians living with diabetes.

The LHINs are committed to improving access to diabetes care by supporting the roll-out of the provincial diabetes strategy.
Enhancing Mental Health and Addictions Services

Beyond these three priorities, the Ontario government has announced that it plans to enhance mental health and addictions services. About one in five Ontarians experiences a mental health or addiction problem at some time, and the cost to individuals and society is enormous.

The Minister’s Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province’s strategy includes mental health and addictions services funded by ministries other than the Ministry of Health and Long-Term Care.

The LHINs will implement the provincial mental health and addictions strategy, helping to create a system that provides everyone who needs care with equitable access to safe, respectful and effective services.

Building on an e-health Framework

Ontario’s e-health strategy supports the province’s other strategies. By investing in information technology infrastructure, including the diabetes registry and electronic health records, we can improve patient care and access. The LHINs look forward to building on e-health strategy innovations to enhance system-wide integration and improve our health-care system.

Lessons Learned from Literature on High Performing Health-care Systems

It is worth noting that across the country and the world, there are many “best practices” and high performing health-care systems. Learning and using best practices contribute to higher performance by transfer of knowledge from one organization or provider to others.

- Birmingham East and North Primary Care Trust, and Heart of England Foundation Trust focused on assertive case management, diabetes management, healthy hearts/cardiac care, end of life care, musculoskeletal orthopaedic services, and vascular care with telemedicine. These efforts improved the flow of patients, ensured they received the care when they required it, and allowed for the implementation and focus on preventative care so as to manage sustainable costs and care.

- The Veterans Affairs New England Healthcare System has a strong emphasis on electronic medical records and clinical reminders. Moving in this direction supported efforts of standardized practices, which improved efficiencies, facilitated accountability and ensured sustainable excellence.

- Jönköping County Council in Sweden focussed on “systems thinking” instead of autonomous practices. There was also a focus on streamlining practices and the integration efforts needed to achieve such goals.

- Intermountain Healthcare in Utah focused on practice standardization across sectors, geography and practitioners. This focus allowed for better use of resources and reduced the chances of harmful (sometimes fatal) mistakes.

- The Henry Ford Health System in Michigan emphasized the importance of physician and administrative leadership to implement change in a measurable and sustainable way.

- Calgary Health Region focused on regionalization, which allowed for significant cost savings and improved care through economies of scale and integration of services. Required factors for regionalization were: creation of formal linkages between organizations; electronic information systems for sharing of information; regional planning; processes regarding flow of patients; and region wide monitoring. This success raises the question of pursuing regionalization of some health care services within the South East LHIN.

- Trillium Health Care in Mississauga provided insights into the four key factors that contributed to the success of quality improvements: leadership, strategy, staff development and culture redevelopment.

Through all of these previous examples we have learned that a focus on regional care with standardized practices will allow us to move forward in the direction of excellence. This direction needs visionary leadership in order to produce sustainable and improved patient care.
5. The Plan: Priorities for Development

A high performing integrated system of health care requires the interdependent functioning of high quality primary health care, mental health and addictions services, supportive care and specialized and emergency services. The South East LHIN IHSP2 reaches for this level of excellent performance by clearly articulating the priorities for improvement of these component parts (see Table 1). The following pages describe the South East LHIN’s priorities for development.

Each priority has objectives, measures and actions. Data analysis and community engagement have substantiated the priorities on which the LHIN has focused.

From the analysis within the South East LHIN and review as outlined in the previous section, the LHIN has focused on information from ReCAP, ENGAGE, IHSP1, priorities and accomplishments, MOHLTC priorities, and lessons learned from high performing health systems to identify its local priorities.

It is important to recognize that priorities outlined in this plan may change and evolve over the course of the plan’s implementation. It is expected, however, that the South East LHIN, through the support of its providers, will assist in the successful delivery of the IHSP2 priorities.

The priorities of IHSP2 continue to flow from the four key areas upon which South East LHIN planning has been configured.

<table>
<thead>
<tr>
<th>Planning Area</th>
<th>IHSP2 Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td>• Developing a system of primary health care</td>
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<tr>
<td></td>
<td>• Enhancing a culture of patient centred care</td>
</tr>
<tr>
<td>Mental Health &amp; Addictions</td>
<td>• Improving mental health and addictions service capacity</td>
</tr>
<tr>
<td>Supportive Care</td>
<td>• Implementing the Ontario diabetes strategy,</td>
</tr>
<tr>
<td></td>
<td>• Furthering access through e-health,</td>
</tr>
<tr>
<td></td>
<td>• Expanding cultural and linguistic health-care services,</td>
</tr>
<tr>
<td>Specialized &amp; Emergency Care</td>
<td>• Developing regional program management</td>
</tr>
<tr>
<td></td>
<td>• Advancing system improvement through Boards working together</td>
</tr>
<tr>
<td></td>
<td>• Improving access to emergency room care</td>
</tr>
<tr>
<td></td>
<td>• Reducing the incidence of alternate level of care</td>
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</tbody>
</table>

The local priorities support relationships between the services the LHIN manages and funds and those such as primary health care and public health which are essential if we are to improve the health of our population. The local priorities support sustainability of our financial and human resources through integration and regionalization. They recognize and support equity with a focus on French language and Aboriginal populations. They focus on putting the patient first, not health-care organizations. They focus on fulfilling our commitment to the residents of the South East LHIN through strong and committed governance that is “Reaching for Excellence.”
A. Developing a System of Primary Health Care

Objectives:

- To support the continued development of access to primary health-care services for everyone who wants access to primary health-care services
- To reduce the use of emergency room and hospital services by patients who can be served by primary health care

Measures

- Number of people who have access to primary health care
- Number of people who are registered with Health CareConnect
- Percentage of Health CareConnect matches completed in 4 months or less
- Number of patients presenting in ER for non-urgent care

Planned Actions

- Open community health centre and satellite operation in Belleville & Quinte West.
- Support the establishment of nurse practitioner clinics or family health teams in communities with unmet primary health care needs.
- Support the establishment of nurse practitioner services on Tyendinaga Mohawk Territory.
- Work with family health teams and other primary health care providers to encourage provision of full scope of practice/services and 24/7 access to primary health care services outside of emergency rooms.
- Collaborate with public health units and other interested community groups (e.g., school boards) to encourage establishment of programs that facilitate reductions in obesity and inactivity.
B. Enhancing a Culture of Patient Centred Care

Objectives:

- To improve the patient experience
- To improve the efficiency and effectiveness with which individuals move within and between health-care services

Measures

The South East LHIN will meet or exceed Ministry targets for:

- wait times for cancer surgery
- wait times for cardiac by-pass procedures
- wait times for cataract surgery
- wait time for hip replacement surgery
- wait time for knee replacement surgery
- wait times for MRI scan
- wait times for CT scan
- median wait time to long-term care home admission

Planned Actions

- Establish coordinated access for all Community Support Services.
- Explore the establishment of an integrated ‘Patient/Client Issues’ office for the region.
- Establish an integrated medical transportation strategy across the region.
- Obtain capital funding for replacement of health vans.
- Where waiting time performance for cancer surgery, cardiac by-pass procedures, cataract surgery, hip and knee replacement surgery, MRI and CT scans, falls below annual targets, require clinical practice improvements.
- Require strict application of long-term care home eligibility criteria.
- Require improvements in the provision of CCAC and selected community support services.
C. Improving Mental Health and Addictions Services Capacity

Objectives:

- To complete implementation of directives of Health System Restructuring Commission (Royal Ottawa Health Care Group - Brockville Mental Health site and Providence Care)
- To comply with the provincial Tier III divestment policy
- To standardize mental health and addictions intake and assessment access across the region
- To implement emerging provincial mental health and addictions priorities

Measures

- To be determined with the intent that they will be consistent with performance measures of other LHINs and the Ministry.

Planned Actions

- Transfer acute care mental health services from Royal Ottawa Health Care Group (ROHCG) Brockville site to Brockville General Hospital.
- Complete Tier III divestment of mental health services from Providence Care.
- Develop shared client access for all mental health and addictions services.
- End use of geographic ‘silos’ in the design and delivery of mental health and addictions services.
- Improve capacity for concurrent disorders (mental health plus addiction disorders) services.
- Develop ‘bridges’ between mental health services for children/youth and for young adults.
- Equalize access to psychiatrist care across the region.
D. Developing Regional Program Management

Objectives:

- To regionally standardize access to and use of selected specialized medical care
- To consider the establishment of centres of excellence for some specialized medical/surgical procedures
- To maximize capacity across the South East health-care system

Measures

- 90% of cardiac by-pass procedures fall within annually defined waiting times
- Ensure palliative care patients are no longer considered ALC
- 30-day readmissions for myocardial infarctions
- Wait time to see a surgeon (TI)
- Development and implementation of medium surge capacity plan

Planned Actions

- Develop regional program management for cardiac services.
- Develop regional program management for end-of-life care including designation of end-of-life care beds in hospitals across the region.
- Finalize regional surgical program implementation.
- Implement integrated management of critical care across all our critical care hospitals.
- Expand the use of integrated back-office services across health service providers.
- Evaluate the performance of the new ‘Surgi-Centre’ at Hotel Dieu Hospital and determine potential for future use.
- Build upon regional efforts to support efforts to improve recruitment and retention of health human resources.
E. Improving Access to Emergency Rooms

Objectives:

- Meet provincial standards for waiting times in emergency rooms
- Reduce the number of people who wait in hospital for an alternate level of care
- For those who do wait for an alternate level of care, shorten the time they spend waiting
- Change ‘culture of placement’ to a ‘culture of going home’

Measures

Meet or exceed Ministry targets for:

- Number of unscheduled ER visits per 1000 population
- Proportion of admitted patients admitted from ERs within Length of Stay (LOS) of < 8hrs;
- Proportion of non-admitted patients treated within respective (LOS) targets of: < 8hrs for CTAS* 1-2; < 6hrs for CTAS 3; < 4hrs for CTAS 4/5

*CTAS = Canadian Emergency Department Triage and Acuity Scale

Planned Actions

- Create an integrated process between the Community Care Access Centre (CCAC), Community Support Services (CSS) & hospitals to promptly provide community support for the most frail elderly (expediting ER discharges, reducing unnecessary admissions and avoiding repeat ER visits).
- Expand the ‘Flo’ Initiative to all hospital sites.
- Implement electronic notification, referral and resource matching systems among hospital ERs, CCAC, and other providers.
F. Reducing the Incidence of Alternate Level of Care

Objectives:

- Reduce the number of people who wait in hospital for an alternate level of care
- For those who do wait in an alternate level of care, shorten the time they spend waiting as ALC
- Change ‘culture of placement’ to a ‘culture of going home’

Measures

Meet or exceed Ministry targets for:

- Percentage of ALC days
- Percentage of ALC patients
- Percentage of patients aged 75+ discharged home from acute care
- Amount of time spent waiting for placement in long-term care

Planned Actions

- Create an integrated process between the Community Care Access Centre (CCAC), Community Support Services (CSS) & hospitals to promptly provide community support for the most frail elderly (expediting ER discharges, reducing unnecessary admissions and avoiding repeat ER visits.)
- Expand the ‘Flo’ Initiative to all hospital sites.
- Implement electronic notification, referral and resource matching systems among hospital ERs, CCAC and other providers.
- Implement daily physical exercise routines for hospitalized patients over age 65.
- Designate clusters of dedicated long-term care interim admission beds across the LHIN.
- Designate clusters of dedicated short stay (convalescent & respite) long-term care beds across the LHIN.
- Establish nurse practitioner services in long-term care homes program.
- Open a new long-term care home in Kingston in 2011.
- Support capital redevelopment of B & C rated long-term care homes across the region.
G. Implementing the Ontario Diabetes Strategy

Objectives:

- Meet expectations of this provincially required priority
- Implement Ontario’s Diabetes Strategy as a first step in a broader chronic disease management model

Measures

- To be determined with the intent that they will be consistent with performance measures of other LHINs and the Ministry.

Planned Actions

- Establish a regional Diabetes Coordination Centre.
- Implement the Ontario Diabetes Strategy.
H. Furthering Access through E-Health

Objectives:

- Meet expectations of this provincially required priority
- Implement Ontario’s Diabetes Strategy as a first step in a broader chronic disease management model

Measures

- To be determined with the intent that they will be consistent with performance measures of other LHINs and the Ministry

Planned Actions

- Establish a joint population and health data analytical collaborative across the LHIN, public health units and selected health services providers.
- Support the establishment of on-line prescription ordering and clinical reporting.
- Finalize implementation of electronic diagnostic imaging services for exchange of images in the 7 hospital corporations in the South East LHIN.
- In cooperation with e-health Ontario improve overall e-health capabilities across LHIN health service providers through improvements to foundational systems.
I. Expanding Cultural and Linguistic Health-care Services

Objectives:

- To establish strong working relationships with Aboriginal populations (Métis, off-reserve Aboriginal population, Mohawks of the Bay of Quinte)
- To assist identified health services providers to meet French Language Services Act requirements

Measures

- Percentage of identified French Language health service providers that convert to designated French language health services providers.
- Designation of the South East LHIN organization as a French language service provider.
- Measures for relationships with Aboriginal populations are under development.

Planned Actions

- Continue engagement with Aboriginal populations.
- Establish designated French language services in Kingston.
J. Advancing System Improvement Through Boards Working Together

Objectives:

- To effectively employ collaborative governance to advance health-care system improvement through integration and better coordination of services
- Health service provider boards to accept fiduciary responsibilities to the health-care system
- To improve collaboration and information sharing between the LHIN and health service provider boards and among health provider boards

Measures

- Voluntary integration initiatives developed
- Health service provider accountability agreements signed
- Health service provider service accountability agreements targets met
- Health service provider board awareness of LHIN accountability agreements and initiatives

Planned Actions

- Implement 1st Service Accountability Agreement (SAA) for long term care homes (April 1, 2010).
- Implement 2nd SAA for hospitals (April 1, 2010).
- Complete 2nd SAA for community health service agencies (including CCAC) (2010/11).
- Complete 3rd SAA for hospitals (2011/12).
- Complete 2nd SAA for long term care homes (2012/13).

Note: Collaborative governance means that the LHIN board and health service provider boards work together to achieve the common goal of ensuring the residents of the South East LHIN have access to high-quality health services when and where they need them.
6. How Success will be Demonstrated and Measured

As the primary planning document for the LHIN, the IHSP is the foundation upon which the entire LHIN accountability framework is based, reflecting the operational expectations outlined within the Ministry-LHIN Accountability Agreements. (See Figure 6).

This document details the means for the South East LHIN to advance its vision, consistent with the needs of its community and ensure alignment with our provincial system of health care. Further, the IHSP provides direction for creation of service accountability agreements with the health service providers that receive funding through the LHIN, as well as provides longer-term direction for the LHIN’s annual business planning purposes.

IHSP achievements and gaps are highlighted in quarterly reports to the Ministry as well as within annual reports that are tabled before the Legislative Assembly of Ontario.

The LHIN is also accountable to the Ministry through the Ministry-LHIN Accountability Agreement. The Board will provide reports to The Ministry on the successes and challenges.

Most importantly, the South East LHIN is accountable to the public for progress in the health-care system. The LHIN will continue to develop ways to monitor projects, improve ways to evaluate the information received, and enhance the health-care system. The South East LHIN will do its best to get lasting results for the local health-care system.

The LHIN will post information about the progress made to date on the South East LHIN website so anyone interested can be aware of what is happening. It will continue to engage the community by being present in the local cities, towns and villages, and by keeping its door open when members of the community wish to visit or discuss concerns and issues.
**LHIN ACCOUNTABILITY FRAMEWORK**

**Local Health System Integration Act, 2006**
- Establishes Mandate & Power of LHIN: role to plan, fund, integrate, engage community.

**Memorandum of Understanding**
- Identifies key roles and responsibilities of LHINs and Ministry (until end of 2011/12).

**Ministry-LHIN Accountability Agreement (MLAA)**
- Establishes key funding and operational expectations of LHINs and Ministry (2007/08 to 2009/10).

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**From VISION to RESULTS**

### Planning

- **Integrated Health Services Plan**
  - Sets out local vision, priorities and strategic directions for each LHIN (2010/11 to 2012/13).

- **Annual Business Plan**
  - Articulates how each LHIN plans to operationalize its IHSP.

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### System Accountability

LHINs negotiate Service Accountability Agreements (SAA) with these sectors:

- Hospitals (Public and Private)
- Community Care Access Centers
- Community Support Services
- Mental Health & Addictions
- Community Health Centres
- Long-Term Care Homes

- Underway Now

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### Reporting Performance

- **Quarterly Reports**
  - LHINs report quarterly to the MOHLTC on MLAA indicator performance and on the financial health and top risks of their sectors and of the LHIN itself.

- **Annual Report**
  - LHINs are required to prepare Annual Reports for the Minister who is required to table the reports before the Legislative Assembly.
7. Conclusion

“Together we can”- Implicit in this statement, is that no one individual or one agency can fully deliver on this plan. To reach for excellence in creating a high performing health-care system that will result in better health for our communities, all those involved in the delivery of services and prevention of illness need to work together.

We are confident our plan is built on a solid foundation. This second Integrated Health Service Plan, Reaching for Excellence, is the LHIN’s assurance to the residents of the South East region for safe, high quality, sustainable care. The South East LHIN is committed to a more integrated, results driven system where patient-centered care comes first.

Improvement in the health care system is an ongoing process which must be developed and implemented within the context of the population needs, focused on improvements to health outcomes, and enabling a higher quality of care. Resources and time commitments are necessary for integration to occur.

The LHIN will work towards alignment of the component parts of the health-care system to ensure care is seamless along the continuum from primary prevention to end of life care. This shift requires changes to our current system, structures, processes and incentives to move from silos to a truly integrated patient-centered system. There will be a greater focus on strong visionary leadership, changes in governance, accountability processes and demonstrated results.

Integrated health systems need to be designed to reflect the premise that different models are required for different populations; one size does not fit all. There is no doubt that service providers must have well developed performance plans; however, the effectiveness of the system must be judged by the interaction of its parts and not just on the performance of individual agencies. If a system is to be truly successful, then the whole must be greater than the sum of its parts. Success will require the system of care to be patient centered, seamless, efficient and effective.

We cannot be complacent. The IHSP2 must be seen as a living document, flexible to meet the changing needs of the health care system. If we are to be true to our commitment to the residents of the LHIN we must work collectively as a system in achieving the six pillars of excellence.

Appreciation is extended to those who have been engaged in contributing to the creation of the second Integrated Health Services Plan for the South East LHIN.
IHSP2 & Appendices
Table of Acronyms

ACTT – Assertive Community Treatment Team
ALC – Alternate Level of Care
BGH – Brockville General Hospital
CCAC – Community Care Access Centre
CCC – Chronic Continuing Care
CCRS – Continuing Care Reporting System
CHC – Community Health Centre
CIHI – Canadian Institute for Health Information
CRP – Citizens’ Reference Panel
CSS – Community Support Services
CT – Computerized Tomography
CTAS – Canadian Emergency Department Triage and Acuity Scale
DATIS – Drug and Alcohol Treatment Information System
EASIER+ – Eldercare Access Strategy in Emergency Rooms
e-health – Electronic health
EME – Electronic Medical Record
ER – Emergency Room
FHT – Family Health Team
GDP – Gross Domestic Product
GP – General Physician
HDH – Hotel Dieu Hospital
IHSP1 – Integrated Health Services Plan, 2006
IHSP2 – Integrated Health Services Plan, 2009
IMHC – Integrated Mental Health Council
KGH – Kingston General Hospital
LACGH – Lennox & Addington County General Hospital
LHIN – Local Health Integration Network
LHSIA – Local Health System Integration Act, 2006
LLG – Lanark, Leeds & Grenville
LOS – Length of Stay
LTC – Long-Term Care
MIS – Management Information System
MLAA – Ministry-LHIN Accountability Agreement
MOHTC – Ministry of Health and Long-Term Care
MRI – Magnetic Resonance Imaging

NACRS – National Ambulatory Care Reporting System
NAMI – National Alliance on Mental Illness
NP – Nurse Practitioner
NRS – National Rehabilitation Reporting System
OBSP – Ontario Breast Screening Program
OMHRS – Ontario Mental Health Reporting System
OPCH – Ontario Prevention Clearing House
PARR – Post Anesthetic Recovery Room
PHU – Public Health Unit
PSFDH – Perth & Smiths Falls District Hospital
PT/OT – Physiotherapy/Occupational Therapy
QHC – Quinte Health Care
ReCAP – Regional Capacity and Assessment Projections
ROHCG – Royal Ottawa Health Care Group
SAA – Service Accountability Agreement
SMILE – Seniors Managing Independent Living Easily
VON – Victorian Order of Nurses
WSIB – Workplace Safety and Insurance Board
Appendix 3

Accomplishments from IHSP1

The first ISHP (2007/08 through 2009/10) also set out many priorities. The South East LHIN acted on these and accomplished much across the region. Some of the highlights are summarized below.

<table>
<thead>
<tr>
<th>Priority</th>
<th>South East LHIN Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care:</td>
<td></td>
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<tr>
<td>• Primary health care</td>
<td>• Two community health centre satellite centres were opened.</td>
</tr>
<tr>
<td>• Specialized medical care</td>
<td>• A new community health centre and a new satellite were approved and are under development.</td>
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<tr>
<td></td>
<td>• Health Care Connect was launched with 95% matching of registered individuals and primary health care physicians within the first 3 months.</td>
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<tr>
<td></td>
<td>• Establishment of a Primary Health Care Council was supported.</td>
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<tr>
<td></td>
<td>• Emergency room access was improved</td>
</tr>
<tr>
<td></td>
<td>• Emergency room waiting times approached the new guaranteed provincial targets.</td>
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<td></td>
<td>• Redevelopment and expansion of Lennox &amp; Addington County General Hospital was completed.</td>
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<tr>
<td></td>
<td>• Redevelopment and expansion of Quinte Health Care – Belleville site was started.</td>
</tr>
<tr>
<td></td>
<td>• Redevelopment and expansion of Kingston General Hospital and the Cancer Centre of Southeastern Ontario was started.</td>
</tr>
<tr>
<td></td>
<td>• Redevelopment for Brockville General Hospital was supported.</td>
</tr>
<tr>
<td></td>
<td>• Renovation of emergency room facilities at Quinte Health Care – Picton site was completed.</td>
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<tr>
<td></td>
<td>• A new MRI was installed at Quinte Health Care – Belleville site.</td>
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<tr>
<td></td>
<td>• A 320-slice CT scanner was installed at Hotel Dieu Hospital.</td>
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<tr>
<td></td>
<td>• A ‘Flo Initiative’ was initiated at one hospital site and then spread into the other hospitals across the region. This helped elderly patients return home sooner.</td>
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<tr>
<td></td>
<td>• Community support services joined together to help move patients from hospital beds to their homes when families were unable to assist with this transition.</td>
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<tr>
<td></td>
<td>• Elderly patients leaving emergency rooms now have direct referrals to community support services.</td>
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<tr>
<td></td>
<td>• Interim admission beds were introduced at four long-term care homes as an alternate location for ALC patients to wait for their longer term care admission.</td>
</tr>
<tr>
<td></td>
<td>• Community care service maximums were increased, allowing hospital patients to go home earlier and community patients to avoid unnecessary hospital admissions.</td>
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<tr>
<td></td>
<td>• Community care case managers were reintroduced into hospital emergency rooms so</td>
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</table>
## South East LHIN Integrated Health Services Plan 2

<table>
<thead>
<tr>
<th>Priority</th>
<th>South East LHIN Development</th>
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<tbody>
<tr>
<td>Mental health &amp; addictions services</td>
<td>patients needing care immediately after ER treatment could return home without delay.</td>
</tr>
<tr>
<td>• Management was reorganized to improve financial sustainability of one hospital.</td>
<td></td>
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<tr>
<td>• Governance was reorganized to improve leadership at one hospital.</td>
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<tr>
<td>• A nurse-offload service to receive patients transferred to an emergency room by ambulance was introduced.</td>
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<tr>
<td>• Waiting times for hip and knee replacement and cataract surgery were dramatically reduced</td>
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<tr>
<td>• An action working group made up of hospitals, long-term care homes, community providers, a public representative and the community care access centre is leading an effort to reduce the incidence of ALC in the South East LHIN. This working group is supported by dedicated staff and has support from hospitals and the CCAC to ensure success.</td>
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<tr>
<td>• Five mental health agencies co-located at one site to provide better integrated access for clients needing services.</td>
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<tr>
<td>• Mental Health Consumer Survivor Initiative services were integrated and a single consolidate agency, replacing four separate agencies.</td>
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<tr>
<td>• Mental health agencies developed three shared ‘points of entry’ across the region.</td>
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<tr>
<td>• Addiction and mental health services were combined into one organization in two centres.</td>
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<tr>
<td>• Supportive housing for people needing addictions services was approved.</td>
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<tr>
<td>• Health Services Restructuring Commission recommendations on Tier 2 and 3 divestments were revived to facilitate transfer of Tier 2 services to Brockville General from Royal Ottawa Health Care Group.</td>
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<tr>
<td>• Tier 3 transfer of clients to the community continued at Providence Care</td>
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<tr>
<td>• Supportive housing for people needing addictions services was approved.</td>
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<tr>
<td>Rehabilitation services</td>
<td>• Seven health vans were deployed across the entire region to provide subsidized, non-urgent medical transportation to and from the rural areas of the region.</td>
</tr>
<tr>
<td>• A nurse-offload service to receive patients transferred to an emergency room by ambulance was introduced.</td>
<td></td>
</tr>
<tr>
<td>• Laboratory services were transferred from a pilot to the community model in two communities.</td>
<td></td>
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<tr>
<td>• An integrated critical care transfer and repatriation system was implemented across all hospitals.</td>
<td></td>
</tr>
<tr>
<td>• An integrated plan to manage surges in the need for critical care was developed in and across all hospitals.</td>
<td></td>
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<tr>
<td>• A shared equipment and supplies purchasing organization for all hospitals was established.</td>
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</tr>
<tr>
<td>Priority</td>
<td>South East LHIN Development</td>
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<tr>
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</table>
| Availability of long-term care services | - Service maximums and improved flexibility for CCAC services was introduced to better support people so they may remain in their homes.  
- A nurse practitioner team that provides urgent care in four long-term care homes and prevents transfers of residents to hospital emergency rooms was developed.  
- The waiting list for long-term care was completely renewed. Premature eligibility designation for long-term care was ended.  
- One hundred and ninety-two new long-term beds, including one new-long term care home, have been built and opened for admissions in Quinte West and Tweed.  
- A new long-term care home has been approved for development in Kingston.  
- A first-of-its-kind approach to providing supported living supports was introduced and an evaluation of the results begun (the SMILE program). This program offers individualized care plans and budgets to address the needs of each senior admitted to the program and of the caregivers who support them in their instrumental activities of daily living. |
| Engagement with Aboriginal communities | - Relationship development moved strongly forward with Métis Nation & off reserve Aboriginal populations.  
- Proposals by Aboriginal communities to the federal Aboriginal Transition Fund were supported and one proposal received partial funding  
- Board members and LHIN staff participated in cultural learning provided by the Mohawks of the Bay of Quinte.  
- A strategic plan for health developed by the Mohawks of the Bay of Quinte was shared with the LHIN. |
| Ensuring French language services | - The LHIN and 14 health care providers were identified as possible French language service (FLS) providers in the Kingston area. All identified agencies are working towards FLS designation.  
- The Ontario Commissioner has recommended the province provide for the appointment of a regional French language coordinator for the South East and all other LHINs. |
| Integration of e-Health | - Some family health teams and hospitals electronically linked their patient records, improving patient safety and speeding up the sharing of clinical information.  
- All community support services, mental health services and addiction services agencies received a full upgrading of computer hardware.  
- The Inter-RAI Community Health Assessment was introduced as the standard assessment for all community support services.  
- A comprehensive Regional Capacity Assessment & Projection analyses of population, health service utilization and health sector capacity was completed.  
- Access to drug history profile for patients receiving Ontario Drug benefits was made available in the ERs of all hospital sites in the LHIN.  
- All hospitals in the LHIN are now “film-less” through the implementation of a diagnostic imaging repository.  
- A Client Health Record Information System was implemented at CCAC. |
<table>
<thead>
<tr>
<th>Priority</th>
<th>South East LHIN Development</th>
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<tbody>
<tr>
<td></td>
<td>• 68 health service providers in LHIN have access to secure email.</td>
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<tr>
<td></td>
<td>• A partnership position with Health Force Ontario Recruitment Agency was developed to share leadership for physician and other health human resource planning.</td>
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**Regional health human resources plan**
ENGAGE 2009: A qualitative analysis of thoughts, ideas and perceptions for IHSP2

July 2009
Executive Summary

The South East Local Health Integration Network (LHIN) undertook a significant engagement exercise in early 2009. The goal was to listen to a variety of stakeholders to obtain qualitative feedback on the current health-care system to help inform planning for the LHIN’s second Integrated Health Services Plan (IHSP2).

Called ENGAGE 2009, the community engagement effort involved three key activities:

- ENGAGE 2009: Providers’ Workshop on Health Services and Integration Planning
- ENGAGE 2009: Citizens’ Reference Panel on Health Services and Integration
- ENGAGE 2009: Community Open Houses

A common five-question survey (Figure 1) was used as a base for discussion at each of the three activities and was also advertised and made available on the South East LHIN website in April and May 2009. In all, 268 responses to the survey were provided.

This report outlines results of the common survey tool as well as other qualitative information collected from each of the ENGAGE 2009 activities. Reports on outcomes from the Providers’ Workshop on Health Services and Integration and the Citizens’ Reference Panel are included, as are comments from many of the 349 people (community, front-line care providers and elected officials) who engaged in one-on-one conversations with South East LHIN representatives during the community open house sessions.

Many people chose to provide their comments anonymously, while others signed consent forms, agreeing to have their names and comments included. Those thoughts, ideas and perceptions represent the opinions of those who participated. While they are not valid from a scientific point-of-view, they do help paint a picture of how many stakeholders view the health system.

What we learned

Overall, the health service providers described significant pressure recruiting and retaining health-care professionals within the South East. Inadequate health-care funding was perceived to be at the root of several problems surrounding health-care delivery in the South East. Many providers also believed a sound plan must be created to deal with the upcoming “grey tsunami.”

While citizen panelists shared similar concerns, they identified access to care as the clear perceived issue within the South East. Several individuals feel there is a shortage of primary care physicians, but the majority perceived a shortage in the number of specialists and specialist services within the region. There is also a consensus of opinion surrounding the need for additional long-term care beds, supportive housing and walk-in clinics.

Many community members stated they felt long-term care beds and walk-in clinics are in short supply and access to health-care services in rural areas was voiced as a concern by many. Transportation issues related to rural health service delivery are perceived to be in need of remediation. Several community members also said they believe there to be a shortfall in the number of primary care physicians within the South East.

The number of participant surveys returned and the number of participants at the community open house and providers’ workshop represents a very small portion of the population. However, the information that was received, along with detailed information from the South East LHIN’s Regional Capacity and Assessment Projections (ReCAP) activity has informed the development of IHSP2.
Introduction

The South East LHIN’s second Integrated Health Services Plan (IHSP2) is a three-year strategic plan for effective delivery of health care within the resources available across the South East region. This plan identifies local health care needs and strategies to address these needs. As stated in the Local Health System Integration Act, 2006 (LHSIA) there are several key principles guide the development of the IHSP. Community engagement is one such principle and its importance is summarized as follows:

“Health needs and priorities are best developed when the community, health care providers and the people they serve have input that supports the making of decisions.”
-- IHSP Roadmap, 2008

Recognizing this principle, the LHIN launched a series of events called “ENGAGE 2009” beginning in January 2009. The first event was a two-day providers’ workshop featuring more than 130 representatives from the LHIN’s funded health service providers.

Held in Kingston, the event featured presentations on socio-demographics, health status and health service utilization information resulting from the Regional Capacity Assessment Projection (ReCAP) project. Using this information, participants then engaged in facilitated groups to address scenarios based on many key challenges.

The next ENGAGE 2009 event was the Citizens’ Reference Panel on Health Services and Integration which took place over the course of three Saturdays in February and March. It featured a group of 36 South community members who were selected by a lottery from positive responses to a random mailing. The participants were provided with an overview from ReCAP as well as a summary of issues identified as areas for improvement at the health-care providers’ workshop.

Finally, a series of 21 sessions took place as Community Open Houses in April and May of 2009. The open houses were scheduled to take place over 5-7 hours in each of the 15 sub-LHIN geographical areas. Evening sessions were also held in Kingston and Belleville. A French language open house was held in Kingston. Three evening sessions for physicians were co-hosted by the LHIN and the Ontario Medical Association in Kingston, Belleville and Brockville. In addition, special sessions were arranged for the Aboriginal and Métis Nation populations. District Labour Councils in Kingston, Brockville and Quinte Districts were invited to meet with LHIN representatives and the Quinte District hosted a meeting with the LHIN.

While anyone who wanted to attend the publicly-advertised Open Houses was welcomed, specific invitations were extended to municipal and other elected representatives and their senior staff through letters from the LHIN Board Chair and Chief Executive Officer respectively. Front-line health providers were invited through a variety of means, as were physicians and the general public.
Survey

The purpose of the ENGAGE 2009 events was identified as being an opportunity to engage in discussion with representatives of the South East LHIN in an effort to inform future health-care delivery. Given that health care is an issue of interest to so many stakeholders, the LHIN identified a need to collect information from not only those who were invited to attend one of the specialized events or who could attend one of the open houses, but to enable as many people as possible to provide their thoughts, ideas and perceptions.

Survey Methodology

A series of five standard questions was first presented to health service providers in attendance at ENGAGE 2009: Providers’ Workshop on Health Services and Integration. Completed questionnaires (including responses) were submitted to the LHIN on a voluntary basis. Twenty-nine participant questionnaires were received from this group by the LHIN.

These five questions served as a base upon which health service provider and community responses were compared. Identical questionnaires were provided to the Citizens’ Reference Panel during the second day of ENGAGE 2009: Citizens’ Reference Panel on Health Services and Integration. Panelists were chosen from more than 200 positive responses to 5,000 invitations that were mailed to randomly-selected homes across the South East LHIN. After accepted invitations were received from the community, a stratified lottery process was conducted to select 36 individuals to participate.

While some selection bias may be present in the data due to the self-selection through voluntary response to the reference panel invitation, the subsequent lottery draw attempted to correct some of this bias. Thirty-one questionnaire responses were received from the 36 panel members.

Questionnaires were also provided to community members at the ENGAGE open house sessions held in each of the 15 sub-LHIN planning regions across the South East during April and May of 2009, as well as at sessions provided for identified groups such as unions, Aboriginal and Métis nation individuals, French language and physician populations. Identical questionnaires were also promoted through earned media and available on the South East LHIN website over an eight-week period.

There was no attempt to determine if any individual submitted more than one completed questionnaire, or if interest groups submitted multiple questionnaires.

As such, content of the questionnaires has been analyzed, but the ‘volume’ of content on any particular issue may not be indicative of the prevalence of any particular idea or issue. Also, no attempt has been made to determine the reason individuals may hold a particular issue out as a concern.

When asked about their natural sources of information at the open house sessions, many individuals cited the media as a strong influence on their beliefs. Secondary citation of influence for the general public was information they had received from health-care providers.
Survey response

Within this analysis, these groups will be referred to as “service providers,” “panelists” and “community members” respectively. Responses to the standard questionnaire were categorized and then ranked for each of the three groups. Responses differed from group to group, and thus categorizations show some variation. The demonstration of common themes allowed for comparison.

Service provider responses

Twenty-nine completed surveys were collected. Beside each question below is the number of responses given in total (i.e. each participant can provide more than one response depending on the question).

1. What are the three major concerns that you have about health care in the South East? 54 responses

- Recruitment/retention of health care professionals (22% of responses) - Lack of psychiatrists, lack of family doctors, lack of future health care leaders, and retention of such professionals

"Inaccessibility of services is primarily a consequence of insufficient staffing of health service providers."

- Funding for health care and health service providers (22% of responses) - Lack of funding for mental health and addictions programs as well as community care programs, and lack of funding to manage high hospital budgets.

"There is inadequate funding for community health care programs … When you seek a balance of funds in the LHIN, the smaller programs may become compromised."

Table 1 – Survey Response Rate by Sub-LHIN Planning Region

<table>
<thead>
<tr>
<th>Sub-LHIN Planning Region</th>
<th>No. of Surveys Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addington, North &amp; Central Frontenac</td>
<td>10</td>
</tr>
<tr>
<td>Belleville</td>
<td>27</td>
</tr>
<tr>
<td>Brockville</td>
<td>11</td>
</tr>
<tr>
<td>Central Hastings</td>
<td>9</td>
</tr>
<tr>
<td>Gananque</td>
<td>2</td>
</tr>
<tr>
<td>Greater Napanee &amp; Tyendinaga</td>
<td>8</td>
</tr>
<tr>
<td>Kingston &amp; Islands</td>
<td>31</td>
</tr>
<tr>
<td>North Hastings</td>
<td>12</td>
</tr>
<tr>
<td>Prince Edward County</td>
<td>7</td>
</tr>
<tr>
<td>Quinte West &amp; Brighton</td>
<td>12</td>
</tr>
<tr>
<td>Rideau Lakes</td>
<td>16</td>
</tr>
<tr>
<td>Smiths Falls, Perth &amp; Lanark</td>
<td>15</td>
</tr>
<tr>
<td>South East Leeds &amp; Grenville</td>
<td>3</td>
</tr>
<tr>
<td>South Frontenac</td>
<td>3</td>
</tr>
<tr>
<td>Stone Mills &amp; Loyalist</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>168</strong></td>
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</tbody>
</table>

Health service providers from the workshop on health services and integration, citizens from the citizens’ reference panel and community members from the open house sessions make up the three groups compared in this analysis.
Access to care (17% of responses) - Access to specialist care, primary care in rural areas, access to mental health services, access issues due to shortages in long-term care beds or supportive housing.

“Particularly in community-based addictions, mental health and primary care services, the health care system fails to inform residents about services that are available and how to access them...none of these three are readily accessible to people (in) rural locations throughout the region.”

Navigation through the system/ poor integration (11% of responses) - A fractured or confusing system of care; poor management of patient records.

Hospital deficits (7% of responses)

“Hospital deficits drain resources and impact all other sectors in the system.”

Wait times (7% of responses) - Emergency room wait times, surgery wait times.

Prevention/health promotion (6% of responses)

“(There) needs to be an investment in primary prevention and health promotion if we are ever to stem the steady increase in chronic disease and the massive fiscal demands such care places on the system.”

Health human resource issues (6% of responses)

Other areas of concern:
- Lack of an electronic health record;
- Lack of physician accountability;
- ALC patients utilizing acute care beds;
- Lack of plan to deal with an aging population.

2. How does the performance of health care in the South East compare to the rest of Ontario? –28 responses

- 32% - The same as the rest of the province
- 25% - Better than the rest of the province
- 21% - Worse than the rest of the province
- 22% - Don’t know

“In most components of the health care system, the South East’s performance is close to average provisions and standards compared to the rest of the province; however, particularly in terms addiction services, the provincial average fails to be sufficient to the needs of the population.”

3. What is the major problem in health care that has not been addressed in the last three years in the South East? –39 responses

- Access to Care (38% of responses) - Access to all levels of care and transportation to and from care; lack of primary care (shortage of physicians), lack of specialist care; shortages in long-term care and supportive housing.

“(The) lack of long-term care beds and lack of sufficient supportive housing overtaxes our system.”

- Lack of integration - fluidity between health service providers (18% of responses)
- Lack of primary care physicians (10% of responses)
- Inadequate health human resources planning (10% of responses) - Insufficient staffing, training, recruitment or retention of health professionals

“A coordinated human resources plan for the LHIN would be ideal.”
Lack of attention to mental health (8% of responses)

Inadequate funding (8% of responses) - Lack of funding for community based programs, long-term care and mental health.

“Equitable funding... and funding to correspond with downloading of services from institutional community settings are prerequisites needed before any major problems (occur).”

Lack of prevention and/or health promotion (5% of responses) - Prevention programs to tide levels of chronic disease.

“Balance the efforts to meet the demands on the health care system with the important task of reducing these demands (through) prevention.”

Other areas of concern - The difficulty low-income individuals face to access pay-based care (e.g., dentistry).

4. Do you believe that the aging population will have a substantial impact on the health care system in the next 3-5 years? –29 responses

Yes (79% of responses)

“The demographics clearly indicate that the baby boomers are aging and will require greater health care services.”

“The aging population is already a bit higher in the South East than in other areas of the province, and the general likelihood is that costs to the health-care system will rise in providing services to the aging.”

No (14% of responses)

“I think the impact is further in the future because the ‘boomers’ are healthier than prior elder generations.”

Maybe (7% of responses)

“Not so much from a demand standpoint, but from a staffing standpoint – large cohorts of nurses are expected to retire.”

“We generally live longer than the previous generation...our seniors may well be in better health than at present due to the embrace of fitness and improved diet. However, there will probably be a need for more community-based services and long-term care beds.”

5. What integration development could be a quick win for health care planners in the South East? –20 responses

Integration across sectors (45% of responses) - Integrating community mental health agencies with community support services, integrating hospitals with community services, integrating community care access centre with community health centres, etc.

“Offer a seamless approach to all aspects of community health care, particularly, with respect to primary health care needs and geriatric services.”

“Integrated communication across services would create efficiencies – saves time, produces a higher standard of care, eliminates diagnostic and treatment errors and ensures patient participation in the delivery of care.”

Sharing of resources between health service providers (10% of responses) - Co-location of health service providers, sharing of staffing, equipment or dollars.

Integration within sectors (10% of responses) - Amalgamation of small agencies within sectors.
“Amalgamate some of the small agencies to create efficiencies and economies of scale... try an approach where there are financial incentives to integrate.”

“Combine small agencies with like services to streamline delivery of services and administration.”

- Greater communication (10% of responses) - Between providers and between provider boards.
- IT integration (10% of responses) - Use of a common database or referral system.
- There are no quick wins (10% of responses)

“(Quick wins) are low hanging fruit... we need a more strategic design now to get at the second level of opportunity.”

“The LHIN should focus on longer term client care and education.”

- Other points of interest - Developing awareness of integration developments already in place.

**Summation: Health service provider responses**

Across health service providers in the South East, the perception of an approaching “grey tsunami” is evident. A majority of providers indicated they feel the aging population will have a significant impact on the volume of health-care demands within the next few years. Several providers stated they are troubled by the lack of a plan for expansion of services to manage this perceived issue.

Inadequate access to care (primary, secondary and tertiary) has also been perceived to be a problem in the South East. Rural areas are a concern, particularly in relation to an apparent lack of adequate user-free transportation services to and from health care services.

The majority of providers believe a lack of access to care is related to a shortage of health-care professionals.

Recruitment and retention of health-care professionals continues to be a concern. A perceived lack of family doctors, lack of psychiatrists and lack of future health-care leaders within the South East were all voiced as significant concerns. Few providers spoke of the need for a coordinated health human resources plan. Reasons for insufficient staffing were thought to stem from an inability to attract health-care professionals and insufficient funding to expand the supply and remuneration of health-care professionals and workers.

Lack of adequate funding for health care continues to be a perceived problem within the South East. Significant areas of concern appear to be community-based programs, particularly mental health and addictions services. Related to such concerns, lack of facilities such as supportive housing and long-term care beds are also perceived in the South East region.

It is important to note that while health service providers acknowledge that the amount of funding allocated to health care in Ontario has continually increased, it is impossible to satisfy every demand, regardless of funding. It was stated it is in the best interest of health-service providers, and the community at large, to search for efficiencies within the boundaries of existing funds that that these efficiencies were not necessarily desirable if they required changes in how services were provided or who provided them. Based on this ideology, integration within the health-care system has proven to have a troubled and difficult passage into efficient processes.

A majority of health-service providers stated they believe that integration across sectors could be a “quick win” for health care in the South East.
Integrating hospitals with community services, mental health and addictions services with community support services, and community care access centre services with community support services were some of the ideas proposed. It is evident from the responses that there is a strong desire to support integration that increases communication across sectors, and develops a seamless approach to health care. Amalgamation of small agencies within sectors was also presented as a possible successful integration development although many providers from small agencies were resistant to this type of development.

Views on the performance of health care in the South East region is varied across health service providers. Most providers felt that health care in this region falls either at par or better than the provincial level of performance. A significant number claimed there is no way to accurately compare the performance of health care services across providers or across the province.

Responses - panelists
31 surveys were completed by the citizens’ panel.

1. What are the three major concerns that you have about health care in the South East? –85 responses

- Access to Care (37% of responses) - To specialist services, primary care, mental health and addictions services, to community supports.

“(There is an) inefficiency of process to access required specialist services and use of specialized equipment.”

- Wait times (13% of responses) - Long wait times for emergency departments, elective surgeries and diagnostic scans.

- Planning for the “grey tsunami” (11% of responses) - Inadequate health service planning and preparation for the aging population.

- Health human resources (9% of responses) - Shortage of primary care physicians, nurses and pharmacists; unavailability of health human resources, inadequate health human resource planning.

“Health-care workers require more education to look after people.”

- Lack of funding (8% of responses) - Funding allocation issues.

- Miscellaneous (8% of responses): Over-prescription of antibiotics, lack of crisis preparation, high level of alternate level of care patients, lack of accountability.

- Quality of care (7% of responses): Quality of care received at all levels of the system from emergency rooms to community supports.

“Aging at home plan – must review if the client is getting enough support and if the worker is a match... many clients fall through the cracks.”

“Long-term care homes need review – many are management heavy and short on frontline care.”

“The need for better at home care and consultation in the case of palliative care.”

- Navigation through the system – poor integration (5% of responses): Difficulty navigating through the system due to a lack of communication between health service providers.

- Prevention / health promotion (2% of responses)
2. In your opinion, how do you think our health care system in the South East performs compared to the rest of Ontario? –31 responses

- 55% - The same as the rest of the province
- 16% - Worse than the rest of the province
- 16% - Do not know
- 13% - Better than the rest of the province

3. What is the major problem in health care that has not been addressed in the last three years in the South East? –31 responses

- Access to care (30% of responses) - To primary and specialist care, to mental health and addictions services; lack of health transportation; lack of community support services
  
  “Cooperative clinics should be encouraged in underserviced areas.”

- Lack of prevention and/or health education (15% of responses)

- Miscellaneous (12% of responses) - Overuse of the system, uncertainty surrounding system sustainability, over-prescription of antibiotics

- Health human resources (9% of responses) - Difficulty recruiting and retaining health professionals, limited continuing education for health professionals

- Quality of care (9% of responses)
  
  “Have a look at services that have been taken away... some mistakes cost all of us.”

  “(There is a) perceived lack of interest in the quality of primary care.”

4. Do you think that the aging population will have a substantial impact on the health care system in the next 3-5 years? –30 responses

- 87% - Yes, the aging population will have a substantial impact
- 13% - No, the aging population will not have a substantial impact

5. Can you think of any opportunities for the South East’s health care system to be better integrated? –20 responses

- Integration (9% of responses): Fluid system of care with no duplication.

- Re-allocation of priorities (9% of responses): Need to change focus on to community-based programs.

- The aging population (6% of responses)

- Greater use of e-health (25% of responses)- Integrated file sharing and enhanced communication between health service providers via telemedicine

  “There needs to be better communication between health care (providers) – this involves the deployment of the same [not similar] technological patient records system.”

- Sharing of resources between health service providers (20% of responses) - i.e. joint administration or joint human resources processes

- Eliminate repetition within the system (20% of responses) - Repetition between services provided in the hospital and the community, as well as repetition in screening processes.

- Miscellaneous (15% of responses) - Additional emergency room alternatives, greater use of
walk-in clinics, further integration within mental health services, immediate access to specialists (no need for referral).

- Integrate across sectors (10% of responses)

“Work with community organizations and the CCAC to ensure that the continuum of care doesn’t stop at a clinic or hospital.”

- Educate health service providers (10% of responses) - Make family doctors more aware of specialist and community services available, further promotion of team-based models in health care.

**Summation: Panelist responses**

Amongst panelists, most stated the upcoming “grey tsunami” would be a concern in the next three to five years. The reasoning behind such concern was a belief in inadequate health service volumes.

A second concern involved long waiting periods for procedures, including diagnostic scans, elective surgeries, as well as long wait times in emergency departments. Proposed explanations for such long waits were varied, but many felt a boost in funding and the number of health service professionals and service centres would mediate the issue.

Access to care was voiced as a primary concern for many, wherein difficulty in access is described as perceived shortfalls in service delivery, service accessibility or service awareness.

Difficulty in accessing specialist services was a top ranked accessibility issue. This problem was blamed partially on a perceived lack of physicians within the area, but most frustration was based on inefficiency within the process to access specialist services – several individuals suggested immediate access to specialists, without the need for referral from a primary health-care provider, was the solution.

Another concern voiced was a difficulty in accessing mental health and addictions services. This access issue was described both as a reticence to access services for problems which society in general continues to stigmatize, and as a lack of volume of mental health services.

A final predominant problem within access to care was a lack of health service infrastructure, including long-term care beds, supportive housing and walk-in-clinics.

Many panelists believed health-care prevention and promotion strategies have generally been overlooked in the past. Many were unaware the role for primary health promotion lies with public health agencies and fell beyond the LHIN. It was suggested by some that health education could be promoted through collaboration between health service professionals and the early education system.

Integration opportunities expressed by the panelists were fairly distributed amongst the following suggestions: greater use of e-health, particularly regarding enhanced communication and file sharing between health service providers; sharing of resources and processes (i.e. joint administration, joint purchasing, and shared facilities) within health service providers; and elimination of repetition in service delivery and screening.

The performance of health care within the South East was generally ranked on par with the rest of Ontario. Several participants stated that they could not compare health care performance from a regional to provincial scale due to the lack of a fair comparator, or lack of experience outside the South East.
Responses - Community Members

One hundred and sixty-eight completed surveys were collected from attendees of the open house sessions and online.

1. What are the three major concerns that you have about health care in the South East? – 311 responses

- Access to care (34% of responses) - To specialist, rural, palliative, respite, mental health services, in rural/northern settings; access issues due to lack of transportation or lack of facilities, etc.

  “Most mental health programs are available only after being on a long wait list.”

- Recruitment/retention of health professionals (14% of responses)

- Lack of funding/allocation issues (8% of responses)

- Wait times (8% or responses) - Long wait times in emergency departments, for diagnostic scans, or for specialist services.

- Navigation through the system/poor integration/uncoordinated care (6% of responses)

  “Given the complexities of the health and social service system, there is a need for a service navigation/case management capacity.”

  “There is an enormous difference among community care providers. Fragmentation is a word that best describes my experiences with the various community agencies.”

- Lack of prevention/health promotion/public education (6% of responses)

  “[There is a] decreased or almost absent focus on health promotion...lack of work in all the social determinants of health.”

- Hospital issues (5% of responses) - Issues surrounding deficits, management and administration.

  “Poor managerial decisions made at departmental levels that result in inappropriate staff performing job functions at a greater cost than necessary”

- Planning for the aging population (5% of responses)

- Poor health systems planning (4% of responses)

  “Direction from the Ministry (of Health and Long-Term Care) is often ambiguous and has a flavour-of-the-day approach.”

  “There is no input from local communities in developing health care policies.”

  “Too many levels of health-care bureaucracy.”

- Lack of attention to mental health (3% of responses)

- Quality of care issues (3% of responses)

- Health human resources issues (2% of responses) - Lack of a coordinated human resources plan; insufficient hospital staff training.

  “Hospital staff requires appropriate training for changes made from (the) top level – whether it be due to decreased money or for more efficiency in the system.”
Other areas of concern - Lack of attention to community services; inadequate chronic disease management; lack of support for caregivers; overuse of emergency departments; alternate level of care patients; environmental toxins and their relation to health issues; lesbian, gay, bisexual and transgender health issues; inaccessibility of dental care for individuals of low income; sense of apathy within the system.

2. In your opinion, how do you think our health care system in the South East performs compared to the rest of Ontario? –141 responses

- 48% - The same as the rest of the province
- 33% - Worse than the rest of the province
- 11% - Better than the rest of the province
- 8% - Do not know

3. What is the major problem in health care that has not been addressed in the last three years in the South East? –210 responses

- Access to care (38% of responses): To primary or specialist care, mental health and addictions services; lack of health transportation; lack of community support services, etc.
- Funding shortages/allocation issues (11% of responses)
- Recruitment/retention of health professionals (10% of responses)
- Lack of prevention/health promotion/public education (9% of responses)
- Difficulty navigating through the system/poor integration/uncoordinated care (9% of responses) - Poor communication between stakeholders, lack of an electronic record.

“I hear about more of a collaborative effort in other LHINs between the LHIN and the providers.”

“Too many small community agencies and services with disparate mandates even within sectors.”

“The municipal leaders are not engaged nor do they understand the complex working funding and decision-making by various health service providers within their own community.”

- Wait times (5% of responses) - Emergency departments, diagnostic scans, specialist services
- Hospital issues (4% of responses) - Due to deficits or management issues.
- Health human resources issues (3% of responses) - Insufficient hospital staff training.
- Lack of attention to mental health and addictions (2% of responses)
- Poor health systems planning (2% of responses)

“Hospital management and funding needs restructuring across the province – not one (LHIN) at a time!”

- Planning for aging population (1% of responses)
- Lack of attention for community-based services (1% of responses)
- Other points of interest - Inadequate infection control plan; insufficient attention to pediatrics; inadequate cancer care; duplication of services; little transparency of patient records; poor quality of care; dental care for low income individuals; need to address poverty issues surrounding health care.
4. Do you think that the aging population will have a substantial impact on the health care system in the next 3-5 years? – 189 responses

- 93% - Yes, the aging population will have a substantial impact
- 6% - No, the aging population will not have a substantial impact
- 2% - Do not know

5. Can you think of any opportunities for the South East’s health care system to be better integrated? – 87 responses

- Sharing of resources between health service providers (28% of responses) - Co-location of health service providers, the “hub” concept; sharing of staffing; sharing of administration.

- Increased communication between stakeholders (25% of responses)

“There needs to be two-way communication; the LHIN needs to be an advocate for health care providers with the Ministry of Health.”

- Integrate across sectors (14% of responses)

“Better transitioning from hospital to community facilities – a transportation system between hospitals and these facilities?”

CCAC needs to work better with community partners for better integration.”

- Greater use of e-health (13% of responses) - Shared electronic records; shared data collection/reporting tool

- Educating the public/providers on what services are available (7% of responses)

- Better health systems planning (3% of responses)

“Health care should be under the LHIN or the Ministry of Health – we need to pick a model and stick to it.”

“LHIN needs to take more of a leadership role in identifying integration opportunities and facilitating discussion with health service provider CEOs/boards.”

- Eliminate duplication of services (3% of responses)

- Integrate within sectors (3% of responses)

“Continued encouragement for collaborative efforts between like agencies.”

- Other points of interest: Removal of middle management within organizations; instill central purchasing for all hospitals; integration should not be the goal – immediate treatment should.

Summation: Community Member Responses

Within the community member group, there is a clear belief the aging population will have a significant impact on the health-care system within the next three to five years. Many participants stated that such a response was obvious.

Access to care was shown to be a significant concern within this group and most believed this to be due to a lack of physical facilities. Several participants claimed there was a shortage in the number of long-term care beds within in the area, and that additional funds should be directed towards the creation of such beds, and, further, that all long-
term care beds should generally receive more funding.

Supportive housing was also stated to be in need of expansion, as were the number of walk-in clinics and after-hours clinics. Developing more of what we have was a common theme. Many community members felt that the issues surrounding unattached patients and long emergency department wait times could be solved with the introduction of more walk-in/after-hours clinics.

Access to care in rural areas was stated to be a clear problem, as was difficulty attaining free transportation to and from medical services. Transportation issues were deemed to be most significant in rural areas, northern areas of the LHIN, and for services geared toward elderly residents.

Recruitment and retention of health professionals was also voiced as a concern within the community. Several individuals claimed there was a shortage in the number of physicians, both within hospitals and outside of them. Many felt there was a shortfall in the number of nurses within the South East, and that further funding must be directed towards the attainment of higher volumes of these professionals.

On a related note, many participants believed there was a lack of funding for some level of service delivery. A small number of participants believed funding on a provincial scale should be increased, while others held the LHIN responsible for the increased levels of funding needed for hospitals, long-term care facilities, mental health and addictions programs and others.

The performance of health care within the South East was primarily believed to be the same as the rest of the province.

Comparison

The Aging Population

Seventy-nine per cent of health service providers, 87% of panelists and 93% of community members stated the aging population will have a substantial impact on the health-care system within the next three to five years. This seems to point towards an obvious desire to examine health systems planning for seniors, however, only 2% of health service providers, 11% of panelists, and 5% of community members placed the aging population as one of their three major concerns about health care within the South East. This disparity between responses suggests that while many believe the so-called “grey tsunami” is on its way, there are more urgent priorities at hand.

Top Three Concerns

Figure 2 – Top Concerns of Health Service Providers

Figure 3 – Top Concerns of Panelists
Figure 4 – Top Concerns of Community Members

From the above figures, we see that among all groups, access to care and funding are predominant issues. Recruitment and retention of health professionals, as well as a need to develop a clear health human resources plan for the region was also discussed in all three comparator groups. Waiting time for services was also stated to be a clear frustration in both the panelist and community member groups.

Potential Integration Developments

Few participants stated a need for further integration within health care in the South East. Eleven per cent of health service providers, 5% of panelists and 6% of community members mentioned this as a key concern. It should be noted, however, that while most participants did not voice this as a major concern or unaddressed issue, those who did mention a need for further integration did so with much enthusiasm and vigor.

When blatantly asked what integration development opportunities participants saw, there was much overlap in the suggestions provided by all three groups. Integration in the form of increased communication between stakeholders, sharing of resources/personnel/process between health service providers and greater use of E-health were all clear options presented. While the idea of integrating across sectors (e.g., integrating hospitals with community services) was largely ignored in both panelist and community member groups, health service providers were quick to voice this suggestion. It made up the majority of responses provided by this group. There was little stated opinion, especially among health service providers, on the need to use integration in other ways. Integration of actual operations is troubling for many providers, although less so for members of the community.

Regardless of the comparator group, many individuals stated the LHIN should take a clear and direct role in facilitating integration developments. Several health service providers and community members claimed that strong LHIN leadership in this area was required.

Community Comparisons

By far, community members contributed the greatest number of surveys and thus constituted the majority of the response sample pool. Key points from LHIN’s 15 planning regions:

Addington, North & Central Frontenac

- Issue of transportation to care is prevalent.
- Many voiced concern about an apparent shortage in the number of primary care physicians.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next three to five years.
Belleville
- Several individuals believe there is a need for more doctors, nurses, and health-care professionals in general.
- Many comments were made about cutbacks being made at health-care facilities resulting in staff layoffs.
- Less than 4% believe the aging population will have a significant impact on health care within the next 3-5 years.
- Overcrowding of the emergency rooms was a common concern.

Brockville
- There is a perceived lack of services, particularly surrounding respite and palliative care.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Central Hastings
- Significant support behind the idea of a “hub concept” within this area. Gateway Community Health Centre is seen to be the champion for such an initiative.
- There is concern surrounding funding – primarily for community-based programs.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Greater Napanee, Tyendinaga
- There was a wide variety of comments made by residents of this planning area.
- Some individuals voiced concern that there is a disconnect within local community services, perhaps due to a lack of attention (too much focus on hospitals) or a lack of adequate funding.

Kingston & Islands
- Issues surrounding the provision of mental health and addictions services were abundant.
- Several participants plainly stated some enhanced level of integration or collaboration between local hospitals (Hotel Dieu Hospital, Kingston General Hospital and Providence Care) was needed. It could include shared administration, management or services

North Hastings
- Access to care and problems surrounding transportation to and from health-care services were frequently voiced.
- Many individuals proposed a shortfall in current long-term care services.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Prince Edward County
- Hospital issues were a major concern voiced by residents of this area.
- Issues surrounding administration, management and deficits were all prevalent.
- Many voiced concern that health-care funding was inadequate.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Gananoque
- This was a very small sample size (2 individuals).
- Comment provided to indicate that there is an issue surrounding wait times for the emergency room and many medical procedures.
Quinte West & Brighton
- There is a perceived lack of doctors within the area.
- Fear surrounding health-care cuts, or a lack of proper funding, particularly as it relates to hospitals within Quinte Health Care was voiced.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Rideau Lakes
- Many voiced concern about a lack of transportation to and from medical care.
- Several individuals stated a need for additional nurses or nurse practitioners.
- 100% of those surveyed believe the aging population will have a significant impact on health care within the next 3-5 years.

Smiths Falls, Perth & Lanark
- Responses varied significantly.
- The need for better transportation, increased communication, enhanced long term care facilities and adequate funding were all expressed.

South East Leeds & Grenville
- This was a very small sample (3 surveys).
- Emergency wait times were presented as a concern.
- Individuals expressed a need for increased long-term care home staffing and funding to do so.

South Frontenac
- This was a very small sample (3 surveys).
- Lack of long-term care beds is perceived to be a problem.

Stone Mills, Loyalist
- This was a very small sample (2 surveys).
- Concern was voiced surrounding health-care delivery within rural areas and the need for enhanced transportation services.

Overall
While the number of participants per comparator group and per geographical planning region varied, it is clear that the dominant concerns expressed by each group are fairly consistent.

- All groups believe the aging population will have a significant impact on health care within the South East within the next three to five years. All groups also believe access to care is a significant problem within the South East, with both the panelists and community members ranking this as their top concern.

- It was the general opinion that more, not necessarily different, health-care services were desirable. To quote one voiced opinion, “we just need exactly what we had -- but more of it”. Opinions surrounding the performance of health care within the South East compared to that of Ontario are largely varied, likely due to biases developed over years attaining health care both within the LHIN and elsewhere.

Future Revisions
The questions asked in the survey served as a good starting base for discussion, however the quality of responses varied greatly from one participant to another. Many participants would answer a question with two or three words, while others would answer the same question with a paragraph. While this variation may be indicative of personal experience or enthusiasm, it may be useful for future iterations of such a survey to standardize the way in which participant respond. A clear difficulty encountered during this process was a lack of sufficient sample sizes. The results of this analysis clearly state the views of survey participants, 228 individuals represent a small fraction of the region’s 480,000+ residents.
Response Breakdown

Health Service Providers

Question 1: What are the three major concerns that you have about health care in the South East?

Recruitment/retention of Health professionals 5
Shortage of primary care doctors 5
Shortage of psychiatrists 2
Lack of funding 7
... for community programs 1
... to support in-home care 1
... for mental health 3
Access to care 2
... in rural settings 4
... mental health services 3
... to specialist services 2
... due to lack of facilities 5
... supportive housing 3
... long-term care bed 2

Prevention/health promotion 2
Chronic disease prevention 1
Health human resource issues 3
Miscellaneous 1
Acute bed use by ALC patients 1

Due to shortage of facilities 5
Lack of supportive housing 2
Lack of long-term care beds 3
Lack of integration between HSPs 5
Lack of communication between HSPs 2
Lack of primary care physicians 1
Inadequate health HR planning 4
Inattention to mental health 3
Inadequate funding 3
Lack of health promotion 1
... chronic disease prevention 1
Miscellaneous 1
Low income people, no access to pay-based care 1

Question 2: In your opinion, how do you think our health care system in the South East performs compared to the rest of Ontario?

The same as the rest of the province 9
Better than the rest of the province 7
Worse than the rest of the province 6
Do not know 6

Question 3: What are some of the major problems in the health care system that have not been addressed in the past three years in the South East?

Access care 15
To primary care 4
To specialist care 1
Due to transportation issues 2

Question 4: Do you think that the aging population will have a substantial impact on the health care system in the next 3-5 years?

Yes 23
No 4
Maybe/it depends 2
Do not know 0

Question 5: What integration development could be a quick win for health care planners in the South East?

Integrate across sectors 9
...community & MH 1
...community & hospital 3
... CCHCs with CHCs 1
Experts of different sectors in agencies 1
Sharing resources among HSPs 1
... co-location 1
Integrate within sectors 2
Merge small agencies 2
Increased communication 2
...between HSPs 1
...between HSB Boards 1
IT integration 2
Common database 1
Common referral tool 1
There are no quick wins 2
Increase awareness of current integration 1
Panelists

**Question 1: What are the three major concerns that you have about health care in the South East?**

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<td>Health promotion</td>
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**Question 3: What are some of the major problems in the health care system that have not been addressed in the past three years in the South East?**

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<td>Aging population</td>
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**Question 4: Do you think that the aging population will have a substantial impact on the health care system in the next 3-5 years?**

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**Question 5: What integration development could be a quick win for health care planners in the South East?**

<table>
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<th>Category</th>
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<td>Greater use of e-health</td>
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<td>Enhanced communication via telemedicine</td>
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<td>Sharing resources among HSP</td>
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Joint administration of KGH/HDH 3
No repetition in system 1
No repetition of community services in hospitals 2
Repeated screening 1
Immediate access to specialists 1
More ER alternatives 1
More use of walk-in clinics 1
Increased integration in Mental Health 1
Integrate across sectors 2
Educating HSPs 2
Provide info to GPs re: specialists 1
Promote team-based models 1

<table>
<thead>
<tr>
<th>Community Members</th>
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<tbody>
<tr>
<td><strong>Question 1:</strong> What are the three major concerns that you have about health care in the South East?</td>
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<td>Lack of supportive housing</td>
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<td>Lack of after-hours clinics</td>
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<td>Lack of walk-in clinics</td>
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<tr>
<td>Lack of transitional beds</td>
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<tr>
<td>Lack of x-ray facilities/equipment</td>
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<tr>
<td>In rural settings</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Due to transportation issues</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>To in-home support services</td>
<td>8</td>
<td></td>
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<tr>
<td>To services for physically/developmentally disabled children</td>
<td>5</td>
<td></td>
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<tr>
<td>To mental health/addictions service</td>
<td>6</td>
<td></td>
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<tr>
<td>To primary care</td>
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<tr>
<td>To palliative care</td>
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<td>To respite care</td>
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<td>To rehabilitation services</td>
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<td>To specialist services</td>
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<td></td>
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<tr>
<td>In northern settings</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recruitment/retention of health professionals</td>
<td>11</td>
<td>44</td>
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<tr>
<td>Shortage of primary care doctors</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Shortage of nurses</td>
<td>9</td>
<td></td>
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<tr>
<td>Insufficient hospital staff</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Shortage of physiotherapists</td>
<td>2</td>
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</table>

| Shortage of specialists | 1 |
| Lack of funding / funding allocation issues | 25 |
| Wait times | 22 |
| Emergency | 12 |
| Diagnostic scans | 3 |
| For specialist services | 2 |
| Navigation through the system/poor integration/uncoordinated care | 16 |
| Lack of communication between health service providers/agencies/public | 4 |
| Lack of prevention/health promotion/public education | 17 |
| Hospital issues | 5 |
| Deficits | 5 |
| Administration issues | 3 |
| Management issues | 2 |
| Planning for the aging population / grey tsunami | 14 |
| Poor health systems planning | 12 |
| Miscellaneous | 12 |
| Lack of attention for community services | 3 |
| Lack of chronic disease management | 2 |
| Lack of support services for caregivers | 1 |
| Overuse of the emergency departments | 1 |
| Environmental toxins | 1 |
| Lesbian, gay, bisexual, transgendered issues | 1 |
| Alternate level of care patient issues | 1 |
| Inaccessibility of dental care for low income | 1 |
| Apathy within the system | 1 |
| Lack of attention to mental health & addictions | 10 |
| Quality of care | 8 |
| Health human resource issues | 4 |
| Insufficient hospital staff training | 2 |

<table>
<thead>
<tr>
<th>Question 2: In your opinion, how do you think our health care system in the South East performs compared to the rest of Ontario?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The same as the rest of the province</td>
</tr>
<tr>
<td>Worse than the rest of the province</td>
</tr>
<tr>
<td>Do not know</td>
</tr>
<tr>
<td>Better than the rest of the province</td>
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Question 3: What are some of the major problems in the health care system that have not been addressed in the past three years in the South East?

<table>
<thead>
<tr>
<th>Access to Care</th>
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<th>80</th>
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<tbody>
<tr>
<td>Due to lack of facilities</td>
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<tr>
<td>Lack of long-term care beds</td>
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<tr>
<td>Lack of nursing home beds</td>
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<td></td>
</tr>
<tr>
<td>Due to lack of facilities</td>
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<td></td>
</tr>
<tr>
<td>Lack of transitional beds/housing</td>
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<td></td>
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<tr>
<td>Lack of after-hours clinics</td>
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<tr>
<td>Lack of walk-in clinics</td>
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<tr>
<td>Lack of supportive housing</td>
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<tr>
<td>Due to transportation issues</td>
<td>15</td>
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<tr>
<td>To rehabilitation services</td>
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<td>To in-home support services</td>
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<td>To services for physically/ dev. Disabled</td>
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<td>For children</td>
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<tr>
<td>In rural settings</td>
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<tr>
<td>In northern settings</td>
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<tr>
<td>To palliative care</td>
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<td>To respite care</td>
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<td>To specialist services</td>
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<td></td>
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<tr>
<td>To mental health services</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Funding shortages / allocation issues</td>
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<td>22</td>
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<tr>
<td>for long-term care homes</td>
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<tr>
<td>for community programs</td>
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<td></td>
</tr>
<tr>
<td>Recruitment/retention of health professionals</td>
<td>5</td>
<td>21</td>
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<tr>
<td>Shortage of primary care doctors</td>
<td>11</td>
<td></td>
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<tr>
<td>Shortage of nurses</td>
<td>4</td>
<td></td>
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<tr>
<td>Shortage of nurse practitioners</td>
<td>1</td>
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<tr>
<td>Lack of prevention/health promotion/public education</td>
<td>19</td>
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<tr>
<td>Lack of communication between stakeholders</td>
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<td></td>
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<tr>
<td>Lack of an electronic record</td>
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<tr>
<td>Wait times</td>
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<td>11</td>
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<tr>
<td>Emergency department</td>
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<td></td>
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<tr>
<td>For specialist services</td>
<td>2</td>
<td></td>
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<tr>
<td>For diagnostic scans</td>
<td>2</td>
<td></td>
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<tr>
<td>Miscellaneous</td>
<td>8</td>
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</tr>
<tr>
<td>Lack of an infection control plan</td>
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<tr>
<td>Inadequate attention to pediatric care</td>
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<td></td>
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<tr>
<td>Need to address poverty issues</td>
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<td></td>
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<tr>
<td>Inadequate cancer care</td>
<td>1</td>
<td></td>
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<tr>
<td>Duplication of services</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Transparency of patient records</td>
<td>1</td>
<td></td>
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</table>

Question 4: Do you think that the aging population will have a substantial impact on the health care system in the next 3-5 years?

- Yes ... a substantial impact | 176 |
- No... will not have a substantial impact | 10  |

Question 5: What integration development could be a quick win for health care planners in the South East?

- Greater use of e-health | 5 |
- Integrated file-sharing | 3 |
- Enhanced com between HSPs via telemedicine | 3 |
- Sharing resources among HSP | 1 |
- Joint admin of KGH/HDH | 3 |
- No repetition in system | 1 |
- No repetition of community services | 2 |
- Repeated screening | 1 |
- Miscellaneous | 3 |
- Immediate access to specialists | 1 |
- More ER alternatives | 1 |
- + + use of walk-in clinics | 1 |
- Increased integration in MH | 1 |
- Integrate across sectors | 2 |
- Educating HSPs | 2 |
- + + info to GPs re specialists | 1 |
- Promote team-based models | 1 |
3. Providers’ Workshop

Introduction

ENGAGE 2009: The Providers’ Workshop on Health Priorities and Integration took place January 28 and 29, 2009 in Kingston. The objective of ENGAGE 2009 was to generate ideas and suggestions for consideration during the development of IHSP2 and to identify opportunities for integration.

ENGAGE was also intended to help break the culture of competing interests and turf battles that often characterize the securing of resources by health care sectors and organizations. Instead of framing the discussion in zero-sum terms — of getting more resources or getting fewer resources — the providers’ workshop challenged participants to think as a system. Its informal motto was how can we do things better by doing things differently.

Representatives from all LHIN-funded health service providers in the South East were invited to participate in the two-day forum where they were briefed on the latest regional health data. There, they also engaged with other providers from different sectors in a series of facilitated discussions.

Following information presentations, there were coordinated groups activities designed to generate ideas and integration opportunities from delegates. Each activity drew upon health and demographic drivers identified in the LHIN’s regional demographic, health status and health service utilization analysis (Regional Capacity Assessment and Projection – ReCAP) and three speculative economic scenarios.

Ideas for integration

Nearly 100 ideas for integration were developed. Here, they have been refined to 71 and organized under the categories of principles, proper system use, scope of practice, partnerships outside the health system, partnerships between health sectors, education and prevention, solutions for regions, recruitment and retention, standardization and best practices, local solutions and health care networking. They are:

Principles
- Promote the LHIN as a large resource to eliminate small ‘p’ politics and focus on the client. Share expertise and resources.
- Promote integration of services based on needs and outcomes

Proper System Use
- Devote money to research in order to avoid duplication of services and to better use money already in the system.
- Close hospital emergency departments at non-peak hours in small hospitals while ensuring that emergency medical technicians are available for immediate transfers and care.
- Take the alternate level of care patients out of hospitals and admit them into long-term care home beds.
- Build on the community health centre model and invest in the services they provide.
- Prevent inappropriate hospital visits and discharge delays by keeping community health centres (CHCs) and family health teams available 24 hours a day, 7 days a week.
- Restructure finding incentives to encourage innovation and appropriate use of health services.
- Have case managers rather than doctors perform triage at CHCs so that people are directed as efficiently as possible to the services they need.

Scope of Practice
- Allow nurse practitioners (NPs) and physicians’ assistants to provide on-call verbal orders consistent with their training.
-
Advocate for legislative changes in the tasks that nurse practitioners are allowed to do without physician supervision.

Ensure that nurses are not doing the work of personal support workers.

Devolve traditional physician roles to other practitioners.

Allow NPs to give prescriptions.

Expand the use of midwives for maternity care.

Don’t get bogged down in territoriality.

Encourage physicians to provide after-hours care.

Keep nurses active in hospitals and in the community.

Partnerships Outside the Health-care Sector

Initiate community specific projects in partnership with non-health service providers.

Align provincial objectives at the ministerial level so that their efforts are combined to meet local needs.

Develop broader social services into intra-professional coalitions (e.g., poverty groups).

Intra-professional coalitions should include providers and provider boards.

Partnerships Between Health-care Sectors

The LHIN needs to help integrate organizations both funded by the LHINs and other institutions (e.g., public health).

Harmonize planning and share resources and solutions.

Improve inter-hospital collaboration. Develop strategies to effectively share techniques, best practices and other relevant information.

Design and build infrastructure to support flexible transfers of people, knowledge and equipment. If nurses are needed to transfer someone safely, they can be taken from hospitals and redeployed temporarily to long-term care.

Improve the allocation of services to allow patients to move more fluidly through the system.

Hospitals need to get back to being hospitals. Devolve non-hospital services back into the appropriate community service and require other service providers to be open 7 days per week.

Create better linkages between the sectors; hospitals need to know about the available range of resources in the community.

Education and Prevention

Develop a community approach to improving front-end prevention programs.

Emphasize preventative health services.

Start prevention early and establish training courses for future practitioners in high schools.

Partner with colleges and universities in the region to offer courses in self-care, proper use of medication and navigation of the health-care system.

Promote good food boxes through community health centres and community care access centres to promote healthy eating among seniors with programs that offer home delivery.

Focus on obesity, chronic disease and addictions.

Introduce cost-sharing programs for early prevention and support services such as nutrition programs and physical exercise.

Focus on the social determinants of health rather than health-care services.

Leverage existing technologies to educate and support the residents of the LHIN.

7. Solutions for Rural Communities

Establish mobile community health centres with health vans to take health care to clients in rural communities.

Promote co-location in rural facilities with emphasis on the community health centre model.

Create interdisciplinary coalitions within geographic areas.

Ensure that nurses and clinical staff can travel to the patients.
Engage 2009

- Create health-care teams in the regions supported by education initiatives for clients and professional development for health care providers.

**Recruitment and Retention**
- Provide funding for current personal support workers to become registered practical nurses.
- Forge health streaming partnerships with schools.
- Create a health-focused stream in high schools to train and encourage young people to enter nurse practitioner and registered nursing programs.
- Create tax incentives for volunteers to build additional capacity in the health system.
- Promote volunteerism as a means to good health.
- Harmonize salaries for service providers and remove barriers to training.
- Organize health care workers into teams to share ideas and best practices.

**Standardization and Best Practices**
- Establish policy on best practices replication.
- Create incentives for efficiency and provide funding for the up-front costs of innovation.
- Develop methods of sharing best practices.
- Standardize patient documentation procedures and care requirements across the continuum of care.
- Ensure flexible but standardized care models for discharge and admittance across relevant services.
- Expedite referral processes between health-care providers through unified access and discharge criteria.
- Establish a comprehensive and secure e-health system of data storage and sharing.

**Local Solutions**
- Reorganize service deployment based on case specific decision making.
- Integrate at the direct service level. Create locally focused multi-disciplinary teams that extend beyond community health centres and family health team structures.
- Educate the community about the role of family health teams and community health centres.
- Provide funding for more family health community support services.
- Deploy community organizations to report on determinants of health in their area.
- Define the health needs of the community based on community experiences and not necessarily statistical reports.
- Fund supportive housing and home care. Keep seniors at home with personal support workers.

**Health Care Networking**
- Use community support organizations to target at-risk populations.
- Pilot a range of different models for using community-based, intra-professional community services, especially community and family health teams.
- Emphasize the team approach instead of the single physician-model.
- Use community health centres to assist mental health patients in finding a family physician.
- Formalize community support networks for maternity care.
- Organize peer-support coordinating bodies to assist cancer patients and their families in navigating and supporting all aspects of care from oncology to nutrition.
- Create more community health centres as a way of providing one-stop-shops for health services and chronic disease self-management.
Another activity involved participants providing input within their own sectors, in order to capture observations that reflect common concerns. Broadly, observations can be categorized by sector with hospitals and the community care access centre reflecting similar concerns while long-term care, mental health and addictions, community support services and community health centres all coalesced around similar themes.

Delegates from the hospitals and the access centre wanted to focus on their core competencies and devolve responsibilities to other sectors. Other sectors noted that resource sharing and greater flexibility would maximize existing capacities LHIN-wide without an increase in funding.

Though there were divisions between expectations and experiences, seven common observations emerged from the discussions. They are:

1. Foster creative and cooperative partnerships. Agencies within the LHIN need to forge partnerships with their natural allies within and across sectors. Moreover, delegates identified the need to be aware of non-LHIN funded services and agencies including police and fire departments, community groups, schools and child services. Similarly, fiscal accountability agreements done in isolation can have negative effects across the larger network when the same service is cut by two or more agencies. Agencies must avoid duplicating cuts through cooperative or consultative budgeting.

2. Standardize information storage and develop e-health technology Standardizing documentation and developing electronic health profiles would expedite information sharing and limit time spent on administration. Streamlined administrative procedures would reduce the burden on staff in non-hospital sectors and increase time spent with patients.

3. Improve data capture among non-hospital sectors All non-hospital sectors expressed concern about the information provided in the ReCAP presentation. Many felt the limited data reflecting the experience of these sectors both marginalized their contributions and jeopardized their funding. Delegates reflected a concern that their traditional inability to quantify their work and the effect they were having or not having on the health outcomes of individuals and the population could have an impact on future funding. Suggestions for resolving this discrepancy alternated between emphasizing qualitative data and developing sector-specific measurements.

4. Create more supportive housing opportunities Delegates from most sectors spoke about the problems that arise from improper housing of patients. Specifically, long-term care home delegates suggested that their sector has become the repository for individuals who cannot be sent anywhere else.

5. Maximize staff and volunteer capacity LHIN-wide, agency staffs run the risk of burnout. Long-term care delegates report problems with recruiting and retention of both staff and volunteers. Mental health and addictions does not have the requisite funding to train volunteers properly and their staffs are unduly burdened with administrative tasks. Community support services, which have a high degree of volunteer management and workforce, do not have adequate staff or resources to participate in decision-making.
6. Loosen restrictions on funding and personnel use

Funding stipulations enumerated in contracts developed with the Ministry of Health place restrictions on people that agencies can serve and how they serve them. Removing restraints would allow agencies to be flexible in developing methods of delivering services and promote innovative solutions without increasing budgets.

7. Non-hospital/CCAC sectors need recognition

Universally, the non-hospital sectors felt they are being systematically undervalued by the local health-care system and oversubscribed by their clients. They all expressed a need to be considered equal partners in the health-care system. Hospital and CCAC delegates expressed a willingness to be a part of a team of providers rather than the centre of the system.

Results from Role-Based Discussions

Question 1: What should be the role of the tertiary care hospital vis-à-vis community hospital care at the other hospital sites: (a) during peak or surge demand periods; (b) during peak vacation periods; (c) during prolonged reductions in key health human resources (e.g. surgeons, specialized nurses)?

Delegates found the question as it was asked missed the point. It is not so much a matter of defining the role of hospitals but understanding the dynamics or personnel and hospital need that determine what that role will be. The question itself obscured a complex interrelationship of actors and systems that have to be considered at the level of the hospital and according to its specific needs. Participants decided that the conversation was about two related issues.

First, where in the region should tertiary care programs be located? Second, how can hospitals balance the needs of doctors with the needs of the hospitals? Delegates discussed the second question at length and identified two significant obstacles to ensuring 24-hour a day, seven days a week surgical coverage: surgeons who prefer to work in larger communities, and the capacity of smaller hospitals to accommodate after-care needs.

Much of the discussion centred on community hospital vacation schedules. In the event a surgeon is not available, many of the smaller hospitals automatically divert patients to Kingston General Hospital. Rarely did they divert patients to other community hospitals as this route was not top of mind.

Delegates arrived at three recommendations:

- Hospitals need to create a regional coverage strategy that would establish key coverage priorities and reinforce the principle of mutual coverage.
- The responsibility of ensuring specific coverage schedules are in line with regional coverage priorities must fall to individual surgeons.
- Hospitals need to create a queuing strategy to deal with non-traditional referral patterns to maximize hospital capacity in the region.

Question 2: What is the role of hospitals in providing non-institutional mental health services?

Delegates agreed that it was extremely difficult to answer this question without context, but settled upon two major principles. Hospitals and community services need to focus on their core competencies; and that the transition of patients to the community services need to be improved.

The role of hospitals in providing non-institutional health services is to discharge and direct outpatients to the appropriate community service. Hospitals are at their best when providing acute care and
community services need to be funded properly so they can provide support for patients and their families upon discharge.

To best facilitate the smooth transition, the LHIN should commit to formalizing a relationship with the Integrated Mental Health Council (IMHC). Service agreements with providers should be signed as a regional group rather than on an individual basis.

There is a lack of consistency between services offered by hospitals and community programs that lead to complications for discharge from hospital. Services need to be standardized and better links are needed between hospitals and the community. Delegates recommended connecting psychiatric teams with local agencies and added that mobilizing community care teams.

Housing is a major determinant of health. More investment in supportive housing for mental health and addictions clients will reduce the burden on hospitals. Practitioners reported that some clients who were in hospitals or alcohol and drug detoxification programs were there due to the lack of safe, affordable housing in the community, rather than due to a pressing psychiatric need.

**Question 3:** What is the role of midwives in hospital-based obstetrical care? What should the configuration of obstetrical beds and services be across hospital sites in the South East?

Responding to the question regarding the role of midwifery in hospital obstetrical care, the participants were confused as to why this issue was being raised at the conference. Upon learning that the question originated out of public desire for accessibility to midwife and obstetrical care, the participants focused on possible sites of integration between midwives, hospitals and other facilities.

Delegates addressing the question of midwifery developed solutions around the principle of de-medicalizing child delivery. They proposed the establishment of birthing centres to relieve pressure on hospital beds. Delegates recommended the expansion of community health centre capacities to provide birthing facilities and using registered nurses to provide support in community health centres for child delivery.

Their second proposal involved consultations between health-care professionals and the public to create a road map for improving the system of pre-natal, natal and post-natal care.

**Question 4:** What should happen to freed-up hospital bed capacity as the numbers and length of stay for alternate level of care patients is reduced?

Immediately, delegates reframed the question. Many were frustrated at the fact the questions were about how to resolve issues within a hospital setting. Difficulty seeing community service solutions to hospital service utilization was an emerging theme. The discussion shifted away from what to do with freed-up ALC beds to how beds housing ALC patients could be made available for acute care.

Overwhelmingly, delegates saw socially supportive housing as the remedy for clearing beds in hospitals. Their suggestions coalesced around the idea that the resources for developing supportive housing already exist in the system. A series of opportunities for integration arose out of these discussions around the reoccurring theme of core competencies.

Creation of ALC patients could be reduced if hospitals focus on acute treatment while the capabilities of community care agencies are used appropriately. Funds need to be redirected into a spectrum of lower-cost home supports provided by existing community services. This can be achieved by developing socially
Delegates also proposed developing a model of mixed social housing with respite beds and enabling home care. Finally, creating partnerships with the Ministry of Housing would allow both ministries to align priorities and coordinate housing options.

Delegates also had an opportunity to raise other challenges and questions they felt were important to the health system. The questions they posed are as important as the solutions they developed.

1) In the field of long-term care, how do we address the different needs of residents within this sector?

There is a need to focus on different age groups as separate units. This is particularly a concern as more patients under the age of 50 are located in long-term care homes. Long-term care is a difficult environment for younger populations and those with special behavioral considerations. Many participants mentioned that younger patients suffered emotional harm while surrounded by residents with extremely different needs.

Creating a facility for specialized long-term care for younger populations would be an asset. Though this would require relocating patients, and may mean longer distances for family and friends to travel, delegates still viewed this opportunity as an improvement from the current situation.

2) How do we attract new workers to long-term care?

This is a pressing issue as long-term care is expecting a large cohort of retirees within the next few years. Compounding the problem is the difficulties facing long-term care in recruiting new workers. Delegates suggested fostering collaborative partnerships with high schools, colleges and universities to reach prospective practitioners. Developing cooperative education opportunities and course-credited focus programs would help foster a large potential workforce for the future.

In addition, the Ministry of Health and Long-Term Care could advertise and fund retraining programs for positions in the field.

3) How can we improve the work environment for existing staff?

Three points of improvement were identified: standardizing wages of nurses between sectors; streamlining and standardizing paperwork within each facility; and increasing opportunities for professional development.

4) How can the LHIN affect a shift from a sickness system to a wellness system?

This question speaks to a fundamental shift in the principles of health care. Thematically, this group organized their thoughts on community’s role in prevention while hospitals focus on treatment.

5) What steps can the LHIN take to shift system focus from expensive hospitals and hospital care to one centred on the patient in the community?

Mandate hospitals to have a community liaison council that meets regularly and develop a model of engagement that is responsive to the community.

6) How can LHINs access funds from areas directly related to the causes of addiction and mental health?

Build relationships with LCBOs, police forces including units that recover drug money and tobacco manufacturers and merchants.

7) How can the LHIN offer incentives and rewards for volunteerism?
Research practices among organizations that are successful in volunteer recruitment and retention. Develop volunteer capabilities through well-funded training.

**Participant Feedback**

**Section 1: Workshop Program**

1) Through the workshop presentations and activities, my understanding of the following aspects about the South East LHIN was improved:

- **Demographics and Health Status**
  - Strongly Agree 3.7%
  - Agree 64.8%
  - Neutral 18.5%
  - Disagree 7.4%
  - Strongly Disagree 5.6%

- **Health Services**
  - Strongly Agree 5.7%
  - Agree 56.6%
  - Neutral 24.5%
  - Disagree 13.2%
  - Strongly Disagree 0%

- **Health Utilization**
  - Strongly Agree 3.8%
  - Agree 58.5%
  - Neutral 26.4%
  - Disagree 11.3%
  - Strongly Disagree 0%

- **Health Human Resources**
  - Strongly Agree 3.8%
  - Agree 52.8%
  - Neutral 35.8%
  - Disagree 7.5%
  - Strongly Disagree 0%

2) Through the workshop presentations and activities, I have gained a better understanding of my role in supporting better integration in our health system.

- Strongly Agree 9.8%
- Agree 51.0%
- Neutral 27.5%
- Disagree 9.8%
- Strongly Disagree 2.0%

3) After the workshop presentations and activities, I have a better understanding of the role that other health service providers can play in supporting better integration in our health system.

- Strongly Agree 9.6%
- Agree 63.5%
- Neutral 19.2%
- Disagree 3.8%
- Strongly Disagree 3.8%

4) I have a better understanding of how vertical and horizontal integration can support our health-care system.

- Strongly Agree 3.7%
- Agree 46.3%
- Neutral 31.5%
- Disagree 16.7%
- Strongly Disagree 1.9%

5) My understanding of the Ministry of Health’s directions and priorities for the health-care system have been improved.

- Strongly Agree 0%
- Agree 33.3%
- Neutral 33.3%
- Disagree 29.6%
- Strongly Disagree 3.7%

6) I have a better understanding of the South East LHIN’s approach to delivering its next Integrated Health Services Plan.

- Strongly Agree 13.0%
- Agree 37.0%
- Neutral 37.0%
7) I feel that my input from the workshop has contributed to the South East LHIN’s next Integrated Health Services Plan.

- Strongly Agree 5.7%
- Agree 47.2%
- Neutral 32.1%
- Disagree 13.2%
- Strongly Disagree 1.9%

Workshop Organization

8) Overall, the ENGAGE 2009 workshop was well organized.

- Strongly Agree 32.7%
- Agree 53.8%
- Neutral 3.8%
- Disagree 5.8%
- Strongly Disagree 3.8%

9) The registration process was well organized.

- Strongly Agree 31.5%
- Agree 51.9%
- Neutral 11.1%
- Disagree 3.7%
- Strongly Disagree 1.9%

10) The location was appropriate for the workshop.

- Strongly Agree 31.5%
- Agree 59.3%
- Neutral 7.4%
- Disagree 0%
- Strongly Disagree 1.9%

11) The presenters provided the appropriate level of information.

- Strongly Agree 13.2%
- Agree 52.8%
- Neutral 17.0%
- Disagree 13.2%
- Strongly Disagree 3.8%

12) The ReCAP presentation provided useful information.

- Strongly Agree 3.7%
- Agree 57.4%
- Neutral 18.5%
- Disagree 13.0%
- Strongly Disagree 7.4%

13) The plenary presentation provided useful information.

- Strongly Agree 22.9%
- Agree 60.4%
- Neutral 14.6%
- Disagree 0%
- Strongly Disagree 2.1%

Facilitation Team

14) I would agree to participate in a similar workshop in the future if I had the opportunity to do so.

- Strongly Agree 39.6%
- Agree 43.4%
- Neutral 11.3%
- Disagree 3.8%
- Strongly Disagree 1.9%

15) In the facilitated group sessions, my facilitator treated every group member with respect and valued all of our opinions.

- Strongly Agree 68.5%
- Agree 27.8%
- Neutral 3.7%
- Disagree 0%
- Strongly Disagree 0%

16) My facilitator remained neutral and did not push his/her ideas on my group.

- Strongly Agree 61.1%
- Agree 31.5%
- Neutral 0%
- Disagree 5.6%
- Strongly Disagree 1.9%
17) My facilitator kept the discussion focused.
Strongly Agree 33.3%
Agree 59.3%
Neutral 1.9%
Disagree 3.7%
Strongly Disagree 1.9%

18) How did you find the pacing of the small group discussions?
Too fast 2.0%
Just right 92.2%
Too slow 5.9%
4. Citizen’s Reference Panel

Summary

The ENGAGE 2009 Citizens’ Reference Panel on Health System Planning and Integration took place on February 28, March 7 and March 21, 2009. The objective of the Citizens’ Reference Panel was to help the South East LHIN set priorities for the IHSP by drawing upon recommendations from a panel comprised of residents of the region.

The LHIN used a ‘civic lottery’ to randomly select the panelists. Winners of the lottery were invited to participate in the program. They were briefed on health issues affecting the region and were invited to share their ideas and experiences.

The Citizens’ Reference Panel serves two purposes. First, it is intended to provide public input on the use of health services to South East LHIN. Second, it demonstrates the LHIN’s commitment to community engagement which it believes is essential to improve the health system.

Following some educational presentations, the panel divided into groups for a series of roundtable conversations, led by a team of facilitators. Panel members discussed their past experiences with the health-care system. They talked about their aspirations and occasional frustrations. They began to identify issues and concerns which they believe should be addressed.

On its second day, the panel met at city hall in Kingston. Between their first and second meeting the panelists had been asked to each review sections of IHSP1. They began the morning by discussing their impressions of the document and contrast the issues they had identified the weekend before with the priorities contained in the first plan. During this session, some panelists expressed frustrations with the plan. They felt the document was difficult to read and did not provide enough detailed planning to understand how the priorities would influence front-line care. Others felt that the priorities were a good start and reasonable but also vague. They wanted something bolder and a document that clearly stated the LHIN’s objectives in a way that would make their progress towards their goals easier to assess.

Panelists also focused on difficulty many patients have “navigating the system.” Because the LHIN is dedicated to promoting the seamless integration of health services, they wondered how the IHSP could be used to dramatically change the way patients and their families access care and move more easily between health services and providers. Many panelists felt that ensuring a more effective way of transferring and tracking patients between these services would improve accessibility and the quality of care that patients receive. Expanding the family health team model to deal with complex cases was seen as an attractive alternative to the current referral process.

Several panelists also expressed concern that the IHSP did not give sufficient attention to mental health issues. In this case, panelists were concerned that the complexity of mental health service delivery requires its own comprehensive approach. They pressed the LHIN to revise this section of IHSP1 in its next plan.

Overwhelmingly, many panelists were surprised that IHSP1 failed to mention the importance of prevention or health education — two responsibilities which fall outside the LHIN’s mandate. This was a good instance of how the Citizens’ Reference Panel was inclined to take the long view and would encourage investments in the short term to produce longer-term results. They believed that investments in prevention and education could help keep people out of the
system, or else could help improve health outcomes following treatment. Panelists worried that too many young people were ill-equipped to make good choices concerning fitness, lifestyle or nutrition — and that this would prove costly to the health system over time.

Finally, virtually all panelists agreed that the LHIN needed to do more to make the public aware of its activities and develop clear milestones for the health system as a whole, and its health system providers in particular.

In the afternoon, the panelists welcomed more than 100 interested citizens who joined the panel to hear a presentation by Dr. Brian Goldman, host of CBC Radio’s White Coat, Black Art. Dr. Goldman’s presentation helped kick off a two-hour discussion facilitated by the panelists with members of the public about their ideas for improving the health-care system.

It was an important opportunity for the wider public to participate in the process and provided an opportunity for the members of the panel to share some of what they already learned.

On the final day, the Citizens’ Reference Panel pulled together the many ideas that had emerged over the course of its first two sessions. Panelists worked to narrow more than 58 separate ideas and concerns into a set of 15 suggestions that they hoped would inform IHSP2.

These 15 suggestions are the basis for the extended public open house process that took place in April and May 2009.

Panelists had the opportunity to become better informed and more clearly understand the policy process. Working alongside public officials, panelists can provide specific, high quality advice that is broadly representative of the attitudes and opinions of the wider public.

Many of the panelists had deeply personal stories to share. This exchange helped the members of the panel to know one another and appreciate each other’s perspectives. It also gave them a sense of mission and consequence. Each anecdote seemed to illuminate a different area of the health care system.

The panelists developed ideas for a new set of IHSP priorities. With the help of a facilitator, panelists compared the priorities in IHSP1 with the priorities and ideas they had brainstormed. Gradually four overarching themes became clear:

1. Patients are getting lost in the system: Concerns were raised that the referral process is not effective and does not serve patients well. Many panelists thought that organizing multi-disciplinary and family health teams around complex patients would be a more efficient, patient-centred approach. Complementary and alternative health care practitioners might also be used to support treatment, in partnership with these teams.

2. Communities need to be enabled to deliver the right kind of care: Make efficiency gains by providing smaller communities with resources that alleviate stress on larger health centres. This includes providing primary care, long-term care and community support services.

3. Improve prevention and education: Follow the conventional wisdom that prevention is the best cure. Promote healthy lifestyles and nutrition in schools and in the communities. Provide learning services needed for people to take control of their own health.

4. Advice for writing the next IHSP: Develop an effective evaluation mechanism to ensure accountability and transparency, produce a citizen-friendly report card to accompany the IHSP, and make the next policy document visible.

5.
and understandable to citizens who are not experts on health care.

More themes emerged after the panel staged a town hall style meeting with a guest speaker. Following that presentation, the 100 members of the general public were invited to share their ideas where the LHIN should be focusing its energy. Over the course of an hour, a series of 39 short-term and 28 long-term objectives for the LHIN were crafted. These objectives reflected a wide range of ideas and concerns.

When shared during a plenary session, many of their short term objectives converged around five themes:

- **Make care personal**: System-level integration is not enough. Personalized integration of care is key to delivering quality health care. This means one-on-one guidance of complex cases through the health-care system; treating patients with the least intrusive care possible; ensuring effective follow-up care for all patients when they return to the community and tracking patients throughout their treatment to identify potential problems.

- **Develop a community model of health**: Move away from a hospital-centred model of care. Identify the needs of a community and provide better suited infrastructure. Diversify the options available to alleviate stress on hospitals by providing more after-hours clinics, establishing community health centres in rural areas, opening more 24/7 clinics, funding resource centres, and ensuring the right social services are integrated into the continuum of care.

- **Develop talent and maximize existing resources**: Widen the scope of care for nurse practitioners, make better use of midwives and create a role for physician assistants in the South East.

- Ensure that long-term care and acute care beds are used appropriately.

- **Make access to information easier**: Patients and non-patients want to know their options. More information is needed about the range of services available to a community. Electronic health records should be accessible to patients themselves.

- **LHIN must prove its worth**: The LHIN needs to make itself known to the public, communicate its objectives to residents and be accountable for its actions. The LHIN need to be flexible, keep a balanced budget and perform its tasks efficiently.

The long-term objectives converged around four themes:

- **Precise and comprehensive care**: The South East LHIN should strive to make the right service available for the right person, in the right place at the right time. The LHIN should aim to provide care tailored to the particular needs of the patient along the continuum of care. In particular, appropriate housing facilities need to be developed to locate patients to settings that are consistent with their needs.

- **Greater agility of health service delivery**: The LHIN needs to balance the abilities of its health service providers to allow the coordinated agencies in the South East to be more agile to be more responsive. This involves decoupling from the hospital model of care and developing community-based assets. Similarly, diversifying health-care practitioners would spread demand more evenly and in a way that is consistent with specific health needs. Volunteers should be developed, trained and retained to ease the human resources demands on understaffed agencies.
Identify and anticipate future health needs: The long-term future of health delivery in the South East depends on the ability of the LHIN to anticipate the needs of its communities and establish the right infrastructure for service delivery. This means identifying the needs of an aging population, the poor and homeless, minority groups and aboriginal communities. Anticipation also means developing prevention programs through education that promotes healthy lifestyles and reduces pressure on the health-care system in the future.

Make the health care system sustainable: Citizens do not believe the health care system is sustainable in its current form. Citizens are concerned that significant changes are needed to make it sustainable 15 years into the future but are equally concerned about cuts to service today.

On the final day, the panelists re-examined the 58 ideas they developed in order to build their final recommendations. Conversation then turned to refining the 58 ideas and identifying 15 “top line” priorities. Through facilitated discussions, the panelists carved out specific objectives for each of the 15 priorities.

Their final task was to order their recommendations. The last activity was designed to determine the range and rank of each recommendation. Rather than ordering the priorities through customary voting, panelists were asked to express their preferences by allocating each one ‘a piece of the pie.’ Panel members received a template with a circle, divided into 32 portions. Panelists shaded in a portion of the pie based on the value they placed on a certain recommendation.

This exercise made panelists think hard about what they value in their health system with limited resources. Facilitators tabulated the results and the panelists were presented with a ‘global pie,’ the collective expression of the panel’s weighted recommendations.

When the ‘global pie’ was revealed, it surprised many members to see that there was no runaway favourite; no recommendations received less than one-third the support of the most popular recommendation.

Though at first glance the results seemed ambiguous, a closer analysis revealed a wealth of subtlety in the panel’s thinking.

- Increased collaboration
- Systems accountability
- Targeted patient populations/groups
- Personal accountability
- Directory of services
- Community support
- Prevention
- Patient-centred health
- Environmental consciousness
- Improved communication and greater clarity in health documentation
- Seamless access to care
- Regional research and education
- e-health and file sharing
- Access to care
- LHIN ombudsperson

The panel’s ‘global pie’ shows a fairly even distribution across the 15 recommendations. Recommendations are stratified within a narrow range with none receiving more than 10% of the allocations and none less than 3%. Seven priorities are located in the middle of that range between 6.4% and 7.9%. Twenty-two of the 28 pies allocated slices for 10-15 of the recommendations.

The final tally did, however, raise an important point about the process that brought the panel to that point. Ultimately, all of the recommendations
considered in the final activity were derived from the
citizens themselves and the even distribution points to
the strong consensus on the panel about the
significance of each one.

Moreover, it validates the deliberative approach taken
by the citizens’ reference panel to reaching their
recommendations.

Preliminary ranking
To get a better sense of which recommendations are
more significant than others panelists took a closer
look at the rankings to see if any of the
recommendations distinguish themselves in a more
meaningful way. Recommendation

Affinity Groups
Throughout the final day of deliberations the panel
gave definition to each of the recommendations that
were made, including a statement of intent, sub-recommendations
and indicators of success. Using keywords drawn
from the discussions, the priorities can be clustered
into affinity groups. These groups come directly from
the voices of Citizens’ Reference Panel. They all
reflect similar themes, concepts and concerns
specifically discussed by the panel throughout the
three days.

This method produces six categories and provides
another understanding of the panel’s weighted
recommendations. However, the six main recommendations establish themselves as the panel’s
main priorities. Ultimately, they make up nearly
50% of the total allocations. They include:
- Increased collaboration 80 slices 8.96%
- Targeted patient groups 71 slices 7.95%
- Patient-centred health 60 slices 6.7%
- Seamless access 63 slices 7%
Total 274 slices, 31%
- Community support 90 slices 10%
- Primary care 81 slices 9%
Total 171 slices 19%
- Directory of services 37.5 slices 4.2%
- Improved communications 40 slices 4.48%
- E-health 68.5 slices 7.67%
Total 146 slices 16%
- Personal Accountability 68.5 slices 7.67%
- Prevention 67 slices 7.5%
Total 135.5 slices 15%
- Systems accountability 58 slices 6.5%
- LHIN ombudsman 30 slices 3.36%
Total 88 10
- Regional research and education 43 slices 4.8%
- Environmental consciousness 34.5 slices 3.8%
Total 77.5 slices 9%

The top group embraced the principles of
collaboration among health service providers and with
related ministries, addressing community-specific
health issues, proactive leadership on the part of the
LHIN and care that is appropriate and respectful to
the individual patient. The recommendations that
populate this group are increased collaboration,
targeted patient groups, patient-centred health and
seamless access to care and received 30.61% of the
total allocations.

The second group coalesced around the panel’s
suggestions of strengthening the ability of primary
care service providers to practice at the community
level.

Panelists called for additional resources to bolster
primary care services and called on the LHIN to
facilitate greater co-operation with advisory and
advocacy groups to identify best practices, areas of
improvement and promote health options in the community. Together, community support and primary care drew 19% of the total allocations.

On their final day, the members of the panel were asked to draft their recommendations, in their own words, with as much specificity as possible.

**Recommendations**

1: Increased Collaboration

*Statement of Intent (what’s the goal?):* The focus of collaboration is to be BOLD: identify barriers and be participatory by building trust and respect across these barriers. This will ensure the patient will receive the right care, at the right times/place, with the right providers. The focus of all collaboration should be to provide patients with the right care, at the right time, in the right place, by the right provider. The LHIN can do this by identifying barriers, taking proactive leadership, being participatory, and building trust and respect.

*Sub-recommendations:* The LHIN could promote the knowledge/experience of outside agencies. The LHIN could develop collaborative projects with these organizations. The LHIN should advocate (upwards) to the Ministry of Health about working with all ministries to improve the health of South East residents and Ontarians in general. The LHIN is to promote co-operation and communication across inside agencies/providers/practitioners to ensure a coordinated provision of care. The LHIN is to facilitate communication with outside agencies/providers/practitioners, while these are outside the funding model, the full utilization of these services could reduce the financial burden of the LHIN.

*How will we know that the LHIN is satisfying the recommendation three years from now?* Conversation with frontline workers; develop nurse practitioner-led teams; promote family health teams / community health centres. In general: LHIN produces report on barriers to collaboration that is produced through consultation with stakeholders (inside and outside of system).

2: Systems Accountability

*Statement of Intent (what’s the goal?):* Systems accountability in the LHIN should be focused on improving their awareness as a critical piece in the health-care system. The LHIN should be open and visible and accountable to both the Ministry and the specific region that it serves.

*Sub-recommendations:* The LHIN should be monitoring the effectiveness of health system providers. The LHIN should bridge the gap between the health system and the public. The LHIN should be reviewing and reporting on its own work and effectiveness, and of the health-care groups that they fund. Pilot a citizens’ report card that tells the public how the health service providers and the LHIN is doing. The report card would be done as part of the accountability agreements for the health service providers.

To complete the mini-report cards, the health service providers must involve the public, frontline workers, the board members, and the clients and community they serve.

*How will we know that the LHIN is satisfying the recommendation three years from now?* Public and open access to all of the reporting and documentation; citizen-friendly report cards are piloted; the LHIN does a one-year update on the recommendations coming from the Citizens’ Reference Panel.
3: Targeted Patient Populations / Groups

Statement of Intent (what’s the goal?): Identify and implement safe appropriate care for people with special health needs throughout the continuum of care.

Sub-recommendations: Have a strategy for dealing with specific health issues (assessment of needs, create specific plans, implement). Have advocates within the system for each health issues (lesbian, gay, bisexual, transgendered, multiple chemical sensitivities, Parkinson’s). Assign costs, attributes, etc., and give a number from 1 to 10 to show costs associated with each health issue / group. Generate statistics for special needs to provide input for the next planning cycle (medical census?). Collaborate with advocacy groups.

How will we know that the LHIN is satisfying the recommendation three years from now? Weight averages for gradation of need/cost. Review costs to the system and the individual. Special health groups have access to current treatment, management and information. Examples of special health needs: rural; mental health and addictions; chronic diseases; physical disabilities; multiple chemical sensitivities; women.

4: Personal Accountability

Statement of Intent (what’s the goal?): This is a prevention tool to save energy and increase general health by facilitating health education.

Sub-recommendations: Increase education for all ages; education efforts should cover the full spectrum of health issues. Increase communication and promotion about available resources. Educate about alternative treatment.

How will we know that the LHIN is satisfying the recommendation three years from now? A better informed public, in particular marginalized populations; increased satisfaction in the health system; better health practices in the population greater use of alternative treatments; decreased use of antibiotics and other drugs.

5: Directory of Services

Statement of Intent (what’s the goal?): Create a resource that provides the tools to quickly find all levels of support services.

Sub-recommendations: The directory will provide the how, what, why and when for available services and needs. The directory will be available in various forms and mediums in order to address the needs of all people. The directory will be comprehensive and dynamically responsive to the ever-changing environment and range of services. The directory could come from one-page standard templates) that must be filled by each organization. The one-pagers could be organized by the 15 sub-regions and made available to the public and describe the how, why and when.

How will we know that the LHIN is satisfying the recommendation three years from now? If people feel they have a place to go to, and to get the information/help they need when they need it.

6: Patient-Centred Health

Statement of Intent (what’s the goal?): We want care that is oriented toward individual needs, that is consistent given the available resources, is collaborative and delivered in a timely manner with the ultimate goal of ensuring patient wellness.

Sub-recommendations: Create separate urban and rural strategies; educate people on their options; develop existing networks online and offline; de-mystify OHIP; develop transparent strategy; improve
communication between services regarding the patient.

**How will we know that the LHIN is satisfying the recommendation three years from now?**
Transportation services expanded volunteerism; LHIN directory along with the phone book. Set realistic and challenging goals now that are measurable and can reported back to the community.

**7: Environmental Consciousness**
**Statement of Intent (what’s the goal?):** Improve health in the South East by researching, understanding and improving environmental impact, from institutions, geographic/communities, personal household. Chronic conditions in South East may be tied to environmental toxins in the South East.

**Sub-recommendations:** Review, expand, and update environmental policies of health service providers. Create an inclusive, comprehensive policy for the LHIN that provides guidelines for new buildings (should be LEED, renewable energy) and the contractors who build them, or retrofits (paint should be free of volatile organic compounds – toxic gases). Develop broader research agenda to study why people are less healthy in the South East; have an environmental building biologist assess buildings.

**How will we know that the LHIN is satisfying the recommendation three years from now?**
The regional office of the Ministry of Environment and the LHIN has shared information and data about the South East LHIN. Chronic conditions are decreasing. Should see a decrease in visits to urgent care and decrease in the level of medical waste (by tonnage). Health service providers could do prevention and education about exposure to common household products and their impact on health.

**8: Community Support**
**Statement of Intent (what’s the goal?):** People are being downloaded to the community, assuming services are there. LHIN needs to recognize that additional resources (people and money) are needed.

**Sub-recommendations:** Mapping of community services that support home care issues across southeastern Ontario; LHIN to work with new community advisory group to identify gaps, opportunities for collaboration and to avoid duplication; identify agencies and service providers funded by LHIN to assist with navigation (through 211); harmonize wages in health care, support services and long-term care. Need to research and resources available in community BEFORE streamlining services.

**How will we know that the LHIN is satisfying the recommendation three years from now?**
Setting up groups in the community representing stakeholders) with a plan to implement recommendations. LHIN logo displayed by all service providers and agencies, with 211 access to information by 2012. Retention of trained workers in support agencies; reduction in the number of personal support workers moving to hospitals and out of health care.

**9: Prevention**
**Statement of Intent (what’s the goal?):** To encourage and implement better individual health practice through outreach and education in order to promote good health care and as a result enable efficient use of the health-care system and overall improvement in the quality of life.

**Sub-recommendations:** Provide vehicles for individuals to access practitioners trained in preventative health care in and outside of the LHIN’s jurisdiction. Organize sessions for individuals to learn
about preventative health measures and opportunities: workshops, mall clinics, pamphlets. Establish an interactive online forum for prevention education.

How will we know that the LHIN is satisfying the recommendation three years from now? Acute chronic illness will decline. General overall health will increase. Data from practitioners trained in alternative health practices will show an increased in use and services.

10: Improved communication and greater clarity in health documentation

Statement of Intent (what’s the goal?): Make available clear information that will educate individuals to care for themselves and effectively navigate the system.

Sub-recommendations: Institutionalize the distribution of the problem-specific information pamphlets to help heal and navigate the system. Use plain language – have documentation test read by intended audience. Communicate best practices, (e.g. LHIN should develop a practitioner-driven website where practitioners can post best practices by area.)

How will we know that the LHIN is satisfying the recommendation three years from now? Pamphlets are produced and widely distributed. There is an established mechanism for population review of the materials produced by the LHIN; More people are aware of the LHIN (and related agencies) and how it functions.

11: Seamless access to care

Statement of Intent (what’s the goal?): Prevent people from falling through the cracks in the system, create organizational synergies; humanize the healthcare experience; create experiences whereby people feel everything realistic has been done to help them.

Sub-recommendations: Integrate LHIN funded community service organizations with non-funded organizations. Ensure automatic referral to appropriate level of care. Ensure all organizations understand the continuum of care by: conducting ongoing consultations to bring together diverse (funded and non-funded service providers) and developing community-specific directories of care for use by hospitals, organizations and individuals. Introduce exit interviews (to the nursing care plan) to conduct needs assessments and determine subsequent services.

How will we know that the LHIN is satisfying the recommendation three years from now? Reduce readmissions; maintain a complete record of exit interviews; increased satisfaction with individual experience in health-care system; spectrum of service providers are satisfied with their integration into the system (surveys and consultation).

12: Regional research and education

Statement of Intent (what’s the goal?): To implement research and education agenda in partnership with other stakeholders to enhance integration and improve the health status in the South East.

Sub-recommendations: Liaise with the research community to provide more clear directions on how to decrease chronic illness in our region. Share the research already being undertaken by academic institutions with the LHIN. Use the health-care organizations such as the lung association, cancer society, etc., professional associations to address research gaps. Develop a coordinated plan to provide educational materials to classrooms.

How will we know that the LHIN is satisfying the recommendation three years from now? Report issued by the LHIN (and partners) that explains the causes of
the region’s high-incidence of chronic illnesses. New partnerships emerge between health providers, universities, for-profits. There is a healthier population and decrease in high-risk activities (i.e. smoking, fast food consumption).

13: E-Health and File Sharing

**Statement of Intent (what’s the goal?):** We want collaborative, comprehensive, and secure e-health that is available where and when it is needed that allows us to have full knowledge of our own health, enables us to take ownership of our health and expedites the delivery of services.

**Sub-recommendations:** Plain, valid, readable, understandable information is available. Establish different levels of access controlled by the patient. Ensure security. Reduce duplicate records, set clear targets (three year >> seven years >> 10 years >> 15 years) on the progress of the development. Roll out broadband expansion projects.

**How will we know that the LHIN is satisfying the recommendation three years from now?** Virtual hospital: offsite input, offsite monitoring; pharmacy-doctor communication; digital processing, directed to the right and available. Security is paramount. System is web linked to the right information. Pilot a web-based file program.

14: Access to Primary Care

**Statement of Intent (what’s the goal?):** Optimize the delivery of primary health care.

**Sub-recommendations:** Educate people about health care clinics, after hours clinics and drop-in clinics and how to use them for which needs. Establish education programs in schools to plant early seeds. Encourage best practice so practitioners work to their higher abilities including nurse practitioners, midwives, physician assistants and medical doctors. Use dental hygienists for screening and cleaning of low-income individuals as well as education for prevention especially in the school system. Standardize wait times for referrals and communication with patients around estimated wait times. Communicate available transportation services through practitioners.

**How will we know that the LHIN is satisfying the recommendation three years from now?** There are less wait times for primary services and an efficiently run transportation network.

15: Ombudsperson

**Statement of intent:** If someone cannot access health care, he/she can go to an impartial ombudsperson that hears and investigates the complaint. If the complaint is well-founded, the ombudsperson can solve the individual problem and report back to the LHIN with recommendations for system improvements. (You can’t afford not to do this!)

**What’s the goal?**: Improve the system; build trust and confidence; no-one falls through the cracks; get rid of patient frustration.

**Sub-recommendations:** Appointed by the LHIN board or Ministry; poster at every health facility “Having problems with healthcare? Call 1-800…”; Communication plan to let people know about ombudsperson; transparency, impartiality, openness to public and media (build trust between people and system); staffed as required for volume of problems.

**How will we know that the LHIN is satisfying the recommendation three years from now?** Annual report/monthly report; feedback to individual (2-5 days, depending on urgency); address issues in a timely way; recommendations to LHIN for system improvement.
The panelists

Lloyd Ambler: I am from Prescott, Ontario. I am retired and married with five children and nine grandchildren.

Anne Arcand: I am a former teacher with the Halton County Catholic School board with 36 years experience. I am now retired and presently own and operate Arcanada Bed and Breakfast in Northport, Ontario.


Neil Coulter: I was born in Brockville, Ontario. I moved to Saskatchewan in 1939 where I received my education. I joined the RCAF in 1957 and spent 27 years in the service. I worked for Coopers Insurance for 13 years and retired fully in 1997. I live in Prescott with my wife. We have two children and two grandchildren. I have been an active volunteer with the Canadian Diabetes Association. I am an avid golfer and have sat on the Board of Directors of a number of golf clubs serving as club captain and president.

Charlene Ervine: I have been working in the health care field for the past 19 years. A number of my friends and family are also health-care providers.

Gino Giannandrea: Five years ago I retired from the Upper Canada District School Board where I was the director of education. In that role, I had administrative responsibility for the amalgamation of four school boards. As a superintendent I had responsibility for human resources and operations for the Huron County Board of Education. From about 1988 to 1995 I was a member of the board for the South Huron District Hospital in Exeter, Ontario. My hobbies include golf, fishing, woodworking and general construction. I have been involved in building five homes and renovating others.

Malcolm Griffin: I was born in New Zealand and spent four years studying in Canada. I returned to New Zealand with a Canadian wife. We came back to work at Queen’s University in the department of Math and Statistics in 1970. I have three sons. I lead an active life, meditate and help my children with various projects.

Karin Grunenfelder: I am a registered nurse from Germany and came to Canada about 11 years ago with my husband to farm. Our farm and my two children, 4 and 8 years old, have kept me busy so far. Last winter, I received a Canadian personal support worker diploma and hope to work in the health-care system.

Paul Hogan: I am a retired dairy farmer. I have two children aged 25 and 23. I presently do some freelance photography and home renovations and I am attending Queen’s University pursuing a degree in political science.

Ahmed Khadra: I am an electronic engineer and a PED member. I have my own business “Kinda Electronics” in downtown Brockville. I emigrated from Damascus, Syria to Montreal in 1995 and lived there until 1998 when I moved to Brockville to run my business service and retail electronics. I am married and have six children. Currently, I am working towards a Master’s Degree in Information Systems. I am the Webmaster of 1000 Islands PED chapter.

Paul Lafond: I am a retired secondary school teacher and have been married for 48 years. In 2001, I moved
to Bath, Ontario from Niagara Falls to be closer to my family in the South East. In Niagara, I had a small grape farm and ran a competitive business for 20 years.

**Tina Lavigueur:** I was a waitress until 2006 when I was brutally assaulted and received a traumatic brain injury. This injury has impaired my ability to work. The Regional Community Brain Injury Services has been a great help to me. I am very grateful for the doctors and the rehabilitation I received at St. Mary’s of the Lake and Kingston General Hospitals.

**Stephen MacDonald:** Married with three children. Holds two degrees: Bachelor of Environmental Studies, University of Waterloo; and Bachelor of Education, Queen’s University. I have been gainfully employed with Kraft Canada Inc. for the past 29 years. I am passionate about the sustainability of the Canadian health-care system and the delivery of health programs at Quinte Health Care. As a primary caregiver to elderly parents, I am especially concerned about senior health-care programs.

**Bonnie Manning:** I share my home in Belleville, Ontario with my life partner, and work as a published writer, lecturer and artist. I have had extensive experience in both the public and private sectors working within mental health and human services. I am a member of the Disabled Women’s Network of Canada, and the Canadian Writers Guild. I advocate for human and disabled persons rights throughout North America. I have lectured at Queen’s University and continue to lecture abroad. I am deeply honoured to have served the public as part of the Citizens’ Reference Panel.

**Sonya Masse:** I was introduced to Kingston as a Queen’s student and recently returned with my husband as a self-employed primary care health professional. I love Kingston and I’m honoured to be a part of the Citizens’ Reference Panel.

**Barbara Mathieson:** I retired in 2000 after 15 years as a frontline counselor working 12-hour shifts at Leeds and Grenville Interval House – a shelter for abused women and their children. Prior to that, I was an office worker. I am the mother of 3 sons. I was widowed in 1980 and my oldest son died in 1984, aged 19—both in accidents. I am also the grandmother of four grandchildren. My late husband was bi-polar. My common-law partner was diagnosed with Parkinson’s and is currently in long-term care at St. Lawrence Lodge. I am active in the community serving on the Family Council at St. Lawrence Lodge, I work for a local Parkinson’s support group and volunteer on a local distress line.

**Susan McCoubrey:** I have four children ages 17-30 and five grandchildren. I live in Kingston with my partner and our daughter who is in her last year of high school. I work as a family and community support worker with families living in Kingston’s north end, providing support and facilitating healthy growth and development. I enjoy spending time with my grandchildren and love playing an active role in their lives. In my spare time I enjoy the practice of kundalini yoga, hiking and walking.

**Peter Milanov:** I am currently a small business owner pursuing a career in law enforcement. I live in Kingston, Ontario with my wife and we are anxiously awaiting the birth of our first child.

**Ian Moore:** Born in New South Wales, I immigrated to Canada with my wife and two children in 1991. Ten years later I took up a position as a professor of civil engineering at Queen’s University. My role as has made me acutely aware of the strengths and weaknesses of health care in southeastern Ontario. My interests include photography, cello and the outdoors.

**Henry Peel:** I was born in Northern Ontario and have resided in Kingston for most of my life. I retired in
August 2007 after a career of over 30 years with the Canada Revenue Agency. At CRA, I served as auditor, appeals officer, group head and section chief of the Public Affairs section. My wife Mary is a retired elementary school teacher. We have one son, Evan, who lives in the Toronto area. Both Mary and I are very active volunteers in our community. I am an avid curler, gardener and downhill skier.

David Platt: I have lived all my life in Ontario in good health and am now retired. Currently, I am the president of the South Crosby non-profit housing corporation, which runs a seniors’ apartment building with 21 units and a family complex with 20 units in Elgin. I am busier now than when I was working.

Richard Preston: I love music, art, travel, sports, movies, grandkids, theater, dining and all social events. I have coached minor and adult sports. I’ve played hockey, baseball, football, tennis, badminton, curling and golf. I love taking on new challenges and exploring new ideas as a team player. I worked at PepsiCo for 24 years where my last position was in new business development and key accounts. I also worked for American Express in Eastern Ontario. Currently I work in the transportation industry. My motto: “Live life to the fullest believing you can live an enriched life without being rich and it’s the journey not the destination but nobody has reached winner’s circle using the brakes.”

Nancy Roberts: I am currently the eastern regional sales manager for a global packaging firm and a part-time college educator. I hold a BA in fine arts and English and have undertaken many successful entrepreneurial ventures in a 27-year career in business. I am a single mother to a son and daughter, both at university (Ottawa University and Queen’s University). I am a practicing fine artist and novelist and dabble in real property investment. I have a proactive personality and fondly enjoy new learning experiences and creative thinking.

Elizabeth Savill: I am a long-time resident of eastern Ontario with a strong commitment to the development of our communities across the region. For more than 10 years, I’ve been involved directly with health care issues and the delivery of long-term care and paramedic services. I am also part of a family of four kids along with many extended members. Our experiences in the health-care system have changed over the years giving us a perspective on many different areas.

Alf Shepherd: I immigrated to Canada 40 years ago, with wife, daughter, son and large dog. I worked as UK liaison for Ferranti Packard for two years, then as a store manager with Canadian Tire before moving to Toronto Transit. I retired 12 years ago and enjoy gardening, motor sports, fishing and watching baseball.

Pamela Stagg: I am semi-retired from an international career as a botanical painter and an advertising writer. Currently, I’m helping Quinte Health Care develop protocols for treating patients with multiple chemical sensitivities (this is a self-initiated volunteer project). I am an avid kayaker. I also participate in a weekly bird census and enjoy walking and snow-shoeing to keep fit.

Jasmine Sweet: I grew up as a military brat. I work at Queen’s University in food services and in my spare time I like to read, listen to music and do crafts. I also sing with the Sweet Adelines.

Shelley Thompson: I am a 52-year-old widow with a 17 year old daughter. She will be going off to college soon, which will be a big change in both our lives. I have had severe Crohns disease since I was 18 years old and a few years ago this led to a copper deficiency. It caused nerve damage to my spine before the doctors discovered what it was. For the past 2.5 years I have been in pain and use a cane and walker to get around. It is a rare condition and the doctors
don’t know where it will lead. My experience has prompted me to be more interesting in our health-care system.

Tom Thompson: I was born and raised on a dairy farm between Campbellford and Stirling. My ambition was to become a partner with my father which I did when I completed high school. During the years I was farming I was very active in my community and my church. I’ve held many leadership positions. I was a salesman for Pioneer Seeds and met many people in that role. My wife and I raised three children who have families of their own. In 1998, I retired from farming and now enjoy living both on a rural property near Campbellford and at a lakeside home north of Bancroft. I have traveled extensively. At 65, I am lucky to have good health and an active lifestyle. I was the primary caregiver for my parents my wife’s parents. This experience has raised my awareness of health care available to seniors.

Jerry Traer: For the past 30 years, I have worked in the pulp and paper sector. As a program / training specialist, I provide resources to firms in Eastern Ontario and conduct training on health and safety. I live in Belleville with my wife and two older children. I am an avid golfer. We moved to the Belleville area eight years ago.

Bruce Turner: I grew up in Gananoque and have been living in Kingston for the past 17 years. I work at the Loblaws grocery store. My hobbies including riding horses, collecting coins and volunteering at the Kingston Youth centre.

Bhavana Varma: I work with the United Way (KFL&A) and am involved with a number of community organizations.

Grace Wales: I have lived and worked all my life in southeastern Ontario. I was one of the first married students to ever return to high school in this area and now it is a common and accepted practice. In school I developed an interest in electronics but could not attend shop classes because they were only offered to male students. In 1979, a women’s upgrading program allowed me to earn certification as an Electrical Engineering Technology Technician. After three years, I graduated fourth in a class of 100 students and was the only female. I am currently semi-retired and continue to live in Napanee, Ontario.

Cindy Weatherhood: I’m the mother of two pre-teens and the graduate of a food service management course in mid-1980s. I’ve been employed in health care field for 13 years; working in acute care for three years, long-term care for two years community support for eight years. I am actively involved in community and children’s activities including the Women’s Institute, Volunteer Association, School programs and sporting programs.

Marilyn Wilson: A teacher for over 30 years, I taught at high schools in both Kingston and Belleville. During that time, I served on the first Status of Women committee and the collective bargaining committee of District 20, and on different parent councils. I have an interest in equality and accessibility issues. Currently retired, I volunteer at the KFLA Public Health, and act as a trustee for the CFUW Scholarship Trust fund. In my spare time I curl at RKCC and support local theatre. My two grown children are both professional health-care workers in Ontario.
Participant Pre-surveys

Personal Interest in Health Care
1) How interested in the health-care system do you usually feel?
Not interested
0 - 0%
1 - 0%
2 - 0%
3 - 3.6%
4 - 0%
5 - 7.1%
6 - 3.6%
7 - 7.1%
8 - 17.9%
9 - 7.4%
10 - 33.3%
Very interested

2) How informed about the health-care system do you usually feel?
Not very informed
0 - 3.7%
1 - 0%
2 - 0%
3 - 3.7%
4 - 7.4%
5 - 25.9%
6 - 22.2%
7 - 22.2%
8 - 7.4%
9 - 3.7%
10 - 3.7%
Very informed

3) How enthusiastic do you feel about the Citizens Reference Panel?
Not very enthusiastic
0 - 0%
1 - 0%

Health Care Opinions
1) It is the right of every person in Canada to receive public health care.
Strongly agree - 85.2%
Somewhat agree - 11.1%
Somewhat disagree - 3.7%
Strongly disagree - 0%
Not sure - 0%

2) The public health-care system is a national treasure.
Strongly agree - 66.7%
Somewhat agree - 25.9%
Somewhat disagree - 3.7%
Strongly disagree - 3.7%
Not sure - 0%

3) The public health-care system is financially sustainable.
Strongly agree - 23.1%
Somewhat agree - 38.5%
Somewhat disagree - 15.4%
Strongly disagree - 3.8%
Not sure - 19.2%

4) If someone does not want to wait for health care, they should be able to pay to jump the queue.
Strongly agree - 7.4%
Somewhat agree - 22.2%
Somewhat disagree - 22.2%
5) People who have bad habits (e.g. smoking) do not deserve the same level of health care as everyone else.
   Strongly agree - 7.7%
   Somewhat agree - 19.2%
   Somewhat disagree - 23.1%
   Strongly disagree - 42.3%
   Not sure - 7.7%

6) The health-care system is not ready for the demands of the elderly population.
   Strongly agree - 23.1%
   Somewhat agree - 61.5%
   Somewhat disagree - 0.0%
   Strongly disagree - 7.7%
   Not sure - 7.7%

7) In general, it is easy to access the health care services that I need.
   Strongly agree - 22.2%
   Somewhat agree - 48.1%
   Somewhat disagree - 18.5%
   Strongly disagree - 7.4%
   Not sure - 3.7%

8) In general, it is easy to access information about health-care services.
   Strongly agree - 11.5%
   Somewhat agree - 46.2%
   Somewhat disagree - 30.8%
   Strongly disagree - 0.0%
   Not sure - 11.5%

9) The major issues in health care today are too complicated for most people to understand.
   Strongly agree - 11.5%
   Somewhat agree - 48.1%
   Somewhat disagree - 14.8%
   Strongly disagree - 14.8%

10) It is the duty of every citizen today to understand where his or her taxes are going.
    Strongly agree - 51.9%
    Somewhat agree - 33.3%
    Somewhat disagree - 14.8%
    Strongly disagree - 0.0%
    Not sure - 0.0%

11) If the decisions could be brought back to the grassroots and the people we would be better able to solve big problems.
    Strongly agree - 14.8%
    Somewhat agree - 33.3%
    Somewhat disagree - 22.2%
    Strongly disagree - 7.4%
    Not sure - 22.2%

**Health care satisfaction**

1) On the whole, how satisfied are you with the health-care system?
   Very satisfied - 3.7%
   Fairly satisfied - 77.8%
   Not very satisfied - 14.4%
   Not satisfied at all - 3.7%

2) On the whole, how satisfied are you with the care that you have recently received from the health-care system?
   Very satisfied - 40.7%
   Fairly satisfied - 48.1%
   Not very satisfied - 3.7%
   Not satisfied at all - 7.4%

3) On the whole, how satisfied are you with the care that a loved one has recently received from the health-care system?
   Very satisfied - 18.5%
   Fairly satisfied - 55.6%
   Not very satisfied - 18.5%
   Not satisfied at all - 7.4%
4) How much do you associate your own general health with the health-care services you receive?
A lot - 14.8%
Somewhat - 51.9%
A little - 29.6%
None - 3.7%

5) On the whole, how would you rate your own health?
Very good - 29.6%
Good - 48.1%
Fair - 18.5%
Poor - 3.7%

6) How much attention do you usually pay to news about health care?
A lot - 37.0%
Somewhat - 55.6%
A little - 3.7%
None - 3.7%

People versus Government
1) On the same scale where 0 means unintelligent and 10 means very intelligent, how would you rate people in general?
Unintelligent
0 - 3.8%
1 - 0.0%
2 - 0.0%
3 - 3.8%
4 - 11.5%
5 - 11.5%
6 - 15.4%
7 - 30.8%
8 - 15.4%
9 - 3.8%
10 - 3.8%
Very Intelligent

2) On the same scale where 0 means unintelligent and 10 means very intelligent, how would you rate people in government?
Unintelligent
0 - 3.8%
1 - 0.0%
2 - 0.0%
3 - 3.8%
4 - 11.5%
5 - 11.5%
6 - 15.4%
7 - 30.8%
8 - 15.4%
9 - 3.8%
10 - 3.8%
Very Intelligent

3) On the same scale where 0 means uninformed and 10 means very informed how would you rate people in general?
Uninformed
0 - 3.8%
1 - 3.8%
2 - 3.8%
3 - 23.1%
4 - 15.4%
5 - 19.2%
6 - 15.4%
7 - 7.7%
8 - 7.7%
9 - 0.0%
10 - 0.0%
Very Informed

4) On the same scale where 0 means uninformed and 10 means very informed how would you rate people in government?
Uninformed
0 - 3.8%
1 - 0.0%
2 - 3.8%
Highly informed

5) Did you vote in the 2008 federal election?
   Yes - 84.0%
   No - 16.0%

6) Did you vote in the 2007 provincial election?
   Yes - 88.9%
   No - 11.1%

7) Have you ever contacted your MP or MPP?
   Yes - 66.7%
   No - 33.3%

8) Are you, or have you ever been a member of your local riding association?
   Yes - 11.1%
   No - 88.9%

Knowledge of the Health-care System

1) Prior to the Citizens’ Reference Panel, have you ever heard of the South East LHIN?
   Yes - 38.5%
   No - 61.5%

2) Do you know in which decade Canadians began to receive public Medicare?
   Yes - 63%
   No - 37%

3) Approximately what percentage of the current provincial budget is used to fund health care?
   5% of budget - 8% of responses
   25% of budget - 12% of responses

35% of budget - 20% of responses
45% of budget - 20% of responses
55% of budget - 12% of responses
65% of budget - 0% of responses
75% of budget - 4% of responses

4) Do you know which Premier introduced the LHINs?
   Yes - 26.9%
   No - 73.1%

5) What type of organization are the LHINs?
   Private - 3.7%
   Charity - 0%
   Ministry of Health - 48.1%
   Public, not for profit - 33.3%
   Crown Corporation - 7.4%
   Other - 7.4%

6) The South East LHIN is responsible for providing health care to 480,000 area residents. Approximately what is the LHIN’s annual budget for providing health services in the region?
   $250 million - 25%
   $550 million - 16.7%
   $870 million - 45.8%
   $1.15 billion - 12.5%

Personal Community Involvement

1) Please identify any volunteer associations in which you have been active in the past five years.
   Community service group - 35%
   Business association - 5%
   Professional association - 35%
   Environmental association - 5%
   Women’s group - 5%
   Labour union - 5%
   Ethnic association - 0%
   Sports association - 15%
   Religious association - 25%
   Other 35%
2) Please identify the activities you have engaged in over the last year as part of your involvement.
Writing a letter - 55.6%
Participating in a meeting where decisions were made - 83.3%
Planning or chairing a meeting - 44.4%
Making a presentation or speech - 55.6%
Contacting a government official - 22.2%

3) How often do you discuss the health-care system with others?
Regularly - 29.6%
Occasionally - 59.3%
Rarely - 7.4%
Never - 3.7%

4) Compared to the average person, do you have fewer opinions about the health-care system, about the same, or more opinions?
Fewer - 11.5%
About the same - 57.7%
More - 30.8%

5) Which statement best represents your viewpoint?
“It is up to experts to make decisions about the health-care system because they are better informed about the issues.” - 31.8%
“It should be the citizens who decide what the most important issues are in the health care because they know what is best for them.” - 68.2%

Public Participation
1) How confident are you that the Citizens’ Reference Panel will be a success?
Very confident - 25.9%
Somewhat confident - 70.4%
Not very confident - 3.7%
Not confident at all - 0%

2) How likely is it that the Citizens’ Reference Panel will reach a consensus about what the best recommendations for the South East LHIN’s Integrated Health Services Plan?
Very likely - 33.3%
Somewhat likely - 59.3%
Not very likely - 7.4%
Not very likely at all - 0%

Participants’ Feedback
Day 1
1. Overall, the Citizens’ Reference Panel on Health Planning and Integration was well organized.
Strongly Disagree - 0%
Disagree - 3.6%
Neutral - 3.6%
Agree - 60.7%
Strongly Agree - 32.1%

2. The presenters provided an appropriate level of information.
Strongly Disagree - 0%
Disagree - 0%
Neutral - 0%
Agree - 51.9%
Strongly Agree - 48.1%

3. After today’s presentations, I have a better understanding of the health-care system in the South East.
Strongly Disagree - 3.6%
Disagree - 0%
Neutral - 7.1%
Agree - 35.7%
Strongly Agree - 3.6%

Day 2
1. Overall, the Citizens’ Reference Panel on Health Planning and Integration was well organized.
Strongly Disagree - 7.4%
Disagree - 0%
Neutral - 11.1%
Agree - 59.3%
Strongly Agree - 22.2%
2. The presenters provided an appropriate level of information.
Strongly Disagree - 3.7%
Disagree - 3.7%
Neutral - 7.4%
Agree - 55.6%
Strongly Agree - 29.6%

3. After today’s presentations, I have a better understanding of the health-care system in the South East.
Strongly Disagree - 3.7%
Disagree - 3.7%
Neutral - 14.8%
Agree - 44.4%
Strongly Agree - 33.3%

Kingston Town Hall - General Public Feedback

1. I learned new information about the region’s health-care system from today’s event.
Strongly Disagree
0 - 0%
1 - 3%
2 - 3%
3 - 6.1%
4 - 0%
5 - 12.1%
6 - 12.1%
7 - 15.2%
8 - 15.2%
9 - 18.2%
10 - 15.2%
Strongly Agree

Day 3
1) Overall, the Citizens’ Reference Panel was well organized.
Strongly agree - 80%
Somewhat agree - 15%
Somewhat disagree - 5%
Strongly disagree - 0%

2) Overall, the Citizens’ Reference Panel raised my level of understanding of the health-care system.
Strongly agree - 65%
Somewhat agree - 35%
Somewhat disagree - 0%
Strongly disagree - 0%

3) Fellow panelists showed respect for each other and were open to each others’ views.
Strongly agree - 85%
Somewhat agree - 15%
Somewhat disagree - 0%
Strongly disagree - 0%

4) I was able to raise questions and express my views as much as I wanted to.
Strongly agree - 100%
Somewhat agree - 0%
Somewhat disagree - 0%
Strongly disagree - 0%

5) Group work was able to produce results based on consensus.
Strongly agree - 55%
Somewhat agree - 40%
Somewhat disagree - 5%
Strongly disagree - 0%

6) Overall, I enjoyed being a member of the Citizens’ Reference Panel.
Strongly agree - 85%
Somewhat agree - 15%
Somewhat disagree - 0%
Strongly disagree - 0%

7) Overall, participating in the Citizens’ Reference Panel was a useful experience.
Strongly agree - 60%
Somewhat agree - 40%
Somewhat disagree - 0%
Strongly disagree - 0%

8) I feel that the Panel accomplished something important over the three sessions.
Strongly agree - 45%
Somewhat agree - 55%
Somewhat disagree - 0%
Strongly disagree - 0%

9) Overall, the speakers and presentations at the Panel provided appropriate information.
Strongly agree - 55%

Somewhat agree - 45%
Somewhat disagree - 0%
Strongly disagree - 0%

10) I would agree to participate in a similar citizens’ process in the future if I had the opportunity to do so.
Strongly agree - 80%
Somewhat agree - 20%
Somewhat disagree - 0%
Strongly disagree - 0%

Participant Post Surveys
Interest in Health Care
1) How interested in the health-care system do you now feel?
Not interested
0 - 0%
1 - 0%
2 - 0%
3 - 0%
4 - 0%
5 - 3.8%
6 - 3.8%
7 - 19.2%
8 - 7.7%
9 - 30.8%
10 - 34.6%
Very interested

2) How informed about the health-care system do you now feel?
0 - 0%
1 - 0%
2 - 0%
3 - 0%
4 - 0%
5 - 7.7%
6 - 3.8%
7 - 11.5%
8 - 42.3%
9 - 26.9%
10 - 7.7%
3) How enthusiastic did you feel about the Citizens’ Reference Panel?
Not enthusiastic
0 - 0%
1 - 0%
2 - 0%
3 - 0%
4 - 0%
5 - 0%
6 - 11.5%
7 - 7.7%
8 - 26.9%
9 - 30.8%
10 - 23.1%
Very enthusiastic

Health Care Opinions
1) It is the right of every person in Canada to receive public health care.
   Strongly agree - 96.2%
   Somewhat agree - 0%
   Somewhat disagree - 3.8%
   Strongly disagree - 0%
   Not sure - 0%

2) The health-care system is a national treasure
   Strongly agree - 76.9%
   Somewhat agree - 19.2%
   Somewhat disagree - 0%
   Strongly disagree - 3.8%
   Not sure - 0%

3) Overall, the health-care system is financially sustainable.
   Strongly agree - 23.1%
   Somewhat agree - 46.2%
   Somewhat disagree - 19.2%
   Strongly disagree - 7.7%
   Not sure - 3.8%

4) Overall, the health-care system is financially sustainable.
   Strongly agree - 11.5%
   Somewhat agree - 15.4%
   Somewhat disagree - 23.1%
   Strongly disagree - 46.2%
   Not sure - 3.8%

5) If someone doesn’t want to wait for health-care services, they should be able to jump the queue.
   Strongly agree - 15.4%
   Somewhat agree - 19.2%
   Somewhat disagree - 15.4%
   Strongly disagree - 42.3%
   Not sure - 7.7%

6) People who have bad health habits (e.g. smokers) do not deserve the same level of health care as everyone else.
   Strongly agree - 26.9%
   Somewhat agree - 46.2%
   Somewhat disagree - 19.2%
   Strongly disagree - 7.7%
   Not sure - 0%

7) The health-care system is not ready for the demands of the aging population.
   Strongly agree - 3.8%
   Somewhat agree - 46.2%
   Somewhat disagree - 34.6%
   Strongly disagree - 15.4%
   Not sure - 0%

Health Care Satisfaction
1) On the whole, how would you rate your own health?
   Very satisfied - 19.2%
   Fairly satisfied - 65.4%
   Not very satisfied - 15.4%
   Not satisfied at all - 0%
2) On the whole, how satisfied are you with the health-care system?
Very satisfied - 61.5%
Fairly satisfied - 26.9%
Not very satisfied - 7.7%
Not satisfied at all - 3.8%

3) On the whole, how satisfied are you with the health care that you or a loved one has received from the health-care system?
Very satisfied - 23.1%
Fairly satisfied - 57.7%
Not very satisfied - 15.4%
Not satisfied at all - 3.8%

People versus Government
1) On the same scale, where 1 means very unintelligent and 10 means very intelligent, where would you place:

People in general
1 - 0%
2 - 0%
3 - 0%
4 - 8%
5 - 16%
6 - 28%
7 - 36%
8 - 8%
9 - 4%
10 - 0%

People in government
1 - 0%
2 - 0%
3 - 8%
4 - 0%
5 - 16%
6 - 28%
7 - 24%
8 - 16%
9 - 8%
10 - 0%

2) On the same scale, where 1 means very uninformed and 10 means very informed, where would you place:

People in general
1 - 0%
2 - 8%
3 - 4%
4 - 12%
5 - 32%
6 - 36%
7 - 8%
8 - 0%
9 - 0%
10 - 0%

People in government
1 - 0%
2 - 0%
3 - 8%
4 - 0%
5 - 16%
6 - 28%
7 - 24%
8 - 16%
9 - 8%
10 - 0%

3) Circle the statement that best reflects your viewpoint.
It is up to experts to make decisions about the health-care system because they are better informed about the issues - 17.4%
It should be the citizens who decide what the most important issues are in the health care system because they know what is best for them - 56.5%
Combination of both - 26.1%
**LHIN Knowledge**

1) Approximately what percentage of the current provincial budget is used to fund Ontario’s health-care system?
   - 15% - 0%
   - 25% - 0%
   - 35% - 4.8%
   - 40% - 9.5%
   - 45% - 42.9%
   - 55% - 23.8%
   - 65% - 19.0%
   - 75% - 0.0%

2) What type of organization is the LHIN?
   - Private - 0%
   - Charity - 0%
   - Public, not for profit - 35%
   - Ministry of Health - 60%
   - Crown Corporation - 5%

3) The South East LHIN is responsible for providing health care to 480,000 area residents. Approximately what is the LHIN’s annual budget for delivering health-care services to this region?
   - $250 million - 0%
   - $550 million - 15%
   - $870 million - 80%
   - $1.15 billion - 5%

4) The following is a list of responsibilities in the health-care system. Please circle the ones that apply to the LHIN.
   - Researching a cure for ovarian cancer - 4.8%
   - Paying for independent physicians - 4.8%
   - Approving hospital budgets - 66.7%
   - Funding community health centres - 76.2%
   - Delivering 24-hr emergency services - 28.6%
   - Integrating health services to ensure efficiency - 90.5%
   - Providing bandages to every household in the region - 4.8%

Engaging the community and stakeholders about our health system - 85.7%
5. Community Open House

Introduction

For six weeks in April and May 2009, representatives from the South East LHIN held 21 community open houses across the region, with 368 people attending. There was an event in each of the sub-LHIN geographical planning areas, as well as additional evening sessions in Kingston and Belleville; three other evening sessions were held jointly with the Ontario Medical Association for physicians and a French language session was held in Kingston.

The open house events were arranged to maximize opportunities to hear directly from the public, front-line health-care providers and municipal representatives. (See Figure 5 for a breakdown of attendance) Open house attendees were welcomed at the event and provided with the five question survey. They were invited to view displays depicting utilization information, as well as results from the ENGAGE 2009 Providers’ Workshop and recommendations from the Citizens’ panel.

Directors from the LHIN Board and senior management team members were on hand to explain the information and to answer questions. In addition to the opportunity to speak directly to senior representatives of the LHIN and to complete the survey, attendees were encouraged to record their thoughts with LHIN staff members.

To advertise the open houses, the LHIN undertook a significant earned media campaign. Public service announcements in traditional print and television media, as well as online postings at media, municipalities, chambers of commerce, in social media (Twitter) and other calendars of events. Health service providers were asked to help promote the events, invitations were issued to municipal leaders, labour councils and Aboriginal and Métis Nation of Ontario representatives.

Participants whose names are published in this report consented to doing so. For the purpose of this report, the South East LHIN has categorized responses from the public by overarching themes. The themes are:

- Aboriginal & Métis Nation Health Care
- Access (General)
- Acquired Brain Injury
- Addictions
- Administration
- Communication
- Community Care
- Community Services
- Diabetes/Chronic Disease Management
- e-health
- Emergency Department
- End of Life Care
- Governance
- Hospitals
- Housing
- Human Resources
- Integration
- LHINs
- Long-Term Care
- Mental Health
- Physician Engagement
- Poverty
- Prevention
- Primary Care
- Seniors’ Services
- Transportation
### Figure 5: Community Open House Attendance By Location with Attendance Breakdown

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### Public commentary

**Aboriginal & Métis Nation Health Care**

- There are many issues around trauma: intergenerational problems related to residential schools; depression; bipolar/schizophrenia; and substance abuse. Many clients have been incarcerated and [the Katarokwi Native Friendship Centre assists them with reintegrating in the community. Poverty, violence, housing and transportation to access programs are huge issues. Many clients are not within city limits. One vehicle is available but limited in what it can offer.

- There are not enough mental health services. The biggest barrier – is a lack of diagnosis. Services are not provided without a formal diagnosis. With the transient nature of population, it is difficult to formalize the diagnosis. Often the point of access is through crisis as there are not a lot of resources to access.

  - *Eartha, Katarokwi Native Friendship Centre, Kingston*

“The major concerns I have would be addressing Métis needs in the area by sharing knowledge about the culture (including medicines, etcetera.) The time spent waiting in the emergency department is long for many people – and here the department it is more like a walk-in clinic than an emergency department. The waiting list for subsidized long-term care facilities is long and there is a real lack of physicians. The Métis population covers a large area. If you are located in one LHIN and go to another for a doctor visit, there may be confusion and a lack of understanding because LHINs operate differently. Typically, patients in the North Hastings area would travel to Barry’s Bay for mammograms and bone density tests; they will go to Peterborough for heart specialists; cancer services in Ottawa. If the person has to go outside of the LHIN – it may make more sense to have the visit by teleconference.
or videoconference. If more specialists could come to this area to serve the people, that would be very positive.

It is also important to recognize the holistic approach to care. The mental, physical, spiritual, emotional aspects of the person need to be looked at as opposed to the physical disease or illness. You need to look into the issues that have caused the problem. The LHIN should look at healing lodges, medicine pouches.

My program has moved to Bancroft and is now looking at getting the entire family involved to support the person. It is difficult to do that because youth are moving away. Who will know what kind of impact that will have on our future?

The population of this area is becoming older. We are a tourist area and more people are moving to the area. They are changing cottages into full-time residences. There are a lot of people from Toronto, Oshawa, and etcetera. The cost of living is going up and there will be more of a demand on our youth, agencies to provide services.

The Métis population have connection Love Sick Lake (Peterborough), Algonquins (Golden Lake) and Tyendinaga. There are a lot of Métis who are not on reserves.

The Community Action Program has a gathering for children -- seniors will go there, to let seniors know there is a connection. The Aboriginal Healing and Wellness strategy does teaching. Last week they did rattle making and talked about culture during the session. There was a lot of laughing, caring and sharing. When you get people together, you can talk about diabetes management, etc. You can talk about what is happening. There is a lot of sharing among our people.

The sash (worn in the Louis Riel day) is now worn as a symbol - each colour has a meaning. You can look at the colours in different ways. We want to be getting people to talk in the whole picture as opposed to one specific ailment/situation.

- Judy Simpson, Métis Nation of Ontario, North Hastings

Access (General)

“...”

The most important thing for me is that health care is not caught in a political battle. When you go for care anywhere, people are talking about the mess the health-care system is in. This needs to be addressed by the leaders. A public relations plan needs to be put in place to make health care a much more pleasant thing.

Some of the workers are being treated very poorly as cutbacks are occurring. This then falls back onto the patient. Access to care is another issue. In Manitoba, I would have to go four hours to get treatment, and there was no compensation for travel. Compared to that, this is a treat here. But still I am looking at the fact that I’m aging and I have a chronic disease. When I need to get to the hospital, it’s a half hour to get there, and a 2-3 hour wait. There seems to be chaos rather than smooth streamlined service. It’s not a money issue, it’s not staff retention. The issue is the anger and emotion involved here. This area has a plethora of services and professionals, so why are we in such a mess?

Maybe our regionalization isn’t working right yet. Not everyone has come together as a whole, and they are instead working separately in their own little areas.

The governance model of our LHIN is disconnected. It’s set up to not work. The people are left powerless, the LHIN can run as a governance model and boards of health service providers can’t run as a governance model. The health service provider boards have been left in place. Was this really the best choice?

I believe that the quality of care starts at the top. There is a disconnect from the top to the bottom in our system, which is why our care suffers. We have the best skilled people in all of Canada, yet they are the most worn out. We need some wise individuals to get in here and fix the mess. Also, why are public health teams and family health groups not under the LHIN? It is nonsensical from a patient perspective.”

- Dorothy Connolly, Public, Quinte West & Brighton

“The patient has to be their own advocate. If someone doesn’t know how to navigate the system, they are in trouble. For this reason, education is also important as well.”

- Anonymous, Public, Prince Edward County

“I work for Canadian Paraplegic Association of Ontario, funded by MOHLC. I have noticed that the northwestern portion of the South East LHIN (Bancroft) has been behind in accessing services, perhaps because many referrals are coming out of Haliburton. We are based in Kingston and serve entire region. We need to determine what services are needed, what is available and where. The starting ground would be an overall assessment of what is available and proximity within the LHIN. I am doing a lot of that legwork. It would be nice to have it done.”

- Anonymous, Front-line health provider, Gananoque

“I am a resident of Alberta who returned home to care for my mother. I have now been in Ontario for three years and have blue coverage, but am unable to locate a doctor. I should be able to access a doctor within the area. I was not aware of that...”

ENGAGE 2009: A qualitative analysis for IHSP2

South East LHIN
physicians are available here. I thought there was a barrier that you couldn’t have a doctor here in Ontario and Alberta. I went to see a doctor here and they thought it was a one-time only visit. I was very clear with my issues, and that I needed a procedure but I was sent home with no referral. No treatment, no care. I then went to the Delta travelling clinic to have my blood pressure checked, but was advised to go to Kingston. Because I don’t have an OHIP card, I received no service.”

- Mary Courneya, Public, Rideau Lakes

“Because people are aging doesn’t mean they are unhealthy. Many take advantage of opportunities for volunteering and getting involved in their own health. There needs to be a focus on health promotion and prenatal education. I think juvenile diabetes is going to suck up our dollars. End of life care is also on the increase, but we do have to be careful. A lot of seniors have buying power for resources and services. This may be the first generation of kids who won’t outlive their parents. We should have more things like healthy gardens. Seniors could show younger people how to grow healthier foods and live better.”

- Anonymous, Front-line care provider, Gananoque

“From the stroke survivor’s perspective, one of the major concerns is access to rehabilitation services to cover many different types of stroke patients in our region. We have inpatients in acute care, rehab patients in rehab beds, outpatient rehab services, community care access centre services within client’s homes and long-term care services. Anywhere (the stroke program) goes there is concern that there are not enough services for stroke survivors. More services are required. It is a big thing - it would have a big difference to their (stroke patient) outcomes. Research and studies show (done in South East region) that those who have accessed rehabilitation services resulted in half the readmission back into the acute care hospitals. There are two aspects that could change this: how we are funding care provided and a human resource shortage within rehabilitation in the community. Specifically, we have a lack of rehab day hospitals. We have none. There is nothing to service our clients. We need an intensive outpatient rehabilitation program available to our region. St. Mary’s-Of-the-Lake geriatric services the frail elderly; however we are not servicing or provide services to the younger stroke and (acquired brain injury) population. This results in increased length of inpatient stays in Kingston versus Perth/Belleville where rehab day hospitals exist. We need to think about rehab as part of primary care. Family health teams don’t think about having PT/OT within the primary care setting.

I also have two major concerns – the first is system navigation for community reintegration for stroke survivor and their family. Individuals are not connect to services, if at all the information is received too late after their stroke, they are not linked to community support and/or community support services. There is also a lack of awareness or disconnect in communication on discharge and through primary care physicians/team. Stroke survivors find out about services through word of mouth not through the health-care system.

We need a better understanding on integration and what it means, especially in acute settings. Ted Ball wrote a paper about collaborating across the health-care spectrum. We need to collaborate around the health-care system - the full spectrum. We need to move forward. The acute care system is increasingly overloaded; we need to focus on prevention, health promotion and community reintegration. We need a designated team that has a vision on community integration. The stroke program has been working with this vision for 10 years but it is difficult when you are working within a system that doesn’t work that way.”

- Cally Martin, Front-line health provider, Kingston

“Chronic disease management – there are similar ways to look at each of them even though they are different (stroke, dementia, arthritis and osteoporosis and chronic depression). We can manage them similarly with education and support. We also need to find ways to educate people about how to navigate the health-care system. Seniors need an advocate to help them navigate the system as their illness is often long term.”

- Anne Belanger, Front-line health provider, Kingston

“Dental care is not covered; eye testing has only partially covered. It is difficult for seniors to have to pay extra for testing. Not many people around here work for organizations with (medical) insurance coverage. We used to have a lady here who provided foot care, but it is no longer available. Country Roads offers many specialty services, but you have to be on their roster. I’ve gone to a doctor in Newboro for years, so I can’t use services at Country Roads. Some drugs are really expensive too. My father takes one for Alzheimer’s; it is not covered and costs $100/month. We are fortunate in terms of transportation, but it is a major concern out here for some folks to get to appointments, etc.”

- Anonymous, Public, Rideau Lakes
“I am here on behalf of Rainbow Health Ontario. I think the major areas where we, as a community, fall short is in the discrimination that sexual and gender minorities face. Research shows elevated rates of several conditions in the gender and sexual minority groups such as depression and suicide. Gay men at are higher risk of some cancers, increased smoking rates, greater social isolation, mental health and addictions issues, etc. Awareness is key to mediating this.

Part of the problem is that health-care providers know little to nothing about this population, so patients are often in charge of passing on information surrounding their conditions to health service providers. There is a need for health-care providers to develop more cultural awareness. There is also a need for more services to be performed locally, but I recognize that this may not be possible for all services as the critical mass may not be present. For this reason, it is vital that doctors and health-care planners work towards addressing the health disparities of the lesbian/gay/bisexual and transgendered population, get education on the radar early.”

- Calvin Neufeld, Public, Kingston

“We are lacking education. People don’t know enough to understand where to go for services, and how to handle some minor ailments rather than just running to the doctor or emergency department.

We, as a society, don’t have common sense anymore. People are not utilizing services properly. Walk-in clinics are a wonderful way to provide services to the public. However, today the set-up of walk-in clinics is not the same (e.g., you have to be a registered patient of that practice to visit them). These clinics do help to alleviate a lot of the pressures.

There is still a gap in the at-home services provided. There needs to be attention to perhaps some additional or expanded programs (e.g., for groceries) to help the emergency room pressures. We need to re-examine the quality of care within certain organizations. Why are we wasting money on resources that are not being utilized?

Work ethic today is not what it used to be. Work ethic and patient care have deteriorated. The SMILE program is wonderful. I’ve seen a huge change in patient care with this.”

- Marilyn Stewart, Front-line care provider, Greater Napanee & Tyendinaga

“We need a diagnostic imaging service in Napanee. Lab work is good and family physicians are very accessible during office hours on weekdays.”

- Lois Thomlison, Public, Greater Napanee & Tyendinaga

“There is a need to support families with an individual living with developmental disabilities, and formulate a way for these people to better access specialized care. I think the strength of a community comes from the ability to care for its most vulnerable citizens. It seems children (who fall into this vulnerable group) are well serviced in this region, and so I look at palliative care patients, seniors, and other people with similar health care concerns and goals, to promote the best quality of life possible.

I can’t stress enough how I think it is important that co-morbidities that come with developmental disability are brushed under the carpet. We’ve decentralized health care in regards to these conditions. Family doctors who don’t have experience dealing with these types of patients are now taking care of them. We need more specialist care for them.

Also, for this group of individuals, transportation is a blockage. The transportation issue is significant. If it was more streamlined and a more coordinated effort, positive results could be seen. Further, family doctors need to be aware of the services available; this is a priority. Also, asthma is rising; what is the root cause? I’m a firm believer that prevention is a key tool. Many things can be managed or prevented. Another concern is that no stats for depression are displayed at this event. This is odd since I feel that mental health is stressed in this region. So that’s a concern. We should encourage partnerships; this doesn’t seem to be at the front of priorities. Community Health Centres are great in terms of a holistic approach, there many different types of caregivers (psychiatrist, family doctors, etc.) at these facilities. Being as responsive and flexible as possible is key...Partnerships! Let’s break down the silos.”

- Holly White, Front-line care provider, Kingston

Acquired Brain Injury (ABI)

- There is a lack of appropriate long-term care for clients with ABI --especially those with moderate to severe impairment. There is an inappropriate use of long-term care for ABI clients instead of supportive housing. Clients can be managed effectively with the right support and more efficiently versus being in long-term care.

- Neil, Front-line care provider, Kingston
"We are lacking a provincial strategy for ABI, as well as a regional strategy. I say that because there are inconsistencies with resource allocation. It doesn’t seem that resource allocation is done in consultation with all the providers; it’s done in a more siloed way (resources = mostly financial resources). We get some funding from automobile insurance or WSIB, but most of it comes from the LHIN. It puzzles me how there’s a day program at my organization that receives funding of XX, and a similar day program at Pathways gets XX. There was no consultation in this process; we just received a letter in the mail informing us what we would receive. There needs to be more equity. Other providers are getting more money for enhancements and I’m not sure how those decisions are made. I would like more transparency from the LHIN in terms of how they allocate funding. The data may support the current regional distribution of funds, but I would just like to hear about that supporting data and have it available.

As long as there is supporting data and also some sort of consultation, that would be satisfactory. There’s a growing need for long-term care residential support for adults with brain injuries, and I believe this calls for more finances. Many adults living with brain injuries live at home with their frail parents; when those parents die there will be some crisis. I want to see these types of adults in their own apartments, with staff trained in the area of ABI. We need to grow and enhance the ABI that we currently have in place. This would be made possible if there were more resources available for these kinds of services. The lack of a strategy is bothersome; I don’t know where the regional or provincial strategy is at. Overall, there needs to be 1) a clear and direct strategy, 2) more equitable funding allocation, 3) more housing supports for adults with ABI."

Dawn Downey, Front-line care provider, Kingston

"Our addictions program is in Smiths Falls. How do you get individuals to the services? They should be in an office within the school system. Perhaps if it was led by a nurse practitioner it would be a better model and we need to be supportive of those with addiction. How does a teen get there without their parent knowing?"

- Catherine Ryan, Front-line care provider, Rideau Lakes

"When people present (to the emergency department) with an addiction problem, they are often treated poorly as if they are author of their own misfortune and we should treat people who had an accident first and let these people wait in a lobby, etc., especially if they are young people. They are also treated disrespectfully for example, if they have an injury while intoxicated, etc."

- Chris Sullivan, Front-line care provider, Kingston
“A comprehensive approach with the hospitals does not exist on a regular basis. We need to change the way hospital emergency departments look at addictions. When a patient needs to go to detox from the hospital, the facility is one hour away and transportation is not available. This is a huge issue for this type of patient. There also is a lack of recognition of addictions agencies. Patients do not have enough financial support. Patients lose all their money because of their addiction and they need to have financial support to get the necessary medicine or other needs.”
- Carol Cecchini, Front-line care provider, Brockville

“Addictions assessments need to happen immediately. When the person is ready, they need care. Also, when a person is released following treatments, they are prone to relapse. That is why it is important they have an agency or group (e.g., AA) to fall back on, they would find help there because the people who sent them for assessments may not be the people they come back to.”
- Caroly Gilchrist, Front-line care provider, Smiths Falls, Perth & Lanark

“I worked for an addictions agency and I think it is difficult to be connected to the larger mental health facilities. The policies in all the agencies are different and this is a barrier to connect all the agencies in this field.”
- Carol Cecchini, Front-line care provider, Brockville

Alternate Level of Care

“I have an elderly mother, who is almost 95 and lives on her own. Because of long waiting lists, she could end up in a far away home deprived of family visits, which is a concern. I have a daughter working in a long-term care home, and she says things get plugged up in the hospitals, regarding patients that are not well enough to go home, but there’s no where to place them. The system seems wonky in that my mother was going to put her name on the list for a home, despite the fact that she’s fine at the moment, but what happens down the road? Will there be a spot when she needs it? What happens if she gets injured?

There’s no smooth transition from an injury occurrence to ending up in a location where you can be cared for. At the moment, my mother has someone who comes and gives her meals at home and also does some cleaning for her. Overall, if there are more funds available in the health-care system, I would like to see that money goes to transitional beds. These beds will help individuals find and appropriate place to receive care.

There needs to be a major overhaul in terms of admissions to nursing homes. There needs to be a better process. The process right now is ridiculous, when your name comes up you must go to the home even if you feel fine, and yet there are others who are truly in need and can’t be admitted due to the wait list. The hospitals are being jammed with people who can be elsewhere. The idea of one big waiting list is troublesome.

I don’t know if we need more nursing home beds, but the problem seems to be in admittance procedures. There are many sad stories we hear about people going into long-term care, for example, you hear about couples getting split up in different homes. The nursing homes themselves are fine. We just need to make sure people in the home really need to be there, and that other people who need to get in can. Another point, we would like to have some choice as to where my mother goes. We don’t want her to end up at a far away place, and be away from what’s familiar. Process process process.”
- Gesina Laird-Buchanan, Public, Kingston

“ʼMy comments are about Quinte Health Care. We should have an alternate level of care unit in the new wing in Trenton. Staff it properly. It could be hired out or maybe run as a whole separate entity by a long-term care group. We need the alternate level of care beds so desperately. We really need to activate and use all those beds. To me, it doesn’t look like they are used properly.”
Patricia Lytle, Public, Belleville

Administration

“LHIN and Quinte Health Care are two very expensive layers of administration. How much money is getting lost in the transfer of funds? Administration is very expensive and sometimes it is unjustified. I am very concerned about Scott Rowand’s report. I went to two or three meetings, but didn’t understand a word he said. He seems to know his stuff, but the public could not understand. I like this hospital (Prince Edward County Memorial Hospital) – and I hate to see cuts. You never know what is justified. We don’t see figures as to what the governance is costing us. How are these costs being spread and why can’t we be on our own? I understand not all hospitals can have everything but I can’t understand why this hospital can’t operate on its own with proper management.”
- Anonymous, Public, Prince Edward County
“Supports are required to keep clients in retirement homes. Nurse practitioner-led teams are a good resource to assist in management of client in home/retirement setting and keep the client out of long-term care.”
Allen Prowse, Front-line care provider, Kingston

“For Trenton hospital, possibly Picton as well, a lot of the community seems to feel that seniors need a hospital bed for treatment. In fact, much of the acute care is specialty medicine. Thus, Trenton should become a state-of-the-art geriatric assessment and prevention site with some longer-term care for alternate level of care patients. It also needs to have space for people to recuperate - something to ensure that following acute care they can optimize independence either through outpatient or short-term inpatient. Trenton already has state-of-the-art diagnostic equipment for diagnosis and prevention. It can work with a family health team approach plus specialty clinical visits from Kingston General Hospital etc. Keep ophthalmology and other diagnostic services and day surgery. Other beds could continue to be used for alternate level of care, nursing home, supportive housing or retirement home (old A or B wing; similar to Campbellford). We may need to supplement ambulance service to minimize fear of wait time to get to Quinte Health Care or Kingston General Hospital. Rent for retirement homes should be geared to income similar to that in long-term care facilities.”
- Anonymous, Front-line care provider, Quinte West & Brighton

“I am concerned that the LHIN’s/Ministry personnel are more focused on the hospitals rather than the long-term care homes. Specifically, I am aware that there are seniors being housed in the hospitals that could receive better and more cost efficient care at a lodge or long-term care home. The solution I am suggesting is to expand the number of long-term care beds to relieve the pressures in the hospitals. I am a member of the board of the St. Lawrence Lodge.”
Ray Young, Public, South East Leeds & Grenville

“We need to better educate front-line providers and discharge planners to the services of retirement homes as an alternative to long-term care. A person goes into hospital, they have an acute situation happening and due to the fact it is a hospital, they look after the acute need, but only have a small window of this individual. They often are delirious, disengaged from reality, their mobility decreases, nutritional needs are not met (don’t feel like eating). They are labeled alternate level of care when in fact the person before acute scenario is likely managing very well. They want to send them onto long-term care and shorter hospital stays is part of the problem. Hospitals need to look at the individual and see if this person has the ability of getting back to where they were. Sending home with limited home care isn’t always the best solution.”
- Clare McCartney, Front-line care provider, Rideau Lakes

“There needs to be more integration and cooperation. Sometimes finances are a problem. If a person is looking at convalescence and they have a home to pay for, they may not have disposable income to be able to afford a lower priced retirement home. If there was some form of short-term subsidy that could be used to even find out what happens with these people. Give them a month. If they get better, can go home, maybe stay at retirement home. To the next level -- can’t go home, but income is still limited, is there some form of subsidy to allow them to stay in a supportive housing environment (not a hotel)? That would alleviate a lot of pressure. A lot of these people need monitoring - they take meds, eat, are directed to have care needs and have people around.”
- Clare McCartney, Front-line care provider, Rideau Lakes

“A major problem in this area is getting alternate level of care patients out of the hospital. The lack of long-term care beds is also a problem, but I’m pleased we have some new beds opening in Tweed.
What we need is an alternate placement for some people, maybe not a long-term care home, but maybe a step up, such as assisted care. Assisted living consisting of two hours a day is not enough; it has to be something that gives the family a break.
The South East Community Care Access Centre has been so helpful; they do what they can with the services and people they are allotted; the bonds they form with clients are excellent.
Having a community health centre in Tweed is excellent; their integrated approach is preventative rather than looking at current issues only. They also ensure the inclusion of marginalized populations. They do however need more dollars, so they can expand (both capital and operating) and get more doctors in. It is key for the community health centre and new long-term care home to work together, and we need new doctors.”
- Jo-Anne Reeve, Public, Central Hastings
Communication

“IT is not possible to handle illness by yourself - you often need an advocate to help navigate the system.”

- Helen Kelly, Public, Belleville

“Consultations will have a positive effect for the integrated health services plan and the local health-care system.”

- Carol Cecchini, Front-line care provider, Brockville

“Communication to the general public about the South East LHIN role is lacking. You need to communicate that there are limited funds and that we have to be responsible for the community’s tax dollars. Balanced budgets are required. We need to impart to the public how the LHIN works and why they are here. Health care is important to the public and we need to ensure they understand what the LHIN is doing and why they are doing it. Hospital boards need to be informed / educated as to how their plans need to be worked in to the over all plan for the region. We need to have direction from the LHIN on the expectations of the hospitals. Quinte Health Care needs more direction from the LHIN on how to meet these expectations and still satisfy their community with providing quality health care.”

- John Williams, Mayor, Quinte West

“Communication and understanding of the services available... all the challenges is the main concern.”

- Pat Dobb, Front-line care provider, Central Hastings

“Education to the general public about palliative care is a concern. It can’t just be individualized organizations promoting education on this issue, because for most people, it is a delicate subject. Thus education needs to come from a greater source, with more clout. There needs to be education both regionally, and outwards. Regionally we should be working together with the community support agencies. People’s perception is that they don’t need our (Hospice Kingston) hospice services, or they feel our services should only be there at the final stage of life. This means we get a referral at the final stage, and by the time we go in to do assessment, the patient has either died or gone to hospital. Perceptions surrounding the importance of palliative care need to change. We as an organization want to be there early in the care process to provide support. When people think of palliative care, it shouldn’t be a topic people discuss only after family is burnt out.”

- Natasha Girard, Front-line care provider, Kingston

“We need to provide information for the public to access about health services required and prevention. We are lucky because we have two family health clinics. Education is important so people are aware of what is available to them. I know because I seek things. There are some people who have no idea they could avail themselves of certain services. Education and outreach.”

- Mabel McLellan, Front-line care provider, North Hastings

“We need to be more creative with who we blend our services with. A lot of groups have the same concerns. For example, accessibility is a problem across a lot of groups. There should be a paradigm shift to create an optimal care system so we don’t see any redundancy. We (the organization I work at) know family doctors are busy, so we’re being as direct as we can with how we communicate with people. It’s about awareness and connections. There are a lot of partnerships out there we just need to find them. A "prevention clearing house" possibly on the web to provide information on the different types of services, research, etc specific to this region would be valuable. OPCH, Ontario Prevention Clearing House, they already have this type of system; we need one tailored to this region. Back to prevention, if we’re aware of what to look for, it can reduce the load on the rest of the health system. Information makes all the difference, enhancing information flow makes all the differences.”

- Holly White, Front-line health provider, Kingston

“Navigation of the system is a concern -- the general public doesn’t understand health teams. I’ve taken it upon myself by being involved, advertising what we do, etc. The province, once it knows what their health teams are doing, they should put it out there. Then you know -- physicians who have not joined family health teams - why can’t you offer those things, and why can’t we access collaborative health care? There are also issues with navigation of mental health -- I’m so confused. I don’t know where to turn if I have to help someone find who they need to call. Also navigation problems with the access centre. They act like they don’t want to help you -- if a client phones and asks for transportation they aren’t clearly told here are your options. They need to keep in mind these people are often suffering from dementia, cognitive ability.”

- Anonymous, Front-line care provider, Brockville
“Communication is one of the biggest things. The big concern I have is that people don’t know the difference between health unit, health-care resources and what is available for people. Often people who need these services are seniors, single moms on social assistance who may get not necessarily be educated and understand what is available. I know when I call and get voicemail, it is frustrating. If you are in crisis you don’t want voicemail. We need to get the information in a format that is accessible. I don’t believe in hand outs. We need to get the information to a point and make it easy for people to help themselves and differentiate the different levels of what health care means to the different residents of Prescott. The LHIN needs to communicate more about what it is doing. Consider a listing of what is available.”

Suzanne Dodge, Mayor, Town of Prescott

“We need better communication between family doctors and specialists. There is a perception that some sites have long wait lists but maybe they have perceptions about us. We need the LHIN to facilitate talks to get key folks from each of the groups to attend.”

- Anonymous, Front-line care provider, Belleville

- We need to begin prioritizing - MRI and CT, does everyone need both? More and more people are coming in and demanding services. How do decide what is a reasonable? The potential benefit for new technology gets smaller and smaller.

- Anonymous, Front-line care provider, Belleville

“Regarding the SMILE program: I am commenting as part of geriatric mental health community outreach team in Lanark Leeds & Grenville. It is great to have a program like this, we certainly miss it in the north part (Champlain LHIN), looking for something like this. Nice you can adapt to local needs -- neighbour, etc. not just restricted to personal support worker, etc. When we first found out about it, we thought we would be one of the teams that would pair well with the program. I found out about it from a caregiver. The initial communication was confusing. We need some clear communication about some of the more specific details. I am an occupational therapist; I want to know what the criteria are so I can talk to people about it.”

- Kim Schryburt-Brown, Front-line care provider, Smiths Falls, Perth & Lanark

“Mobility Care provides custom wheelchairs. In February, a memo went from the access centre to long-term care facilities saying they would no longer fund mobility assessments in South East LHIN for patients in long-term care. The important words are mobility assessments. They do fund occupational therapy for other things such as feeding issues. If an individual in long-term care needs a wheelchair, they need to pay out of own pocket for OT to do assessment or in some cases the LTC facility has a private arrangement with a therapist. My question - is it not the edict that everyone has equal access to services? Someone in LTC in the South East would have to fork out $300-400 for an assessment, while someone in Champlain has it paid for. There was to be effective communication, but there was not. Some contracted providers to the access centre had no advance notification of that change, no opportunity to tell their therapists.”

- Anonymous, Front-line care provider, Smiths Falls, Perth & Lanark

“There is no handover from the hospital to the access centre to say go in to talk to this person who just had surgery.”

- Anonymous, Public, Smiths Falls, Perth & Lanark

“SMILE and EASIER+ create a need for more resources for community support sector. We are worried that we aren’t getting our biggest bang for the buck. Need more case managers and advocacy for the clients. Servicing a need but the group is very frail and they will slide through the cracks if we don’t provide more resource and support. They need the people to navigate the system for the frail elderly, not necessary more services, but follow their care.”

Anne Belanger, Front-line care provider, Kingston

“Need solutions for elderly care - referral service. I am frustrated with lack of services for my family, therefore I created my own consulting business. There is missing case management and ethics of caring for our elderly, case coordination, support within the home.

What is the role of community care access centre in regard to case management? I understand the mandate of CCAC; however, they are not meeting their mandate given inconsistency in providing care and service to community members. Case managers are not fulfilling their role. My family needed coordination of care, transportation, respite service, geriatric assessors.”

Kim Schryburt-Brown, Front-line care provider, Smiths Falls, Perth & Lanark
The access centre declined providing services as it was not their role to coordinate -- just to provide information. The access centre doesn’t recognize the stressors that the family was experiencing. It is during times of family crisis that CCAC should be engaged not pushing them away.”
- Anonymous, Public, Brockville

“Because of confidentiality - everything is so tightlipped. Families can’t gather information in order to assist the patient in decisions, care treatment and clarification of the information that was exchanged between patient and physician. Also, the timeframe from diagnosis until treatment is very long. The linkage is missing, poor working relationships therefore leaving the patient and family at a loss. Phone tag is horrible, ethnicity is a major issue. Insurance company won’t release information because of privacy act, however if the patient is deaf or mute, the information is not being shared and exchanged. Hospitals are not sharing information. How do we educate staff to care for these individuals how do we share our information? How can we share health care and education records?”
- Catherine Ryan, Front-line care provider, Smiths Falls, Perth & Lanark

Community Care

“Currently, working in homes (as volunteer) I see a lot of support (nursing and personal) given to palliative patients. I think housekeeping should be back in. Personal support workers have some time to kill after they are done providing care (now they may) spend it chatting, while there is some housework that could be done. It would make the client feel better as well. Patient has a lot of service coming in, but she doesn’t like there is not a set out time frame. She has to sit by the phone to see when they are coming every day. I realize they get caught, but if patients are given an idea of when services may be there, it would be better. The care, however, is great.”
- Patricia Lytle, Public, Belleville

- I experienced a lack of follow-up after discharge from hospital after an extended hospital stay (seven weeks). I felt very much like I had been ‘dumped’ at my house and largely was bedridden. No one called or came to check on me which concerned me especially given I had no close relatives nearby. Had to rely on church member for social contact and then to lend assistance. I ended up ‘hiring’ her for light housekeeping, transportation - was perfect for my situation.
- Elizabeth Newton, Public, South East Leeds & Grenville

“Improving home care will go a long way to reducing emergency room congestion.”
- R Viola, Front-line care provider, Kingston

“Home support for the frail elderly is a must. If they can stay longer in their homes, the better. I have been through this in my 20s when I looked after both of my grandparents. I have been through the system. It is getting better, but it could be better.”
- Anders Carson, Municipal representative, Rideau Lakes

“We had home care for my mother. Some of the workers needed to be updated and they didn’t know how to bathe a dialysis person. She’d experienced infection a few times so I had to show them where to put saran wrap, etc. to ensure water doesn’t get into the port. If you go to a client who is on dialysis, you should know how to bathe them.”
- Mary MacKinnon, Public, Rideau Lakes

“I have concerns about continuity of care between the Community Care Access Centre’s school health program and child treatment centres as areas of expertise of some of the therapists providing service. In many cases, it would be more cost effective and more efficient overall for the treatment centre staff to provide the service in schools for the individuals who they also provide home service for. The child treatment centre is not permitted to provide services in the school, consequently, as a child starts school, a therapist has to start over again compared to the child treatment centre therapist who would already be totally familiar with the child and it would be a seamless transition.”
- Margo Russell-Bird, Front-line care provider, Belleville

“The new Home at Last program sounds good -- but it is not here in Bancroft now. How does it help patients we’re trying to get out of hospital? They are alternate level of care. The manager and discharge planner need to have fingertip access to the things available. One of the challenges we have is that I want to work with Community Care Access Centre to have a better flow through. We have barriers that are financially driven and they end up increasing length of stay. We have CCAC in the hospital...
Monday, Wednesday, Friday. They have a community load when they are there, and are only there a short period of time. If it doesn’t get done, you’re delayed in getting your discharges. Soon I’m going to be working with six beds, so it gets even more urgent.”
- Tammy Davis, Front-line care provider, North Hastings

“I am concerned about the care. I work in the community. I am finding there is less care for people in the community, for those who are not getting onto home care. There is a six-month waiting time for community service. Home care agencies don’t have work, they are losing staff. Agencies coming in are not supposed to refuse new clients, but when times are slower, how can you keep your staff? Community nursing agencies are losing staff because there is no work. The Community Care Access Centre is over budget, so they are not taking clients on, so community nursing agencies are losing their staff. It’s very difficult to keep staff.”
- Anonymous, Public, Greater Napanee & Tyendinaga

“I don’t think the access centre amalgamation has been successful at all. There isn’t continuity anymore. The amount of services people get is abysmal. People come out of hospital and they are frail, if they don’t need help with a bath, they get nothing. There is no role for a nurse or personal support worker. They are lost again into the system and come back to the emergency room. If you’re dealing with these people all the time, you see it. I don’t know how to fix it. It scares me for the future.”
- Anonymous, Front-line care provider, Prince Edward County

“There will always be a lack of community nurses. Community nurses have traditionally been underpaid, and something has to be done to attract them. Funding models need to be re-examined to harmonize the wages of nurses. Also, the access centre doesn’t have the proper level of respect for community nurses that they should.”
- Anonymous, Front-line care provider, Greater Napanee & Tyendinaga

“We know there is no more money. You have to make choices. If you could have a knee replacement or home care which would you pick? I would pick home care. That is what I would choose today. I would pick home care if I could have it when I needed it. I had a knee replacement before and I had some one come in to give me a bath, but could not get someone to help with the laundry. So, that means that some people may get a bath and then have to put dirty clothes back on. It doesn’t make sense.”
- Leona Neal, Public, Addington, North & Central Frontenac

“What I am hearing in the community is concern about going into the hospital for day surgery and there being no one to look after them at home. I know someone who went in for a hysterectomy and just had her 16-year old to look after her when she came out. You don’t want to call the hospital after but you may not know what to do, don’t feel well enough to do it. The other problem is home care. There isn’t enough home support for people who are at home and need to be cared for at home. There just isn’t enough home help available. Those who are available are terrific. It can create a huge burden on families. Often it is an elderly spouse and is too much for them. I’m all for less hospital visits, but it would be nice to have more home support available. The other thing I would like to see is more obvious inclusion of alternate therapy such as chiropractors, that sort of thing so people can feel equally comfortable going to chiropractor as physical therapist. Make it clear that alternate therapies are embraced by the LHINs. You want to help with keeping people well, rather than treating them when sick.”
- Anonymous, Front-line care provider, Smiths Falls, Perth & Lanark

“The booklets from access centre need to be updated and include information on the alternative to long-term care homes. We need more cooperation and inclusion of the fact a retirement home is a person’s home. Now with our cost containment efforts, it needs to be really included and attitudes have to change.”
- Clare McCartney, Front-line care provider, Rideau Lakes

Community Services

“The biggest gap to me is there is a perception that health care is all about hospital. There is very little acknowledgement that the community services sector has expertise in health care and the most able to shift and change to meet the changing needs of health care. We don’t have the bureaucracy, etc. The biggest concern I have is there has to be a more balanced approach to health care than just hospitals.”
- David Townsend, Front-line care provider, Kingston & Islands
“Our concern is keeping people out of other health-care institutions. [The LHIN’s] financial support is much appreciated. Make sure people are referred properly when they come out of hospital care. SMILE is creating a lot more clients for us, making our workload heavier. If there could be compensation for that, it would be helpful. For now, we carry on, doing the best we can with the funds we have. People are pleased with what Community Care in South Hastings is doing.”

Leona Hendry, Front-line care provider, Belleville

“I am a nurse and it is getting very frustrating. On paper, it looks as though there is a lot of care available, and this is not true. It’s not available in time, in nurses, and it’s just not present in what organizations like the Community Care Access Centre and LHIN are promoting. People are coming out of the hospital expecting all kinds of services, and it’s just not there for them. If it’s not available, then the services should not be promoted. There is a lack of communication between the LHIN, CCAC and the public. Community nurses are stuck in the middle. Nurses become the scapegoat once people realize the services are not there. I realize organizations need to have a budget, and you can’t spend money you don’t have, but you must provide the services that you state are available. This is a problem in the CCAC specifically.”

Anonymous, Front-line health provider, Greater Napanee & Tyendinaga

“Our community care agency has 10 staff and 800 volunteers. We acknowledge the importance of volunteers in the community agencies. My concern is that volunteers and their involvement are neglected when plans are created. They are an important part of health-care delivery. I wish that this piece would be incorporated in health-care planning. The other piece is to acknowledge that it takes training and funds for someone to coordinate volunteers in those programs. They need to be screened and placed, and I think that this is erratic, there’s no trained support because there isn’t financial support. That is very important since we are dealing with seniors. Our agency does things like Meals on Wheels, and friendly visiting. As people are living longer and staying in homes longer, this is a growing area. We would like to look at funding for these programs.

People are aging and staying healthier and in homes longer, they need us more. Therefore we need more volunteers. In community agencies, is there a structure to support growth? The volunteer management piece is significant. There is a big difference in hospitals and community arenas. The long-term organizational support is higher in hospitals now, as opposed to communities. Volunteers are not getting the support necessary, and it hasn’t really been looked at. The profile of community agencies isn’t as high as hospitals. The piece of looking at how much these agencies do isn’t there... the funding structure may not be adequate.

There is a lack of knowledge by seniors as to what is available. There is a need for education. There is not a good integration surrounding assessments. More communication is needed between all people dealing with seniors. There needs to be more sharing of information. There is a disconnect around the sharing. This is very important because seniors get confused easily, and they don’t need to.”

- Nancy Hanson, Front-line care provider, Belleville

“We have great health care access with the Community Care Access Centre. The seniors can get health care, but it is the other essential activities daily living that are being missed. SMILE is good, however not enough. I think we have a great opportunity with some of this type of help, to keep people out of the hospitals and long-term care. We are also lacking transportation within this area to the health centre. Volunteer drivers are available but limited. We are missing the social aspect such as visiting a dying friend. We have come a long way but we are not there yet in keeping our seniors within their own homes and community. Quality of life has improved for our seniors but we need to keep moving forward.”

- Sue MacLatchie, Public, Rideau Lakes

“There is a huge need for funding in community support services. We still have to fundraise for our budget and it can really hold agencies back. There are inequities within the system and community agencies have to work on that. The SMILE program is wonderful -- helping the frailest frail... it is continuing to change. Too fast to get it up and going before pieces are in place... they are wonderful in administering it, but were forced to move too quickly.”

- Anonymous, Front-line care provider, Gananoque

“There is a lack of overnight respite care, or a bed where the primary care giver can leave their loved one for a weekend while they take a break. There is a need for more facilities, e.g., a physical building, for this kind of thing. This type of service...”
typically goes through the access centre, but if someone can’t afford to pay for that level of respite care, where do they go? There needs to be more funding available to the health service providers to provide care specifically for the purpose of overnight respite care, greater than a 24-hour period. This type of service hasn’t received all of the attention that it needs. There needs to be more research into opportunities as to what we can all do together to make this kind of care available. Different agencies need to start working together to provide this, with the access centre being the underpinning organization to organize this, especially if the patient is already receiving care through them.”
- Natasha Girard, Front-line care provider, Kingston

“How long will the SMILE program be in place? I have families planning on this thinking it will be there forever. The problem is people are counting on it. I would like to see the SMILE program being cut front about it. It is a big chunk of people’s respite -- the meal preparation, etc. I’m really worried about some people counting on it. It’s hard. I’m not sure they anticipated the demand at the first. Assessments are being done over the phone. It is not a good mesh for people with dementia -- not getting in contact with Power of Attorney. How can we work together to get these people the help? I feel qualified to assess that. How can we pass information along? Some of the caregivers are very frustrated. Just talk to us, please. Here we don’t have people with pension plans from companies. Let’s think more flexibly.”
- Kim Schryburt-Brown, Front-line health provider, Smiths Falls, Perth & Lanark

“Fee for service is a deterrent in all of our programs. It is difficult for people to understand when they go to other agencies -- transportation, meals on wheels, Diners Clubs, anything that we have to buy food for... a lot of the other programs are free. We know that sometimes fees are a deterrent. We do our best to subsidize, but there is only so much you can subsidize.”
- Pat Dobb, Front-line health provider, Central Hastings

“CCAC is cutting back on respite, so our services are taking more clients. SMILE was good, now maxed out. There are so many needs out there. We have huge caseloads, we’re not able to do as much work with as many people. We’re more crisis, urgent needs-based as opposed to being proactive. We’ve been in business for 25 years and still have doctors’ offices asking where can we go for Meals on Wheels? It is the education component. I believe providers and agencies need to be educated on providers in their communities. LHINs are closing that gap. This is the first time community support services are being brought to the table.”
- Anonymous, Front-line care provider, Rideau Lakes

“My wife was recently diagnosed with Alzheimer. More investment and support in Alzheimer disease is needed in Brighton. Currently there is not enough support in Brighton: only one health care provider working 17 hours a week is currently supporting the Brighton and outlying areas re the Alzheimer issues (34 people are currently supported by this person in Brighton alone). There is an Alzheimer Society in Belleville but none closer. Brighton is a retirement community; more Alzheimer issues can be expected in the future. Trenton with a population of 16,000 people / Brighton 10,000 people: similar access to services should be available. In Trenton there is the VON, not in Brighton, and the difference of population is not so great. This issue and provision for more help should be included in the three-year IHSP. All that is necessary needs to be done to better support the patients with Alzheimer, now.”
- Dennis Atha, Public, Brighton

“The most pressing concern is the way the SMILE program has been dealt with. It hasn’t been equally accessible for all -- criteria have tightened up somewhat before all the people who need it have even been informed about it. I think the program itself is a good program, but when it was rolled out, it wasn’t rolled out in the way it needed to be. It is taxpayers’ money. I have a client who was accepted -- we have a Meals on Wheels program – but through SMILE there are people going to M&Ms to buy meals. It’s not the most nutritious. If you’re going to put money into it, they need to take into consideration the organizations that are existing already.”
- Anonymous, Front-line care provider, Prince Edward County

“I live in an apartment, so there are a lot of facilities available to me. But I am wondering about services around for major cleaning, some of the bigger jobs. Right now I am able to look after things, but if there are some bigger things to be done, I would be able to live better at home.”
- Marion McWilliams, Public, Addington, North & Central Frontenac
Diabetes/Chronic Disease Management

“I am delighted to hear about concentration on diabetes.”
- Leona Hendry, Public, Belleville

“People are generally uneducated about diabetes. I don’t know if you can do advertising, you can’t force people to do what they have to do to keep their blood sugar in line. But you can promote diabetes education centres and the importance of making links with specialists in general. There also needs to be better communication between doctors -- physicians are not called in. Lots of Type 1 diabetes folks who haven’t been re-educated. They’ve always said the diabetics should manage their own diabetes -- but some may be too young, too old, and too sick.”
- Dianna Inkster, Public, Kingston

“I want to stress the importance of recognizing mutual support for people coping with a chronic health condition. This type of support, where you build connections between individuals sharing the same experience, is very cost effective. Through support groups and learning sessions (and anything that brings people with common experience together), we can incorporate a self help methodology, which is capacity building. Peer leadership is a very effective way to help groups self manage, and deal with their conditions. This type of system already exists such as at the Alzheimer Society in Kingston offers support for people with dementia and their caregivers. It’s been very successful. The stroke support network also offers this type of support and this could grow. Starting new networks is important, but starting up links between groups is essential. Another point is it is very important to get people early on, so these individuals don’t struggle along alone, unaware that these kinds of supports exist. Educating the public that these supports exist is a key piece as well. Health service providers are vital in this process: they could refer diagnosed individuals into the support systems directly. A system of “partnering care” could take place; offering support not only to diagnosed individuals, but also their family members, caregivers and friends. Adjusting to the change is a difficult portion of dealing with a chronic condition; peer groups allow people to be more at ease, share their experiences, and better adjust. People respond differently to knowledge shared by others in their peer group opposed to a facilitator or “professional”. It’s very effective when the information is delivered on a personal level, since there is more of a relation.”
- Kathleen Pratt, Front-line care provider, Kingston

“There is a need for a clinical diabetes educator for hospital inpatients to educate about diabetic care to patients and staff. They used to have this program at KGH, but don’t have it now. You can go into diabetes ketoacitosis -- your blood becomes acidic. Inpatients should also have access to an endocrinologist. Use the specialists where they are needed.”
- Dianna Inkster, Public, Kingston

“We are doing work on managing chronic disease with the community health centre and that helps relieve the pressure on the system.”
- Anonymous, Front-line care provider, Smiths Falls, Perth & Lanark

e-health

“I would love to see improved communication between the sectors across the continuum. There needs to be access to diagnostic imaging and reports and records within the acute care setting. Long-term care has a problem recruiting physicians. Combine that with the e-health projects.”
- Stacey Karp, Front-line care provider, South Frontenac

“Electronic health systems is an area LHINs can help. I spoke with a patient today whose husband is in renal failure. They went to Ottawa for care, but the report from their ultrasound wasn’t there, and they told the patient to come back in a week. Why couldn’t they just tap into the hospital? Somebody needs to move it forward. Mail could take seven days.”
- Susan Turnbull, Front-line care provider, Rideau Lakes

“I would like to see more of an integrated aspect - having a database of your health out there for all medical professionals... especially when in crisis. That would mean it could speak for people being rushed to emergency department or psychiatric ward -- to communicate what is happening... so the care providers know what types of drugs, dose levels, any of that type of information.”
- Paige Offer, Public, Kingston
“We are in an electronic world, in health as well in terms of imaging. So why do we refer patients by fax? This is very redundant, and there is a lot of waste. All referral systems should be electronic to avoid this.”
- Anonymous, Front-line care provider, Kingston

“I am a process engineer. Some doctors are behind in e-health, I’ve been speaking with a company at the recommendation of some general practitioners. There’s an opportunity in the area because of the number of new doctors and the number who are still lagging in record keeping. Talking with health professionals in other areas, looking at pilot projects – so doctors at the hospital can get access to records at home, etc. I want to talk with GPs and see where they are at - having done some research, Ontario Medical Association has put out guidelines with six pre-approved companies. I’ve been pushing that and we’ll see how it goes. It’s a matter of improved health care really – the better communication, the better record keeping you have. Let’s get health care to the point where business has been.”
- Anonymous, Public, Napanee/Tyendinaga

Emergency Department

“I don’t have a problem with the wait in emergency. If you’re going and if you need it, you’re treated well. It may take a bit of time. I find it a bit frustrating and realize that some don’t have family doctors.”
- Patricia Lytle, Public, Belleville

“There needs to be medical clinics as opposed to emergency rooms. A lot of the stuff people go to emergency for – is stuff that should be dealt with in another way. It is much cheaper.”
- Anonymous, Front-line care provider, Prince Edward County

“I am concerned about access to emergency services in a timely manner at the Brockville hospital. There is a lack of communication with those waiting, giving them an impression that the triage nurse may not be prioritizing waiting patients properly. More communication within the emergency room would help the patients understand where they stand on the waiting list.”
- Anonymous, Public, South East Leeds & Grenville

“The wait times in emergency rooms are ridiculous. Half the people in there shouldn’t be there, overuse of emergency room is persistent, mainly because a lot of them don’t have their own doctors. We don’t have enough doctors in this region. We got a nurse practitioner in this area, so things are improving, but there is a need for more doctors, whether it is primary care or in the emergency room. Money is a problem related to this. The aging population is also going to be a significant problem. There is a need for more resources and staffing for services for the elderly in this area, because these individuals are going to end up in the hospital as well. Overall there needs to be something done regarding emergency departments in our region. Whether it is more doctors, or more alternate services available, the funding for this has to be found.”
- Anonymous, Municipal representative, Central Hastings

“Wait times at the emergency department are long. We need more doctors in the emergency department during peak times. If nurses were given more authority to order x-rays if necessary without needing to see the doctor first, it would be helpful. We access the emergency department when our family physician is unavailable evening and weekends. If there were a primary care clinic available in the community during the times that the family physician is unavailable, we would be willing to use it instead of utilizing the emergency department for this purpose. Access to doctors evenings and weekends is very important.”
- Lois Thomlison, Public, Napanee/Tyendinaga

End of life care

“I think it is really naive to think an end of life care strategy is realistic. There are different kinds of people who are dying for certain reasons, e.g., cancer. There are other situations, some people want to die in the hospital. There are a lot of people who want to die in the hospital, but I think it really takes away from when people are scared. There are supposed to be things in place like the palliative care part of the system. I don’t think the system will convince people to die at home. If people want to, that’s one thing... some don’t want to. They may not want their family to go through that. It’s cheaper to die at home.”
- Anonymous, Front-line care provider, Prince Edward County
“I am a palliative care physician, also medical lead for Cancer Care Ontario palliative care in South Eastern Ontario. My responsibility is to liaise with other physicians and to be on working groups for the South East LHIN. Homecare hasn’t kept up with community needs for patients who want to remain at home, chronic and terminal. Patients who are dying and their families who want to be at home cannot, because they cannot get the appropriate resources. Satisfaction, being where they want to be, appropriate use of resources are both going unmet.”
- Ray Viola, Front-line care provider, Kingston

“We need access to palliative care beds between home and hospital - hospice type or long-term care dedicated to palliative. There are 2 that are hospice that are not in hospital setting... In areas such as Ottawa, there is a nine-bed and a pediatric hospice, other areas such as Renfrew has capital funding to get hospices. Kingston has trouble with operating funding.”
- Ray Viola, Front-line health provider, Kingston

In the South East there has been the same number of deaths -- 4,500 in the region. With the help of the LHIN, we’ve looked at how we stack up to other areas in Ontario, Canada and other countries. What do you need to be able to support people so they can live, have care at home and die at home. We see palliative and end-of-life care really need to be integrated into planning that goes on. When we look at shifting people from hospital to community, don’t stop short of providing the type of care needed. We did look at what is necessary for a good system. It is building upon primary care -- it is the basis, people at the front lines. All those people need to have an understanding of palliative care. There is a need for secondary care -- whether through expert teams, secondary services, people the primary levels can call on, available 24/7. To care for people in the community so they don’t end up in hospital inappropriately. When we look at place of care, in this region we’re not doing well. We do not have residential hospice in the South East. We do have two beds, but not funded through Ministry of Health. We do have very few tertiary beds that would be appropriate for a palliative resident. We need to have a balance in the system so people can be cared for where most appropriate. To have people stabilized.
We also need more nurses to deal with the person themselves as well as families. We need personal support workers as well. A lot more needs to be done. With proper supports, we will decrease the number of people who go to emergency rooms and the number of alternate level of care patients – many of whom die in hospital waiting for care.
We don’t have a residential hospice. A number of organizations would be able to do capital, but ongoing fundraising to compete with the community would be difficult. We could also benefit from more expert teams. There is one operating out of Brockville and it is excellent, but is financed through fundraising. The hospice in North Hastings is a two-bed hospice and does not get funding.”
- Margaret George, Front-line health provider, Kingston

“Last week was National Hospice Palliative Care week – the theme was palliative care is a human right. Focusing their efforts on raising awareness and putting it into the context that it is not a wish, it is a right.
Historically death wasn’t so ostracized from health care -- people died at home. There was a recognition that we’re born and die and get looked after throughout lives. With advent and growth of hospitals in the 50s, it became ostracized from the human experience. Now we have a death-denying society. A real challenge here to ensure people get the care they need. Our approach is that palliative care is not exclusive of going ahead with new treatments or therapies.”
- Margaret George, Front-line health provider, Kingston

“I am a general practitioner. I want to be able to access the local long-term care home for emergency admissions such as palliative care without having to go through an assessment process. In the old days, we just called the home directly and it was much easier. It would just make it easier for us and better for families if we could tell them that a bed could be available in 24-48 hours.”
- Anonymous, Front-line care provider, Addington, North & Central Frontenac

“There is a gap of care provided through the Community Care Access Centre regarding what the need is in terms of home palliative care patients. I’m not just referring to the medical care,
but also the home care like bathing, laundry, cooking, etc, for those that don’t have a lot of family to assist them. We as an organization see that need, and we don’t provide those services as a personal support worker would provide, but we are attempting to address that service need based on the fundraising dollars we have available. Example: We go in after receiving a referral, we do an assessment or the individual, and often the sink is full of dishes, the laundry is piled high, and the place is a mess. We attempt to address this, but the problem is that these individuals have used up their hours provided through the CCAC. There needs to be another way for patients to revisit the amount of hours available for them in home care (through CCAC). We just need to focus on enhancing the system currently in place, as opposed to changing the entire system.”
- Natasha Girard, Front-line care provider, Kingston

“Where can I go to die with dignity? You have two options here -- in the hospital or at home. Go peacefully when someone is there. An injustice to how we treat our fellow human beings. We can do better. We need to have a game plan -- need to have the empathy, humility and humanity to help people find the services they need.”
- Anders Carson, Municipal representative, Rideau Lakes

Governance

“I think one of the biggest challenges for community organizations is attracting qualified and capable Board directors. The requirements and expectations of directors have increased a lot in recent years due to a number of factors and there is also increasing competition for good directors who have the time and expertise and interest in serving in the community. A lot of organizations that provide instruction to boards suggest looking at the retiree community. I think the retirees of today are not our parent’s retirees, they are not just retiring to sit on a rocking chair, and they retire to enjoy their retirement. They travel, they are active. Time commitments for a board are not part of their plans.”
- Tom Addison, Front-line provider, South Frontenac

“Board governance stuff is crazy. We have older ladies in their 80s who may not have a lot of education and not everybody has the time or energy to sit on the board. It takes a lot of time and energy. You need a higher level of education to read what you need to read or stamina to sit through eight-hour days. Working people on our board can’t give up a day to go to a meeting -- it stops people who may want to be on a board. Too much time required. A lot of professional people just want to retire. They don’t want to necessarily volunteer.”
- Anonymous, Front-line care provider, Prince Edward County

“I don’t think its materiel whether we have one or four corporations running the hospital (Quinte Health Care) -- but the interests of the four hospitals locally have to be considered on an equal basis. What we have had is a centralization of new technology and development in Belleville and no such attempt for any of the other locations. The latest development, the supervisor, did the wrong thing in the past (he should have taken away the management, not the board). The management is the one controlling the board. Because we have had mayors in the board, we have had some local input to decisions. This is not acceptable to the province, but I think the mayors are the only ones who are doing things right. Local issues have been eliminated from consideration at QHC. There is a big importance for volunteers are many services are provided by them. A lot of funding comes from raising money locally. When you have local input into hospitals, it is easier to get volunteers. People lose interest and contribution once it is not their hospital anymore (when direction comes from above, and not locally).”
- Alan Whiteley, Public, Prince Edward County

Hospitals

“It is important to have not fewer beds but more beds. People are being sent home far sooner than they are able to look after themselves and they end up back in hospital. Don’t discharge people prematurely which seems to have been a tendency.”
- Helen Kelly, Public, Belleville

“I have attended a number of Quinte Health Care Board meetings and found the discussion healthily argumentative and give-and-take, overall a democratic process. The Board was not dysfunctional. The QHC amalgamation has never worked. Over the years the funding formula has not recognized the level of services being delivered and as deficits developed the "bag of money" from the Ministry has bailed them out. This year there was no bail-out. [The CEO] was given a problem he could not solve - he is not to be blamed for the current situation, or are the Board. In the
Netherlands and UK there are laws to restrict the occupancy of hospitals such that they have approx 30% open spaces available for emergencies. We do not have that buffer.

Hospital cost increases are reasonable compared to GDP and population. Pharmaceutical costs are excessive. To be fair to hospitals the government and LHIN should be comparing hospital cost increases to GDP and population not just government revenues. What we do not want to see is a reduction in staffing or services in the hospitals. A "big-box" philosophy is being applied to health care - it is not appropriate to apply a normal business model to health care. Business exists to make a profit. Health care is to provide a service to the taxpaying public."

- Michael McMahon, Public, Belleville

“We require that our hospitals be maintained, including the four sites of Quinte Health Care so acute patients can be transferred within QHC as required. This way a patient, specifically an elderly patient, can easily receive care where they need it.”

- Anonymous, Public, Prince Edward County

“Children’s Treatment Centre in Quinte Health Care is smallest in province, one of four in Ontario (Belleville & Kingston in South East LHIN) not completely stand alone facilities and funded totally as "other vote" in hospital. As the hospital now expects approximately 10 per cent of budget as rent, the CTC is being forced to cut programming. Ministry of Children & Youth Services is not coming through with funding to maintain programming and is caught in a bureaucratic limbo as a result of governance structure (no Board) - they are essentially a small department within QHC providing service at Belleville, Trenton and Bancroft. Management and other staff positions have been pared to the bone. Service is available in Bancroft only one day a month. Referrals overall for 2008 are up 47 per cent over 2007 and to March 31/09 are 68 per cent above 2008 levels.”

- Margo Russell-Bird, Front-line care provider, Belleville

“Will there be an audit of Quinte Health Care? Will it be available to the public? It should be advertised that it is available. I am unhappy that Graham Scott, who was part of the amalgamation is named as Supervisor and has now disposed of the board. Reports are that the mayors will be removed from the board - they are the only ones who have spoken up for the community. The board has in the past been a closed club controlled by the CEO, nor representative of the community. There have been too many highly paid positions within QHC taking away from nursing staff and provision of service. Scott appointing a Board of Directors is wrong - they should be elected similar to school boards.”

- Anonymous, Public, Prince Edward County

“There is a lack of understanding of the true distances in Prince Edward County toward the hospital. The land is difficult to navigate, the planners need to recognize this. This area is unique, and that can’t be displayed on paper. Our school system was amalgamated years ago. We had no choice but to conform to what the Ontario government wanted, due to our population. We started closing schools, and it was like losing a true piece of the community. Doing this to the hospital is the same. You can’t put the sentimental value of it on paper. There needs to be a specific plan set up for these rural areas, opposed to just applying what is used in urban centres. The Ontario government forces the urban plans to work in our rural settings, which doesn’t work! It’s a square peg in a round hole. Quinte Health Care does not work -- we all see it, but the government refuses to acknowledge this. QHC has been in constant financial trouble, this did not occur before amalgamation. We will look after our own hospital, just give us the chance. Give us our fair due of funding to run this place, and we will run it. If there is a deficit, we will make up the shortfall. There is a lot of dedication in this own community, people will dip into their own wallets to save our hospital. We don’t have a doctor issue in this area. Young, good doctors come here, and we have no shortage. If we keep monkeying around with this hospital, we will lose that advantage, and they will go elsewhere. Doctors do not want to work where there is no hospital present. My doctor is not going to drive all the way to Belleville to visit me if I have to go there for care. Gas prices are unpredictable. Expecting people to drive all the way to Belleville for care is not realistic, it could prove to be very expensive. This is our hospital, we paid for it, just like we paid for QHC. -- not to have a say is a travesty..”

- Ray Best, Public, Prince Edward County

“I’m not sure what I think about Quinte Health Care. I did have a family member in Kingston teaching hospital. That was a real experience, the hospital was not clean. The windows are dirty. The set up of the way [they provide medical coverage] is abominable. They do it in three-week rotations. You always get a
residents, not an attending doctor. The person overseeing the resident might not have a clue - residents depending on whether first, second or third-year resident may not know anything and then after three weeks, it changes. You get a different resident, a different overseeing person. It causes a lot of frustration and seems to be aimed at teaching doctors to be doctors, but not about appropriate care. I know it is part of the human resources issues. A human resources thing. I don’t know how we are supposed to make it attractive for people.”

Anonymous, Front-line care provider, Prince Edward County

“I have been in this community for many years, concerned the hospital will be impacted with cut backs. There should be no cut back to the budget, the staff or the services provided to this community through our hospitals. Our seniors need the services provided by our hospital. The community is very spread out and we need a centre point for our care. As a community, we are trying to encourage individuals to live in our community and we do this by referring to our hospital and the services it provides to the community. Personally I would like to see this hospital leave the amalgamation structure and stand alone. The amalgamation agreement needs to be seen publicly which will keep the powers that be in line and avoid doing these public forums every three years.”

- Keith MacDonald, Municipal representative, Prince Edward County

“This session was poorly advertized in the community, in church bulletins and word of mouth only. I am totally against layering of a health-care organization… doling out of money through layers of health-care bureaucracy. One channel method is what we need. Liberal government needs to avoid layers, we need the money for our hospitals not through a control group. There are good knowledgeable people, however, they need to look at the community. Picton hospital - increased health-care costs, we need to be in black. How would anyone know we can’t work within the black? We should have fought harder back in the restructuring days.”

- Eleanor Lindsay-MacDonald, Public, Prince Edward County

“I believe that the province of Ontario should fund hospitals in such a way as to not cause closures / deficits.”

- Sally Freeman, Municipal representative, Quinte West

“The border between us and Central East LHIN creates issues if we have a patient brought to us from Woodview or Lakefield, (which we get because the ambulance will bring them here because it is a shorter offload time for them). In reality, we have the patient whose medical records and complicated history is attached to Peterborough. They won’t accept the transfer because it is not in the region, so we have to send the patient to Belleville. We then have to put an ambulance out of service for five hours... It is the appropriateness of transfer. We have the same issues with mental health and orthopedics with Oshawa. Those referrals are often made by physician contact or CritiCall. We have issues with transfer of patients because of distance. We have only one physician and two nurses on nights. Transfers only work when the ORNGE Land program comes with a full crew so you don’t have to send an escort. Transfers are a huge issue for us.”

- Tammy Davis, Front-line health provider, North Hastings

“The upper echelons of health care include too many personnel - it should be shrunk. The bureaucracy is too large in Belleville, there is too much overlap and duplication in the four hospitals of Quinte Health Care. The salaries are on too high a grid for this area. Nurses have the same job to do in these hospitals as in Toronto, however, the cost of living in this area is lower and salaries should also be lower. The hospital at Trenton should be able to be a specialist centre, the facilities should be able to be better utilized in the outlying hospitals.”

- William P. Dunk, Public, Quinte West & Brighton

“There is a lack of after hours care in Trenton area with the exception of the Emergency Department at Trenton Hospital. Why can’t we use a nurse practitioner at the hospital to run onsite nurse practitioner-run clinic for non-emergency care? There used to be two after hours clinics in Trenton, however, we lost the physicians which resulted in closing of clinics.”

- Anonymous, Front-line care provider, Quinte West & Brighton

“I am concerned about perception that the amalgamated hospital is detached from the needs of the local community. Maybe can be overcome with a local health-care advisory committee to offer input into the delivery of services instead of waiting until items become a crisis. A committee can actively take role in providing input. I also am concerned about patients going to Belleville for
longer-term care and linking patients to family (esp. elderly). Hospital boards can help local community connect to patients that are in their facility. Boards provide reassurance to family members that coordination can assist them to connect with community supports and family. There needs to be conversation when centralizing services. Enhanced ER ward at Trenton would be great. Clarity on what emergency room services are provided and when they should be accessed should be better articulated. Need to tap into good local clinics with accessory services (lab, x-ray) to provide services that don’t need to go to emergency. Clinics may be expensive to set up but beneficial to system in long run with avoidance.”

- Anonymous, Public, Quinte West & Brighton

Housing

“The local housing corporation is run by Kingston Housing. It used to be seniors’ housing, now it is geared to income. I am not sure why it happened. Seniors and geared to income doesn’t work. We have some interest in the community from investors to build something – to build in our area (Verona). You can’t rely on the government to build anything. A couple of investors interested, they have got money for business plan from the County of Frontenac Futures Development Corporation. The business plan is just finished and we are looking at sites, will need to canvass community. We found there are people who had to move into Kingston because they were alone in old farm houses, etc. It has been difficult - friends, church, doctors.”

- John McDougall, Public, South Frontenac

“It would be beneficial if transitional housing were designated for seniors who can no longer live alone unassisted, as opposed to being placed on a waiting list for a long-term care facility. One effort to alleviate alternate level of care patients in acute care beds would be having transitional beds designated in retirement homes. The access centre budget was consumed well before the end of the fiscal year which caused them to establish waiting lists for their services, which precluded clients from receiving the services which would have enabled clients to stay at home.”

- Lorna Lumley, Public, Belleville

“We certainly need more senior’s housing. We have Pine Meadow Nursing Home. We need more nursing home beds. Lennox & Addington County has given money to help them come up with more funding. We could probably use some supportive housing. A lot of seniors try to stay in home as long as they can. There is a place in Northbrook, but they are full all the time. We need to have more. Public or private doesn’t matter as long as the standards are there and are met.”

- Anonymous, Municipal representative, Addington, North & Central Frontenac

“There needs to be more beds available in Lanark County. We need different kinds of supportive care, i.e. parent was in retirement home at tune of $3,500/month. Not everyone can afford that and there is not enough housing for people in lower income when they have to give up their home. Not everyone owns a home. There needs to be more supportive housing and more affordable supportive housing.”

- Caroly Gilchrist, Public, Smiths Falls, Perth & Lanark

“We’re trying to get a seniors home on Wolfe Island right now, not a nursing home, but a seniors’ residence. People who live alone, find it lonely, but don’t want to leave their community. It is very difficult.”

- Wayne Grant, Municipal representative, Frontenac Islands

“The waits in alternate level of care beds are only going to get worse because of our aging population. So we need some alternate care for these people, or perhaps more monies for assisted living programs, or retirement homes. There has to be a transitional house in between for these people. It doesn’t make sense to go straight to long-term care.”

- Anonymous, Public, Central Hastings

- Need investment in community. Need affordable housing, rent supplements with operational supports.

- Allen Prowse, Front-line provider, Kingston

“Our area needs an affordable not-for-profit retirement residence where people can have medication, etc. Our people know the beds are needed... Nobody is pushing for it. (Assisted living).”

- Arlyn McMillan, Public, Smiths Falls, Perth & Lanark
Human Resources

“My major concern is that we have sufficient nurses on staff to allow them to provide the care required without them becoming burned out. If people are to be adequately cared for you do need enough nurses to do it.”
- Helen Kelly, Public, Belleville

“We don’t have the human resources that we need - need more [palliative care] trained physicians. Physicians need to feel this is a specialty they can make a living at... to get family doctors to do house calls. This is a huge thing. A family doc can take training with Queen’s palliative medicine and have them as backup. House calls are something we struggle with.”
- Margaret George, Front-line care provider, Kingston

“We’re really struggling with ministry’s requirement to use new funding dollars for staff and that you need to show you’ve hired staff. We have a very good complement of staff and want to look at how to do things differently, but can’t use those funds to do it. We’d like a new money allowance [that provides more flexibility] -- we hate to send money back.”
- Julie Shillington, Front-line care provider, South Frontenac

“The major problem that I see is that there are not enough doctors and nurses and health-care providers for the wants of the population.”
- Anonymous, Front-line health provider, Smiths Falls, Perth & Lanark

“Community nursing pays $10 an hour less than in hospitals. The agencies are struggling to stay within their budgets and pay their staff. It is difficult for them. It is also difficult to keep up staff education. The nurses in the community have to know everything... soup to nuts. You have to have very high skilled folks out there. The last client I saw was three days post-bypass surgery. You need to have all the skills of being in the hospitals and you are on your own out there. Rural wise, it is the travelling. I can see agencies having difficulty, they have had no increase in funding. It’s difficult.”
- Anonymous, Front-line care provider, Napanee & Tyendinaga

“Right now in our area there are three agencies each sending a nurse to the same area every day -- too many of us out there you are going out for one or two people. We’re talking about integration. All to the same area at the same time, three times the cost.”
- Anonymous, Front-line care provider, Napanee & Tyendinaga

“We need more people who want to take care of seniors -- not many people who want to, or who get paid for travel time (wear and tear - side roads are bad). If there was compensation for travel time, there would be more incentive to do more.”
- Mary MacKinnon, Public, Rideau Lakes

Integration

“A move towards rolling out integration of back office systems in the community sector is a concern. We must remember that consolidation doesn’t necessarily save money. We really need to think about whether there is value in making services consistent across the board or what organizations like Community Care South Hastings is doing. We need to be sure we are not putting in a system that is much more costly.”
- Leona Hendry, Public, Belleville

“If you look at an individual’s health - education, employment, income, access to services, which cuts across a lot of ministries. It cuts across health, education, social services. The ministries have to be integrated. It has always been a problem to deal with high risk families. That is something we spend a lot of time doing, coordinating for a high risk family. Isolation can be a real barrier. If we can do teleconferencing, videoconferencing, it would be more beneficial.”
- Janice Giffin, Front-line care provider, Rideau Lakes

“Our communities could be really exciting. There is a lot of passion for our communities to work together. We can’t get bogged down in the politics. The focus should be the need and being proactive. Let’s celebrate what we have in our communities. We have great people in our communities, family members, caregivers, etc. We can be the best LHIN in the area. Change is good. It is opportunity. It’s changing for the better and building on positive. We also need change within the LHIN – you can’t say no to the LHIN, or you get blacklisted. You have to have openness. It is out there. We need
to encourage discussion. We have to be able to dialogue openly -
true reciprocity. The landscape is changing, let’s have a chat.
Really stop and celebrate -- look where we have come from.
Recognize there may be glitches. Be big enough to do it.”
- Anonymous, Front-line care provider, Gananoque

“There are differences in the rural communities - vast territories to
cover, trying to provide health care for something, physically two
hours away. Difficult to get to hospitals for treatment, get to
other centres for cancer treatment, etc. There is integration within
the geographic region, rather than consolidating care in other
areas. If you could integrate health care providers in a locality
rather than community health centres work together, Puts work
together, home care - let’s get home support, mental health,
community health centre and hospital all working together. Look at
geographic rather than specialty.”
- Anonymous, Health care provider, Smiths Falls, Perth & Lanark

“There needs to be validation of years of experience and voice
within the system. If you identify a problem, you may be seen as
problem making. Simple solutions may be required for problems.
Resource the experts not the management – front-line staff know
what the clients need. Let’s forget the hierarchy and get back to
the clients and the solution they require. We also need to revisit
the current duplication of services. We need to share information
together openly and transparently. Standardized forms between
institutions, within services and within hospitals. Some
organizations are electronic, other not. We need to get up to
speed. Everyone is working in silos, we need to be working
together within the hospital and the community.”
- Catherine Ryan, Front-line care provider, Smiths Falls, Perth & Lanark

“We need to develop integration between family health team and
community health care. They are both funded differently. Integrate
Primary Health Care providers and health-care professionals. The
family health teams need to be brought under the LHIN umbrella in
order to integrate the primary health care.”
- Liz Palmer, Front-line care provider, Brighton

“Opportunities for integration exist in palliative care. There is a
model to develop innovative collaborative structure -- a working
group in different cities across the region. The Queen’s palliative
care network has leadership and plan for improvement across
Ontario.”
- Ray Viola, Front-line care provider, Kingston

“Bancroft Community Transit partners with agencies and they
partner with clients. It works well, but there are always people
who are not connected with an agency. We try to be creative and
available to people. Word of mouth works well. People are isolated
- they are out of the loop. Some are just not aware of what is
going on. The agencies up here have an interagency meeting once
a month and I chair that -- people who visit us from other areas are
amazed at how we network and how we chair. Our minutes are so
inclusive. I’m proud of this community. I am very community
oriented and believe in giving back.”
- Mabel McLellan, Front-line care provider, North Hastings

“On integration, I agree that integration should be local or
geographic which enables it to be more patient-centred. Through e-
health you can track a patient. More multi-disciplinary teams
where people meet to talk about the needs of their patients. It
would be ideal, would improve patient safety (conflicting
medication, etc) In the Community Health Centre system, that is
great, but it is largely just for people who are just seeing a
doctor.”
- Anonymous, Front-line care provider, Smiths Falls, Perth &
Lanark

“Education, knowledge, etc .I think Inter RAI will be good for us --
we should be using it as a communication tool. Something that
pops up to say CSS should be contacted and give out a phone
number to call. Let’s keep it simple. Sometimes we try to reinvent
the wheel - it needs to be honed in on. There is no time to train
providers, so just give us a snapshot. Something that pops up.”
- Pat Dobb, Front-line care provider, Central Hastings

“Services available in the community are piecemeal and not
coordinated well. A lot are volunteer, but there should be someone
more responsible for them. We spend a lot of time trying to access
service to figure out how to access.”
- Tammy Davis, Front-line care provider, North Hastings
“The model to follow is the Prince Edward Health Care Family Team. The benefits through cooperation are incredible. There are many disciplines in health care, and they recognize this. They have achieved health saving by sharing and reducing duplication. I think we can use this same process and expand onto other health service providers in the region. No individual silos, rather use tents which are more maneuverable.”
- Alan Whiteley, Public, Prince Edward County

“Discontinuity between hospital and community care - for people with chronic care do not have access to specialized care. People that have higher need have to go back to hospital for support. Think that specialty teams need to be more broadly distributed so that they can be supports to FHT, primary care and CCAC can call out. Teams could be standardized. e.g., dialysis and cancer programs. Try to use general resources for specialized services and they do not serve client as well. Specialized teams similar to ACTT mandate with local contact.”
- Allen Prowse, Front-line care provider, Kingston

“I have major concerns about health care. I am a board member for the Belleville community health centre that is in development (not up yet). My concern is that we don’t spend all our energy on dealing with illness response models, and we don’t really bridge over into primary health care. The health promotion and wellness model needs to be examined. Hospitals are the major money people, but I would like to see it move over a bit into the community agencies. We need to be aware of individuals with very complex needs, especially if they don’t have a family doctor. If they have mental health issues, and are not receiving services, or have exhausted the services, these people are often marginalized, or in poverty. It is very complex. In terms of unaddressed needs, I would highlight the inability for the systems in place like Ontario Medical Association to support other initiatives like nurse practitioners and midwives. This is a patriarchal system.”
- Anonymous, Front-line care provider, Belleville

“Interdisciplinary model of care demonstrated at KGH to include community clergy services should be encouraged in all hospitals. It offers connectivity for patient and family from community to hospital and back to community again.”
- Anonymous, Public, Quinte West & Brighton

“We are dealing with broader determinants of health and are very well integrated. Our challenge is getting access to more providers, with the primary problem being a lack of funding. We’ve requested extra social work staff for years. It is necessary. We integrate as much as we can - MHS rent spaces, everything is on-line now. It is a great way to access clients. It is an excellent model in the sense of holistic care... Crisis intervention worker helps as well. She’s a core person.”
- Karen Mick, Front-line care provider, Central Hastings

“The Brighton Family Health Team has the skills and personnel to open a cervical screening service to the general public. The government is limiting them to limiting the service to their own patients. The Ministry recognizes that this program is important as a preventative measure for women and they should make it easier to provide it not more difficult. Community health centres are able to provide these kinds of services but not family health teams, even if the resources are available. The need exists in Brighton to run this type of services.”
- Liz Palmer, Front-line care provider, Brighton

“When examining services regionally, I hope local health service providers are approached to determine what can be done at the local level, by existing providers, and in consideration of the geography in which to provide those services. I hope ReCAP enhances existing local services - instead of creating new regional programs - to meet the needs of those who wish to return to their home communities.”
- Michael Whiteman, Front-line care provider, Belleville

“It would be nice to get better services for chronic pain, return to work and people with personality disorders. Chronic pain would be clinics integrated into family health teams. If you had that, some people who could do it and offer service, could move from place to place.”
- Liz Palmer, Front-line care provider, Brighton
Anonymous, Front-line health care provider, Belleville

“Working with other community partners (in the mental health system) is poorly coordinated. Many different agencies providing same or similar services - better if under one umbrella. Feel there is a stigma from community with working for hosp services. Need more psychiatry services in community and be better coordinated.”

Anonymous, Front-line service provider, Kingston

“My concern is the fact that different portions of health care are not under the same umbrella. Doctors are working for the Ministry, the ambulance is funded by the County, long-term care by the LHIN. I think they should be part of a one-window approach. We’re looking to form a Family Health Team, but it hard to know who to talk to and how to approach things - how to go about it generally.”

Henry Hogg, Reeve, Addington Township

Regarding Quinte Health Care: “Belleville doesn’t see that Trenton or Picton don’t have what they need, for example, if there is a code. They don’t understand what is happening. I hope there is a better understanding, that they are brought together and work together better. They have got to come to the realization. Things have got to change.”

Patricia Lytle, Public, Belleville

“Land O’ Lakes Community Services really like having the van. We are really big into transportation and we lobbied for the van. The VON is getting paid to coordinate services, drivers, etc. through the SMILE program. We are coordinating the sharp end, so it is like it is being done twice, except we don’t get any funding. We think that is grossly unfair. We need a part-time coordinator three days a week to ensure the job is done properly. Most of the work that we do is medical transportation. Because the VON is stuck in the middle, it hasn’t helped us. We also need to look at how things can be better coordinated -- incentives should be provided for patients who pay if they can arrange to travel with two or three others for dialysis service, etc.”

Gordon McCulloch, Public, North Addington/North & Central Frontenac

LHINs

“We need the LHIN to stop making our job (the Board’s job and by extension, the challenge we can have attracting directors) even harder. The more onerous the LHIN makes it for the Board, the harder it is to attract. Be very thoughtful about the material that gets sent out. Does it really need to be sent? It adds to the amount of information we need to read. We were the first agency to go through an integration agreement. It was a nightmare. We are seriously questioning how to deal with this -- do we want to create a parallel company -- one agency does all the dealing with the LHIN and the other does everything else. The LHIN makes it so onerous. We’re being asked to flow funds through us to another agency.”

Tom Addison, Front-line care provider, South Frontenac

“We have to do something about your public relations. There needs to be more advertising for LHIN events. For years, policy changes have come from above and haven’t involved consultation. There needs to be more public relations, and better methodology. Communication is required two ways.”

Alan Whiteley, Public, Prince Edward County

“Because integration has never been done, it’s not like a lawyer can pull out a template and fill out the form. It costs a lot of money and a lot of time. Whole question in the MSAAs about "permission" for what we are doing. It is ludicrous. Instead of integrating, you’re going to end up with more fracturing. I can’t put in for United Way Success by Six funding without the LHIN’s approval - we can’t wait 60 days for the LHIN’s approval. Needing to provide the LHIN with notification would be fine -- not permission. The LHIN has to remember it should be there to serve the best interests of the public and the best interests of the public should be at the forefront. Sometimes it gets tangled up in red tape and ensuring we follow the rules.”

Tom Addison, Front-line provider, South Frontenac

“Let’s not forget that this corner of the LHIN -- we have seen a lot of focus on Belleville and Kingston and we are a rural community with different concerns. One of our biggest concerns is under the theme of access. We’ve heard a lot about transportation -- less of a concern in Smiths Falls - a lot of people don’t have cars.”

Anonymous, Public, Smiths Falls, Perth & Lanark
“My first concern when the LHIN was created was that there is duplication. I like the idea, because it is localized. If they are going to put you in there to run the show, let you run the show. The same goes for QHC.”
- Patricia Lytle, Public, Belleville

“I am excited about the LHIN’s move to really listening and hopefully implementing it. It almost feels a step removed as it used to be with program management. It is good to have the ability to speak to someone. That said, LHINs are not as responsive to the process train. That piece has been lost and it is missed.”
- Anonymous, Front-line care provider, Gananoque

“As a municipal home, municipal council makes authorizing decisions. We don’t tend to get enough [advance] notice from the LHIN to approve things. We want the LHIN to realize that council meets monthly. We really need 45 days’ notice. This is particularly important when we go to sign accountability agreements.”
- Julie Shillington, Front-line care provider, South Frontenac

“I think the LHIN is doing a relatively good job, but there should be some orientation for people who are new LHIN people. There doesn’t seem to be a lot of education, perhaps a level of ignorance about how things work. Also, I don’t like this method for feedback. The last time was a better way – you met with us in small groups and those groups shouldn’t include the LHIN, so people can’t politically hang themselves. If I was an executive director, I would not feel free to express my concerns.”
- Anonymous, Front-line care provider, Prince Edward County

“Advertising for this community session was sporadic. There weren’t paid ads taken out. Can that be done for next time so that more people can find out about the meeting?”
- Anonymous, Public, Prince Edward County

“We’ve hit some bumps in making referrals for services outside of the LHIN - i.e. driving assessment takes place in Ottawa or Toronto. Other LHINs have responded to say they are only providing to their LHINs.”
- Anonymous, Front-line care provider, Gananoque

“I would like to know what the change in total MOHLTC staffing has been as the LHINs were implemented.”
- Anonymous, Public, Prince Edward County

Long-term care

“A full-time nurse practitioner is needed in all 36 long-term care homes in the South East LHIN to provide improved access to primary care residents on site, to help support physicians that provide LTC. There is a shortage, LTC has a problem recruiting physicians. Combine that with the e-health projects.”
- Stacey Karp, Front-line care provider, Gananoque

“I have a 92-year-old sister who is in a private nursing home, sharing a room with three other people. I know there is a ruling on the number of people in one room, but it is only enforced right now in publicly-run long term care homes and is being phased in for the private homes. I don’t think my 92-year-old sister will benefit much if she has to wait another five years to move to a room with only one other person.”
- Leona Neal, Public, Addington, North & Central Frontenac

“In the US, it is very different because nursing homes have open beds. There you have options, you don’t have to take the first bed available. Here in hospital, you need to go to different part of the hospital – not able to meet needs of patient socially, may not want to go to the home they wanted – may be different city. Then once they get used to the facility – when their first choice comes up, often too difficult to move, so the person is not in the place they want to be in. In-home respite is lacking, but also options for out of home. We utilize day away services as much as possible. There are four LTC beds in LLG available for respite. I am on task force for dementia network in the area, looking at options like the Guest House in Champlain area -- barriers are reduced. It’s an in between option.”
- Anonymous, Front-line care provider, Rideau Lakes

“Supportive housing and long-term care is a concern. Centre Hastings has a large piece of property, and we are looking for partnerships to develop supportive housing and a long-term care facility. We’re doing that because there is a big need in this community. We have done a study on the financial capabilities of a private company to develop something like this, and we believe a municipal deal with a private structure, with assistance of the
LHIN or MOHLTC, it could affordable. To make it viable the average income has to be $30,000. The most we can achieve here is $25,000 so we are in a position to partnership, which would take a lot of pressure off this region in regards to supportive housing. We would also like to partner with the Ministry of Health and Long-Term Care. The LHIN should approach the ministry to increase the number of beds in this area. The last estimates the county provided was a request for 320 more beds, 128 Centre Hastings, 128 in Belleville, and an increase of beds of 64. This would make it viable, and help relieve the $4 million budget pressure at QHC.”
- **Tom Deline**, Mayor, Centre Hastings

“The people who don't have money suffer in their options. If they do need more care and cannot afford retirement facility, don’t have that option. Often go into nursing home earlier than should.”
- **Anonymous**, Front-line care provider, Rideau Lakes

“Was happy to see there is a strategic plan. I want to ensure the northern part of the LHIN is recognized. We have gaps here that are different than the urban parts of the LHIN. One of the issues we have is long-term care bed accessibility. From our perspective, the wait list for any male space is too long (particularly subsidized beds). Our patients here are ending up in Marmora, Stirling or further south where beds are available. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton. The new LTC beds being added are in Tweed and Trenton, so if you are an elderly person from north of here, you may end up there or in Picton.
- **Tammy Davis**, Front-line health provider, North Hastings

“We need a long-term care facility out here -- demographics are showing it. In township of Rideau Lakes, much of our population is retired...want to come live by the lake, and when they come to a certain point, they have to leave to go elsewhere. There is a long wait in Athens, etc. Good start to open one in Brockville. So they can stay close to home, put flowers on grave of those who have passed.”
- **Anders Carson**, Municipal representative, Rideau Lakes

“Long-term care beds are needed in Perth area. Nobody seems to be doing anything in the Perth area. There are new places all around. We read about Champlain and Ottawa - Lanark Lodge is wonderful, but there is really nothing else in Perth to replace Lanark Lodge. It is big, institutional and old. They keep renovating -- it is near the end of its life. The more money they pour in, won’t make it better. Our area (Lanark County -- in the census 2006 was 28% more than other areas) lost Fairview Manor in Almonte when they did division of LHINs.”
- **Arlyn McMillan**, Public, Smiths Falls, Perth & Lanark

“Educate the families of these people and the general public that there is an alternative to long-term care. It should be called short term care, not forever care. Refine the eligibility for LTC -- it is much too broad. Doctors and case managers -- needs to be tightened. Whenever people do put their names on the list and get phone call, instead the manager should say it’s great you don’t need to go now instead of now we are taking your name off the list because you have refused a bed... that's not the way to treat people and all it is doing is causing problems for the system.”
- **Clare McCartney**, Front-line care provider, Smiths Falls, Perth & Lanark

“We do not have enough nursing home beds - there really should be more.”
- **Helen Kelly**, Public, Belleville
“We have enough allied health professionals paid by the Ministry that could flow through the LHIN. We’re the only provider group. We’re the western blip of the South East LHIN. We feel neglected because we’re not seen. We’ve had a couple of people come and do surveys with us (diabetic registry) -- we seem to be considered. We could be better integrated into the fold.”
- Sue White, Front-line care provider, Brighton

“Is it not possible to utilize closed beds at Picton hospital for long-term care purposes?”
- Anonymous, Public, Prince Edward County

“Access to transportation is also an issue. It ties into e-health, telemedicine, being able to use AV technology to have residents virtually seen by specialists while remaining in long-term care. That is so beneficial for patients in the northern areas, etc. It would be ideal if residents never have to leave the home.”
- Stacey Karp, Front-line care provider, South Frontenac

“Long-term care is having staffing issues. On a one-to one basis, they are not staffed to where they should be. I know they are short staffed because they are not getting the funding they should have. They have cut back on RN staff. It’s quality of care for the clients and staff as well. How can you keep your staff when they are overworked, and working double shifts, etc. Certainly the resident care suffers for that and the staff burn out is very high.”
- Anonymous, Public, Greater Napanee, Tyendinaga

Mental Health

- Increased family support results in families coping better at home with someone with dementia.
- Long-term results include fewer visits to emergency department, less use of alternate Level of care and placement in long-term care delayed by 18 months.
- Basis is a study at New York University by Mittelman over a 12-year period ending in 2006.
- Laura Hare, Front-line care provider, Belleville

“International studies show that developmentally disabled who are undiagnosed with physical and mental conditions can lead to premature and preventable deaths. I think it is important that the LHIN provide funding to these agencies that service these individuals in order to ensure best quality and specialized service in order for them to achieve best quality of life. This group of people is often over looked. Policies often are not adequate in addressing required services need by this group. Generically trained professionals, do not have the necessarily require skills to best service this group. The LHIN needs to keep track of services provided to individuals with developmental disabilities to ensure the agency can access adequate training and specialized consultation to ensure good quality services to these clients.”
- Philip Burge, Front-line care provider, Kingston

“A teen workers’ program in Kingston is closing down, my concern is: I have an autistic son with ADHD, and if this program is closed, what happens to him? There are no programs close by, we must travel for that. The program is being closed because they don’t have enough money. This program has just started making progress with them, if they leave what do we do? They did mental health counseling primarily, and provided services a family doctor cannot. There aren’t enough doctors in this area dealing with special needs. He is in the age where he is too old for child program yet too young for adult programs. There is a need for more programs, specifically for this age group (in terms of all developmental disabilities really). I have gotten more help in Kingston than I have here. I would not mind to travel for necessary services, I don’t mind if they are placed in Kingston or Belleville, as long as they are available. One child of mine has severe behavioral problems - there is no specific service for her needs.”
- Cathy Jackson, Public, Prince Edward County

- We represent the Brighton Circle of Friends, a group of 28 strong and growing of husbands, wives, friends, family members, sons and daughters who care for a loved one with Alzheimer’s disease.
- We ask the South East LHIN to make it a priority in understanding Alzheimer’s disease and other dementias and the impact on me the caregiver, and my loved one and support us in our effort.
- We ask three things:
  1. the LHIN provide funding to the Alzheimer Society of Belleville-Hastings-Quinte to provide adequate support
services in Brighton and surrounding areas to continue to support this growing group.
2. The LHIN provide funding to the appropriate service such as the VON for an adult day program in Brighton.
3. The LHIN provide funding to the Alzheimer Society to provide adequate education, training and support to families, support services and health care professionals in the Brighton and surrounding areas.

- Jeanne Bates, Front-line care provider, Quinte West & Brighton & Margaret Henderson, Public, Brighton

“Mental health and addictions - there is a Mental Health Act and a Mental Health Commission -- I would hope they would include addictions under that Act. The fact that people get into psychiatric hospitals and the discharge plan is not able to be implemented in the larger community (rural) is a problem. The followup that they need in the system is to have that somebody to help them through recovery - like case management. Example – [family member] with schizophrenia has been in treatment five years. In denial for 25 years - went through Justice of the Peace, police to psychiatric care and to a community treatment order and Capacity Hearing Board and became their SDA. When [they] were released from hospital, I was advised there were no case managers at the time, found out a year later CMHA would take an application and within three months [the individual] had a case manager. In the city of Ottawa, do not have one common list of people being released from hospital care who are waiting on a case manager. There are several businesses that do it, but not all communicating. It took me at least 10 years to get help. I became a member on boards of consumer businesses and that was the only way I started to learn about mental illness. I became a NAMI teacher and went to St Louis Missouri and took course on how to be a teacher. There are only four of us in Ontario -- all done on a volunteer basis. Agencies that support services for the consumer need to involve the family member to educate. This way, more families are able to cope with mental illness in their family. Education of a family member is about $500 for a class of 25 -- service providers don’t have that in their budget to be able to assist. Family members can get just as ill as the person with the illness in trying to cope.”

- Caroly Gilchrist, Front-line care provider, Smiths Falls, Perth & Lanark

“More community mental health services for long-term patients are required in the region in the community. Short-term services exist but longer term services are required. Hope that there is an understanding that short-term counseling does work in the some cases but 6 to 8 sessions for individual who have experienced significant trauma is simply not adequate.”

- Sandra Chopping, Front-line care provider, Greater Napanee/Tyendinaga

“I’m a mental health counselor, I discharge mental health patients from hospital (HDH, PC, and QHC). Something that happens is that people stay in hospital longer than they need to because of a lack of supportive housing, minimal to intensive support. It is very expensive as well to support patients, so this could give a lot of savings. A lot of the time these people are homeless, they do not have life skills, any family, etc. A lot of support needs to be provided - their quality of life is just dismal. For cost savings: sometimes a person may seem to need to be admitted to hospital, but they don’t make the criteria, or they do meet the criteria, but there are no beds available. If we had some beds in the community (i.e. crisis beds) that solution would work well. People who could really use 24-hour staff support just for a day or two. This would save a lot of money for the hospital system. Transitional beds would be helpful, this would help with ALC patients. It should be time-limited (i.e. 30 days). This could have minimal staff.”

- Sandra Clayton, Front-line care provider, Central Hastings

“Another problem is that a lot of my clients don’t have health cards. This holds up getting housing, or any other level of care, plus it costs the hospital a significant amount of money. ODSP is very good at providing some money for these kinds of people. A lot of our folks are living in small apartments, or a parent’s basement. They can’t manage, so are in and out of emergency room. We have a revolving door syndrome, and supportive housing can fix this. Supportive housing would save money, boost quality of life, and help with the family members too. We have some transitional housing in Belleville. There is not wait list, so it’s really just luck of the draw. We do need more, and hopefully something specifically for mental health issues.”

- Sandra Clayton, Front-line care provider, Central Hastings

“I’m a mental health and addictions professional. An issue we experience is that a lot of our clients have difficulty finding a
physician, for example many physicians are now interviewing for the patients they will accept. Transportation in rural areas is also a challenge for any community-based service. How do you service such a large area, specifically a rural area? I hope that the needs of mental health and addictions people are represented clearly and thoroughly in the next IHSP. Also a continual emphasis in community services should also be present, as this supports many of the issues we see for example in our emergency departments. I also emphasize the need for low-income housing to support patients; this is a key factor in assisting several considerations such as emergency department visits, length of stay, etc.

Individuals need continual support outside of the hospital as well."

- Anonymous, Front-line care provider, Napanee & Tyendinaga

“I’m involved with a program called Connect Youth - based out of South Grenville District High School. It was started by students who said they are mad as hell... spoke to head of guidance at the school and she knew that something had to be done for youth mental health. We have a long history of being concerned about child and youth mental health. In the late 80s, Public Health, Police, Child and Family Services, a lot of good people set up a group called Youth Under Construction - an annual conference for youth. One of major concerns was about drugs but issues far greater than that slowly emerged. These slowly became more streamed to mental health, addictions, self esteem. In 90s, I was approached by Henry deSousa - he had been so helpful to us... We knew who the right people were, knew what to do in a way that was Health Canada gave us funding to write a book -- chair on Task Force on Mental Health Reform -- Michael Wilson was one of the members. I was being coached by Dr. Simon Davidson, chief of psychiatry at CHEO. We were able to convince the province to expand the scope, and able to convince them the review had to be across the entire lifespan. Although I am extremely interested in all aspects of health, the area of greatest need is in child and adolescent mental health. It is elsewhere as well, right through to dementia.

In our report – the primary recommendation was the child and adolescent mental health needed to have MOHLTC as the prime ministry. We said you can cooperate - a real challenge with child and adolescent mental health orgs in Kingston, Leeds Grenville and Lanark, not so much in Belleville area -- they were more tuned into the mental health as a health issue.”

- Sandra Lawn, Public, South East Leeds & Grenville

“Mental health is the number one issue. Bed closures have been excessive and that has led to crimes by mentally ill people, and it means that they have an inferior quality of life in many cases. With bed closures, we are lacking support in the community. If you close a bed, and put a person in the community, you have to monitor their care and manage their treatment. The theory is good, but the essential components (management and monitoring) haven’t been there. Most mentally ill people need ongoing support and medication. This hasn’t been delivered adequately. I think this is part of the problems with our entire system. Housing and workers in the community to manage treatment are vital. Also, when people are mentally ill, there needs to be a mechanism for them to receive care, even though they may not seek it, or may even reject it. In the realm of physical health, our care has been very positive in this area, mental health is my concern. The person with the illness is a victim.”

- Anne Normile, Front-line health provider, Napanee & Tyendinaga

“There is a Mental Health First Aid program at Queen’s - something the LHIN could encourage that is like a train-the-trainer model to roll out to front line staff.”

- Sandra Lawn, Public, South East Leeds & Grenville

“If we’re not really doing anything about mental health in children, we’re a stupid province. I know what we’re doing in South Grenville -- we are creative but we’re on a shoestring. I believe everything is connected - diabetes, heart disease - have a lot to due with early childhood development. There’s a growing number of young doctors taking mental health much more seriously. Our child and youth wellness groups are beginning to understand one way to reduce stigma is to recognize this is a health issue that affects people all around the world.”

- Sandra Lawn, Public, South East Leeds & Grenville

“We’re getting better with mental health care, but there is still a stigma associated. It needs to change. In1999 my mother took her own life - she had mental health issues. We were cut off. After that, I helped organize a mental health awareness. We need a federal action plan -- they have one in New Zealand.”

- Anders Carson, Municipal representative, Rideau Lakes

“Mental health sector - from personal experience in working with people, especially with youth – I know there are contacts, but
there isn’t the help for them. It is difficult to get someone in crisis or who may be at risk to talk to somebody once, but when you’re forced to battle to get to them, you really lose them. Somewhere people have to go where they are taken seriously – where people understand, care and have the right feedback. Mental health is so touchy. That is a big problem. Accessing good professionals takes time and in the interim, you can lose people that need help. The Youth and Wellness Centre is fabulous. Such a demand, I don’t know how they continue. The workers we have in the area are fabulous, but they need resources and staffing.”

- **Anonymous**, Front-line care provider, South East Leeds & Grenville

“I have concerns in the Tweed area - we have a high population with mental health issues - there is a need for more social work services. There is a wait list to see me (I’m a social worker). We have a crisis intervention worker who is part time. The other issue in terms of access is there is the General in Belleville – but it is restricted because of transportation and poverty issues in our area. Poverty has a huge impact on our area as well. Physicians at Gateway refer many for mental health issues -- quick service is the best. Health promotion and prevention is important -- not much time to do it now. Children’s’ mental health operates in Madoc... not an option. You have to specialize where the need goes.”

- **Karen Mick**, Front-line care provider, Central Hastings

“As our population ages, more physical issues arise such as diabetes, heart disease... more likely to become mentally ill -- poverty, isolation, food security issues are factors that can contribute to it as well.”

- **Karen Mick**, Front-line health provider, Central Hastings

“Changes in hospital care for mental health services at Hotel Dieu means beds have been cut. I have concerns about the cuts and the availability of treatment for unstable individuals to provide monitoring, assessment and medication management have been reduced. Community service is struggling to get services for individuals that require a higher level of care than the community agency can provide. The shortage of beds in the hospitals has created a crisis in finding appropriate care for individuals in need of these mental health services.”

- **Sandra Chopping**, Front-line care provider, Greater Napanee/Tyendinaga

“More supportive housing for individuals with mental health issues is needed in the region.”

- **Sandra Chopping**, Front-line care provider, Greater Napanee/Tyendinaga

“High unemployment rate will have a big impact on the mental health sector and health care sector -- focus on short-term band aid solutions. Mental Health and youth services need to be assistance - middle age are not likely to access as quickly as the youth. Middle age are likely to receive pills from Family Health Team that be directed to support groups or counselor. Counselors should be linked with Family Health Teams.”

- **Anne Belanger**, Front-line care provider, Kingston

“Mental health may be a bit better understood than addictions, but I would advocate for anything that can be done to improve the background, understanding, etc. of those working in emergency departments around mental health and addictions would improve care. Outside of a traumatic injury, people need to put their personal biases at the door and treat individuals with more dignity. If the ability was put in place for education/prevention/promotion to improve the reception of people when coming into emergency rooms. The last thing they need is to be stigmatized when they arrive for treatment.”

- **Chris Sullivan**, Front-line care provider, Kingston.

“I used to work in the Central East LHIN - working here in Lennox & Addington, I see there isn’t a walk-in clinic for people to access services and therefore they are more dependent on emergency department. Because of a lack of doctors, and no schedule 1 facility in Lennox & Addington, people have to go to Kingston or Belleville. People are relying on police or ambulance. Closures of psychiatric beds at Hotel Dieu will make that worse - they are closing nine of their 30 beds. We don’t have acute mental health beds here in L&A. When there is nothing in the community, some people are isolated.”

- **Shannon Horrigan**, Front-line care provider, Napanee & Tyendinaga

“It is important that seniors feel comfortable to access psychiatric services for dementia care... they have a fear. There is a service that will go to their home to assess them, but they must first get
over the fear/stigma. There’s a lot of stigma attached here because of former Brockville Psychiatric.”
- Janice Giffin, Front-line care provider, Rideau Lakes

“Transportation is a huge area of concern. Our agency provides services to the northern part of the county of Lennox & Addington. There used to be a local bus services but it no longer exists. Our small agency has some great services I haven’t seen in large areas. We’re doing a lot with a few people. The local hospital is fantastic when we send folks down. But they are not a Schedule 1 facility -- so transportation again becomes a problem. If they are not admitted or if they are, once they are discharged, we often struggle with how we get people home again. The police are acting as a shuttle service.”
- Shannon Horrigan, Front-line care provider, Napanee & Tyendinaga

“I work as an advocate for addictions and mental health services. I’d like to see the South East LHIN include in its priority selection Addictions & Mental Health services as an important priority for South Eastern Ontario. Addictions and Mental Health doesn’t discriminate, easily one in five persons will suffer a mental illness at some point in their life. That is 20 per cent. Family members are equally affected. They cross all boundaries, affect so many lives and families. Yet it’s a poor cousin to other diseases, cardiovascular, hip and knee... what politicians like to scream out during their sound bites. I would like to see it have a higher profile. This is an opportunity for the LHIN to increase and improve access to mental health and addictions services, working with the sectors to ensure they have sufficient staff available. Human resources are important. Related to all that is funding. The LHIN has made it clear there is a finite amount of resources. To attract skilled, dedicated resources, you need the resources to pay them. Otherwise, poorly skilled transient workers.”
- Chris Sullivan, Front-line care provider, Kingston & The Islands

“Decreasing stigma of mental health -- the information is distributed across the board... to normalize mental health. There is still a huge issue with stigma -- I’m a communications major -- and am studying the importance of understanding individual’s needs and not inflicting your personal agenda. This person needs to talk to you, you need to give them a game plan and give them the tools. I find you’re often not heard. A huge clientele of values for peer support initiatives. We don’t always see the value of that in society. People need to be receiving support as well.”
- Paige Offer, Public, Kingston

“There is a real gap in services for youth 17-19 years of age. Not children’s mental health, not adult mental health. It is a gap. There are also a lot of services set up for those who are seriously ill, but not for prevention. A lot of the work I do is marriage/family counseling -- in our area, it is free, it is preventing people from becoming seriously ill. If we can provide more services earlier, would save in the long run.”
- Janice Giffin, Front-line care provider, Rideau Lakes

**Physician Engagement**

“I am an orthopedic surgeon. I see the problem of hiring people who have finished their residencies and fellowships. We have had many well qualified residents graduate, they were looking for a job in Ontario, they then went on an American fellowship, and we can’t bring them back. We have four grads working now out of 12, and the others go to the States. This after we spend thousands on training them. We don’t have the ability to hire them, but we have the demand. If the Ministry identified that they would have manpower issues in certain specialties, but they don’t have a way to deal with it. Any service that is recognized as having a manpower issue, should have some way to get the resources to fix it -- just having an automatic solution would be easy, like doing a needs assessment, and then there is an automatic flow of funds to hire new individuals. Another issue is surrounding short staffing of surgeons in hospitals. We hired two more surgeons, and now my operating room time has gone down, and I am probably less efficient as I could be. We’re probably over-staffed based on our resources (not based on community demand).”
- Mark Harrison, Physician, Kingston

“I’m concerned about medical transport for emergency rooms specifically. To be able to get people in the door, you have to get people out too. There’s bottlenecks like, a patient sitting in a bed in a different hospital, has a greater priority to a bed than an emergency department patient, but we can’t get them over here. The transport system isn’t involved in inter-hospital transfer.”
- Anonymous, Physician, Brockville
“Coordination of services is where I see the biggest bang for your buck. Coordination of things like orthopedics, mental health, cardiology, etc; an integrated service model is something we should pay attention to. Improving communication, through electronics, is a huge area for improvement as well. Another concern is around keeping on decentralizing services, getting some services to some of the smaller communities; keeping a balance being centralized efficiency and the immediacy of decentralization. On the demand side of service delivery, blaming only demography is too simplistic. It misses half the picture, patient expectations are also an important consideration. Expectations are much higher than they were years ago. Economic realities need to be communicated by the LHIN. Things are tough and there needs to be some communication to people that we cannot keep increasing funds to health care indefinitely. Get this message out to people in a meaningful way, more taxes for more service? Are they willing?”
- Charles Mustard, Physician, Belleville

“The capability of defining orthopedic problems very early at the general practitioner’s office in a way that provides that doctor with an easy to use referral mechanism. The mechanism I’d recommend is a web-based, validated, scoring system that includes assessment of disability and image processing. That score can then be used as a way to triage. This score can also be used to say this is where a patient is at time A, and then if review is needed, this is where they are at time B. It will also show if they have improved or worsened, showing progression, and perhaps a need to accelerate or slow down referral.
The current orthopedic referral mechanisms involving outpatient review is excellent, but expensive and redundant. The above approach could avoid this, and streamline access. The principle could be used for other areas as well, these elements are used everyday in many services. If the fundamental issues of diagnosing and imaging could be included, decisions could be made easier.
Make it accessible.”
Derek Cooke, Physician, Kingston

“I would like to introduce a concept of attaching funding to the actual service provision. When a hospital receives a budget for service provision, I am assuming the budget is for the service continually through the funding interval. If the hospital stops the service, it is my view that the component of the funding flowing for that, should go to the institution that backs up the first hospital. There is a lot of time when my sister hospital doesn’t have the specialists available, the procedures get sent to me. I would like to see acknowledgement of funding for services that are not actually being provided.”
- Anonymous, Physician, Kingston

“What does it mean to be patient-focused? There are roadblocks with divesting or diverting services surrounding money alone. Patient focused funding is something that is beyond the LHIN, but we should all begin thinking about it, because there are some downsides to it. We also need to be trying to plan for chronic disease management. What comes up is that you can prevent half of that, so we should focus on this side. But the LHIN has no control over public health or primary care. So there needs to be some communication here. Health promotion individuals are often far away from the stats and are more into what looks and feels good. There is a disconnect.”
- Anonymous, Physician, Brockville

“The human resource side of things is big with the LHIN. Aging health human resource providers is an issue, as is the differing expectations of providers today (i.e. people not willing to work long hours anymore). These are areas of important consideration. A health human resources strategy always needs to be a priority in health care planning, and I would hope that the LHIN continues to recognize this.”
- Charles Mustard, Physician, Belleville

“Access to things like investigations and specialists is interesting. One of the hardships is that we all have a list of people that we guard because we have relationships, and we know that person will understand us. We have a bond with them. Automating a referral process completely with specialists, due to the above point, may be difficult. Where there is an ability to triage, the problems may be helped, because you will get service regardless of your relationship. I have better access to secondary care here than other places in the province. i.e. blood tests, nursing homes, general surgery, scans. Tertiary care is often a real struggle. Access to mental health is also worse here than in other places. It may be resourcing, it may be a lack of service due to our geography, I couldn’t say.”
- Anonymous, Physician, Brockville
“Wait times tracking is costing physicians in loss of time to input information and cost to hire staff to complete it means loss of front line service and contact with patients. Software not connecting well; connection is low or malfunctioning consistently. Hospital health software is slow and non-compatible with others in Ontario. We need an Ontario universal solution for records. Connectivity between primary health care and specialist needs to be better. Central repository for patient info would help.”
- Anonymous, Physician, Brockville

“Quicker referrals allow for bypass of residents (KGH)- specialists should be able to access appropriate specialist when needed.”
- Anonymous, Physician, Brockville

“From an e-health perspective, I would like to have a program where I can understand the cost associated with prescribing types of medication. This can help with making rational decisions, and rational drug use overall. The medical record in the States for example, has something called “drug store” where there is collated data available. A useful tool to allow me to know what drugs actually cost is needed. This tool is not available at the present. One of the important aspects is being able to present interaction data and warning signs. We have the ability to do this, but the systems aren’t set up properly. There is a pharmaceutical component with EMR, but the cost is not accounted for. An iterative process is important, so further specifications can be accounted for.”
- Anonymous, Physician, Brockville

“A dramatic change in the face of primary care has taken place. The first IHSP noted primary care as a key priority. The uptake of alternative models of primary care has been higher in this LHIN than elsewhere. This has solved a number of issues.”
- Anonymous, Physician, Brockville

“When you teach, you can’t throughput the same number of cases as someone who is working solo. But when my productivity is measured, I’m held to standards developed by solo practitioners. It takes 50% longer to do an endoscopy test when you are teaching someone. When practitioners are taking on training, the model of funding must understand that our performance standards should be adjusted due to the dedication to teaching.”
- Anonymous, Physician, Kingston

“Within a LHIN, once a decision is made about distribution of services by different institutions, that institution should agree that if national standards exist, they should provide proof that they are living by those standards. This way there is consistency in the level of service standards followed by institutions, making sure that the costs are on the same plane, and some institutions don’t slack and still get the funding.”
- Anonymous, Physician, Kingston

“I hope that the LHIN will help us all make headway with electronic communication with sister hospitals. People are leaving hospitals quicker than before, and so referring doctors need to know what is going on. The lack of communication caused by inefficiencies is bothersome, and some electronic mechanism could resolve this. I understand that this is probably a provincial effort, but the LHINs should take a direct approach to steer this.”
- Anonymous, Physician, Kingston

“Breast assessment– I want to have this as a priority LHIN-wide. We need to develop a plan to meet with representatives from different centres within this LHIN. With these centres, we need to create a LHIN-wide approach to breast assessment. We need the LHIN’s help with organizing this, and developing statistics to monitor wait times, and other performance standards. We need to bump up the priority level of assessment. We also need a LHIN-wide regional educational program for breast assessment. These initiatives should be aligned and coordinated along with the Ontario Breast Screening Program (OBSP). Breast assessment is from the time of breast screening until diagnosis and initial surgery.”
- Eric Sauerbrei, Physician, Kingston

Poverty

“I am a social worker. The major issue I see is poverty and that affects an individual’s ability to access services in the rural areas. Transportation becomes a serious issue to access services and resources. To travel to Brockville, Kingston, Ottawa – poverty is a key barrier. Poverty affects everything - ability to access good food, etc. A lot of the work I do is mental health. For psychiatric services there are services in the urban centres for children and adults. I will drive a family in that takes a day.”
There’s also a big gap for seniors if you don’t have a lot of money, but need support. They need to have a lot of services, but unless they have a lot of money, they can’t do it. A lot of seniors live in poverty. There are no benefits (unemployment, not eligible for Trillium) anymore. People cannot afford drugs -- either no plan or have to pay in front -- therefore they often go without. That affects their health -- can affect people who were fairly healthy previously. We have a high rate of referrals for welfare -- how can these people access resources? Affordable housing is another problem -- you can’t afford rent, food, and daycare. I support a lot of single parent women to get out of poverty -- needs to be more scholarships for college, etc.”

- Janice Giffin, Front-line care provider, Rideau Lakes

“A dental health program is needed for people on low income. If you don’t invest in the mouth, other things happen, longer term.”

- Anders Carson, Municipal representative, Rideau Lakes

“There is a need for denture/dental care – for seniors and others. There is no OHIP or LHIN support to purchase them, but it has health concerns for the senior over 65, as they can not afford this vital service. Welfare will take your teeth out but won’t replace them for you to eat or get a job.”

- Sue MacLatchie, Public, Rideau Lakes

“There needs to be recognition that some of the barriers to service are really inability to pay. Now you have people with SMILE who are not paying for certain services while their neighbors are ... and some can afford it -- there are huge inequities. The people who get connected to SMILE have family members who are most educated. The most vulnerable are falling through the crack -- a lot of rural areas you get that. We get a lot of people retiring here, so it is interesting the inequities that are set up. We try to reach out to people. For some there is a stigma in asking for help.”

- Anonymous, Front-line care provider, Gananoque

“Poverty needs to be addressed in this area. There is also a lot of abuse is apparent and resources are being impacted. Service providers are closing and more will likely be gone in a very short time, due to resources. A lot of people are associated working in their own little camps, but we need to work together as we are not alone. North Leeds Poverty Coalition is a zero funding, community-based organization to address poverty, bring people together to address abuse and addiction.”

Rodney Smith-Merkley, Public, Rideau Lakes

“One concern I have is that we talk about affordable and accessible health care. We need to talk about maintaining it. There is a lot of privatization now. There are a lot of things in our system now that are not affordable - medication, accessibility. Living in rural area, one of the concerns is a lot of agencies and services are located in Brockville, Smiths Falls, Kingston. If you are living in poverty, how do you get there? Seniors especially. Poverty is a huge concern. We see this all the time -- with accessing services, have treatment, need test - no car, education, money, transportation. Oral health comes in there. We know that employment is so important, but if you have no teeth, it becomes more difficult to get a job.”

- Susan Turnbull, Front-line care provider, Rideau Lakes

“I am concerned about fragile elderly folks with mental health issues - where are they going to be housed? My mother was a victim of a bad system - first acute care psychosis phrase. I am worried about our the fragile elderly with mental health issues will be cared for, housed.. the current resources available are not sufficient. The current medical model doesn’t not look at these clients. These clients are multi-factorial individual, deterioration is rapid but preventable. Advocacy was family- driven, health care worker was restricted because of the system. Institution is not the right setting, mother did better at home. Aging at Home - SMILE program has been a real bonus for my parents. Long waiting list for services, non sufficient frontline staff to assist with these services are concerns. Care giving agencies charge large administrative fees. Consider about money pull back from the aging at home strategy, cognitive need might be hamper if money for their support is decrease, are we being short sighted? Preventative support, equal opportunity is required.”

- Brigitte Irwin, Public, Brockville

Prevention

“More prevention programs are needed. I think there is a fair amount being done with seniors, SMILE program, etc. I am thinking more about newborns and child care (i.e. Early Years). I am not sure how that is looked at or how it is viewed in health care... High risk. Prevention starting at birth, so that it is lessened by the
time we get to the senior years. We need to look at healthy family planning, giving people tools. We need to align public health with the health portfolio to get everyone together. Remove the barriers, integrate services from birth throughout the lifespan.”

- Jean Smith, front-line care provider, Kingston & The Islands

“Prevention of costly complications of Type 1, Type 2 and gestational diabetes is important. The government is funding insulin pumps for Type 1s, just now starting adults, supplying $2,400. It costs about $10,000 a year for strips, insulin -- including costs amortized for pumps. Trillium will also provide you with glucose monitoring sticks, but there’s a cut off for Trillium, if your income is too high, you get cut off. Except that people neglect getting sticks -- so it should be calculated on one spouse’s income. One spouse makes too much money, and the other goes without medication. It should be on the individual’s income, not the family. We all pay when that patient has heart attack or stroke, to prevent the big costs -- open heart surgery.”

- Dianna Inkster, Public, Kingston

“I’m from a Community Health Centre and have major concerns about determinants of health. In this area, stabilizing things like housing and food issues are important, we also need adequate support to stabilize the community. High risk youth and families are another area of concern. Areas for improvement: we need to promote wellness more. We need to look at more things like the CHC model of care (prevention, and looking at the social determinants of health, giving services at the front end to prevent chronic disease to prevent hospital visits). More effort into upfront dollars for prevention is important, especially mental health for youth. More money has to be put into chronic disease prevention and management as well. We’re doing a good job in primary care, we have nice access, extended hours, etc. Reaching everyone is difficult though, because of things like our literacy issue here. Education is a key indicator of positive health. Seniors living in poverty or isolation is also a problem due to the lack of transportation. CHCs need more support for this.”

- Carrie Salsbury, Front-line health provider, Central Hastings

“Integration of ministries at the provincial level -- we sit on coalition for children -- lots of people coming from different ministries. It would be much easier than us trying to coordinate that the ministries talk to one another. There’s some work that needs to be done at the higher level.”

- Susan Turnbull, Front-line care provider, Rideau Lakes

“Health care is not about closing the door once the horse has left. It is about ensuring that the horse gets to the barn. One of the examples is First Link - liaise with physicians, provide education, services, knowledge, some basic counseling and the studies that are out state the number of crises diminish because people know they are not alone. A study by Middleman says early education and intervention delays placement in LTC by an average 566 days. What kind of savings would that provide our health-care system? I look at the seniors association here - how they are keeping people active, integrated, involved.”

- David Townsend, Front-line care provider, Kingston & The Islands

“We need some more support in prevention and in training and teaching health promotion on nutrition. We’re working on managing chronic disease. Need more in schools, etc. Especially in Smiths Falls which is low income. Really need some nutrition and managing on a low budget to address obesity, etc. Community health centre does a lot of it. Public Health is also involved. Also hear the comment that the government wouldn’t let it be sold if it wasn’t good for us. Education at a young age of what is good for you, what isn’t and why.”

- Anonymous, Public, Smiths Falls, Perth & Lanark

“We need to address prevention programs - long term planning on prevention programs, nothing specific. Educate people how to look after themselves. Provide financial support to develop education program and ongoing support in creating education program to help individual prevent further illness and help manage their health.”

- Anne Belanger, Front-line care provider, Kingston

“Prevention is needed. A lot of focus on screening and chronic disease prevention, but we need to look at the early childhood, teenagers, etc.”

- Susan Turnbull, Front-line care provider, Rideau Lakes
Primary care

“Family health teams (and getting nurse practitioners to work under doctors) are really meeting the needs. It is a really good effort and a good start. I like the diversity of care that is provided through family health teams. I like how they offer social work. I would expect that anything under the medical umbrella that could be managed by [other professionals such as physiotherapists, social workers through a family health team] takes some of the burden off of the hospital system and some of the travel burden off rural areas.”
- Anonymous, Front-line provider, Belleville

“I want to know that somebody has a big picture of primary care. I am with the family health team. Since we do not come under the LHIN for funding, I feel we fall under the radar and then when they are doing their planning for family care, I don’t feel we get the same consideration. I know there is a Community Health Centre plan for Trenton and Belleville, we are trying to attract some physicians to Belleville and Trenton, but will not stay if they don’t get the patients. The more physicians the family health teams attract, the more allied health we can attract. Being able to provide this model means better care - patients have continuity in seeing the same physician. To go on attracting physicians, we have to be assured of them having patients.”
- Sue White, Front-line care provider, Brighton/Quinte West

“Once an initiative in a Community Health Centre is finished, there is no room to expand the program due to the way funding is streamed with the LHIN. We need to look at complete and comprehensive programs, instead of just poking at multiple things. CHCs are leading the way, especially in terms of integration and prevention. The comprehensive approach of CHCs should be LHIN-wide. The hub concept, bringing in a team across different sectors to serve the community. This is greatly beneficial in rural areas, as an example, mental health and addictions are tied to primary care, etc. Case management style of service delivery is also great. The aging population will bring more chronic disease, so again this stresses the need for prevention and promotion, which CHCs are focused around. In rural areas, children are moving out and not taking care of their parents anymore as most people suspect exists. This shows the greater level of need now more than ever for elder supports.”
- Carrie Salsbury, Front-line care provider, Central Hastings

“I have a feeling that some doctors only want to address one health concern per visit. I can I appreciate where that comes from, but as a service to consumers, it is limiting. It becomes more about processing people through. That said, some of the new physicians are working together well. It is really positive.”
- Anonymous, Front-line care provider, Belleville

“We need more doctors. My doctor is part-time, which is okay if I get sick on Tuesdays or Fridays. If you are feeling unwell at other times, you can call and are often told to just phone the ambulance.”
- Marion McWilliams, Public, Addington, North & Central Frontenac

“Family Health Teams are not under the LHIN. We (CHC) find this discouraging, because it is against the model of care we support. Sometimes family health teams are upfront and centre, but we don’t know why that is because they are not under LHINs. Perhaps you can work with family health teams to make sure you all have the same message. We often have difficulty coordinating with them, because they focus on primary care, and we on preventative care. Some level of LHIN initiation with the family health teams would help.”
- Carrie Salsbury, Front-line care provider, Central Hastings

“I think that LHINs are going to work better with Community Health Centres than the ministry has, because they seem to understand our model better. I am, however, concerned with keeping up with the cost of living -- especially with staffing. Demand for services keeps going up, but unless we have support to do it, it will be difficult to carry on. Perhaps re-examining funding models to keep up with the cost-of-living can be a solution. Related to this, with volunteers there is a huge learning curve, so training them is difficult. Also the volunteer base is shrinking, so this is not a suitable short-term solution. With our CHC, rent is an issue. Rent costs have increase significantly, but our budget line hasn’t changed, so we keep diverting from staff pay, and services. It’s not sustainable. This plays right back into the funding.”
- Mary Beth Raycroft, Front-line care provider, Napanee & Tyendinaga
“The benefit of the Community Health Centre for me is when I see a need in the community, I can work with clients around that. I do a lot of groups for people (i.e. depression), the model works for me, and so I can see a number of people. We developed a Good Food Box program which is run by volunteers (started five years ago). Same with Interval House, the counselor comes here to the centre and helps with people who are abused as opposed as them traveling to Brockville -- we look at the whole person. Because health has been so focused on medical model -- problem is finding funding for prevention, etc. It is that piece that needs funding in the rural areas. It’s the prevention piece.”
- Janice Giffin, Front-line care provider, Rideau Lakes

“There is a shortage of doctors in Ontario. I can’t understand why doctors won’t let nurse practitioners carry more of the load. We do have a doctor at the clinic on Wolfe Island - tried to get a nurse practitioner, but the doctors didn’t want to set it up.”
- Wayne Grant, Municipal representative, Frontenac Islands

“Most people in Tweed go elsewhere for primary care. We need more here, and we are lucky to have the Community Health Centre for that. Health centres (CHCs) are the key within health care. They encourage sharing of services across sectors, which is very positive. One location based on area needs improves access to services, better use of meeting spaces and common resources, as well as better use of IT. With the community health centre, I wasn’t as involved when it was first established, but now being a client I see all the good that comes out of it. The CHC is the best place to work in partnership with all other services (i.e. even child care or recreation). We have to promote health promotion, and they could be a key player.
CHCs were made to deal with rural communities and marginalized people; they do not have a vehicle for example, and it’s important these centres are there so the people have somewhere to go. The CHCs may be costly in the short term, but it will pay off in the end, because they keep people out of hospital.”
- Anonymous, Public, Central Hastings

“One of my big issues is the Ministry is not being straight with [family health teams] -- cutting funding for certain things, saying we are not meeting our numbers, but we are. To start, we were allocated four nurse practitioners, this year said we can only have three, which is a problem when we’re trying to look after patients. Nurse practitioners are so important to look after people who come in without appointments so they don’t end up in Emergency. The Ministry is not giving family health teams enough time to see what we have done. They have not truly measured what family health teams can do for the overall health-care system. Also, in regard to the IT budget - they are not giving us money to connect ourselves. We are trying to connect between BGH and our FHT, but they don’t want to pay. They want us to be doing that. Have hired one IT specialist for the all of Ontario. That person has to look at every family health team. Our ministry rep is talking to us, has never been to our facility and does not understand how we work. They need to see the collaboration, you have no idea.”
- Anonymous, Front-line care provider, Brockville

“I am concerned with the lack of a clinic in the Prescott area and that we are forced to visit the Brockville or Kemptville emergency departments for non-critical care. I believe there is a part-time clinic of 1-2 days per week but there is not a drop in clinic for after hours or during the day. My work schedule dictates the hours that I can see a family doctor for non-urgent care which restricted access for me during the day.”
- George Marsh, Public, South East Leeds & Grenville

“The Ministry needs to get with the real world. They are very complacent people who are not proactive, but only react. Family health teams are a good way to go about it but they need support in many ways such as having the Ministry outline its expectations – provide us with a format. There are no templates in terms of Ministry expectations... lack of guidelines, best practices, etc. There’s a lot of waste because there is no organization.”
- Anonymous, Front-line care provider, Brockville

“The whole doctor shortage issue is a major problem here too. I don’t know where it stands now, but we’ve looked at nurse practitioner-led clinics, but the funding for them is now on hold and that means we can’t provide better services right now. We are hoping to get a new family health team when the next round comes out. It could help address some of our problems. But it is difficult for us to get an application together as well. We simply don’t have big dollars to help get it ready. There is also usually a short timeframe to apply once those things are announced to try to get them in as well.”
- Henry Hogg, Reeve, Addington Township
“I question the statistics – there are a lot of people in Smiths Falls who do not have a family doctor. I moved back here four years ago, and until last month, I have not had a family physician. I have to go to Portland. Another person I know goes to Smiths Falls Community Health Centre – I’ve been contacting them at regular intervals and have always been told no openings and there was a one-to-two year wait. There is very conflicting information going out. I’ve been told numerous times they are not taking any new patients. It is inconvenient for me to go to Portland because I work in Perth.”
- Anonymous, Front-line care provider, Smiths Falls, Perth & Lanark

“Make things happen that have may have been stalemated, by thinking differently. A doctor in Westport may be retiring shortly, in their place consider a satellite of Country Roads.”
- Anders Carson, Municipal representative, Rideau Lakes

“What we’re really concerned about is maintaining our doctor at the Northbrook Medical Clinic. We are also in the process now of trying to get a Family Health Team in place. Over the years, we have been very frustrated with continual change in government preferred models of care. We think we are working toward a target, then the Ministry of Health changes the rules. That’s the way it is. It isn’t anyone’s fault. We would like them to pick a model and stick with it, instead of having a willy-nilly approach. We know what we would like for the community.”
- Anonymous, Municipal Representative, Addington, North & Central Frontenac

“The Verona & District Health Services Committee has a goal to find a doctor for Verona. Our community association was contacted by Dr XXXXX because she is going to be retiring. We spent two years doing a business plan and engaging in the community and did an awareness. Drs. XXXX and XXXX are doing their best to find someone else. We’re prepared to offer incentives, purchase clinic to lease back to any potential doctor if that is what they want to do. Wanted poster and offer $1,000 in gold, visit yourverona.com website. If you know someone who might be interested, registered their name... if that pans out, then you get the $1,000 in gold.”
- John McDougall, Public, South Frontenac

“Because we are rural, we have a long way to go for services. About two-thirds of the people go somewhere else to get a doctor. It is hard to get a doctor. I am on a waiting list at the local clinic and they estimate it will be about 15 years. I’ve tried to get into other clinics using NPs south of here, (most of my visits could be to a NP), but I’m told I am not in their catchment area. I see a podiatrist in Belleville, a heart specialist in Kingston, four other specialists in Mississauga. I have so much transportation for my medical services.”
- Gordon McCulloch, Public, Addington, North & Central Frontenac

Seniors’ Services

“I believe that the aging population is having an impact on the health-care system. Changes in the rate of dementia per 1000 and magnitude of population at risk. Creates demand in primary care and behavioral and cognitive supports. Supports in retirement home allow people to stay in that environment longer – consider a NP led team.”
- Allen Prowse, Front-line care provider, Kingston

“General geriatrics should develop in a team-based way, offering support to LTC homes (Easier+ as example where team could intervene more quickly).”
- Allen Prowse, Front-line care provider, Kingston

“We need more nursing homes for seniors in this region. More gerontologists are required in this region, due to the aging population. There is a need for them specifically in rural areas such as Picton, because we do not have proper access to senior services.”
- Anonymous, Public, Prince Edward County

“I’m a caregiver for my mother, and I’m also an urgent care family therapist. I see a need for support systems. Because I see a lot of the resources out there for mental health and addictions, I wonder why there isn’t a lot of support for Alzheimer’s. I don’t see support for the caregivers themselves. The high risk burnout for caregivers in this area for those dealing with Alzheimer’s is significant due to the cognitive aspect; it takes a toll on families and finances. As the health-care system puts more responsibility onto family caregivers, who is going to help these people? The risk of elder...
abuse is also a concern. Funding for agencies in place is a good way to support this, opposed to making new programs. The Alzheimer Society is fantastic, but their caregiver support program needs to be expanded. Coping strategies need to be focused on. Cancer, for example, has a lot of support available, if only we could expand this onto other conditions.”
- Denise MacDonald, Front-line care provider, Central Hastings

“This community is deficient in the services and supports from the Alzheimer Society. The society needs their program to be augmented. We aren’t getting all the education and support we need. My wish list: we have services augmented with Alzheimer Society Belleville to better meet the needs of Hastings County, and provide services like those in other communities (one on one, phone contact, training, networking with doctors, etc), to break down the barriers regarding lack of trust, and build a stable network to close the circle of care. Doctors are not making the referrals they need to make to the access centre or Alzheimer Society because they are not educated on this condition. Much work needs to be done regarding education and training.

We need an adult day community in Central Hastings so we can have respite in these communities. A lot of the people who could be here today, can’t because they are at home taking care of loved ones: their voices aren’t heard.

First Link coordinators position within the Alzheimer’s Society (linking doctors with support services like ours) position was cut because it was not funded. So who is the doctor talking to now? How are patients reaching the services? This position needs to be re-evaluated as it was vital.”
- Darlene Jackson, Front-line care provider, Central Hastings

“People are retiring in the rural areas, it is not just the aging population that we deal with. We have healthy seniors in Tweed, we start dealing with them in 70s and 80s. Madoc is the same. Then into Marmora - we’re dealing with people younger (59) because income, they are frail in that area. Stirling is our artsy area. You have to look at the whole picture. All programs are consistent, just handled differently. It is more difficult to get volunteers in areas such as Marmora.”
- Pat Dobb, Front-line care provider, Central Hastings

“With seniors, we’re able to provide a lot of services. There is a rising need for respite. There are so many caregivers out there.

The respite end is broad. The problem with people, as much as we love the people we care for, we’re not all skill set to do it. The problem with family caregiving for family is it changes the family dynamic. Yes, I am a spouse, but I have to be objective, supported, etc. Caregivers need time to regroup emotionally. I think personally what people need is respite where it comes into the home.

Normally the client who needs caregiving may not be happy outside of a normal place. They may get agitated, upset, unless it is someone who is comfortable being outside. Need to encourage caregivers to leave and do something that gives them a break -- not to do the chores. Do something that will refresh you. A couple of days -- not a few hours... take breaks throughout the week. Having one weekend is nice, but you’re not coming back rested or refreshed. It needs to be predictable time.”
- Anonymous, Front-line care provider, South East Leeds & Grenville

“I am concerned for seniors living alone at home and baby boomers who will be left to deal with all the seniors. Seniors should be able to stay at home as long as possible - good for mental well-being to be around familiar things, people. May need supplemental support but should have the option of when there they want to live.”
- Elizabeth Newton, Public, South East Leeds & Grenville

“My major concern is transportation to dialysis three to four times a week. I am also concerned that respite for caregivers needs more support for caregivers who assist the senior in staying at home. Increase options for respite for both client and caregivers such as daycare for seniors’ subsidization for retirement homes. More dollars for community support agency such as RESPITE and transportation. These hit home. Seniors need more at home to help them with the daily activities living. Program needs to help reduce the burn out for family member caring for the older family member in the community.”
- Lesley Renwick, Front-line care provider, Smiths Falls, Perth, Lanark

“I work with people who are frail and have dementia and want to remain in their own home. We provide assistance for providers (respite, spa day for caregivers at Camp Merrywood). I have an early stages group for people with dementia -- need more assistance in figuring out what it means, overcoming stereotypes. Caregivers get so burned out. I don’t know many people who get so burned out. Not only taking care of spouse, all household...
chores, etc. Not capable of physically doing, etc. Things out of their comfort level. So many don’t want to ask their children because they have own lives, or may not want kids to know how bad off mom or dad may be. There are not enough resources available for options for these people. Respite services are not sufficient enough. Some kids are working full time and are limited to what they can do. Dependent on the system or are in LTC way too early for a lot of reasons. That adds to the whole lack of LTC and waiting lists. People go on the waiting list because they might have to use bed and then name comes up. If they turn it down they have to start over, so they take it.”
- Anonymous, Front-line care provider, Rideau Lakes

Transportation

“Ambulance service here is always a big issue. It has been downloaded to the county and the county is huge geographically. If you look at the map, it is good but it doesn’t show all of the roads. All of this is part of the area we represent. The cost of ambulance service is the big thing. We know if you go by ambulance you get treated faster, but it is quicker sometimes to go by car. If you are in Denbigh and the ambulance is on standby down in Cloyne, it has to drive all the way back. I know that we have to be reasonable with our expectations. If the government is mandating that people have access to emergency services within a reasonable period, we know it could take at least 45 minutes to get to an ER on a good day.”
- Anonymous, Municipal representative, Addington, North & Central Frontenac

“Sometimes I think the ambulance services are underutilized in the area. Maybe the people at the ambulance base could provide some preliminary services to people. Right now, we know the ambulance in Denbigh gets two calls in three days. What do these people do? The cost is there whether there are calls or not. The ambulance base is funded by L&A County yet 60 per cent of the calls are outside of L&A County. The county boundary thing doesn’t make sense to something that is supposed to provide seamless service.”
- Henry Hogg, Reeve, Addington Township

“Medical drivers are supposed to be volunteer, but it costs so much. I’ve had more fights over the years on this volunteer thing.”
- Leona Neal, Public, Addington, North & Central Frontenac

“There is an issue with ambulance on Wolfe Island the big problem is in trying to get volunteers. They take the courses, get paid for standby. It’s run by Frontenac Paramedic, but they are all volunteers. Part of the problem right now, time for getting the training is long and they get discouraged. We’ve had 24-hr coverage, but now there is a shortage of volunteers. If there is no one on standby on Wolfe Island, then you have the time for the ferry.”
- Wayne Grant, Municipal Representative, Frontenac Islands

“The bulk of the population lives in the southern part of the region and transportation is less of an issue for them. Anyone north of the 401, there is no transportation. It can mean lengthy drives... I don’t know what the solution is. The idea with the vans and Aging at Home may be a step in the right direction... it’s a huge issue. Volunteer drivers, taxi chits, etc. at the end of the day, it’s often family members. Transportation will always be a problem in this part of the world. It’s not downtown Toronto.”
- Chris Sullivan, Front-line care provider, Kingston

“Six months ago, wheelchair transportation is a big issue in this area and the cost to even go shopping. In Central Hastings, it was not accessible. We will be getting a wheelchair van through the LHIN. We don’t truly know the true need, because we have not provided the service yet. We don’t know the true need of that. I don’t think our agency has trouble with transportation, but there are some agencies out there that are not LHIN-funded who provide transportation without guidelines, so there is no way to monitor. The agencies funded through the LHIN - we try to provide consistency.”
- Pat Dobb, Front-line care provider, Central Hastings

“I spend a lot of time in cancer centre - people travel long distances to get there. Some of the transportation needs are addressed by volunteers. I don’t have an easy solution, the South East LHIN is so rural for a southern LHIN, there are significant number of people living scattered across the region. Satellite...
services in Belleville. Getting physicians to supervise nurses up to speed and maintaining skill levels. In the rural part it is transportation. Outside of cities, people are spread out and there is travel distance for health professionals. Home visiting is difficult. Rurality is a real challenge. We need innovative ways to deal with that. Technology may be a way to do that. Video conferencing may help.

- Ray Viola, Front-line care provider, Kingston

“There are a lot of situations where people travel a long distance, even with volunteers, it costs a lot of money. Is the solution to move services closer? There is a lot of financial pressure on people. Organizations are helping where they can, but you are always making choices. It is difficult to make those decisions. Transportation for medical needs is always a priority for people who providing those services - but you have people who may want to get their own groceries. In Prescott, we contacted the grocery store, so they will now take calls and deliver. That was a wonderful solution. We’re always looking for volunteers as well. Transportation is widely used - that and meals on wheels, the amount of service we offer in those areas. With the aging population, more requests for home health home maintenance ... a lot of families have temporary needs. When they need it, it is important... changing bed clothes, helping bathe and dress and having a meal.”

- Anonymous, Front-line care provider, South East Leeds & Grenville

“There are a lot of eager groups wanting to look into transportation, but we need to have something pulled together regionally. Right now we find success with specific providers (ie St. Mary’s) and we need to duplicate that elsewhere.”

- Anonymous, Front-line care provider, Gananoque

“Transportation is always a huge issue. Many organizations that are starting up don’t think about transportation. it isn’t necessarily specific agency’s mandate to get people there. Sometimes it can be poverty or age-related. There is a lot of poverty as well.”

- Anonymous, Front-line care provider, Gananoque

“My major concerns are health care cuts and transportation issues for people in our area. Our population is smaller therefore has a smaller voice. We have lost a voice to larger centre such as child

need to go to Ottawa for treatment versus staying with Perth/Smith Falls we don’t have the expertise to care for our children when the beds have been cut in order to meet the bottom line.”

- Catherine Ryan, Front-line care provider, Smiths Falls, Perth & Lanark

“The transportation services that began over the last year need to be continued and expanded to include a wider area. The Community Support Sector agencies have good transportation services to get to appointments. The transportation services should fit in and enhance the services offered through municipalities or EMS. You should do a traffic flow analysis to track where people are travelling. How can we combine transportation offered? We will run out of volunteers. People across the region all have similar issues.”

- Anonymous, Front-line care provider, Quinte West & Brighton

“I think a lot about the problem in getting transportation getting to the cancer clinic, for an MRI and other treatments. We should consider a shuttle bus service. Perhaps have an endoscopy suite within this area if we have the capacity. Appointment at hospital A @ 0800 and then you have to go hospital B.. shuttle bus transports individuals around... Parking at QHC is horrible, Picton Hospital you can do - Next week, taxi company develops a schedule to transport patient around to their appoints at all the hospital.. Hospital A,B & C. Pay for it perhaps through municipal government. No parking issues. We should have the ability to do this with the technology available today.”

- Wayne Cooper, Public, Prince Edward County
PROGRAMS & SERVICES:
A listing of existing resources in the South East LHIN
July 2009
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INTRODUCTION

Purpose of the Study

The South East LHIN is required by the Ministry of Health and Long Term Care (MOHLTC) to develop an Integrated Health Services Plan (IHSP). The plan will be presented to the Minister and will provide the basis for the coordination and integration of health services, and ultimately, the funding of these services by the LHIN.

An integral part of the IHSP is to understand both the demand for services and the supply of services. As a result, the LHIN has undertaken the development of the Regional Capacity Assessment & projections (ReCAP) report which will provide the foundation for the present and future Integrated Health Services Plans.

This report provides information on existing programs and services. The database information was then compared with provincial standards to assess gaps and trends.

Methodology of the Study

To undertake the study, the following secondary source data was collected:

Local Program and Service Data: Local program and service data were collected, reviewed, and data was extracted to develop a database of local programs and services across the LHIN. Programs and services included: community services, mental health and addictions services, long-term care, and hospitals.

Sources of data included:
- Service level agreements;
- Management Information System (MIS) Data: Financial and staffing information was collected to the greatest extent possible from available MOHLTC Data;
- MOHLTC Online Healthcare Indicator Tool (HIT Tool): All year-end and quarterly data as well as a breakdown of financial data sets by functional centre;
- Location of Programs: Programs and services within the LHIN catchment area were mapped using postal codes;
- National and Provincial Program and Service Data: MOHLTC program and service data were collected for hospitals and mental health and addictions services. Additional literature and data were obtained from the MOHLTC website and from Health Canada and Statistics Canada.

Limitations of the Report

The following are limitations:
- For those organizations where the only financial data available was from the MIS database, the information provided in the Programs and Services database developed is based on LHIN related base funding which does not represent the total budget for the organization.
- There is limited information of volunteer service and for the provision of services in French language.
- No information about waiting lists, or lengths of waiting time for services was analyzed.
- No information from consumers about quality of services was analyzed.
- Few organizations have undertaken evaluations of programs and services to identify strengths and limitations of services.

Organization of the Report

The study reports information from the data collected. Section 2 begins with a description of programs and services within the South East LHIN, followed by a discussion of issues that were identified, trends, and gaps. The findings are then discussed and where possible conclusions are provided.

Programs and Services Overview

Throughout this section, unless otherwise noted, the data presented is drawn from the sources listed in section 1.2 of this report. The Programs and Services analysis is largely based upon
existing information as it was presented in the Service Level Agreements received.

**Location of Services**

All information included in this section is comprised from the information available to the South East LHIN. The number and types of organizations are shown based on the postal code information that is available to the LHIN.

The South East region extends from Brighton on the west to Prescott and Cardinal on the east, north to Perth and Smiths Falls, and back to Bancroft (Map 1). Service locations are dispersed throughout the LHIN geography, with concentrations of services in the urban areas.

**Types of Services:**

There are eight sectors that the South East LHIN is responsible for funding and planning. The following figure describes the types of services within each sector.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>7</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>34</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14</td>
</tr>
<tr>
<td>Addictions</td>
<td>5</td>
</tr>
<tr>
<td>Community Health Centres</td>
<td>4</td>
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<tr>
<td>Family Health Teams</td>
<td>14</td>
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<tr>
<td>Community Care Access Centre</td>
<td>1</td>
</tr>
<tr>
<td>Community Support Services</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total Organizations</strong></td>
<td><strong>111</strong></td>
</tr>
</tbody>
</table>

In total, there are currently 111 funded organizations in the South East LHIN.

**Hospitals**

Map 2 (Appendix B) indicates the locations of hospitals throughout the LHIN. The following is a list of the 7 hospitals within the South East region and an overview of their services and capacity.

**Quinte Health Care Corporation (QHC; Multi-Site)**

There are four sites within the QHC Corporation; QHC Belleville General (Belleville), QHC Trenton Memorial (Trenton), QHC Prince Edward County Memorial (Prince Edward County), QHC North Hastings (Bancroft). The following is a description of service provided by each of the four QHC sites:

QHC Belleville General - is the largest of the four hospital sites with a total of 206 beds. Services include: ambulatory care, cardiology, obstetrics and gynecology, complex continuing care, oncology services, diabetes education centre, oral surgery, diagnostic imaging (ultrasound and CT scanning, nuclear medicine), orthopedics, emergency medicine, pediatrics ENT, pathology, family practice, pharmacy, general surgery, physiotherapy and occupational therapy, intensive care, psychiatry/mental health, internal medicine, speech and language, children’s treatment centre, crisis intervention, ACTT, laboratory medicine, and urology.

2. QHC Trenton Memorial - with 70 inpatient beds, supports primary and some secondary care including emergency services, complex continuing care, AND medicine/surgical. QHC Trenton Memorial site is the district centre for ophthalmology services. Other services are provided in physiotherapy, diagnostic imaging, laboratory, and outpatient clinics including the Ontario Breast Screening Program.

3. QHC Prince Edward County Memorial - with 30 inpatient beds, provides care to the residents of the community with services including complex continuing care, a diabetes education centre, emergency services, laboratory, obstetrics (low-risk), outpatient clinics (including crisis intervention; general surgery; gynecology; internal medicine; orthopedics; urology; dialysis), pharmacy, physiotherapy, radiology, and outpatient surgical services.

4. QHC North Hastings - a rural acute care hospital site with 10 inpatient beds provides a variety of services including a diabetes education centre, diagnostic services, emergency department, and
outreach clinics specializing in obstetrics/gynecology, urology and telepsychiatry.

**Kingston General Hospital (KGH; Kingston)**
KGH is a 456-bed teaching hospital, affiliated with Queen’s University and is the community hospital for the Kingston area. KGH provides a range of specialized acute and ambulatory clinical services including trauma, cardiac, stroke, pediatric, perinatal, end stage renal and stem cell transplants. KGH also is home to the Cancer Centre of Southeastern Ontario. KGH supports an academic research as well as provides hands-on skill training for 1,900 health care students annually.

**Hotel Dieu Hospital (HDH; Kingston)**
Hotel Dieu Hospital is the ambulatory care teaching hospital located in Kingston. Specialized services include outpatient pediatrics, ophthalmology, diabetes education, breast assessment, day surgery, urgent care and mental health programs. Affiliated with Queen’s University, HDH is responsible for research and training health care professionals.

**Providence Care (PC; Kingston)**
Located in Kingston, Providence Care provides care related to rehabilitation, specialized geriatric care, complex continuing care, specialized mental health care, palliative care and long-term care. Through their affiliation with Queen’s University, the hospital is responsible for teaching and research.

**Lennox & Addington County General Hospital (LACGH; Napanee)**
The Lennox & Addington County General Hospital provides both General Medicine and general surgery. In partnership with KGH, a wide range and scope of clinics services are provided. Emergency services are available 24 hours a day, treating 24,000 patients last year. The hospital currently operates 52 beds and offers a comprehensive range of diagnostic services supported by a well equipped laboratory and diagnostic imaging department.

**Perth and Smiths Falls District Hospital (Multi-Site)**
There are two sites within the Perth and Smiths Falls District Hospital offering similar services and in relatively close proximity to one another. The locations of this hospital are Perth and Smiths Falls. There are sixty-three medical and surgical beds available between both sites. Services include general medicine, internal medicine, general surgery, dental surgery, ENT, orthopedics, urology, obstetrics, gynecology, anesthesiology, pediatrics, complex continuing care and emergency services.

**Brockville General Hospital (BGH; Brockville)**
BGH is a 141 bed hospital with specialty services that include various ambulatory clinics, emergency services, diagnostics, surgical services, ECG, cardiac services, respiratory therapy, and is a screening site for the Ontario Breast Screening Program.

**Long-Term Care**
Long-term care homes are intended for people who require 24-hour nursing care and supervision within a safe setting. These homes are owned and operated by various organizations. Nursing homes are usually operated by private corporations while municipal homes for the aged are owned by municipal councils. Municipalities are required to operate a home for the aged in their area, either on their own or in partnership with a neighbouring municipality. Charitable homes are usually owned by non-profit corporations, such as faith, community, ethnic or cultural groups.

As shown in Map 3 (Appendix B), there are some pockets of concentration long-term care facilities, but for the most part, these homes are scattered throughout the LHIN, in rural areas and cities and towns. There are 3,778 beds (short and long-stay) in total.

**Beds in Operation:**
New Beds – 1,224
A Beds - 331
B Beds - 997
C Beds – 1,085
D Beds - 78
Interim Beds - 45
Short Stay Beds - 18
Total Beds – 3,778
Mental Health

Mental health programs and services include specialized hospitals and mental health agencies. Map 4 (Appendix B) indicates the locations of mental health services/programs.

Brockville and Area Centre for Developmentally Handicapped Persons Incorporated

Clients receiving services are characterized as being 16 years of age or older who are experiencing a mental health crisis or distress. The following are of LHIN-funded services:

- Crisis intervention
- Distress centre – offering toll-free telephone services
- Living works suicide intervention workshops in Lanark, Leeds and Grenville

Canadian Mental Health Association, Leeds-Grenville Branch:

Clients receiving services are characterized as being 16 years of age or older who are experiencing a serious and persistent mental illness or adult family members of individuals with mental health, concurrent disorders or dual diagnosis issues. Clients may also include transitional aged youth (16-18 years old) before the courts and experiencing mental health, concurrent or dual diagnosis issues (limited services to those under this age as required by the courts); adults who reside in rural catchment areas whose transportation needs are restricted. In addition, youth attending grade 10 receive suicide awareness and anti-stigma workshops.

The following are LHIN funded services and annual usage:

- Mental health diversion and court support – 130 individuals served in 2007/2008
- Mental health social rehabilitation/recreation – 2,231 individuals served in 2007/2008
- Health promotion and education – 1,559 individuals served in 2007/2008

Frontenac Community Mental Health Services

Clients served are individuals 16 years of age or older living with severe and persistent mental illness and/or clients with co-occurring disorders such as developmental disability, forensic, geriatric and addictions. The following are LHIN-funded services and usage rates in 2007/2008:

- Residential services – 18 bed high support housing beds; 10 medium/high support housing beds; 87 low to medium support housing; 44 rent supplement housing.
- Vocational program – provides support to achieve competitive employment for clients – 143 individuals
- Case management services – provides clinical treatment and support services to clients and to persons released from forensic unit – 372 individuals
- Court support services – provides post-charge advocacy and linkage for individuals who commit minor offences – 127 individuals
- Assertive Community Treatment Teams - provide intensive support and comprehensive treatment to individuals diagnosed with severe and persistent mental illness – 187 individuals
- Crisis services – provides 24-hour crisis intervention to individuals to help them avoid hospitalization via mobile crisis response and a 24/7 crisis telephone line response. Short-term crisis beds are available to persons in acute situations not requiring hospitalization or as a diversion to criminal justice system – 288 individuals
- Family Resource Centre (FRC) – provides resource materials to broader community on issues related to mental health. FRC provides support to families of persons experiencing mental health issues.

Leeds and Grenville Rehabilitation & Counseling Services

Clients served are individuals 16 years of age or older living with severe mental illness and/or mental health problems. Services are also provided to those persons who are experiencing acute situational distress. The following are LHIN-funded services and usage rates in 2007/2008:

- Intake/ assessment counseling
- Intensive case management – 618 individuals
- Vocational programs – 99 individuals
- Therapeutic, social, recreational and wellness programs – 120 individuals
- Life skills rehabilitation
- Range of supported and supportive housing options from a 24/7 group home, crisis bed, less supervised group homes, cooperative housing to independent rent geared to income housing. Housing includes: 26 units in housing program 750; 11 units in housing program 500; 51 units in homeless; 22 independent agency owned apartments; 27 group home beds
including one crisis bed – 147 individuals served with housing supports.

Lennox & Addington Community Mental Health Services Inc.
Clients are individuals experiencing acute and chronic symptoms of serious mental illness and addiction. The following is a list of LHIN-funded services and their usage rates in 2007/2008:

- Case management – 164 individuals
- Community support services
- A criminal justice program consists of two main components: Release from custody program that assists mentally ill persons with reintegration into the community and case management that includes programs to decrease the risk of recidivism.
- Counseling and treatment – 234 individuals
- Concurrent disorders
- Diversion and court support – 43 individuals
- Social rehabilitation/recreation – 28 individuals
- Addiction treatment – There are six main components to substance abuse treatment: assessment and treatment planning; community-based treatment; outpatient counseling; case management and referrals; youth programs for children and youth affected by their own abuse or the substance abuse of others; family support services; and a needle exchange program.
- Addictions treatment: problem gambling
- Crisis Intervention – 661 individuals
- Residential mental health: provides support within housing
- Rent supplement – 18 individuals

Mental Health Services-Hastings Prince Edward
Clients are individuals 16 years of age or older with serious mental health issues defined primarily by schizophrenia, mood disorders, personality disorders, post traumatic stress disorders, concurrent disorders, dual diagnosis, anxiety disorders, dissociative disorders, dementia and cognitive disorders with pre-existing SMI. The following are LHIN-funded services and their usage rates (2007/2008):

- Case management – 1077 individuals
- Court diversion – 157 individuals served in 2007/2008
- Social rehabilitation/recreation – 201 individuals served in 2007/2008
- Support within housing – 113 individuals served in 2007/2008
- Consumer Survivor Initiative
- Marketed Services Residential Mental Health

Mental Health Support Network - Hastings Prince Edward Corporation
Clients are individuals 16 years of age or older with a self-identified mental health issue. The following are LHIN-funded services:

- Peer Support – support groups between individuals struggling with mental illness
- Education
- Activities – lunches, trips, games and hobbies
- Advocacy – assistance in dealing with demands and agencies that impact their lives
- Resources – books, pamphlets and other information sources are provided to clients
- Employment – assistance in job searches and volunteer opportunities
- Computer – assistance with learning how to operate computers

Perth and Smiths Falls District Hospital
Clients are adults and youth aged 16+ experiencing moderate to serious mental illness; seniors in need of dementia-related specialized assessment/consultation; and female victims of sexual assault. LHIN-funded services include:

- Case management
- Counseling and treatment
- Diversion and court support
- Abuse services
- Social rehabilitation and recreation
- Crisis intervention
- Housing support (rent supplement)

In addition, there are two services in affiliation with regional hospitals: Geriatric psychiatry outreach (ROHCG and Providence Care); General psychiatry assessment and consultation (ROHCG and Elmgrove).
Providence Care
There are a variety of individuals who are provided with care at Providence. LHIN-funded services include:

- Attendant care outreach program – for individuals 16+ who are willing and able to direct their own care but may be in need of physical assistance with personal care.
- Psychogeriatric specialty outreach services – targeted to older clients with late onset cognitive or responsive-associated behavioural needs.
- Dual diagnosis community outreach team – for individuals 16+ or older with an intellectual disability, autism or pervasive developmental disorder with a suspected or diagnosed mental illness or behavioural disorder.
- Community treatment order program - for individuals 16+ with a serious mental illness who voluntarily choose to receive treatment and supervision in the community that is less restrictive then a psychiatric facility.
- Hildegarde Centre – for persons 55+ with dementia or complex care needs requiring a safe and stimulating environment.
- Regional Community Brain Injury Services – for individuals 18+ with a diagnosed moderate to severe acquired brain injury.
- Telepsychiatry – For individuals aged 18+ with mental health issues in a tertiary setting.
- Psychogeriatric resource consultants – front-line staff in long-term care homes and community support agencies who provide service to older individuals with complex cognitive or mental health needs and associated behavioural disorders.

Quinte Health Care
There are two main agencies within QHC offering services in mental health:

- Hastings Prince Edward Counties Assertive Community Treatment Team: For individuals 16+ with long term and serious mental health issues. Priority is given to people with schizophrenia or other psychotic disorders and those with bipolar disorder who have two or more admissions to hospitals or one admission to hospital lasting longer than 30 days. Other people provided with priority services are those with high use of Schedule 1 hospital services or specialty hospital services, tertiary level services or psychiatric emergency services and/or coexisting substance abuse problems or clients who have significant functional impairments demonstrated by the inability to perform a range of daily living activities.
- Crisis Intervention Centre: For individuals 16 years + in crisis who require help to resolve immediate crises and stabilize psychological/psychiatric conditions.

Hotel Dieu Hospital
There are three main mental health programs:

- Early intervention in psychosis – for individuals aged 14-35. Goal is to reduce the duration of untreated psychosis, decrease the utilization of inpatient hospital beds while actively targeting recovery of social functions and maintaining recovery for the first five years of care.
- Mental health eating disorders – targeted to adults 18 years or older diagnosed with anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified.
- Detoxification centres – assisting in the non-medical withdrawal from drugs and alcohol. Additionally there is 24-hour phone support.

Sexual Assault Centre Kingston Incorporated
For women aged 16+ who have experienced sexual violence. Services include feminist client-based counseling and up-to-date resources on issues related to sexual violence and other community supports. In 2007/2008, 60 women utilized these services.

Sexual Assault Crisis Centre Quinte and District
For individuals aged 16 years+ who have been victims of sexual violence. Group and one-on-one counseling services are provided. In 2007/2008, 40 women utilized these services.

Youth Habilitation Quinte Incorporated
For youth between the ages of 16 and 24 (transitional age) who have housing needs and symptoms of mental illness. Clients are connected to adult service systems during their stay. LHIN-funded services and their utilization in 2007/2008 include:

- Case management mental health – 178 individuals
- Counseling and treatment – 139 individuals
- Support within housing – 102 individuals
- 14 supported housing units – 102 individuals
Addictions Services

Addictions programs and services include those targeted at gambling and substance abuse. Map 5 (Appendix B) indicates the locations of addictions services/programs.

Addictions Centre Hastings Prince Edward
For community outpatients aged 16+ with problematic substance abuse, gambling and/or concurrent disorders. Clients in the residential addiction treatment program are men aged 21+ with problematic substance abuse and concurrent disorders. LHIN-funded services include:
- Concurrent disorders services
- Substance abuse program
- Initial assessment and treatment plan
- Residential addiction treatment services
- Problem gambling prevention.

The Brock Cottage Incorporated
Clients served at Brock Cottage are exclusively male; female clients are served at Tennant House. All clientele must meet MOHLTC standardized admission criteria and be afflicted with a severe and persistent addiction. There is no specialized program for concurrent disorders. In 2007/2008, 107 individuals were provided drug and alcohol rehabilitation.

The Governing Council of the Salvation Army in Canada –Kingston Harbour Light
For men aged 18+ with problematic substance abuse. LHIN-funded services include:
- Addictions treatment for substance abuse
- Initial assessment and treatment planning

Options for Change: Community Addictions Treatment Services
For any individual with substance abuse and problem gambling or women who are pregnant and substance involved. LHIN-funded services and their utilization in 2007/2008 include:
- Case management – 314 individuals
- Assessment and treatment – 1,524 individuals
- Problem gambling prevention and awareness – 960 individuals
- Mental health concurrent disorders

TriCounty Addiction Program
For individuals aged 10+ who are challenged by substance use, problem gambling, concurrent disorders, and/or crises while in correctional services. LHIN-funded services and their usage rates in 2007/2008 include:
- Case management – 1,811 individuals
- Initial assessment and treatment – 865 individuals
- Substance abuse treatment – 1,082 individuals
- Problem gambling treatment – 106 individuals
- Problem gambling awareness and education
- Concurrent disorders – 284 individuals
- Crisis intervention – 21 individuals
- Health promotion and education

Community Health Centres

Community Health Centres (CHCs) are non-profit organizations that provide primary health and health promotion programs for individuals, families and communities. A health centre is established and governed by a community-elected board of directors.

The LHIN has four Community Health Centres, located in Kingston, Merrickville, Portland and Tweed as shown in Map 6. Satellite CHCs are also in Smiths Falls and Napanee. A fifth CHC plus a satellite are under development for Belleville and Quinte West respectively.

Country Roads Community Health Centre
Provides services for those aged 0-18, seniors, low income persons and those living in rural areas. LHIN-funded services include:
- Primary health care
- Illness prevention
- Health promotion
- Capacity building

Gateway Community Health Centre
Provides services for individuals in rural areas and those at risk due to issues such as poverty, illiteracy, mental health, seniors, addictions and age. LHIN-funded services include:
- Access to primary care
Early Years Program: a health promotion and educational program ranging from how to properly cradle babies to providing playgroups

Community capacity building

Kingston Community Health Centre
Provides services for individuals who may be marginalized or face multiple barriers in everyday life, due to low income, illiteracy, chronic diseases, sex trade workers, drug addiction, history of incarceration and off-reserve aboriginals. There are four sites of care within the Kingston CHC:

- North Kingston CHC offers interdisciplinary primary health care and health promotion.
- Street Health Centre provides an inner-city health partnership offering primary health care.
- Better Beginnings for Kingston Children provides individual or group programs for peri-natal care and peer support as well as school readiness programs to assist pre-school children in succeeding.
- Napanee and Area Community Health Centre offering community engagement and information and an off-reserve aboriginal outreach program.

Merrickville District Community Health and Services Centre
Individuals given priority include seniors, former residents of the Rideau Regional Centre, families with young children and pregnant women and the population living in designated underserviced areas. Merrickville District Community Health and Services Centre operates the Smiths Falls CHC and the Merrickville CHC as well as the Rideau Valley Diabetes Service. LHIN-funded services include:

- Primary health care
- Chiroprody
- Dietitian/nutritionist
- Health promotion and community development
- Respiratory therapy
- Social work
- Community nursing program
- Nursing foot care
- Smoking cessation
- Early Years Program
- Diabetes education
- Oral health initiative

Family Health Teams

Family Health Teams (FHTs) are groups of health-care experts, such as physicians, nurse practitioners, nurses, social workers and dietitians who work together to provide primary care for a group of patients. They provide a wide range of services including health promotion, treatment services, chronic disease management and prevention, rehabilitation and palliative care.

They provide after-hours coverage to provide health advice and care so their patients do not have to go to busy hospital emergency departments for non-urgent care. They also help patients navigate their way through the other parts of the health-care system to receive the best possible care.

FHTs are a new approach to delivery of front-line, family medical services. As shown in Map 7, there are 14 Family Health Team within the LHIN. The following is a list of the family health teams in South East and the locations of their main operations:

- Athens and District FHT – Athens
- Bancroft FHT – Bancroft
- Brighton/Quinte West FHT – Brighton
- Brockville FHT – Brockville
- Kingston FHT – Kingston
- Central Hastings FHT – Madoc
- Maple FHT – Kingston
- North Hastings FHT – Bancroft
- PFIMMA FHT – Prescott
- Prince Edward FHT – Picton
- Queen’s FHT – Kingston
- Community Primary Health Care (CPHC) Brockville Community FHT – Brockville and Gananoque sites.

Community Care Access Centre

Community Care Access Centres coordinate services for seniors, people with disabilities and people who need health-care services in the community to help them live independently in their own homes for as long as possible. The CCAC also provides information and coordinates professional, personal support and homemaking services for people living in their own homes and for school children with special needs. Additionally, the CCAC will assist in
making arrangements for admission to long-term care facilities. In 2007/2008 the South East CCAC served 33,731 clients and experienced total visits (face-to-face and telephone) of 453,712 individuals. The South East CCAC has 7 offices. They are located in Smiths Falls, Brockville, Kingston, Selby, Northbrook, Belleville and Bancroft. Map 8 shows the locations of the Community Care Access Centre offices.

Public Health Units

Public health focuses on three areas: preventing conditions that may put health at risk (health protection), early detection of health problems (screening), and changing peoples and societies attitudes and practices regarding lifestyle choices (health promotion).

Health protection works particularly in the areas of food and water safety environmental risks such as toxic waste handling and air pollution, second-hand smoke, public sanitation, spread of rabies, vaccinations against major communicable diseases, and mandatory tuberculosis screening of immigrants to Canada.

Screening programs are aimed at specific groups, where the early detection of an illness or problem can lead to significant improvements in health. Examples of this are the Healthy Babies, Healthy Children program, school-age dental exams and breast and cervical screening for cancer.

Health promotion programs include education around effects of tobacco use, nutrition, physical activity, injury prevention, birth control and reproductive health, prevention of sexually transmitted diseases including HIV/AIDS and breastfeeding.

Public health unit locations are shown on Map 9. There are 3 PHUs in the South East LHIN -- located in Belleville, Kingston and Brockville.

Community Support Services

Community Support Services (CSS) help individuals to maintain safety and independence. Services are delivered either in the home or in different locations around the community. Organizations that provide these services can be either non-profit corporations or private companies. Community Care Access Centres (CCACs) help in defining individual needs and situations, determining support services that might be eligible for CSS services, locating providers and applying for care. The CCAC also provides information about the availability of financial subsidies for particular CSS service options.

The following is a summary of the LHIN-funded community support services within the South East. Map 10 shows all agencies across the LHIN.

Alzheimer Society: There are 5 Alzheimer Societies within the South East: Belleville, Kingston, Lanark, Leeds-Grenville and Prince Edward County. These services are targeted to those individuals with memory loss, Alzheimer’s disease and related dementia. Also served are health professionals and informal caregivers. LHIN-funded services provided include:

- Full-time public education coordinator;
- Information and support group sessions for persons with dementia;
- Information and support group sessions for caregivers;
- Mobile offices;
- Individual counseling for persons with dementia and/or for caregivers;
- Outreach programs to caregivers and businesses;
- Resource centre;
- Advanced care planning;
- Gentle persuasive approach training for front line staff (Prince Edward, Kingston, Belleville and Lanark);
- Elder abuse prevention training (Belleville).

The Alzheimer Society of Kingston offers additional services including:

- Grade 4 program – a one-hour in class program to teach children the importance of protecting their brains and how to communicate to those with dementia;
- Safely-Home Alzheimer Wandering Registry – nationwide partnership with RCMP to speed up the search process for those who have gotten lost. This involves the use of a confidential database and identification bracelets;
- Volunteer Companion Program – matches an early stage ADRD patient with a volunteer for stimulation and caregiver respite;
- Support to research to help uncover causes and possible cures for people with dementia
**Brockville General Hospital – Leeds Grenville Volunteer Hospice Service**

Largely for individuals with cancer (65%) and those over the age of 65 (64%). LHIN-funded services include:

- Home visiting.
- Bereavement support - individual support; group support; grief walking group; monthly grief support group.
- Day Hospice - enhance client’s quality of life; respite; socialization; therapies; pain and symptom expertise.

**The Canadian Hearing Society**

For individuals 55+ with an acquired hearing loss and those under 55 who may have acquired hearing loss and another disability requiring home visits. LHIN-funded services include:

- Hearing care counseling program; and
- General support services.

**Canadian National Institute for the Blind**

For all individuals with significant vision loss. Almost three-quarters of all clients are 60+ with vision loss caused mainly by macular degeneration. LHIN-funded services include:

- Rehabilitation services
- Registration and referrals
- Low vision services – training on how to use low vision devices
- Independent living skills
- Orientation and mobility – safe traveling and indoor and outdoors
- Assistive technology and consumer products – provides assessment on technology products and assists in purchases through the Assisted Devices Program.

**Central Frontenac Community Services**

Services for seniors aged 55+ or those 18 and over who have physical disabilities. LHIN-funded services include:

- Service arrangement and coordination
- Meal delivery
- Social and congregate dining
- Transportation
- Crisis intervention
- Day services
- Caregiver support
- Social and safety visiting as well as hospice service
- Foot care
- Good food box program
- Licensed home childcare
- Financial assistance programs
- Free office space provided to the Arthritis Society, Alzheimer Society, Canadian Hearing Society, Kingston Community Counseling Centre and Community Living Kingston
- Diners program

**Cheshire Homes**

Services provided to those aged 16+ with a physical disability who may require comprehensive physical supports (i.e. transferring, dressing, bowel and bladder care, bathing, breathing, meal preparation, eating etc.). LHIN-funded services include:

- Assisted living services;
- Personal support and independence training; and
- Some sub-contracting

**Community & Primary Health Care – Lanark, Leeds and Grenville**

Provides services for individuals 18+ with physical or mental challenges as well as seniors with Alzheimer’s, dementia, frailty and other aging medical challenges. LHIN-funded services include:

- Meals on Wheels
- Social and congregate dining
- Transportation
- Crisis intervention
- Day services
- Homemaking
- Home maintenance
- Respite
- Caregiver support – for those caring for people with dementia or Alzheimer’s
- Friendly visiting
- Foot care

**Community Care**

There are three Community Care centres located within Hastings County - Community Care for North Hastings, Central Hastings and South Hastings. Clients served are adults and seniors living with permanent physical disabilities. Each of these three centres offers the following services in common:

- Meal delivery;
➢ Transportation;
➢ Crisis intervention and support; and
➢ Social and safety visiting.

Each Community Care centre also offers services unique from its counterparts, they include:
➢ Foot care services – North Hastings and South Hastings;
➢ Social and congregate dining – Central and South Hastings
➢ Alive driver refresher courses – South Hastings
➢ Homemaking and home maintenance – Central Hastings.

Community Home Support Lanark County
Provides services for senior citizens with physical disabilities. LHIN-funded services include:
➢ Meals on wheels
➢ Congregate dining
➢ Transportation
➢ Client intervention and assistance
➢ Home help and home maintenance
➢ Friendly visiting
➢ Volunteer hospice visiting
➢ Foot care

Gananoque and Areas Services to Assist Independent Living Incorporated
Provides services for adults with physical disabilities, adults convalescing from illness, injury or surgery as well as senior citizens who have become frail or disabled. LHIN-funded services include:
➢ Service arrangement and coordination
➢ Meals delivery
➢ Social and congregate dining
➢ Escorted transportation
➢ Crisis intervention
➢ Social and safety visiting
➢ Foot care

Hospice
There are six hospice services in the South East region:
➢ Heart of Hastings Hospice
➢ Hospice Kingston
➢ Hospice Lennox and Addington
➢ Hospice North Hastings
➢ Hospice Prince Edward
➢ Regional Hospice of Quinte Incorporated

These organizations provide services to clients who have a life-threatening illness or have been terminally diagnosed. LHIN-funded services include:
➢ Palliative care volunteers home visiting – Lennox and Addington, Quinte, Prince Edward, North Hastings, Heart of Hastings;
➢ Bereavement support;
➢ Respite care – Kingston, Quinte and Heart of Hastings
➢ Medical equipment loaning free of charge – Quinte, Heart of Hastings, Kingston

Land O’Lakes Community Services
Clients served are those individuals 55 years of age or older who are physically disabled but have chosen to live within their own homes. The following is a list of LHIN funded services:
➢ Meal delivery
➢ Social and congregate dining
➢ Transportation
➢ Caregiver support
➢ Social and safety visiting
➢ Hospice visiting

Lennox and Addington Seniors Outreach
Provides services for senior citizens who are both frail as well as seniors who may be slightly more active. Additionally, clients may have memory loss, cognitive impairment, social or emotional problems or may be limited in their capacity to be left alone safely. Support is also provided to caregivers requiring regular periods of relief. LHIN-funded services include:
➢ Meal delivery
➢ Social and congregate dining
➢ Transportation
➢ Day services
➢ Respite
➢ Social and safety visiting
➢ Foot care

Mohawks of the Bay of Quinte
Clients served are those individuals living within the First Nations community of Tyendinaga Mohawk Territory who are 18 years of age or older with a physical disability or senior citizens 55 years of age or older. Services provided include:
Friendly visiting
Security checks
Client intervention assistance – crisis intervention and support
Emergency response
Social and recreational programs
Foot care

Northern Frontenac Community Services
Clients served are senior citizens with physical disabilities including frailty; those who may have suffered or currently suffer from serious illness, palliative clients and support to families and caregivers. LHIN-funded services include:
- Meals delivered
- Social and congregate dining
- Transportation
- Crisis intervention
- Day services
- Homemaking
- Respite
- Caregiver support
- Emergency response support services
- Social and safety visiting
- Foot care

Pathways to Independence
Clients served are adults who have been diagnosed with an acquired brain injury who are being supported in homes that provide 24-hour supervision or in foster homes or those individuals living in supported apartments. LHIN-funded services include:
- ABI day services
- ABI assisted living services

Providence Care
Clients served include those clients within the following services, all of which are LHIN funded:
- Attendant Care Outreach Program: for those persons 16 years of age or older willing and able to direct their own care but in need of personal support or independence training, or assisted living services.
- Psychogeriatric Specialty Outreach Services: for older adults with late onset, complex mental health disorders and/or cognitive and responsive behavioural needs.
- Dual Diagnosis Community Outreach Team: persons aged 16 years or older with an intellectual disability or autism or pervasive developmental disorders with suspected or diagnosed mental illness or behavioural disorder.
- Community Treatment Order Program: for those individuals 16 years or older with serious mental illness who voluntarily contract to receive treatment that is less restrictive than a psychiatric facility.
- Hildegarde Centre: for persons over 55 with dementia and/or complex care needs who require a safe and stimulating environment.
- Regional Community Brain Injury Services: for persons aged 18 years of age or older with a diagnosed moderate to severe brain injury who may wish to receive day services, vocational training and support, personal support and independence support, assisted living services or in-service education.
- Telepsychiatry: for persons 18 years of age or older with a mental issue requiring tertiary care.
- Psychogeriatric Resource Consultants: front-line staff who provide services to older individuals with complex cognitive or mental health needs and associated behavioural disorders.

Rehabilitation Foundation for the Disabled (The Ontario March of Dimes)
Provides services for individuals aged 16 years+ with a permanent physical disability who are able to direct their own care. LHIN-funded services include:
- Respite services
- Assisted living services
- Homemaking
- Day trips and transportation

Seniors Association Kingston Region
Services provided to seniors and older adults living within the Kingston region. LHIN-funded services include:
- Foot care
- Congregate dining
- Transportation
- Home help and maintenance
- Counseling – not directly LHIN funded but often co-sponsored by other health service providers.
Prince Edward County Community Care for Seniors Association
Provides services for seniors and adults living with a permanent physical disability and their caregivers. LHIN-funded services include:
- Meal delivery
- Transportation
- Caregiver support
- Foot care
- Social and congregate dining
- Crisis intervention
- Social and safety visiting

Victorian Order of Nurses for Canada – Ontario Branch of Hastings Northumberland Prince Edward and Greater Kingston Sites
Services are provided for seniors who may be frail or have cognitive or physical impairments. LHIN-funded services include:
- Meal delivery
- Transportation
- Caregiver support
- Respite
- Crisis intervention
- Social and congregate dining
- Social and safety visiting
- Home maintenance
- Homemaking
- Day services

In addition, the VON provides support and/or management of the following programs offered within the South East LHIN:
- SMILE Program: to assist seniors in their effort to age at home by providing in home support to those senior citizens most at risk of premature hospitalization or long-term care admissions.
- Assistance with foot care offered by many community support services.
- Health Vans: Transportation to and from health care services provided regionally using seven minivans.

Accountability Agreements
Accountability agreements provide a mechanism for the LHIN to ensure that public funded agencies achieve desired performance.

The agreements are intended to cover a period of two fiscal years. They outline the terms and conditions that will govern the relationship between the LHINs and the LHIN-funded health-care providers and includes:
- Operating funding for both fiscal years.
- Negotiated performance obligations for both fiscal years.

Hospital Accountability Agreements
Responsibility for negotiating accountability agreements with local hospitals was transferred from the Ministry of Health and Long-Term Care (MOHLTC) to the LHIN in April 2007. This agreement reflects the joint responsibility of the LHIN and the hospitals for improving the efficiency of the health-care system to ensure patients receive high quality and timely care.

The agreement defines performance requirements for the hospital, including performance in the following domains: access and clinical outcomes, system integration, financial health, and workplace health and safety. The agreement also specifies the service profile and multi-year funding allocations of the Hospital.

As of July 2009 all but one of the South East LHIN hospitals has signed their Hospital Service Accountability Agreements.

Multi-Sectoral Service Accountability Agreements
The LHIN has also negotiated service accountability agreements with all Community Health Centres (CHCs), the Community Care Access Centre (CCAC), Community Mental Health and Addictions (CMH&A) providers, and Community Support Service (CSS) agencies to take effect on April 1, 2009. These agreements are called Multi-Sectoral Service Accountability Agreements (M-SAAs) and cover the fiscal years of 2009-2011.

In order to facilitate the negotiation of the M-SAA, health service providers in each sector were required to submit a Community Annual Planning Submission (CAPS). Health service providers are
asked to provide a description of the services they provide and a
draft financial/statistical budget.

**Organizations Offering Services in French**

The following organizations have been identified under the French
Language Services Act. This requires them to undertake
significant planning to achieve designation under the act, while
also ensuring French language access to their services. The
identified providers are:

- Alzheimer Society of Kingston
- Canadian Hearing Society
- CNIB Kingston District
- Frontenac Community Mental Health Services
- Hospice Kingston
- Hotel Dieu Hospital Detox Centre (all HDH)
- Independent Living Centre, Kingston
- Kingston General Hospital and all community programs
- Mental Health Support Network of South Eastern Ontario
- Options for Change
- Providence Care and all community programs including long-
term care (Providence Manor)
- Salvation Army Harbour Light Kingston
- Seniors Association Kingston Region
- Sexual Assault Centre Kingston
- South East Community Care Access Centre
- South East Local Health Integration Network
- Victorian Order of Nurses for Canada
**Staffing data**

Staffing data will be presented in more detail in a Health Human Resource report which is under development. The most comprehensive staffing data are provided by the hospitals and is reported in the table below.

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>ADMIN AND SUPPORT SERVICES</th>
<th>NURSING INPATIENT SERVICES (IP)</th>
<th>AMBULATORY CARE SERVICES (AC)</th>
<th>DIAGNOSTIC AND THERAPEUTIC SERVICES</th>
<th>COMMUNITY AND SOCIAL SERVICES (COM)</th>
<th>RESEARCH/EDUCATION</th>
<th>UN-DISTRIBUTED FUNCTIONAL CENTRES</th>
<th>GRAND TOTAL</th>
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<tbody>
<tr>
<td>NAPANEE LENNOX &amp; ADDINGTON</td>
<td>45</td>
<td>41</td>
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<td>23</td>
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**Programs and Services Financial and Usage Data**

Financial data from information provided by the Financial Information Branch of the Ministry was used. The overall funding for the organization are included, coupled with any breakdowns of the budgets by funding sources.

The total amount of LHIN transfer payment funding for 2007/2008 fiscal year was $865,290,124. The funding amounts by type of organization were as shown in Figure 2.
THE LHIN and Provincial CCAC Financial and Service Usage Data
(Based on MOHLTC Data)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Total Expense</th>
<th># of Individuals Served</th>
<th>Cost per Individuals Served</th>
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<td>South East CCAC</td>
<td>$86,208,655</td>
<td>25,519</td>
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<tr>
<td>Total Provincial CCAC</td>
<td>$1,620,530,782</td>
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<td>$2,547</td>
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The above table provides information about both the SE LHIN and province-wide CCAC expenses, total number of individuals served and total number of admissions. Based on the MOHLTC data provided, the cost per individual served by CCACs is as follows:
THE LHIN & Provincial Mental Health and Addictions Financial and Service Usage Data
(Based on MOHLTC Data)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Total Expense</th>
<th>Total # of FTE’s</th>
<th># of Individuals Served</th>
<th>Total Visits (Face-To-Face)</th>
<th>Total Visits (Telephone)</th>
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<td>KINGSTON Hotel Dieu</td>
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<td>KINGSTON General</td>
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The Table above provides information about the total expense and number of individuals served by organizations providing mental health and addictions services in the LHIN, totals for the LHIN, and the total for similar services.
Figure 3 provides total revenue across the LHINs.

Community Mental Health And Addictions (CMH&A) - Global Indicators
LHIN Comparison

Fiscal Period: 2007/2008YE
Indicator: 1 - Total Revenue

- Erie St. Clair, $38,804,030
- Waterloo Wellington, $46,498,663
- Central West, $29,762,976
- Toronto Central, $207,918,502
- Central East, $56,724,881
- Champlain, $124,267,444
- North East, $74,364,321
- 50th Percentile, $51,611,772
- South West, $63,366,264
- Hamilton Niagara Haldimand Brant, $80,933,733
- Mississauga Halton, $24,384,938
- Central, $110,701,929
- South East, $34,364,401
- North Simcoe Muskoka, $30,495,697
- North West, $44,663,402
Issues and Trends

Provincial and National Issues and Trends Identified

At the national level and provincial level, issues that flowed from the Romanow Commission and the Kirby Report, among other reports, are being addressed. The Romanow Commission identified issues related to:

- Adequacy of funding and sufficiency of the federal funding contribution to health care (the federal share of health funding had decreased and required the provincial component to increase).
- Likelihood of increases in health-care costs and the need to manage choices in health-care spending to address increases in health-care costs.
- Establishing/continue working on personal electronic health records, ensuring privacy protection, better access to health information for professionals to make better, more-informed, faster decisions concerning patient care.
- Creating research centres to undertake research where there are gaps in applied research and ensure linkages between Canadian researchers and internationally.
- Undertaking change in the way health-care services are delivered toward collaborative teams and networks of health providers.
- Ensuring rural and remote communities have health-care providers to meet their needs.
- Improving knowledge about Canada’s health-care provider workforce.
- Reviewing current education and training for health-care providers and focus on integrated approaches to educating and training providers.
- Having a common approach to developing primary health care nationally based on: continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives for health care providers to participate in primary health care approaches.
- Integrating prevention and promotion as a central focus of primary health care (e.g. tobacco use, obesity, physical activity).
- Shortening waiting times for diagnostic services.
- Managing wait lists better.
- Ensuring the system provides services and addresses the needs of official language minorities and other diverse groups.
- Developing new approaches to service provision in rural and remote communities.
- Addressing the need for health-care providers in rural and remote communities.
- Expanding tele-health to improve access to care.
- Establishing a platform for home care services nationally.
- Improving the quality of care and support available to people with mental illness.
- Including three priority areas in the Canada Health Act: home mental health case management and intervention services; post-acute home care; and palliative home care.
- Developing new programs to provide on-going support to informal caregivers.
- Bettering integrate prescription drugs into the health care system.
- Offsetting costs to provincial/territorial drug plans and reduce disparity in coverage.
- Consolidating health funding for Aboriginal health and support Aboriginal Health Partnerships to manage health services for Aboriginal people.
- Establishing a clear structure and mandate for the Aboriginal Health Partnerships for the use of funding to address needs, services delivery, assess outcomes on an on-going basis, and provide public reports on results.
- Ensuring on-going input from Aboriginal people on the direction and design of health-care systems in their communities.

The Kirby Study (Reforming Health Protection and Promotion in Canada: Time to Act) resulted in a large number of recommendations, including but not limited to:
• Developing a new federal agency called the Health Protection and Promotion Agency (HPPA) which will work with provincial and territorial governments to develop a coherent long-term vision and action plan for health protection and promotion.

• Underlying the HPPA develop a Communicable Disease Control Fund to aid provinces and territories in building their disease surveillance and control capacity.

• Establishing a comprehensive network to link surveillance and control activities in all jurisdictions.

• Working with the provinces and territories and in consultation with major stakeholders to develop and implement a National Chronic Disease Prevention Strategy which builds on current initiatives through better integration and coordination.

In addition to the funding increases, the Accord supported initiatives related to patient safety, health human resources, technology assessment, innovation and research, and healthy living.

The federal government has also been assuming a role in development and implementation of a Pan-Canadian Health Human Resources Strategy. There is recognition that there are imbalances in the supply of health care providers in a wide range of disciplines. The federal government recognizes the urgency to recruit and retain health care providers to enable the Health Accord objectives and requirements to be fully implemented across Canada. The Pan-Canadian Health Human Resource Strategy is intended to ensure health human resource planning, recruitment and retention of health care providers, and inter-professional education for collaborative patient-centered practice. It is recognized that collaboration in health care provision is required to ensure quality health care provision and increase accessibility of health care.

At the provincial level, the issues identified in the Romanow Commission Report, and through the Health Accord are primary issues of concern. Ontario has been developing approaches to addressing the issues at the provincial level.

Discussion of Findings

Programs and Services

In developing the programs and services database, we attempted to be as thorough as the data would allow. This is a starting point for understanding what programs and services are available within the LHIN, where they are located, and what expenditures and staffing are associated with each. In addition, the database provides a solid examination of the current issues and trends faced by organizations delivering programs and services within the LHIN catchment area.

The data presented regarding Programs and Services and included in the database has a number of areas of weakness and gaps including:

- **Financial data:** The financial data presented in the report only represent the MOHLTC 2008/9 base funding allocations. These data are not an indication of the overall expenditures for the organizations because many receive funds from other organizations and sources (e.g. fundraising, client fees).

- **Many agencies/programs that are not MOHLTC-funded are part of the health-care system in its broadest sense:** There are many agencies which provide health and health-related services that are not funded by MOHLTC but which are part of the health care system in its broadest sense. As such, they will not automatically be included in LHIN activities but do have an impact on health service delivery. For example, many children’s services are providing children’s mental health services but are not considered Children’s Treatment Centres and therefore not included in MOHLTC funding packages. However, in developing integrated services, it will be necessary to include these organizations because of the types of services they deliver and their relationship to the broader health-care system.

- **Waiting lists and waiting times, actual capacity of organizations:** Very few organizations provided information about their service capacity levels, their
waiting lists and number of people on the waiting list, and length of waiting time for services. While waiting lists have been an issue within the hospital sector, they are also an issue in other health-care service delivery areas and will have an impact on the ability of the LHIN to successfully integrate and coordinate services and ensure that reasonable wait times are in place where waiting lists exist. For example, patients requiring community mental health services for which they must wait for an available psychiatrist or therapist are likely to become more ill and subsequently require hospital based services if the waiting time is too long.

- **Consumer information:** While some organizations routinely collect client satisfaction ratings, many organizations do not have formalized or validated approaches to collecting this information. This is most noticeable in community-based organizations. In addition, there is no data available to the LHIN from clients/patients concerning their level of satisfaction with services and with the level of integration and coordination of services they receive. This an important gap to address in information available to the LHIN because consumer input is vital to successful planning activities that the LHIN must undertake.

- **Performance measurement, performance monitoring:** Based on the information provided and included in the database, there is either limited or no performance measurement, performance monitoring, benchmarking, and quality management activity in most organizations, with the exception of primary health care providers (e.g. hospitals, CCACs, Community Health Centres). Some organizations such as the hospitals have indicated that they will be, or have just begun putting indicators, data collection processes, benchmarking, and quality management processes in place.

- **Evaluation:** There are few organizations that undertake evaluation routinely, even large ones, are not reporting evaluation activity. Evaluation is a tool for use in quality management and compliments performance measurement and monitoring. It is an approach that is supported by MOHLTC and other organizations and one which can not only aid in management and improvement of services and programs, but also expand the knowledge of staff in many organizations and across sectors when undertaken and reported. While not all organizations have a need to do large scale, formal evaluations, some evaluation activity would be beneficial. Again, this is a gap strongly related to performance measurement and monitoring, that will weaken the ability of organizations to effectively manage their programs and services and to integrate with other programs and services.

- **Accountability and reporting to the public:** Related to both performance measurement and monitoring and evaluation is the fact that few organizations have indicated that they are actively reporting to the public about their performance. However, there is some progress made based on the required forms for Service Level Agreements, most organizations are reporting though WERS. However, where performance information is provided, it is often not outcome information, but rather service usage data.
Map 1
The South East Local Health Integration Network Boundaries
Map 2
THE LHIN Hospital Locations

<table>
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<tr>
<th>Number</th>
<th>Organization</th>
<th>Location</th>
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<td>1</td>
<td></td>
<td>Bancroft</td>
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<tr>
<td>2</td>
<td></td>
<td>Trenton</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Belleville</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Picton</td>
</tr>
<tr>
<td>5</td>
<td>Lennox and Addington County Hospital</td>
<td>Napanee</td>
</tr>
<tr>
<td>6</td>
<td>Kingston General Hospital</td>
<td>Kingston</td>
</tr>
<tr>
<td>7</td>
<td>Providence Care</td>
<td>Kingston</td>
</tr>
<tr>
<td>8</td>
<td>Hotel Dieu Hospital</td>
<td>Kingston</td>
</tr>
<tr>
<td>9</td>
<td>Brockville General Hospital</td>
<td>Brockville</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Perth</td>
</tr>
<tr>
<td>11</td>
<td>Perth and Smiths Falls District Hospital</td>
<td>Smiths Falls</td>
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Map 3
THE LHIN Long Term Care Facilities

***See next page for Map Legend***
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<tr>
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<td>Stirling Manor Nursing Home</td>
<td>Stirling</td>
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<tr>
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<td>Maplewood</td>
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<td>Crown Ridge Place</td>
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<td>Hastings Manor</td>
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<td>Westgate Lodge Nursing Home</td>
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<td>E. J. McQuigge Lodge</td>
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### Map 4

**THE LHIN Mental Health Organizations**

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<td>3</td>
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<td>Picton</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Belleville</td>
</tr>
<tr>
<td>5</td>
<td>Mental Health Services – Hastings Prince Edward</td>
<td>Belleville</td>
</tr>
<tr>
<td>6</td>
<td>Mental Health Support Network – Hastings Prince Edward Corporation</td>
<td>Belleville</td>
</tr>
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<td>7</td>
<td>Sexual Assault Crisis Centre Quinte and District</td>
<td>Belleville</td>
</tr>
<tr>
<td>8</td>
<td>Youth Habilitation Quinte Incorporated</td>
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<td>9</td>
<td>Lennox and Addington Community Mental Health Services Inc.</td>
<td>Napanee</td>
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<td>Frontenac Community Mental Health Services</td>
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<td>Brockville and Area Centre for Developmentally Handicapped Persons Inc.</td>
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<td>Canadian Mental Health Association, Leeds-Grenville Branch</td>
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<td>16</td>
<td>Leeds and Grenville Rehabilitation and Counseling Service</td>
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Map 5
THE LHIN Addictions Organizations

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<td>3</td>
<td>Options for Change: Community Addictions Treatment Services</td>
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<td>The Brock Cottage Inc.</td>
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<td>TriCounty Addictions Program</td>
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Map 6
THE LHIN Community Health Centres

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<td>2-5</td>
<td>Kingston Community Health Centre</td>
<td>Kingston (incl. 3 satellites also in Kingston)</td>
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<td>6</td>
<td>Country Roads Community Health Centre</td>
<td>Portland</td>
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<td>7</td>
<td>Merrickville District Community Health and Services Centre</td>
<td>Smiths Falls (satellite)</td>
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Map 7
THE LHIN Family Health Teams

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</tr>
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<td>5</td>
<td>Brighton Quinte West FHT</td>
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</tr>
<tr>
<td>6</td>
<td>Belleville FHT</td>
<td>Belleville</td>
</tr>
<tr>
<td>7</td>
<td>Prince Edward FHT</td>
<td>Picton</td>
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<td>8</td>
<td>Queen’s FHT</td>
<td>Kingston</td>
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<td>Kingston FHT</td>
<td>Kingston</td>
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<tr>
<td>10</td>
<td>Maple FHT</td>
<td>Kingston</td>
</tr>
<tr>
<td>11</td>
<td>Community Primary Health Care Community FHT</td>
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<tr>
<td>12</td>
<td>Athens and District FHT</td>
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<td>Brockville FHT</td>
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Map 8
THE LHIN Community Care Access Centre
Map 9
Public Health Units

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<tr>
<td>Number</td>
<td>Organization</td>
<td>Location</td>
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<td>--------</td>
<td>------------------------------------------------------------------------------</td>
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<td>1</td>
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<td>Hospice North Hastings</td>
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<td>Heart of Hastings Hospice</td>
<td>Madoc</td>
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<td>Community Care Central Hastings</td>
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<td>Victorian Order of Nurses</td>
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<td></td>
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<td>7</td>
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<tr>
<td>23</td>
<td>Seniors Association Kingston Region</td>
<td>Kingston</td>
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<tr>
<td>24</td>
<td>The Canadian Hearing Society</td>
<td>Kingston</td>
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<tr>
<td>25</td>
<td>Gananoque and Areas Services to Assist Independent Living Inc.</td>
<td>Gananoque</td>
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<tr>
<td>26</td>
<td>Alzheimer Society of Leeds-Grenville</td>
<td>Brockville</td>
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<tr>
<td>27</td>
<td>Brockville General Hospital – Leeds-Grenville Volunteer Hospice Service</td>
<td>Brockville</td>
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<tr>
<td>28</td>
<td>Community and Primary Health Care – Lanark, Leeds and Grenville</td>
<td>Brockville</td>
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<tr>
<td>29</td>
<td>Community Home Support Lanark County</td>
<td>Perth</td>
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<tr>
<td>30</td>
<td>Alzheimer Society of Lanark</td>
<td>Perth</td>
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<tr>
<td>31</td>
<td>Northern Frontenac Community Services</td>
<td>Sharbot Lake</td>
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<td>32</td>
<td>Central Frontenac Community Services</td>
<td>Sydenham</td>
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<td>33</td>
<td>Land O’Lakes Community Services</td>
<td>Northbrook</td>
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</table>
DEFINING HEALTH FOR TYENDINAGA

On February 19, 2007 community members were invited to a strategy meeting on community health.

As a result of this historic meeting a number of health issues and priorities were identified. It was decided at this meeting to form a retreat of health providers within our community that would compile issues identified and then develop a strategy to meet the health needs for the community. This group was tasked with this challenge and then to present their work back to the community at a later date.

I had the pleasure and honor to attend Blaine Loft, as the Mohawk Council Health portfolio holder, March 9-11, 2007 in Brighton Ontario, where the retreat was held. In total there were ten attendees, 2 members from council, myself and Councillor Roy Maracle, CAO Rod Jeffries, Lynn Brant, Karen Lewis, Janet Brant Nelles, Jeanne Hebert, Scott Maracle, Suzanne Brant and Luke Jeffries representing the youth of the community.

It was a tremendous experience, despite the fact that it was the weekend, all of those in attendance, put forth a great deal of energy to the work at hand. The work groups completed their tasks with enthusiasm and excellent understanding of the direction, facilitator Rod Jeffries challenged them with. Lively discussions not only during the working group functions but at lunch and breaks added to the coming together process. I was very happy to witness and participate in this exciting and stimulating exercise. It illustrated to me how much can be accomplished by working together for a common cause, the health of our community members. Thanks for your hard work team!

Councilor Blaine Loft

TYENDINAGA HEALTH STATEMENT

Health is a gift and it is our responsibility to take care of it.

Health is balance and harmony of body, mind, spirit and our emotional well-being. Honoring diversity, respecting Creation’s life cycle, embracing our interconnectedness and practicing Kanyen’kehaka traditional beliefs, are the foundation of health and well-being. The respectful relationships we develop with self, with each other, and with Creation, are how we experience holistic health.

Our self-determination for the preservation and sustainability of the gift of health, will protect us for generations to come.
<table>
<thead>
<tr>
<th>Health and Human Resources</th>
<th>2 year Goals</th>
<th>5 Year Goals</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>To offer services that include:</td>
<td>To offer services that include:</td>
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<tr>
<td></td>
<td>• long term care medical doctor</td>
<td>• midwifery</td>
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<td></td>
<td>• nurse practitioner</td>
<td>• occupational therapy</td>
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<td></td>
<td>• traditional medicines practitioner</td>
<td>• physical therapy</td>
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<td></td>
<td>• traditional practitioner program that includes body, mind &amp; spirit</td>
<td>• psychiatrist</td>
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<td></td>
<td>• mental health workers (men’s, women’s, youth)</td>
<td>• speech therapy</td>
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<td></td>
<td>• full-time diabetes educator</td>
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<td></td>
<td>• full-time dietitian with traditional knowledge base</td>
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<td></td>
<td>• chiropodist with foot care nurse</td>
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<td></td>
<td>• develop and implement an ongoing 25 year community education awareness plan</td>
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<td></td>
<td>• client safety</td>
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<td></td>
<td>• to maintain or revise existing programs to meet needs of the community</td>
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<td>(see appendix)</td>
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<td></td>
<td>• health and safety committee</td>
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<td></td>
<td>• social worker</td>
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<td></td>
<td>• linkage with police services</td>
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<td></td>
<td>To be accredited in all community well-being services</td>
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<td></td>
<td>To support an exchange of traditional foods access by purchase or trade, (i.e.</td>
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<td></td>
<td>grocery store, food bank, community market)</td>
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<td></td>
<td>• All schools will have a cafeteria</td>
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<td></td>
<td>To educate our own traditional practitioners and herbalists</td>
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<td></td>
<td>To have a functioning full service health facility staffed by qualified and</td>
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<td></td>
<td>competent MBQ members</td>
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<tr>
<td><strong>Language, Culture and Traditional Ways</strong></td>
<td><strong>2 year goals</strong></td>
<td><strong>5 year goals</strong></td>
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<td>To have training programs for all workers and community members in the areas of:</td>
<td>• lateral violence</td>
<td>• To have a multidisciplinary health, healing and wellness facility</td>
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<tr>
<td>• cultural identity</td>
<td>• To have full language immersion for day care</td>
<td>• Immersion for elementary grades</td>
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<td>• community healing activities</td>
<td>• to have junior and senior kindergarten</td>
<td>• Living museum for cultural education</td>
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<tr>
<td>• Revitalization of traditional ways, ie. traditional practitioners program</td>
<td>• Full time language nest</td>
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<td>• ceremonies</td>
<td>• Traditional roles and responsibilities learning group</td>
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<tr>
<td>• traditional medicines</td>
<td>• Life skills training for youth</td>
<td></td>
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<td>• traditional sources of knowledge</td>
<td>• Healthy trails- ensure trails are safe and integrate medicine walks</td>
<td></td>
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<td>• language access</td>
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<tr>
<td>• alcohol and drug prevention &amp; aftercare</td>
<td></td>
<td></td>
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<tr>
<td>• prevention of violence and bullying</td>
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<td>• mental health</td>
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<td>• healing the culture of self-hate</td>
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<td>• healthy changes in the workplace</td>
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<td>• To have annualized funding for Mohawk language acquisition</td>
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<td>• Cultural competency training for school and health staff</td>
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<td>• Traditional research department</td>
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<td>• Traditional parenting classes</td>
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<tr>
<td>• Childcare offered at all community workshops</td>
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<tr>
<td>Environment</td>
<td>2 year goals</td>
<td>5 year goals</td>
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</table>
|             | • To implement a massive environmental public relations campaign for all ages, with provision for curriculum development  
• To increase the level of the community cultural awareness specifically addressing our responsibility to the environment  
• To complete the research for the development of environmental policies  
• Good water | • To deliver environmental education to the whole community, which includes cultural awareness and our responsibilities to the natural world | • To have a fully staffed environmental research department operating in their own building with their own laboratory | To have self-sustaining practices in the following areas:  
• education  
• housing  
• employment  
• renewable energy  
• food security  
• resource management, ie. water, land, biodiversity, etc. | • To be a self-sustaining community that respects the environment through knowledge of our traditional ways  
• To have protected natural resources |
<table>
<thead>
<tr>
<th>Sustainable Development</th>
<th>2 year goals</th>
<th>5 year goals</th>
<th>10 year goals</th>
<th>15 year goals</th>
<th>25 year goals</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• To have a new MBQ administration building with a Health Director position&lt;br&gt;• Community wellness director and conjoin community wellness &amp; alternative therapies programs in one building&lt;br&gt;• To develop the framework for the MBQ Health Authority.&lt;br&gt;• To have established prioritization of Health needs&lt;br&gt;• To have a fully accessed recreation center&lt;br&gt;• To have equivocal resource sharing and linkages between community programs&lt;br&gt;• To offer nurse practitioner clinic services&lt;br&gt;• To offer E-Health for the community&lt;br&gt;• To utilize a health lobbying process&lt;br&gt;• To have health care providers educated in cultural health practices&lt;br&gt;• Development of central warehouse/depot for medical supplies</td>
<td>• To implement the MBQ Health Authority&lt;br&gt;• To have a fully functioning clinic and pharmacy&lt;br&gt;• To develop partnerships with health services educational facilities (ie. FNTI, First Nation communities, Queen’s University)&lt;br&gt;• To have a long term care facility&lt;br&gt;• To have completed health services transfer&lt;br&gt;• To have framework for health service capacity building&lt;br&gt;• To have TMC actively lobbying for capital $ (ie. through Rama or partnerships)&lt;br&gt;• Youth lodge &lt;br&gt;• Infant/toddler daycare&lt;br&gt;• Trades training</td>
<td>• To have infrastructure that operates a fully functioning counseling center for private and public access&lt;br&gt;• Cultural learning centre&lt;br&gt;• Developmentally challenged group home&lt;br&gt;• Adult daycare&lt;br&gt;Housing – low income, supportive, affordable</td>
<td>• To actively improve the development of the MBQ Health Authority policy and guidelines&lt;br&gt;• Addictions/family treatment centre</td>
<td>• To live in a community where everyone takes responsibility for their own optimum health and for community health&lt;br&gt;• To have hospital and all medical services available within the community including emergency clinic&lt;br&gt;• To have traditional medicine readily available for community members’ choice&lt;br&gt;• To have increased long term care access and capacity within the community&lt;br&gt;• To have well established medical partnerships with Queen’s University&lt;br&gt;• To actualize intern placements at facilities within the community&lt;br&gt;• To have a confidently functioning MBQ Health Authority&lt;br&gt;• To have an ongoing health services capacity building process&lt;br&gt;• To have ongoing capital fund-raising (possibly Rama $)</td>
</tr>
</tbody>
</table>
**TASKS COMPLETED**

1. To have a community meeting offering:
   - feedback from these planning sessions
   - input by the community
   - discussion for action.

   (completed)

2. To establish a health partnership working group, comprised of community members, MBQ staff and Council members, that will drive the strategic plan.

   (completed)

3. (this as internal issue not necessary to publish in the newsletter)
   Involve MBQ departments in the process through awareness sessions.

   (completed)

**WHAT’S NEXT**

Develop an operational plan
Develop subcommittees for four core areas
Securing financial resources for mental health programs
Random acts of kindness