



**Clinical Services Roadmap:
Community Engagement Report**

July 27, 2011

Version 1.1



Ontario

Local Health Integration
Network

Table of Contents

1. Introduction	2
2. About the Clinical Services Roadmap	2
3. Our Engagement Approach	3
4. Communications and Outreach	6
5. Who We Heard From	7
6. What We Heard	10
6.1 Cardiovascular Disease Services	10
6.2 Emergency Department Wait Times	11
6.3 Healthcare Acquired Infections	13
6.4 Maternal and High Risk Newborn Care	15
6.5 Mental Health and Addictions Services	17
6.6 Regional Surgical Services	23
6.7 Restorative Care Services	24
7. Feedback on the Process	27
8. Final Comments	28

1. Introduction

The South East Local Health Integration Network (LHIN) works to engage and involve patients, caregivers, health care professionals and local residents in discussions to create a more accessible, efficient and effective health care system in our region.

In a groundbreaking new initiative, the *Clinical Services Roadmap*, the South East LHIN has partnered with hospitals and Community Care Access Centres (CCACs) from our region design plans for continued improvement in how our local health care services are organized and delivered.

To create this Roadmap, seven teams of health experts, each led by a doctor (with the exception of Maternal and High Risk Newborn, led by Eleanor Rivoire, Chief Nursing Executive at Kingston General Hospital) worked together to find new ways to improve different health services within the current budgets available for health care.

To help these experts listen to the views of people in our communities, the South East LHIN launched an innovative online community engagement which ran from March 21 to May 15, 2011. Participants provided important feedback on the clinical teams' initial work, and shared their experiences about strengths and challenges in accessing health care when and where they need it.

This report describes the engagement portion of the Clinical Services Roadmap project, including what the South East LHIN and its partners heard from participants.

The results of the community engagement initiative will be used to inform the work of CSR's seven Clinical Work Teams as they work with the community to move plans forward.

2. About the Clinical Services Roadmap

A key mandate of the South East LHIN is to develop and continually improve the local system of health care, particularly with respect to improving access and quality of health care services.

Reaching for Excellence, the South East LHIN's second Integrated Health Service Plan (IHSP), was developed with our health system partners, and contained a number of priorities for development from 2010-13 that reflected this mandate. In order to advance these priorities for development, the hospitals, South East Community Care Access Centre (CCAC) and the South East LHIN are developing the Clinical Services Roadmap.

Using local knowledge and expertise, this process involves a critical examination of current hospital services and available funding, with the goal of ensuring the sustainability of high quality, accessible hospital services for the residents of the South East. In collaboration with all

hospital service providers, and with community and primary care providers, the South East LHIN is seeking to further develop an integrated regional system of care, including seeking opportunities to improve service provision, reduce program duplication, and improve access, efficiency and effectiveness.

2.1 Clinical Work Areas

Through extensive research and collaboration among the South East LHIN, our hospitals and the South East CCAC, seven clinical “areas of opportunity” were chosen. These were chosen because we believe that they have the greatest potential to improve care by reducing duplication, red tape, and administrative barriers to getting care. These areas are also some of the highest in demand, which may mean that people have to wait longer than they should to receive care.

The clinical work areas are:

- Cardiovascular Disease Services
- Emergency Department Wait Times
- Healthcare Acquired Infections
- Maternal and High Risk Newborn Care
- Mental Health and Addictions Services
- Regional Surgical Services
- Restorative Care Services

3. Our Engagement Approach

3.1 Public Engagement Objectives

To develop a Roadmap that is inclusive and sustainable, the public engagement phase of the CSR project had three objectives:

1. Inform the community on the CSR project and the work of the Clinical Work Teams;
2. Gather community feedback on the draft clinical area plans, including:
 - a. Validating proposed approaches;
 - b. Exploring options and identifying gaps;
 - c. Suggesting new ideas as appropriate; and,
3. Engage a broad and diverse set of participants from across regional communities.

3.2 Online Engagement

To help the South East LHIN to hear from as many local residents as possible, a decision was made to make use of online technologies and web surveys.

By using an online approach, local residents could participate at a time of day and location with internet access that worked best for them – whether at home, work, school or a public building, such as a community library. It also provided a way for local residents to overcome the travel barriers that may have prevented them from participating in an in-person community event.

A special online engagement website was created to gather participants’ views. People could complete a series of online “workbooks” to learn about the health care issues facing our region, and provide their feedback and input.

An image of the Clinical Services Roadmap Engagement website.

South East LHIN

[Home](#) | [FAQ](#) | [Contact Us](#) | [Log Out](#) | [Francais](#)

Home

Engagement
Home
How to Participate
Paper Version
Help / Contact Us
Background
About this Project
Spread the Word!
Join us on Facebook!
Clinical Areas
Cardiovascular (Heart) Disease
Emergency Dept. Wait Times
Healthcare Acquired Infections
Maternal and High Risk Newborn Care
Mental Health & Addictions
Regional Surgical Care
Restorative Care Services

Welcome to the community engagement homepage of the Clinical Services Roadmap!

All of the hospitals, the Community Care Access Centre (CCAC) and the South East LHIN are working together to create a better, more efficient healthcare system that will improve access to high quality care for all residents of the South East.

We want to create a regionalized system of integrated health care that will ensure everyone has access to the right care, in the right place, at the right time.

We’ve already started work on the Roadmap, thinking about ways to make our system more efficient in 7 vitally important areas. Now we want to hear from you.

What are your ideas to improve health care in our area? What do you think? Click the link below to participate.

[How to Participate](#)

News
LHIN to seek public input (Belleville Intelligencer)
Have your say on health care (Belleville Intelligencer)
LHIN needs to listen, not just collect input (Belleville Intelligencer)
Give LHIN your views on region’s medical services (Brockville Recorder and Times)
Network calls for overhaul (The Kingston Whig-Standard)
Archives >

Recognizing that not all residents of our region are comfortable using online tools, the South East LHIN also developed a paper-version of the process which people could complete without needing a computer, and send back to the LHIN's office.

3.3 Online “Workbooks”

Participants could complete an online workbook on each of the clinical work area. These workbooks were survey-like tools that allowed users to learn about the clinical issues and tough questions the team was dealing with, and share their views on which options or choices made most sense. Participants could complete one or all of the Workbooks, one after another or at different times, when it worked best for them.

An image from one of the online workbooks

Creating a “Senior-friendly” Emergency Room

As the average age of the population in our region rises, more and more older adults are visiting doctors’ offices, community clinics, and emergency rooms. To accommodate the increased number of seniors in our emergency rooms, there is a need to make clinics and hospitals more friendly (or accessible) to older people. This could mean things like having more comfortable seating, signs that are easier to read, entrances that aren’t slippery, and staff who have more time to answer questions.

How “senior-friendly” would you describe our region’s healthcare services today?

	Definitely not senior friendly	Not senior friendly	Neither senior unfriendly nor friendly	Senior friendly	Very senior friendly	I Don’t Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PREVIOUS 71% NEXT

Workbooks were written and designed in close collaboration with each of the Clinical Work Teams, to ensure that they accurately explained proposed changes, and asked questions that would truly inform the Clinical Work Plans as they moved to the next step.

4. Communications and Outreach

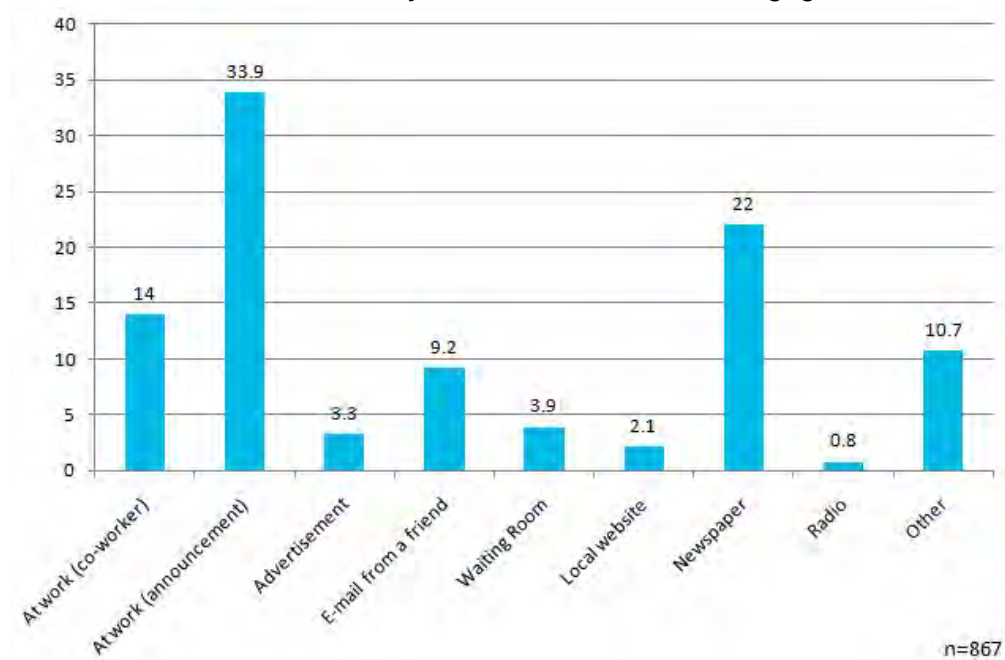
The public engagement phase of the Clinical Services Roadmap was accompanied by a comprehensive communications and recruitment campaign to ensure that as many South East Ontarians as possible were aware that the project was taking place and could decide whether and how to participate.

The communications strategy, developed in collaboration with the communications offices of area hospitals and the South East CCAC, was multi-pronged, using a combination of traditional media (newspaper, radio) and stakeholder, employee and community outreach. The strategy included the following:

- E-blasts to South East LHIN stakeholders (internal and external)
- Newsletters (health facilities)
- Posters and postcards in health facilities
- Municipal libraries
- Churches
- Municipal offices
- Seniors' Centres
- Facebook (South East LHIN page)
- Chambers of Commerce
- Media outreach and coverage of CSR and the Engagement Process in regional newspapers, TV and radio
 - Display advertising in all regional daily and weekly newspapers

The most successful methods of reaching participants were announcements and word-of-mouth at the workplace (accounting for 47.9% of participants), print media (22%), and word-of-mouth shared through e-mail (9.%)

Chart: How did you hear about the CSR Engagement?

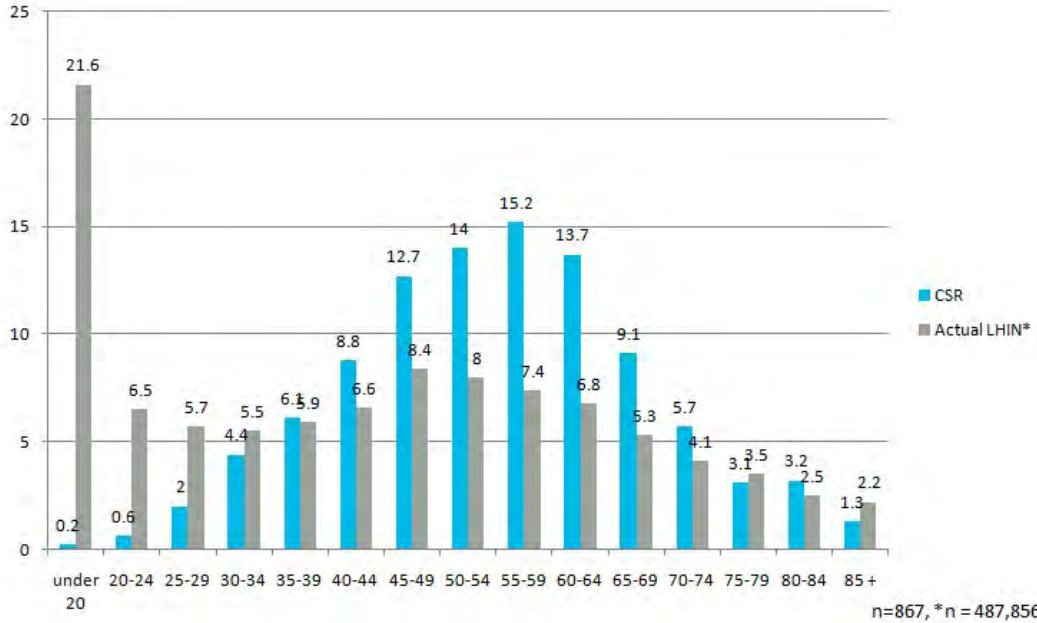


5. Who We Heard From

The South East LHIN was encouraged by the high level of response that the Clinical Services Roadmap garnered. Our objective to engage a broad and diverse set of participants from across regional communities was achieved, with more than **867 registered participants**. Here is a breakdown of our participation numbers:

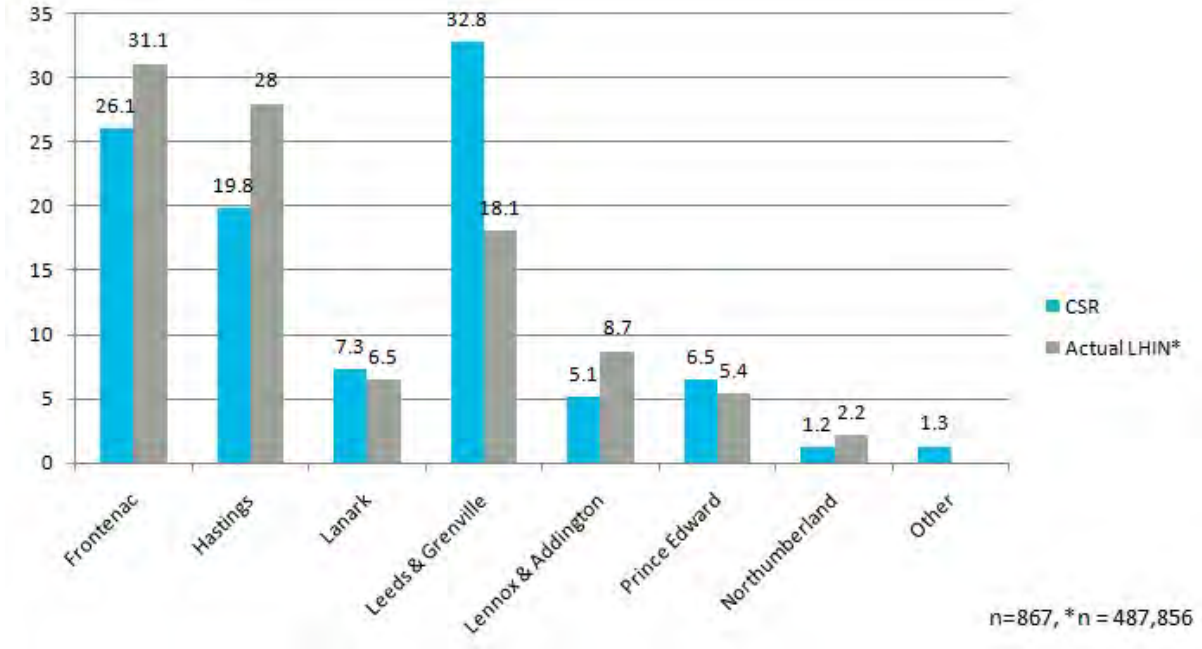
Participation	Totals
Participants	
Registered participants	867
Workbooks	
Completed Workbooks	1,775
Online vs. paper participants	787 vs. 80
Stories and Experiences	
Words of stories and experiences	85,335
Completed Workbooks by Clinical Area:	
Cardiovascular Disease Services	291
Emergency Department Wait Times	312
Healthcare Acquired Infections	221
Maternal and High Risk Newborn Care	138
Mental Health and Addictions Services	277
Regional Surgical Services	305
Restorative Care Services	231

Although the community engagement process was not a public opinion research exercise, we heard from a fairly representative sample of our region’s population. Of the 867 registered participants, 75.5% identified themselves as female, which corresponds to similar community engagement processes.



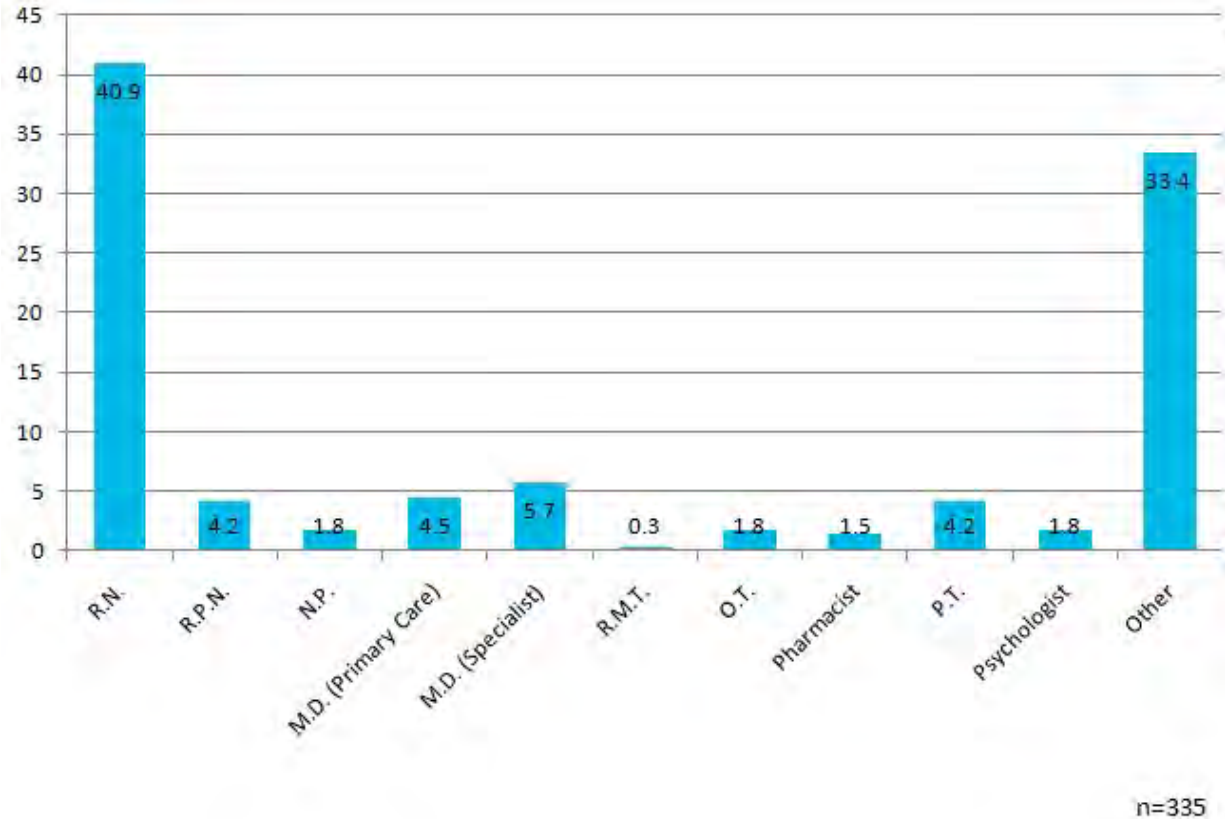
The age distribution of participants reflects the actual age distribution of the South East LHIN, except for an underrepresentation of those under the age of 24 (attributed to a lack of interest in health care issues, as well as often being too young to participate), and an overrepresentation of those aged 45 to 69 (attributed to the higher numbers of this age group working as health service providers.)

The participant breakdown by county also mirrors the actual population makeup of our region, save for an overrepresentation of participants from United Counties of Leeds and Grenville, attributed to heightened media attention of the Clinical Services Roadmap project. In terms of community of residence, the top six most popular responses were: Kingston (21.3% of participants), Brockville (15.9%), Belleville (11.2%), Prince Edward County (6.5%), Quinte West (4.2%), and Elizabethtown-Kitley (3.1%).



The engagement process targeted health service providers as well as those outside the health care system. A total of 335 health service providers, or 38.6% of all participants, took part.

Of those, nurses were the largest group of participants (46.9%), followed by physicians (10.2%). In the “other” category, the largest professions were social worker, administrator/manager, mental health counsellor and medical laboratory technologist.



6. What We Heard

By completing one or more Workbooks, participants shared their views and opinions on a variety of ideas proposed by the seven clinical work teams. All 1,775 Workbook responses were analyzed using leading industry qualitative and quantitative analysis software, combined with the careful touch of professional social science analysts. Quantitative responses (or “closed” answers, expressed through numbers) were fed into SPSS to determine frequencies, while qualitative responses (or “open-ended” answers, expressed through text) were analyzed using NVivo to uncover recurring themes and ideas.

6.1 Cardiovascular Disease Services

A total of 291 participants completed the Cardiovascular Disease Services Workbook.

6.1.1 Key Findings

- Participants expressed a high level of concern about information sharing and communication flow among healthcare professionals, sites of care, and patients (76.5% chose ‘very concerned’ or ‘concerned’).
- There is a strong feeling amongst participants that a “one stop shop” model of service coordination would make a difference to patients with heart disease (85% chose ‘a big difference’ or ‘somewhat of a difference’)

- According to participants, the top three factors that need to be considered in choosing a location for ongoing heart health and disease care are:
 - Travel time (30 minutes or less) (53.6% of participants chose it as the most important factor);
 - Travel time (1 hr or less) (17.9%); and,
 - Parking (10.7%).
- Participants felt that patients and family doctors have the most important roles in preventing cardiovascular disease (chosen by 96.2% and 95.9% of participants respectively)
- The most frequently recurring positive theme when participants were asked to reflect on their experiences with information sharing and communication between heart healthcare professionals was the strength of linkages between different players in the system, including primary care providers, specialists, hospitals and tertiary care centres.
- Conversely, when participants were asked to reflect on negative experiences with information sharing, the most frequently recurring theme was the transfer of medical records and test results between heart healthcare professionals.

6.1.2 Positive information sharing experiences

The most recurring positive experiences with information sharing between heart health professionals were as follows:

1. **Strong linkages** between primary care providers, hospitals, emergency departments and specialists.

“My family physician is linked to KGH/HDH. He can access all of my KGH reports from his office. As a patient and caregiver, I feel it is my job to ensure that all relevant information/history is provided to the professional at any appointment”

“The communication between BGH cardiologists and KGH cardiologists must have been good, as we felt that he received good care in such a brief period of time”

“My cardiologist has been in ongoing contact with my internist and The Ottawa Heart Institute regarding my difficulty to control hypertension. This is done with e-mail, phone and physical delivery of reports through me. They actually talk to each other!”

2. **Quick referrals and care.**

“Our [Family Doctor] sent my husband to an internist, who set him up with testing at OHI and followed up afterward. It all went smoothly.”

3. **Seamless care experience**, with participants feeling that they saw high levels of information sharing and ultimately, coordination.

“My father was identified with severe CHD and required heart surgery. A referral was made through CCN to KGH, an ambulance was arranged and the surgery was completed. When he contacted his FHT – they knew about his surgery, as did his own heart specialist in Peterborough. Everything appeared to be coordinated”

4. **In-depth medical file**, to ensure high levels of communication between health service providers.

“While working in a hospital and community agency, I have found that receiving past information from Doctors and reports is very valuable in assisting new patients or clients with current situations.”

6.1.3 Negative information sharing experiences

Participants also shared a number of negative experiences with information sharing between heart health professionals:

1. **Transfer of medical records and test results**, including discharge papers, reliance on family members to pass along information to other health service providers, and the slow pace at which test results travel between providers.

“Everything needs to be on a system that helps all healthcare professionals have access to patient information, especially when many teams involved. Not all info is passed on to all team members. Therefore making the patient have to keep repeating themselves. Gets very tiring.”

2. **Low level of communication between health service providers**, including between providers in general, between hospital staff, between on-call cardiologists and tertiary care centres, and between hospitals and primary care providers.

“[I] kept having to go between family physician and specialist and physio with no one having the same information or addressing the basic need”

“My first 4 days in Intensive Care Unit gave me a different internist and different treatment each day; all ineffective. It appeared there was no communications between these specialists”

“Most of the cardiologists on call at one hospital will not contact the heart transplant team at the other when my husband comes into emergency with heart failure or pneumonia. They have told me to contact them”

3. **Poor communication with patients and caregivers** about treatment, discharge, and rehabilitation programmes; and,
4. **Lack of case management / patient coordination**, resulting in patients who ‘fall through the cracks’.

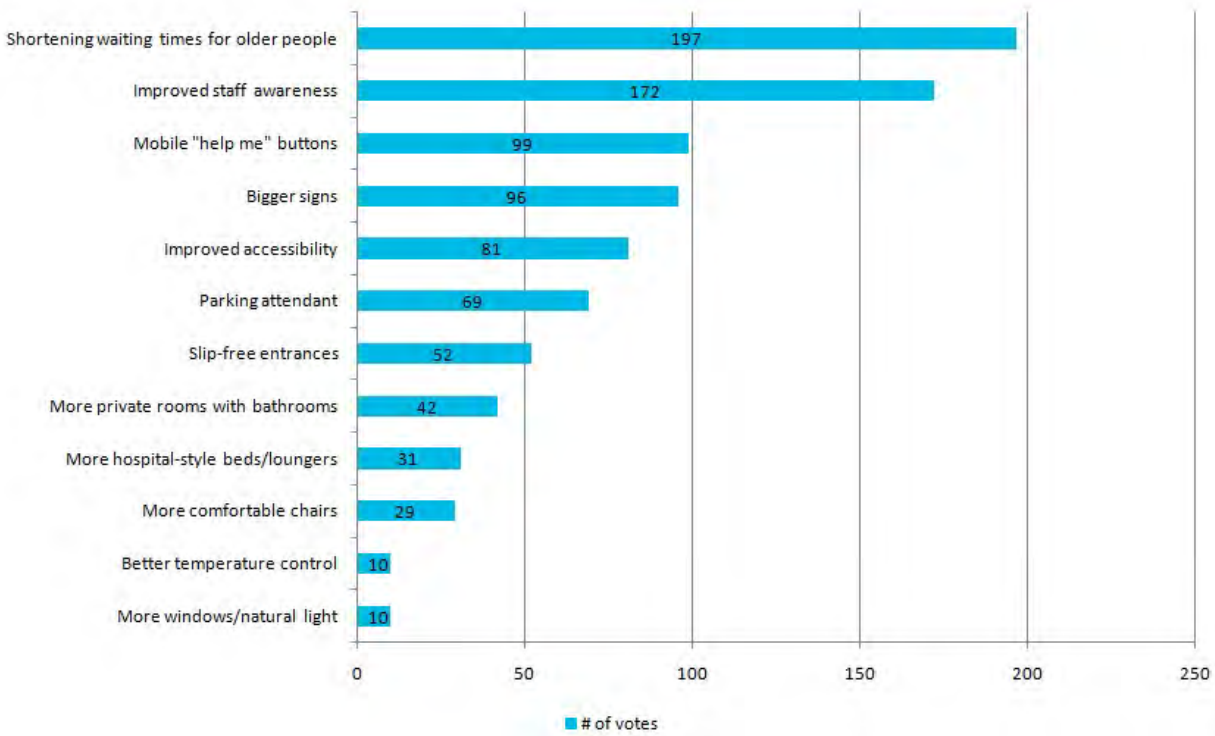
“My wife had a number of mini strokes and then a major one from which she died. She was shuffled in and out of two hospitals and died while on the ‘waiting list’ for a MRI. There was no one in charge of her treatment and co-ordinating tests and analyzing results. Much of what did happen was the result of our persistence.”

6.2 Emergency Department Wait Times

Three hundred and twelve (312) participants shared their views on waiting times in our region’s emergency rooms, making this the most popular topic of the community engagement phase of the Clinical Services Roadmap.

6.2.1 Key Findings

- Participants indicated a high level of comfort in being seen by a nurse practitioner or registered practical nurse for less serious emergency department cases (70.6% of participants answered they would feel ‘comfortable’ or ‘very comfortable’)
- Participants’ views were mixed on whether our region’s healthcare services are senior friendly” or not (41.6% of participants answered ‘not senior friendly’ or ‘definitely not senior friendly’ versus 28% who answered ‘senior friendly’ or ‘very senior friendly’)
- According to participants, the most popular ideas to make emergency rooms more “senior friendly” are:



6.2.2 Other suggestions to make our emergency departments more “senior friendly”

Participants shared a variety of other ways to make our region’s emergency departments more “senior friendly” for older adults. The six most popular ideas were:

1. **Physical space**, including providing complimentary warm and cold beverages, having more beds and private examination areas, having separate spaces for seniors or different kinds of patients, improving seating, and improving washroom facilities.

“Split a waiting room in 1, 2, depending on the type of situation they are in for, therefore not having an overall room of hacking, crying, or any loud noises which may help to overcome anxiety in being there.”

2. **People to help**, tasked with helping patients navigate the hospital and checking up on those waiting.

“This...person could help keep people informed about their expected wait time. People need to know they are not abandoned (this has happened). Some patients may not understand triage and need reassurance that they will be seen. This same person could steer the patient in the right direction when it is time to be seen, and hand them off to the nurse. Patients may be confused, uneasy, upset, and disoriented, but they do not want to be seen as such. A little help could go a long way toward having a cooperative, content patient.”

3. **Communications**, including instructions that are given more clearly and slowly (and by staff more mindful of communicating with older adults), more information on approximate wait times, and tools to help older adults more easily understand (larger print sizes on forms, better signage, and hearing devices that may be loaned while in hospital).

“Be aware of the impact of a hearing loss on a senior, and be sure staff are appropriately trained to deal with communication needs of people who are hard of hearing or deafened.”

4. **Prevention**, including better education on what sort of medical ailments require an emergency department visit, more local walk-in clinics, and better equipment at local clinics to avoid ED admissions.

“What is really needed is urgent care and after hours clinics, so many of the people who access emergencies could be seen elsewhere and not burden the system – most people go to [emergency departments] because they have no other choices”

5. **Staffing**, including staffing levels in emergency departments as well as in primary care facilities to avoid emergency department visits. Some suggested hiring more registered

nurses, nurse practitioners and physicians, addressing weekend and after-hours staff shortages, and having a counsellor on staff to help with personal difficulties.

"I am full time and my phone rings most days off looking for overtime. That is costing the place a fortune and not effective. We're exhausted. The OSI police are not effective in reducing sick time abuse. There are many, many abusers that are not dealt with."

6. **Attitude**, referring to how staff treat older adults and other emergency department patients.

"Creat[e] an atmosphere of caring and empathy. I do not use emergency rooms often, but it has been my experience that ER staff do not seem that interested in the person. I suppose this would require workshops and education in addition to ensuring the right people are on the front lines."

6.3 Healthcare Acquired Infections

Healthcare acquired infections (HAI) garnered a considerable amount of interest among participants, with 221 completing the Workbook.

6.3.1 Key Findings

- Through the Workbook, participants have an increased awareness of the role that **all** actors in the healthcare system play in preventing infections. In a "pre/post"-type question, in which participants were asked at the beginning and end of the Workbook to rate the role that a number of actors play in preventing infections, the following was observed:
 - The percentage of participants who rated 'patients' as playing a 'key role' increased from 47.4% to 56.7%;
 - Doctors increased from 74.7% to 78.7%;
 - Nurses and other frontline health workers increased from 88.2% to 90.3%;
 - Hospital cleaning staff increased from 77.3% to 81.0%;
 - Pharmacists increased from 19.5% to 29.3%;
 - Visitors increased from 46.3% to 65.4%; and,
 - Healthcare managers increased from 53.9% to 62.7%.
 - The percentage of participants who rated 'laboratory staff' as playing a 'key role' **decreased** from 48.2% to 43.5%.
- The vast majority of participants are concerned about health care acquired infections (85.5% of participants are 'worried' or 'very worried' about what they have read in the news about it).
- Participants expressed a strong level of support for limiting visitors during outbreak (91.8% of participants said 'yes'), using hand sanitizer at hospitals and long term care facilities (99.1% said 'yes') and reducing the use of antibiotics (94.9% said 'yes').

6.3.2 What worked well?

Following protocol was the most recurring theme when participants were asked to reflect on what worked well during their experience with healthcare acquired infections. Participants shared that following the posted protocol, including the use of face masks, handwashing and wearing of gowns, had positive outcomes.

“The use of face-masks and frequent handwashing, as well as signs to discourage those with infections from visiting hospitals has helped decrease infections.”

Other participants reflected on the high quality of care they received from their primary care provider, the effectiveness of proactively cleaning their hospital room, receiving a quick diagnosis for their HAI, and taking probiotics.

6.3.3 What didn't work well?

Participants shared a number of stories of negative experiences with healthcare acquired infections. The three most recurring negative experiences were:

1. **Health service provider practice**, participants felt that the posted policies and procedures were not always being followed, leading to the transmission of HAI.

“[My] abdominal incision became infected when an aide (when dressing the wound post-operatively in hospital) sneezed on the open wound”

“The staff did not always comply. Hand washing was definitely not a priority for many staff”

2. **Physical Space**, including cleaning, presence of carpets, lack of isolation space and dangers of sharing spaces).

“Hospitals have cut back on the cleaning protocols and number of staff to perform them and many areas, such as computer keyboards, are never touched by cleaning staff.”

3. **Communications** to general public, patients and visitors on risks and precautions.

“The patient was isolated and would have appreciated more communication about the treatment and how it complicated the surgery”

“Sign just left on door for visitors. Left to patient to explain. NOT sought out or no explanation from health care staff, no phone call, no visit when they knew you were in the room.”

4. **Other:** Participants also mentioned the lack of coordination and preventative measures, poor quality homecare / follow-up after hospital stays, the overuse of antibiotics, and the time required for diagnosis as negative experiences.

6.3.4 What are you willing to do to prevent HAI?

An overwhelming majority of participants shared that they would be willing to practice good hand hygiene, including when entering and exiting a hospital, when entering and exiting a patient room, and more frequently around the house.

“I believe that hand hygiene is the most important precaution that ordinary individuals can take.”

Others shared that they would be willing to follow the posted policies (“whatever it takes”), educate those around them, remain at home unless healthy, reduce the number of visitors (including during outbreaks), wear gowns, masks and gloves as required, ask health service providers to adhere to procedures, and pay closer attention to the cleanliness of hospital rooms.

6.4 Maternal and High Risk Newborn Care

A total of 138 participants shared their views on Maternal and High Risk Newborn Care.

6.4.1 Key Findings

- A small majority of participants preferred specialized care at a large hospital in a city over care at a smaller hospital or clinic locally (on a scale from 1 to 5, 51.9% chose ‘1 – large hospital’ and ‘2,’ versus 24.1% who chose ‘3’ and 24% who chose ‘4’ and ‘5 - care at a smaller hospital locally.’)
- “Not having adequate support in your nearest hospital” and “having to travel to a hospital further away for specialized care” were rated by participants as the two most worrisome aspects of a high risk pregnancy or birth (chosen by 31.2% and 23.2% of participants respectively).
- From a list of ten attributes that a maternal and high risk newborn team could have, participants chose the following at the highest frequency:
 - High level of medical skills and training (selected by 44.9% of participants as the most important attribute); and,
 - “Patient centred” with a focus on you and your choices (selected by 40.6% as the most important).

6.4.2 What worked well?

Participants shared a number of positive experiences with high risk pregnancies and births in our region. The four most frequently recurring themes were:

1. **Quality of Care**, including the level of skills and knowledge that the care team brought to patient care, prenatal care and testing, and post-operative care.

“She was one of the lucky ones to have a well-trained and responsive-acting MD to take the action needed immediately after assessment, rather than wait for a period before acting”

“I had in-home visits from provincial healthcare workers. I felt safe with such a small baby, and had follow-up visits to the hospital with him.”

2. **Communication**, namely, the healthcare team helping the patient understand more fully how the pregnancy and birth was progressing

“Through an urgent caesarean and a later planned caesarean, communication from the medical staff was very good. With the planned caesarean, I felt the risks were very clearly explained, and I felt very respected to make that choice, given time to think in case I changed my mind.”

3. **Accessibility** - Some participants felt that the most positive aspect of their birthing experience was having access to care locally, or being transferred back to a local facility once stable.

“I was able to access care in my town. I had an evaluation in the city, where it was determined that I could be well cared for in my local community, where they had the resources necessary for my safe care. It was a relief, because the thought of delivering in a big hospital was just too distasteful for me.”

4. **Teamwork** – The quality of coordination and collaboration amongst health service providers was commended by some participants, including linkages between midwives, primary care providers, hospital-based birthing teams, and doulas.

“I had a normal pregnancy turn high risk. I received incredible pre-care from a midwife, who accompanied me to the hospital (it was a planned hospital delivery) at the Toronto East General Hospital. When things went sideways, there was a seamless pass-off at the hospital and the obstetrician took over. The midwife came back afterward, and carried on with post care. Awesome system – no politics, no nastiness, no positioning – just looking out for me and making sure we were safe and cared for properly.”

6.4.3 What didn't work well?

Participants also shared a number of negative aspects of their high risk pregnancy or birthing experience.

1. **Accessibility**, referring to access to specialized care in a local hospital.

“I had to travel an hour to the hospital. This was concerning, and limited my support network of family to be near me when needed.”

2. **Communications**, including communication between birthing team and patient, as well as between health service providers.

“Communication could be improved...some health care team members didn’t have all info, requiring my brother to function as the ‘keeper’ – he was able to prevent a poor outcome once because he informed the health care provider of some info that he did not have – which changed the decision-making and treatment course.”

“Doctor was not advised of the death of the child when the patient returned for her six-week check-up. Be sure that medical records about death of a new infant be forwarded to the family doctor and ob/gyn”

3. **Pressure** facing some health service providers.

“[I] feel rushed when trying to ask questions – nurses looking after too many patients to give individual care.”

4. **Procedures**, including policies that in some cases prohibit a newborn baby from being held by the mother after delivery.

“It was heartbreaking as a new mom, who had just undergone what I had, not to see her baby. It was over 25 hours after his birth before I could nurse him.”

5. **Other** – Participants also shared their negative experiences with the level of staffing, education and training of health service providers, coordination between players, and early detection of high risk pregnancies.

6.5 Mental Health and Addictions Services

The Workbook on Mental Health and Addictions Services attracted participation from 277 residents of our region.

6.5.1 Key Findings

Participants felt that the most important skills for mental health and addiction workers are:

- “Skilled in assessment, diagnosis and therapy” (93.9% of participants chose ‘6’ or ‘7’ on a scale from 1 to 7, where 7 was ‘most important’),
- “Strong interpersonal skills” (90.6% chose 6 or 7), and,
- “Uses patient-centred care approach” (88% rated it 6 or 7).
- In terms of system navigation, most participants prefer one-on-one, in-person care (69.1% of participants chose it over telephone and online access), and rated the following four navigator responsibilities as the most important:

- “Answering questions and helping people work out where to go” (rated ‘very important’ or ‘crucial’ by 84.7% of participants);
 - “Providing crisis assistance to emergency room patients” (83.9%),
 - “Making sure they have follow-up with family doctor or nurse practitioner” (83.8%), and
 - “Follow a patient’s treatment to help prevent them from ‘falling through the cracks’” (83.7%).
- In terms of “other” responsibilities for system navigators, participants emphasized the connection and coordination tasks (connecting patients to different system services and players, and coordinating their care as they move about), as well as providing ongoing care and support.
 - Participants expressed a high level of support for “behavioural health transition teams” (85.8% of participants were ‘very supportive’ or ‘supportive’ of the idea) but less support if it reduces services at central hospitals (only 58.2% were ‘very supportive’ or ‘supportive’).

6.5.2 What worked well?

Participants shared a number of positive experiences with the mental health and addictions, with the top four most recurring themes being:

1. **Treatment**, including counselling, the use of medication, and specialty services).

“Access to a skilled counsellor who was compassionate, non-judgemental, had many strategies to offer and practical solutions that could be implemented right away.”

“[I was] fortunate enough to find appropriate medication quickly and require little modification to dosage, and have very minor side effects to it”

2. **Approach to care**, including attitude of health service providers, collaboration, and the involvement of family.

“What works well is when all agencies and systems involved work together for the benefit of the client. Hospital, crisis, community supports and peer support all having the same information and working together to provide the best support for the individual.”

“Service providers who understand the mental health issue in the context of the person's life. Service providers who focus interventions on achieving outcomes that result in improvements that enable people to engage in activities that matter to them in their life.”

3. **Assessment / intake process** - Many participants expressed satisfaction with the quality and speed of intake, assessment and referrals to the proper service providers, including centralized intake where available.

“Someone at the front end that listened, explained the process and helped navigate through the system. They did not say they were the wrong service and give us a phone number. They helped navigate.”

4. **Health service provider quality** - For a large number of participants, their most positive experience with the mental health and addictions system was dealing with their family doctor, therapist, social worker or another health care worker, who provided high-quality care.

“We were extremely grateful to be placed in the ‘first episode’ treatment program and had WONDERFUL social workers who allowed me to call at any time for reassurance or to have questions answered. We had the BEST psychiatrist who was most accommodating as well.”

“Having access to someone to talk to who was empathetic and knowledgeable about what is available in the community.”

6.5.3 What didn’t work well?

Participants also shared a number of negative experiences with mental health and addictions services in the region. The top five most frequent responses were:

1. **Lack of resources**, which had an impact on the amount of beds available, staffing levels, and wait times.

“It looks like the Hospital has not enough personal to take care of mentally ill patients. Most of the time, our relative was left alone on his bed in the corridor of the hospital. He was deteriorating progressively going deeper and deeper in to his own word. It was because there was no one to talk to him. In a couple days he could not even to walk, because he was constantly [tied] to the bed. In old-age home he got much better and even started to walk holding himself on the nurse.”

“The idea that a person should have to ‘wait’ for care with a mental health/addictions issue is ludicrous – in your first example, where the husband stops taking his meds, could potentially be catastrophic for the wife and may even endanger her life or her children. He should have immediate access to assistance.”

2. **Treatment**, which included early discharge, lack of continuity of care, lack of follow-up care, and medication.

“The first two psychiatrists that this person saw gave her prescriptions for anti-depressants, but provided no counselling. When she told the psychiatrists that she was not feeling better, but getting worse, more meds were prescribed. It was clear the meds were not working, but the patient was seen for less than 15 minutes each time and told to be followed by her family doctor who had limited experience with this type of patient.”

3. **Approach to care**, not only on the part of health service providers, but of the public at large, and the provincial government.

"It would appear that proper credentials and capacity to understand clinically does not necessarily transfer to ability to empathize with others, tend to real-life needs, and think outside the box as required."

4. **Assessment / Intake / Referral** - Many expressed not knowing where to go for help, and having difficulties being admitted for help.

"No one agency, too confusing, duplications"

"The phone help line was not listening and not making appropriate referrals to other community mental agencies and peer support services."

5. **Access** - Participants expressed difficulties accessing mental health and addictions services locally, and lamented the travel time required to access some services.

"No help on evenings, nights or weekends – when...people get into trouble!!!"

6. **Other** – Participants also shared their negative experiences with the lack of coordination between services and inadequate levels of training of health service providers.

6.5.4 *Suggestions for Improvement*

Participants overwhelmingly suggested more resources (largely financial) in a number of areas as a way to improve the provision of mental health and addictions services, including funding music and art therapy programs in the community, increasing funding of community mental health and addictions agencies, ensuring the appropriate treatment staff and facilities are in place before discontinuing services, and increasing access to mental health care and beds for short-term admissions.

"[We] need much broader range of addictions options available to clients outside of cities e.g. Bancroft; Locally available, in-person crisis services; Locally available harm-reduction programs that are not 'added on' to a for-profit pharmacy (as is currently the case)."

"I can't emphasize enough how important it is to provide support for the youth/kids. Young people need to learn mental health self-care techniques, and knowledge about where they, or their families, can go if they have a problem...There needs to be a team that responds to kids/youth the same way that your proposed team responds to seniors. On this matter, I feel you 'missed the boat' and the kids are sinking!"

"My biggest complaint is that wait times are too long."

Participants also suggested more coordination and integration between providers to improve the level of care (including eliminating duplication of services where possible), changing the approach to care provision, increasing the education and training of the public at large as well as health service providers about mental health and addictions, developing a more streamlined assessment and intake system, improving the level of ongoing care, and creating a more responsive and accountable system.

6.6 Regional Surgical Services

This was the second most popular Workbook topic, completed by 305 participants.

6.6.1 Key Findings

- Participants generally prefer their pre-surgical care, surgery and post-surgical care (rehabilitation) to take place within a 30-minute drive of their home (51.5%, 43.5% and 60.7% of participants answered as such respectively).
- Participants were most willing to access blood work (92.5%) and medical imaging (81%) and receive information on how to prepare for a surgical procedure (food, drink, dress) from their primary care provider (81%), and least willing to receive a 1-week post-surgical consultation (51.1%) and a consultation on how the surgery works (including side effects) (55.7%).
- 80.3% of participants felt that the post-surgical consultation on how the surgery works (including possible side effects) should be conducted by the surgeon, while only 23% of participants felt that surgeon's offices should be providing information on directions (parking, transportation options).
- Before and after surgery, participants would feel most comfortable using an interactive website (25.2%), a booklet / pamphlet (23.8%) or a telephone follow-up call (17.7%) to access further information.

6.6.2 Increasing the role of primary care providers in surgical care

Participants shared a number of their worries about having more pre- and post-surgical care provided by primary care providers. The top four themes were:

1. **Level of knowledge**, skills, training and experience of the primary care providers.

“Family physicians and nurse practitioners need to be very well informed regarding the procedures, possible side effects, and when the patient should be seen by the specialist.”

“I would be concerned that my GP only has a general knowledge of the procedure and has not been trained to address related to specific surgery. General Practitioners are just that – general in their knowledge. Specialists are specialized in their knowledge.”

2. **Coordination of care and flow of information**, particularly the transfer of medical records, test results, and discharge letters between the surgeon and primary care provider.

“Splitting up care leaves room for errors.”

“Lack of demonstrated ability to quickly and accurately share patient information and health records (including test results, imaging, etc...) electronically amongst those who are involved in my care”

3. **Accountability** of the surgeon over her or his work, including the amount of confidence and trust that is developed through in-person consultations with the surgeon.

“The family doctor/nurse practitioner is not familiar with the ‘individual’ surgical event. The surgeon is the only one who truly knows about your individual surgical experience and can assist you should there be any complications. Post-operative complications have been missed in the past by a patient being seen by a family doctor/nurse practitioner. Keep the scope of practice where it belongs!!”

4. **Primary care providers are already busy** with their regular workload.

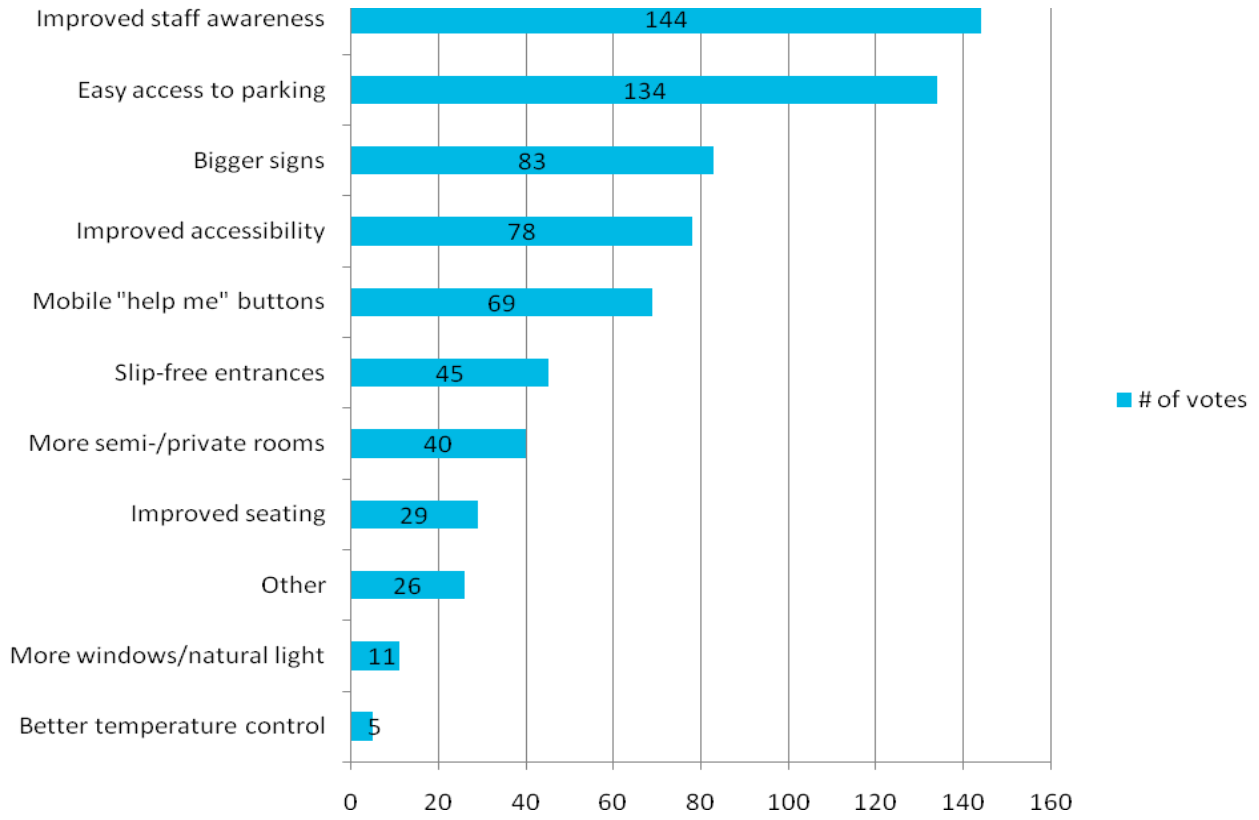
“Family Doctors are difficult to access now as they are overbooked with patients”

6.7 Restorative Care Services

A total of 231 participants completed the Workbook on Restorative Care Services.

6.7.1 Key Findings

- Participants expressed mixed views on how “senior friendly” our region’s health facilities are (38.7% chose ‘definitely not senior friendly’ or ‘not senior friendly,’ 31% chose ‘senior friendly’ or ‘very senior friendly’ and 24.5% chose ‘neither’)
- Respondents expressed a slight preference for care closer to home over timely access to services (47.6% of participants chose ‘care close to home’ or ‘prefer close to home’ versus 38.8% who chose ‘prefer timely access’ and ‘timely access, even at a distance’ and 12.3% who chose ‘it’s an even trade’)
- Participants prefer to be sent home with follow-up visits at a clinic or at home rather than staying in a hospital (on a scale from 1 to 5, 64.6% of participants chose ‘5 – to be sent home, with follow-up visits at nearby clinic’)
- The chart on the following page shows how a number of changes to make healthcare services more “senior friendly” were rated:



6.7.2 Creating more “senior friendly” spaces

Participants shared a number of other ideas on how to create healthcare environments that are more “senior friendly” for older adults. The top four suggestions were:

1. **More senior friendly physical space**, including providing complimentary warm and cold beverages, having more beds and private examination areas, increasing accessibility, and making improvements to outpatient service layout, seating, and washroom facilities.

“Some seniors are very sensitive to sharing spaces with members of the other sex, no matter what the practical reason is for this to happen. I’m not sure how it address this, but perhaps it could be taken into consideration in emergency room/inpatient room design.”

2. **People to help**, tasked with helping patients navigate the hospital and checking up on those in waiting rooms.

“[Have] enough volunteers/staff available to handle issues in waiting areas. If these people have no family member accompanying them (and sometimes even when they do), they often are

unable to communicate their needs. Staff are always rushing around, expecting these seniors to speak up as they rush by.”

3. **Better communications**, including instructions that are given more clearly and slowly (and by staff more mindful of communicating with older adults), more information on approximate wait times, and tools to help older adults more easily understand (larger print sizes on forms, better signage, and hearing devices that may be loaned while in hospital).

“I think that stress / anxiety would be lessened if patients were given a number and a monitor board showed what number was being served, with an indication of wait times. If a senior needed to use the washroom or make a phone call, they would be less concerned about missing their turn. They would have some information to be able to provide families regarding waiting.”

“Not all seniors are deaf, just speaking slowly and making sure the senior actually understand what you are saying, today’s terminology and slang is sometimes not clear to everyone, not just seniors.”

4. **More senior-friendly approach to care**, referring to how staff treat older adults and other patients. Participants asked that health service providers be more patient, sensitive to their needs, respectful, compassionate, and more client-focused.

“Older people should not be patronized e.g. staff calling someone ‘hon’ or ‘sweetie.’”

“I believe that every person should be treated as a client, which means that they are listened to, information is shared with them, and they are then able to part of the decision-making process. Some staff, both professional and non professional, sometimes forget this and feel that they are the ‘professionals who know best.’”

5. **Other** – Participants also suggested training programs for frontline staff, improving parking (more accessible spots, reducing or eliminating parking fees), increasing staffing levels, decreasing wait times, improving discharge and follow-up care, focusing on prevention, maintaining stroke support groups, increasing the role of family members in care, and moving alternative level of care (ALC) beds away from hospitals.

6.7.3 Concerns with “High Risk” Flagging

One idea to improve care for older adults was to flag certain patients as “high risk”. Participants shared a number of concerns with this idea, and the four were:

1. **Definition and identification**, including who determines which patients are flagged as “high risk”, and the need for standardized training on identifying “high risk” patients.

“If the emergency staff do not have the proper training to identify seniors at risk, or take the time to thoroughly assess the patient, then the patient and time will be wasted.”

“There would need to be a clear definition as to what ‘high risk’ or any other definition meant. For this to be effective, there needs to be ongoing and effective communication within the hospital setting, etc... between all health care professionals working with that patient.”

2. **Staffing**, particularly the need for adequate staff resources to give “high risk” patients the time and energy they require.

“It certainly SHOULD make a difference, but as things stand today, health care providers are run off their feet and really have no time for ‘extra’ care.”

“Any idea of this nature is significantly dependent on the assigned caregiver and the empathy they are trained/prepared to demonstrate when faced with ‘high-risk’ clients. Will always be constrained by the vagaries of ‘human nature.’”

3. **Labelling**, including the fear of health service providers treating those flagged as “high risk” negatively.

“It will only marginalize people and put them at risk of being ignored by workers as ‘frequent flyers’ or problem patients.”

4. **Equality**, namely the concern that those not flagged will receive less attention.

“[I’m] concerned that those without the sticker might not receive adequate care. I think all patients are vulnerable. If you are in a hospital, you are vulnerable, you are not there because you don’t need to be. Therefore, all patients should receive the care and attention they require...no more or ‘extra’ and no less.”

5. **Other** – Participants also expressed concerns about the format of the flag (whether it would be an e-flag or paper based, and the repetitive nature of the flag).

7. Feedback on the Process

Participants rated their participation in the community engagement phase of the Clinical Services Roadmap project as positive. Fifty six percent of participants agreed that they enjoyed completing the Workbook, while 57% agreed that completing a Workbook helped them understand what the CSR project was about. Based on their experience with the Workbook(s), 74% would consider completing another Workbook in the future. Lastly, 72% indicated that they would now follow the South East LHIN’s work more closely.¹

¹ 1695 participants responded to the question “I enjoyed completing the Workbook”, 1680 responded to “Doing this Workbook helped me understand what the CSR was all about,” 1694 answered “Based on this experience, I

8. Final Comments

The community engagement phase of the Clinical Services Roadmap project generated valuable community input on ways to strengthen the health care system in South East Ontario.

The South East LHIN would like to thank all participants for their feedback, ideas and suggestions submitted during the project.

The South East LHIN will use this information to inform the further development of the seven Clinical Work Plans, as well as ongoing allocation decisions. This engagement process built on existing community engagement efforts, and the South East LHIN looks forward to a continuing dialogue with communities about ways to strengthen the health care system in our region.

would consider doing another Workbook in the future,” and 1693 answered, “After being part of this project, I will follow the LHIN’s work more closely.”