

South West
LOCAL HEALTH INTEGRATION NETWORK

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APPENDIX C:

Summary of Community Engagement

October 31, 2006



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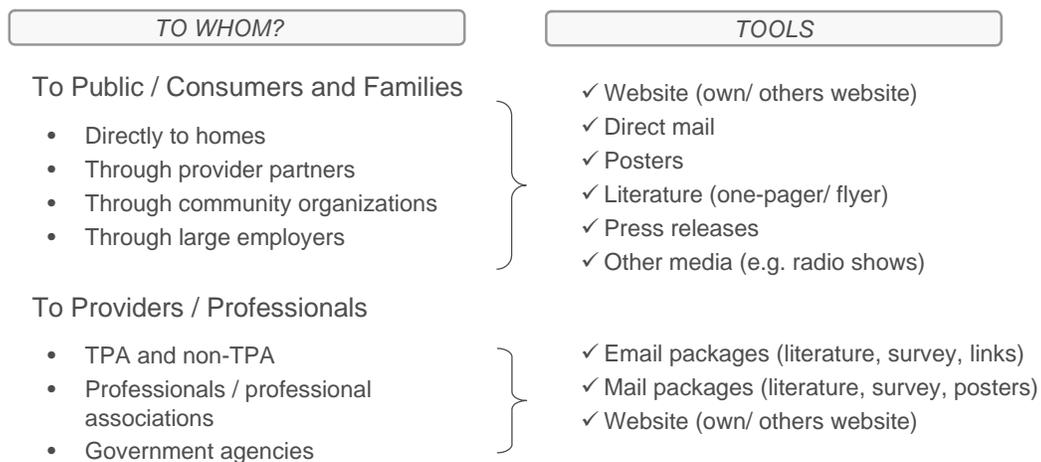
APPROACH

Our approach to gathering input for the Integrated Health Service Plan (IHSP) was based on the following commitment to community engagement:

- **Collect information “from the source”** – use surveys and workshops to gather data directly from consumers, families, the public, and front line workers
- **Inclusive discussions** – ensure that engagements involve participants from a cross section of provider organizations and communities
- **Maximize face-to-face interactions** – “walk the talk” of the LHIN’s commitment to community engagement across the South West
- **Use local communication vehicles** – build on existing communication vehicles and partner with local organizations to engage communities
- **Keep it simple** – use clear, concise language and avoid health care jargon

Disseminating Information

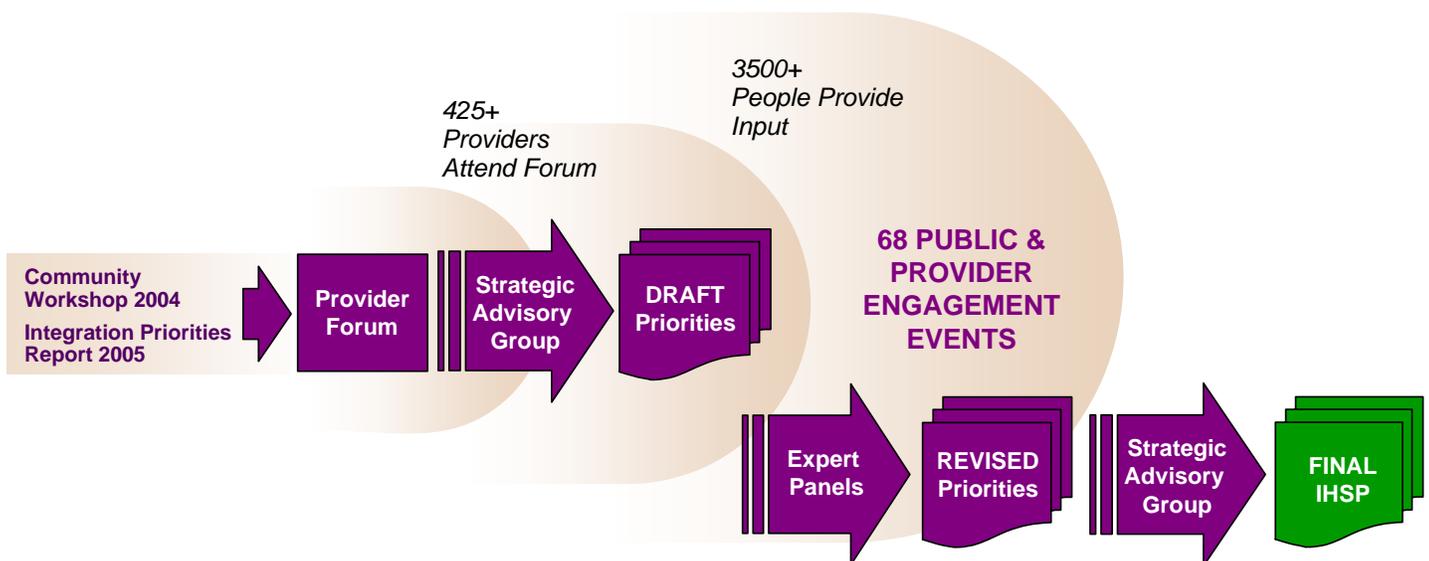
Our Goal: reach a broad cross section of the community to raise awareness and invite input on the IHSP through face-to-face, online and paper-based formats



Engaging our Partners

Goal: To provide an easy and accessible method for interested parties to provide input, making use of multiple formats

- **Area Provider Table (APT) Input:** Forums were held with members of the North and Central Area Provider Tables as well as providers from the South area. Participants offered feedback on the draft priorities. The full draft IHSP was circulated to the North and Central Area Provider Tables for more detailed review and comment.
- **Clinical and Population Network Input:** Clinical and population networks within South West Ontario submitted information about their integration initiatives and suggested opportunities to align with the South West LHIN priorities.
- **Telephone Poll:** More than 600 people provided input through a random survey telephone poll aimed at gauging awareness about the LHIN and gaining feedback on priorities.
- **Web-based survey:** Almost 200 people participated in an online survey that allowed for more detailed response to the LHIN priority areas and asked for a ranking of most important issues.
- **Public and Provider Forums:** Workshop style public and provider forums and meetings with special populations were held across the South West to initiate intensive dialogue in as many communities as possible, raise awareness about the LHIN, and invite input for planning.





SUMMARY OF INPUT TO THE DRAFT PRIORITIES

Key inputs to the draft priorities:

South West LHIN Integration Priority Assessment

In November/December 2004 the Ministry of Health and Long-Term Care invited health care and community partners from across the province to participate in the 14 LHIN Community Workshops to share insights and experiences and identify local integration opportunities. In the South West LHIN, more than 300 providers and community representatives attended the Workshop. In total, some 47 integration opportunities were discussed, and through a facilitated process the participants' top ten priorities were identified.

Based on the priorities identified at the Workshop, a number of reference groups and committees were formed with the aim to develop next steps and action plans for the short and long term. The work of these groups contributed to the development of the South West community's final report – the *South West LHIN Integration Priority Assessment* – released in February 2005.

South West LHIN Providers Forum, May 2006

On May 12, 2006 providers from across the South West LHIN congregated for a second time. The full-day Forum was an opportunity to explore opportunities to work in partnership and revisit the priorities identified in the previous community workshop. Participants were provided with a summary of the *Integration Priority Assessment* and asked to share their perspective on the previously-identified priorities, identify gaps or additions, and discuss their relative emphasis or ranking.

The following pages summarize the input received to the integration priorities.

1. OUTCOMES OF AN INTEGRATED SYSTEM

Improving access to primary care

- **Creating an integrated primary care strategy** – Forum participants acknowledged that a primary care strategy would need to integrate across all health care sectors and take into account specific communities faced with challenges of access to primary care. Involvement of physicians in the LHIN partnerships was identified as a critical factor, as well as the involvement of variety of other primary care groups (FHGs, FHNs, FHTs, CHCs) which may have an impact on delivery. Specific opportunities identified by the group included:
 - Focus on development of Family Health Teams to ensure that redundancies are not created
 - Focus on access to primary care in rural settings and recognition of the need for outreach programs in remote areas
- **Linking family physicians to community care** – Several priorities identified by participants touched on primary care, including: an integrated and coordinated primary care/community care system; and the need for a model to provide comprehensive integrated care to patients/families who do not have a primary health care provider. The report outlined several existing primary care initiatives, including the North East London Primary Health Care Project proposal, Community Care Access Centre London-Middlesex Hospital in the Home program, and the Sauble Community Health Centre Proposal.

Next steps proposed by the Reference Group Action Plan included:

 - *An environmental scan to identify trends and unique challenges related to access;*
 - *Definition of principles for a primary health care model that supports innovative, flexible services in the South West LHIN;*
 - *Design of local education strategies to expand public understanding of the challenges impacting primary health care services;*
 - *Development and funding for electronic integration strategies for primary care services such as telemedicine, e-health, community health information network, and video conferencing.*

Ensuring a consistent level of service and quality in rural and remote communities

- **Building links between rural communities and urban centres** – Forum participants focused on the value of strong linkages between rural hospitals and specialized services, as well as with tertiary care centres. Rural issues were identified as fundamentally about access to care; availability of Alternate Level of Care (ALC) services including Long-Term Care homes and rehabilitation facilities were highlighted.
- **Supporting and enabling rural networks** – Issues facing rural and remote communities were a recurring theme among the priorities identified. Rural networks (hospital networks, mental health networks, long-term care networks) were recognized as an important mechanism to address rural issues, enabling health care providers to work together in formal networks where the emphasis is on collaboration, not competition for scarce resources.

Next steps proposed by the Reference Group Action Plan included:

- *Develop partnerships between the LHIN and existing rural health networks and support establishment of new networks in areas where no formal structures currently exist;*
- *Develop a comprehensive Rural Health Action Plan that includes:*
 - *Definition of a core basket of health services for rural communities*
 - *Performance targets for rural health system improvements*
 - *Strategies to create healthier rural communities and mechanisms to accommodate unique challenges of accessing rural health;*
- *Work with academic institutions to promote innovation and best practices in the organization and delivery of rural health services.*

- **Delivering quality health services to those living in rural or remote communities –**

Concern about access to quality health services was another prevalent theme in the discussion of rural communities. Priorities focused on service equity with those in an urban setting, as well as removing barriers to access for those living in rural or remote communities. Participants argued that the “best” health care is that provided as close to home as possible.

Next steps proposed by the Reference Group Action Plan included:

- *Undertake a gap analysis to better understand what is needed, and how linkages to urban areas can be facilitated;*
- *Shift the “centre of excellence” to the home and community setting, identify opportunities to move to a higher level of in-home services, and optimize new technologies to improve delivery of health care services;*
- *Focus on community capacity building and foster knowledge sharing and learning on best practices.*

Addressing transportation challenges

- **Support for rural transportation –** Support for transportation services in rural communities was identified as a significant factor in accessing services, as well as an important contributor to independence of seniors and those living with long-term disabilities. The report identified several factors for improving transportation services including more effective use of volunteer providers who are already active in rural communities, and improved coordination and a standard level of service across jurisdictions. The reference group called on the LHIN to become a leader in the provision of innovative and accessible transportation.

Next steps proposed by the Reference Group Action Plan included:

- *Inventory service providers and create strategic plan for rural transportation;*
- *Establish Transportation Working Groups in each county to identify local resources, needs, gaps and other issues.*

Forum participants also highlighted the current dependence on volunteer providers and suggested that this approach should be examined more closely, pointing out that it left some vulnerable populations with no access to transportation.

- **Effective use of non-emergency transportation** - Inter-facility patient transfers and non-emergency transportation were identified by many forum participants as a growing challenge. The group acknowledged that transportation posed unique challenges in rural communities, but recommended an examination of the issue across the South West, including urban centres.

Building linkages across the continuum of care

- **Improved quality of care and standardized care pathways** – Standardization and patient-focused health care pathways were two commonly-identified opportunities to achieve improvements in quality across the care continuum. Participants stressed the need to maintain and enhance the quality of services and program standards locally as well as among LHINs and at the provincial level.

Forum participants acknowledged the value of care pathways but suggested that clarification is needed on the role of hospitals in the pathways of care. With reference to standardization, the group suggested that best practice and quality measurement were more important to ensure quality of care across the LHIN than standard practices, and encouraged the LHIN to remain focused on issues of quality.

- **Chronic disease management** – Chronic disease prevention and management were focal points of many integration priorities outlined in the report. Two suggested opportunities were:
 - A system to handle primary and secondary prevention of chronic illnesses across the life continuum, health sectors (e.g., public health, primary health care, home care, acute care) and other sectors;
 - Development of a lifelong system of support for people with significant physical and/or sensory disabilities.

Forum participants emphasized the importance of a **LHIN-wide strategy to coordinate and link services**, avoid duplication and maximize the use of scarce resources. The group encouraged the LHIN to include the full spectrum of strategies in the chronic disease strategy including **health promotion and prevention**. Some participants suggested focusing on a specific issue such as diabetes among Aboriginals or mood disorders.

- **Community Support Services** – Participants in the workshop identified the need for an ongoing commitment to a service delivery system that supports individuals to live securely and independently at home. It was recognized that Community Support Services support many people in their homes who would otherwise be institutionalized.

Next steps proposed by the Reference Group Action Plan included:

- *Build a quality framework to implement shared best practices, indicators and an evaluation system to facilitate benchmarking;*
- *Build a foundation of shared information and knowledge;*
- *Meet with existing groups working on integration initiatives including Community Support Services to identify current linkages and strategies;*
- *Define a vision, philosophy and principles to support service provision.*

- **Rehabilitation services across the spectrum** – Forum participants raised the importance of rehabilitation services across the continuum, from children to seniors and across many disease processes.

- **Assistance navigating the health system** – Navigation across the care continuum was a theme that ran throughout the report, including in the discussion of seniors' services, mental health and addiction and chronic disease management. Additional opportunities for improved system navigation were identified in paediatrics and palliative care.

Building linkages to promote wellness and encourage collaboration

- **Promoting wellness and prevention** – Forum participants emphasized disease prevention and wellness and encouraged the LHIN to ensure that integration spanned the full continuum of care. The group suggested the involvement of public health and other non-health support services, and highlighted the importance of public education, outreach and awareness-raising.

- **Inter-jurisdictional coordination and collaboration** – Forum participants encouraged the LHIN to involve municipal, provincial and federal partners. The group emphasized the role of the LHIN in building linkages with federal and provincial initiatives, particularly in response to Aboriginal health needs and challenges. The group also discussed opportunities to involve other ministries (e.g., housing, social services, etc.) to support and reinforce the LHIN's strategies.

Coordinating Mental Health and Addiction Services

- **Coordinated services for those living with mental health and addiction issues** – The focus of the mental health discussion in the report was on:
 - Better understanding of mental health and addiction issues and improved capacity to identify and respond;
 - Effective and coordinated response for those at risk;
 - More appropriate and effective use of acute care services.

Priority areas identified by participants included: maintaining and building mental health consumer and survivor initiatives; women's mental health and addictions; community mental health services; and rural mental health networks to assist planning and ensure a local voice.

Next steps proposed by the Reference Group Action Plan included:

- *Establishment of a Mental Health and Addictions Advisory Committee to participate in planning and priority setting;*
- *Integration of mental health and addiction with the planning and delivery of other health care services;*
- *Commitment by the LHIN to ensure sustainable multi-year funding.*

Forum participants also highlighted the need to incorporate the whole age spectrum, and suggested the importance of a strategy for crisis response.

Services for seniors

- **Integrating seniors services across the continuum of care** – Many of the priorities identified had direct or indirect impact on seniors services, including:

- Networking to enhance care of the elderly;
- Strategies for end-of-life care services;
- Geriatric and therapeutic (rehabilitation) programs for seniors;
- Formal structure for rehab services in LTC for target populations (SCI/ABI/Stroke).

Additional priorities for improved seniors care were articulated with reference to rural health, chronic disease management, and Community Support Services. In particular, the issue of Alternate Level of Care (ALC) was identified as a significant opportunity for integrated solutions to providing care in an appropriate setting.

- **Closing the gap between LTC and care in the home** – Forum participants suggested an explicit focus on home care strategies and promoting healthy aging. The group encouraged the LHIN to look at strategies to enable seniors to remain in the community as they age, including supportive housing, respite care, and support for family caregivers. Key issues identified by the group included complexity of the client, rural isolation, and lack of formal support for caregivers.

2. ENABLERS OF INTEGRATION

Implementing e-Health

- **Creating a common e-health strategy across the South West** – Many information management and technology initiatives were identified throughout the report, and several strategic initiatives were described, including the Information Management Task Group of the Grey Bruce Health Network and Huron Perth Connect Ontario. It was recognized that a number of e-health initiatives are complementary and can be done in parallel, but that a common framework and alignment with provincial directives is imperative.

Next steps proposed by the Reference Group Action Plan included:

- *Thames Valley - focus on developing “1 Patient, 1 Record” and sharing that information across the continuum of care. Initiatives include development of a single repository for Thames Valley hospitals and a possible pilot to develop Mental Health Information.*
- *Grey Bruce - focus on expanding use of its current patient care system to include not only hospitals but also tertiary centres, primary care physicians and community agencies. Initiatives include a business case for their EPR and development of a physician portal.*
- *Huron-Perth – focus on full implementation of the Electronic Patient Record, connecting with family physicians, and integration of voice, data and video.*
- *In all areas, focus on the CCAC review of the Community Health Information Network, and the expansion of thehealthline.ca, telemedicine and videoconferencing capacity.*

Forum participants also highlighted the importance of e-health but argued strongly for the need for one **comprehensive e-health strategy** across the South West LHIN. The group emphasized the value of e-health as a **vehicle to increase access to services and resources**.

- **Creating a common data system or platform across the South West** – Facilitating integration across the continuum of care through the practical application of information technology was a key priority of the group and participants highlighted the need for common information and platform in Long-Term Care and community care services. The report outlines a model called *Connecting the Continuum of Care: an e-health strategy for the South West LHIN*, which describes a two-pronged approach aimed at building bridges across “streams” (access management, discharge management) and enhancing each stream across the continuum of care.

Next steps proposed by the Reference Group Action Plan included:

- Mobilize community partners through an analysis of information system readiness;
- Determine essential shared data elements;
- Identify existing models that could be used as a base to move forward;
- Define measurable outcomes and benefits of participation.

Forum participants emphasized the importance of a single strategy regardless of sector or provider, although the group recognized that an “e-model” would need to interface with other systems and platforms. Participants suggested that an e-health strategy should include a **sub-focus on cross-sector functionality**, rather than on a specific region, sector, or population.

Mobilizing existing networks, partnerships and institutions

- **Coordinating and building on existing networks** – Participants highlighted opportunities to capitalize on established resources by enhancing existing networks. Several community-specific opportunities were identified including:
 - Integrating rehabilitation networks;
 - Networking for care of the elderly;
 - Regionally integrating cancer care;
 - Creating rural networks.

Profiles of current integration initiatives also described the role of networks in enabling regional technology and communications integration, enabling regional clinical services integration, and enabling regional health system development.

- **Leadership role for Academic Health Sciences** – Academic Health Sciences Centres can model and show leadership for standards of care across the South West. The report outlined their role in innovation of patient care, including introduction of new methodologies and advanced technologies. Workshop participants also wanted to ensure that the academic and research mission of the Academic Health Sciences Centres was protected.

- **Enabling integration through improved communication and knowledge sharing** – Some of the specific priorities identified at the workshop were:

- Access to standard sets of evidence-based information resources;
- Communication and information as enablers for integration;
- Support for tools such as thehealthline.ca, information and referral, and 211;
- Effecting cultural change.

Enabling access to resources and ensuring a sustainable foundation

- **A LHIN-wide health human resources plan** – A survey conducted for the development of the report indicated the need for a LHIN-wide human resources plan and drew attention to several challenges including recruitment and retention, delivering services to rural communities, and an aging work force.

Next steps proposed by the Reference Group Action Plan included:

- *Support and contribute to a provincial Human Resources Plan to address issues of recruitment and retention;*
- *Develop an education plan in partnership with the academic institutions for training in the professions that are in short supply;*
- *Evaluate the impact of managed competition on human resources within the community health care sector;*
- *Evaluate current practices with respect to casual and part-time positions.*

Many forum participants identified **human resources as a top priority** in the South West, referencing challenges in recruitment and retention of health care professionals. They posed the question, “How do we continue to attract health care professionals to the South West, particularly to rural communities?” Participants acknowledged the unique challenges in the South West:

- Managing workload and pay differences across rural and urban communities;
- Examining institutional vs. community HR issues;
- Leveraging academic health sciences for training and research.

- **Needs-based funding** – Participants noted the importance of a needs-based funding model that linked resource allocation with population health needs, measurable care standards and defined outcomes.

Next steps proposed by the Reference Group Action Plan included:

- *Promote the importance of a needs-based model for planning and resource allocation;*
- *Work in partnership with the Ministry of Health and Long-Term Care and others to define funding standards and policies;*
- *Establish working groups as appropriate to assist in the assessment of current services and existing resources/ funding within the LHIN.*

Forum Participants said that the concept of “needs-based funding” required further clarification and some suggested that it could be reframed to reflect the **issue of rural health service**, i.e., funding based on population alone does not adequately service large sparsely populated geographic areas.



SUMMARY OF INPUT TO THE FINAL IHSP

- During the summer and fall of 2006, the South West LHIN undertook extensive community engagement on its draft priorities for the Integrated Health Service Plan. This included meetings and forums with providers, community leaders and the public, which invited detailed feedback and input on each of the four integration priority areas. In total more than 2500 people attended the sessions, Specifically:
 - 31 Public Forums with nearly 2000 participants in total
 - 3 Area Provider forums, 10 provider forums & 5 expert panels with over 600 providers attending
 - 3 Forums for Union and Human Resource Leaders with over 100 participants
 - 3 Forums for physicians with over 130 attending
 - 7 Forums for mental health and addictions consumers with nearly 200 participants
 - 6 Forums for Aboriginal and First Nations communities and community leaders
 - 3 Forums for Immigrant populations
 - 1 Forum for the Deaf community
 - 1 Forum for the Francophone community
- In general, those attending the sessions responded positively to the integration priorities and the proposed action plans, and provided a significant amount of input to revise or further refine the priorities. At the public forums, participants were asked to join discussion groups to share their perspective on the proposed priorities, potential gaps, challenges and their role in the process of change. At the provider forums, participants were asked to join discussion groups to focus on particular priority areas and to respond to a series of questions about the proposed action plans. Input from each group was captured at each session, and is summarized in this document.

1. Summary of Input from Public Forum Participants

1. Overall, do the priorities make sense and which one is most important to you?

- Overall, participants responded positively to the priorities, and shared numerous experiences to support the need for action in these areas. The integration priority identified as most important varied from community to community and many participants pointed out the inter-connectedness of the priorities.

Participants discussed and provided input on each of the draft integration and enabling priorities presented by the South West LHIN. Their comments are summarized below:

- **Strengthening and Improving Primary Health Care:** A consistent theme among providers and the public alike was a shortage of family physicians across the South West. Comments included:

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- There is a shortage of family physicians in many communities and many doctors are nearing retirement age
 - Team models afford opportunities
 - Better communication is important – e.g., new group clinic in St. Marys where providers share information
 - We must increase the ability of individuals to work in teams
 - There must be an increased role for Nurse Practitioners
 - The recruiting efforts of small communities trying to attract new doctors should be strengthened
 - Primary care is governed by doctors – we need more nurses in the system
 - Education must take an inter-disciplinary approach in education so that providers are supported to work in teams
 - Human resource issues
 - New students need to be encouraged to go into primary care. We need incentives such as tuition reimbursement
 - We must strengthen recruiting efforts of small communities trying to attract new doctors
 - We need to balance the LHIN role and the MOHLTC role regarding physicians
 - The compensation of providers should be reviewed
 - Access issues
 - Access to a family doctor is difficult (e.g., in Ilderton you need to have an Ilderton address to get a new doctor)
 - Doctors are selective about taking new patients, creating difficulties for people with complex needs, and mental health and addictions challenges
 - At a doctor's appointment, patients can only talk about one issue per visit (5-10 minutes per visit)
 - There is a significant wait time to get a doctor's appointment. It seems that gatekeepers are slowing the system down
 - Physicians can't be the only "gatekeepers" to the system. We need more access points
 - **Preventing and Managing Chronic Illness:** participants welcomed the focus on prevention and health promotion and many suggested that this area be emphasized in the South West LHIN's priorities and plan. Other comments included:
 - Consequences of chronic illness are huge – this needs to be a primary focus
 - Importance of prevention and promotion
 - We need to reach people earlier with more focus on promotion and prevention
 - The focus should be on our children. There is concern about lifestyle choices being made by youth today
 - There is not enough emphasis on healthy lifestyles in the schools – we need to link with teachers and schools
 - There is an opportunity for Family Health Teams to support wellness and health promotion
 - We must move beyond health care and work with non-health agencies to provide education in schools
 - Alternative medicine and complementary care need to be included

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- Environmental effects should be factored in (e.g., is there a link between Parkinson's and MS and pesticides?)
 - Public health is not within the LHIN structure – how will this work?
 - What is the impact of pollution, nutrition etc.?
 - Can we put some teeth behind this? (e.g., the anti-smoking by-law is a big start)
 - We need to partner with the education system
 - People need exercise and nutritional counselling
 - Service and action issues
 - People in the system often don't know what services are available and how to access them
 - Many services are only available in London; this is a barrier and many individuals never access needed services
 - More follow up needed for people after an episode
 - Cancer should be included in CDPM discussion
 - We need to strengthen the relationship with Aboriginal and First Nations communities
 - Rehabilitation should be part of the CDPM discussion
 - We need to understand variations in disease rates within geographic areas
 - Seamless flow is important, but we have worked at it for a long time—it's tiring!
 - **Building Linkages Across the Continuum – All Seniors, and Adults with Complex Needs:**

Participants recognized the unique needs of seniors. Comments included:

 - Appropriateness of senior-focused priority
 - The seniors priority is very important given the aging population. We must increase resources during last 6 months of life
 - We need to reach out to seniors, because it is hardest for them to access the system
 - We need an advocate or ombudsman for seniors
 - The current process is fragmented, tough to navigate
 - Challenges facing seniors
 - They need system navigators (links to health human resources)
 - Volunteer programs for driving are important because transportation is not affordable or not available for some
 - The cost of transportation to get clients to London is significant
 - Appointments with a specialist can take all day -- too large a commitment for volunteer drivers
 - A "Guardian Angel" is a good idea but it takes a lot of time and resources to help people navigate the system
 - Rehabilitation services are not available
 - Seniors are being discharged to inappropriate places
 - We need more and better Long-Term Care services
 - We need to protect funding for existing facilities. There is concern that existing beds will be taken away (e.g., Lion's Head)
 - Case management needs to go across sectors and providers
 - We should build on end-of-life care programs

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- Once in the health door, the full spectrum of services is available, especially for seniors
 - We need to work closely with municipalities on issues related to Long-Term Care homes
 - There is community apathy about the seniors population
 - Include health seniors in the plan
 - We need to remember the seniors who are healthy and not a burden on the system. The focus should be on prevention and healthy living
- **Access to Services in the Right Place, at the Right Time, by the Right Provider:** Participants linked the issue of access to many of the other priority areas and provided examples of many of the existing challenges accessing services. Comments included:
 - Access is the number one priority – right service, right place, timely
 - Physicians need to refer out to the right services
 - We must look at alternative ways to provide services – e.g., Family Health Teams, video conferencing
 - We need to get information about available services to the public (i.e., where to go) and support knowledge about treatments
 - Many people need extra help to navigate the system – e.g., mental health consumers, seniors, children
 - Family doctors expect specialists to inform their patients; specialists expect family doctors to do it
 - Multiple referrals and follow-ups make access complex, especially when travel is involved
 - When you are really sick, it is easier to get the help that you need
 - Access to doctors and primary care providers
 - There is a shortage of doctors, who should open the gateway to primary care services
 - We need more entry points than just the family doctor
 - People avoid seeking services because they are not accessible
 - Nurse Practitioners need a larger role - Family Health Teams will help
 - We must strengthen access to allied health care workers, to take pressure off doctors
 - Wait lists
 - Wait lists go beyond Hips and Knees and MRIs
 - There are wait times for specialist services, but also for primary care to get the referral
 - There are long waits for diagnostic testing in the north. This also has a major impact on the prevention priority (i.e., people are diagnosed later) and rehabilitation issue (i.e., it takes longer to restore people to good health)
 - Information technology
 - IT could help overcome wait lists and access issues (e.g., it could allow for more efficient movement of records)
 - Testing could be done locally and information shared with specialists in London
 - This will require more investment in technology
 - **Enabling Priorities – e-Health and Health Human Resources:** many participants at the public engagements were knowledgeable about underlying system issues facing the health system in



the South West and focused on staffing and technology challenges identified in the South West LHIN's enabling priorities. Comments included:

Health Human Resources:

- We need to better utilize existing staff
- Equity is needed across all job areas, including pay and benefits (e.g., disparities between community and hospital providers)
- Community services are at risk if we cannot make this an attractive job opportunity (e.g., it is difficult to attract new Personal Support Workers because they are the “lowest on the food chain”)
- Funding would be better invested in people, not technology
- We must support training of professionals
- Staff must be treated better, especially nurses
- Communities should establish bursaries for medical students
- With regard to the education of health professionals, we must look further out beyond 10 years
- Younger docs have different lifestyles and expectations
- With increasing patient complexity and increased load doctors need team support

e-Health and Information Technology:

- Electronic access to health records should be available for health care workers
- This has big potential to make the system more efficient and effective
- If there is no electronic health record, people should be able to carry their health records with them
- The cost of transferring records between providers can range from \$20 to \$100
- Universal patient information (patient record) should include consideration of the patient's level of understanding
- We use up a lot of resources (and time) to take down people's information
- Information needs to flow better across areas and between providers. We need:
 - A provincial approach (e.g., cards or a computer chip)
 - Consistent standards for capturing information (e.g., templates or data formats)
 - Central database
 - Performance information to support accountability
 - Full connectivity – eight hospitals are connected in the south, why not all of them?

2. What else do you think we need to add to make this a success?

Success Factors: Some participants focused on additional factors that the South West LHIN will need to consider as it begins detailed planning in each of its priority areas. Comments included:

- **Additional funding requirements:**
 - We will need additional resources to invest, and a better funding cycle

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- The current system is reactive; we need to invest in the long term
 - Community services are not given enough resources to provide care
 - Funding will be needed to make things happen
 - **Working with other ministries and levels of government:**
 - We must:
 - Build partnerships with other sectors, ministries (e.g., to address poverty, domestic violence)
 - Partner with municipalities and communities to reduce competitiveness in recruiting
 - Influence MOHLTC on local needs and standards (e.g., Golden Dawn Nursing Home)
 - Advocate for providers to ease regulation barriers. A review of regulatory issues is needed
 - Link with schools for promotion and prevention. We have to reach children at an early age because not enough is being done in the home
 - Link with other ministries, such as Education, Recreation, and Social Services
 - Make public health part of the LHIN
 - **Better information for the public on available services:**
 - A telephone line is needed to find out where and how to access services.
 - Physicians lack of knowledge of other services
 - We must promote what services are available
 - A directory could be included in the phone book or could be on a computer at the library
 - The public does not have information on costs of services and procedures. To better understand costs we might consider a print-out of costs or a summary report in the newspaper
 - **Clear understanding of geographical differences within this region:**
 - There are transportation problems (e.g., the timing of pre-operative visits and then treatment)
 - People who can't access services opt out of the system
 - Don't re-invent what's working well
 - Don't take a "cookie-cutter" approach that won't work in rural areas
 - We need to look at the economics of the services provided – what is provided and what other options are available
 - We need to consider local needs – reconsider funding formulas and service allocations, the community's health services and education planning
 - Planning needs to consider the sub-areas within the geography of the LHIN

What is missing from the draft priorities?: Some participants focused on possible omissions from the current priorities, or issues that the South West LHIN should also consider. Among them:

- Concerns about abused women and children and domestic violence
- Non-emergency transit
- Continuum of care for all ages

- Alternatives to institutions (e.g., don't just look at Long-Term Care homes but at all Long-Term Care services)
- End-of-life care
- Mental illness – this needs its own priority
- Spiritual care and supporting individuals with those needs (e.g., look at Owen Sound/Wiarton model of communicating to spiritual care providers)
- Women's clinics in many smaller communities
- Services for youth, particularly those suffering from mental illness
- Individual and family counselling
- Prevention for low income families
- Children services (e.g., for children arriving in rural communities from acute care (Sick Kids) there is no local intermediate care)
- Maternity care
- Public education
- First Nations issues
 - There should be a special focus on the service requirements of Aboriginal communities
 - Ontario and federal programs need to work together
 - We must overcome resistance to asking help (based on a history of being self sufficient)
 - Prevention/promotion must be available and affordable for everyone
- Role of volunteers
 - Volunteer services not as organized for children and non-seniors
 - Volunteers are aging
 - Volunteer drivers face insurance problems
 - Parking fees at the hospitals are very high
 - "Fund-raising fatigue" is setting in, because it's always the same people participating

3. What challenges do you think need to be overcome?

- **Shortages:** A large number of the challenges or barriers raised by participants centred around shortages of resources or infrastructure – whether it's funding, human resources, or the availability of appropriate care beds. In many instances participants shared experiences or insights into the cause and impact of the shortages, as well as possible solutions. Comments included:
 - **Human Resource Issues:**
 - There are no incentives for health professionals to move to rural communities (this is the responsibility of the municipalities)
 - It's difficult to attract and retain health professionals
 - There are not enough family physicians and it takes too long to train them
 - 30% of the doctors in our community are approaching retirement age
 - We need to look at pay scales for rural providers

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- The stress level of health care workers are very high; they are overworked and have too much paperwork
 - 30% of doctors are over 55 years of age
 - We need to recruit the younger generation to rural communities
 - Foreign-trained physicians should be supported to work in Canada
 - The system is not set up to attract specialists to smaller communities
- **Distribution of funds/resources:**
 - We need fair distribution of money across the South West: all the money can't go to major cities
 - Regional competition is a problem – we are all proud of our communities
 - Funding decisions need to be looked at closely (e.g., CCAC funding)
 - The system is not financially sustainable; there is not enough money to pay
 - There is concern that the north will lose services because it has a smaller population
 - What about the ethical implications of what gets funded and how we make those choices? Do we have a decision framework?
- **Availability of Long-Term Care services:**
 - Respite care must be accessible and affordable.
 - Some communities have no Long-Term Care beds (e.g., Dorchester is perceived as being too close to London to need its own beds)
 - There are long waits for Long-Term Care homes, and people often have to travel long distances to visit spouses who are in nursing homes
- **Barriers to Access:** Participants discussed a number of factors that made it difficult to access services. One of the biggest factors raised by participants was transportation, not only in rural areas but also among many populations in more urban centres. Comments included:
 - **Transportation:** Transportation issues include the long distances travelled, but also the ability to travel for many people such as seniors and the disabled
 - Providers also face long travel times (e.g., community care)
 - More local testing, diagnosis, follow up services could make the system more efficient (e.g., a provider may accompany a patient to London one day for “marking”, then again the next day for radiation treatment. The marking could have been done locally.)
 - The lack of local services in small communities means that people travel to multiple sites across the continuum
 - Funding needed for a consistent approach to transportation issues
 - We need more volunteers and must address the lack of coordination
 - **System is complex and difficult to understand:**
 - For many people the amount of information required to navigate the system is a burden
 - People don't know the roles different professionals play in the system or how they are supposed to work together

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- Better communication is needed, using a full range of methods and media
 - Many people need a patient advocate to help them through the system
 - People don't trust providers and think that they are protecting their turf rather than helping
 - Some communication services are available (e.g., hospices donated books to a public library)
 - There should be multiple information sources for those trying to navigate the system
 - Patients should only have to provide their information to one provider, one time
 - We need to get away from red tape
 - De-listing health services presents a challenge
- **Unique problems facing seniors:**
 - The complexity of seniors' health problems increases over time
 - It can be hard to cope and to keep up, and hard to change
 - Trips to specialists can take an entire day - care needs to be better coordinated
 - Seniors who live alone need an advocate
- **Specific service areas where gaps were identified:**
 - Availability of group homes for mentally ill
 - Cost and availability of rehabilitation services
 - Acute care for mentally ill children and youth
 - Psychiatric beds and psychiatric care
- **Capacity and Commitment:** Participants expressed concern about the commitment of government to follow through on the changes, and the challenges of implementing change among providers. Comments included:
 - **Capacity of community providers:**
 - Hospitals cannot discharge people into the community until community services are in place
 - Community services are at risk.
 - Young adults are put in Long-Term Care homes due to lack of services in the community
 - Care providers need more support
 - With early discharges from acute care we need to have the infrastructure and money to support care at home. We must make better use of allied professionals and support workers
 - We must address professional practice limitations so we don't burden doctors
 - **Implementation of information technology:**
 - The electronic health record will be extremely costly to implement
 - There are confidentiality and privacy concerns (e.g., who has access to my information?)
 - How will information systems be updated and maintained?
 - We need to respect different levels of familiarity with technology among the public and providers

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- Physicians need to buy in to a system where they regularly share and exchange information
 - Too much paper work takes away from patient care
 - **Enabling change among providers:**
 - New planning can have impact on existing relationships
 - Public health is not being utilized
 - Incentives are needed
 - The current funding system creates competition - it's hard to be cooperative with agencies vying for the same money
 - There is change needed in the mindset of doctors and the public (e.g., pills are not always the answer)
 - We need to focus on the people not the providers
 - Providers need to look for early signs that people are having problems and could be “lost” in the system
 - There is competition between CCAC and CHC because of overlapping responsibilities
 - Medical technology has improved but learning and supports do not follow the individual (e.g., premature babies often face health challenges over their lifespan)
 - We need a more efficient system - paperwork and administration need to be reduced and referral patterns made more efficient
 - We need a solutions orientation, but must preserve existing services that are working well
 - **Accountability of providers and the LHIN**
 - We need to:
 - Address the accountability of providers for wait times (e.g., MRI), referral patterns, etc. Why are there big differences between people’s experiences, even in the same community?
 - Focus on outcomes
 - Ensure people see follow-through
 - Create a performance management system
 - **Ongoing commitment required by government:**
 - What happens after the next election? Will the LHINs continue?
 - LHINs need to set standards across the province
 - A change in government could undo what’s been accomplished
 - Who ultimately makes the choice between one program and another?
 - People are concerned about privatization
 - Policy decisions go against the focus on promotion and disease prevention
 - The Board needs to ensure next election does not result in process changing again
 - We need a mechanism for the LHIN to be accountable to the communities

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- **Need to recognize the role of people in the community:**
 - There is concern about consumer taking advantage of services
 - Our food consumption and lifestyle must change
 - We must support caregivers and volunteers
 - We must develop trust (e.g., by having drop boxes for ideas or issues, timely responses to requests and ensuring people know what's being done and why)

4. What role can you play to make this plan a success?

- There was considerable creativity in the responses to the question “what role can you play” although participants were unanimous on the need to stay informed, stay involved, and participate in community engagements in the future. Other suggestions and comments included:
- **Taking responsibility for our own health:**
 - We need to stop being dependant on others/ large organizations/ government to solve the problems
 - We need to take our health seriously, and understand how our behaviour influences our health
 - We must take a role in how our health dollars are spent
 - We must be healthy role models
 - We must eat healthy, and help ourselves, even if facing health challenges
- **Taking responsibility for the health of our communities:**
 - We need to look after each other
 - We must build on the good work and informal networks of neighbours, friends and families, to make it better
 - The school system needs to support healthy behaviours, and participation
 - We must improve our knowledge of services and educate others
 - We must be open to change
 - We must make health care a priority for young people, making it the social norm through health education and physical education
 - We must advocate for ourselves and our families
 - We can support existing providers by saying thank-you and recognizing burn-out of volunteers
 - We need more ongoing dialogue and gatherings within communities - we need to know what works well and what doesn't
 - We must speak up about our geographic and transportation challenges when setting up appointments



- **Getting involved:**

- Select a priority and become involved
- Join the Priority Action Teams
- Inform yourself and educate others
- Ask questions and voice our concerns
- Read the information available and come out to meetings
- Make noise
- Participate and volunteer if you are able
- Lobby the government
- Support recruitment for new physicians in the community
- Hold our providers and government accountable; watch over the LHIN
- Take action on environmental and food policies
- Volunteer
- Carry your own disk/flash drive with your record in the future
- Write letters to MPPs and newspaper editors



2. Summary of Input from Provider Forum Participants

STRENGTHENING AND IMPROVING PRIMARY HEALTH CARE

1. Are these the right action plans? Do we need to consider any others?

In general, there was agreement with the priority and the suggested action plans. However, several participants acknowledged that the “how” is the bigger challenge – implementation will be challenging and will require a multi-faceted approach. Some specific topics discussed included the following:

- **Inclusive definition of primary health care:** Participants suggested further clarification of the South West LHIN’s definition of primary health care and recommended that the term be used broadly to include not only family physicians but also the full spectrum of providers delivering care in the community (e.g., social workers, dietitians, nurses, etc.). Among the comments:
 - What is the role and function of primary care?
 - Who is included in primary care – is the definition in the South West different than that of a larger centre like Toronto?
 - The definition of primary health care needs to be broader than “physician” - it should include all patient and service delivery options
 - Use ‘inter’-disciplinary rather than ‘multi’-disciplinary
 - Ensure that all physician roles are part of plans (emergency room, hospital etc.), not just Family Health Teams
 - Create linkages between those involved in renewal models and those not involved

- **A model for primary health care in the South West:** Participants noted that there was no system-level model for primary care on which to build in the South West, and some said that they needed to better understand the model which the LHIN and the Priority Action Teams would be proposing. Some comments included:
 - We don’t yet have the primary care continuum successfully developed
 - We need to create incentives for participation in new models and educate providers on alternative pay structures
 - We need to understand a model of primary care that includes the full range of providers such as social workers, nurse practitioners, etc.
 - Implementation will require integration of models that support connection and adoption (e.g., hospital and physicians, CCACs - and partnerships among providers)
 - The system should focus on points of care, system navigation, and case management
 - Current models need to expand to address areas of limited services. How do we get teams to small communities?
 - A focus on primary care should emphasize the important role that providers play in prevention and health promotion

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- Primary care providers could travel. Social workers, mental health workers, and others already have traveling clinics and support services
 - **Benefits of a team-based approach:** Participants saw many benefits to a team-based approach, and the involvement of diverse primary health care providers. However they cautioned the LHIN not to focus all of its resources on Family Health Teams. Comments included:
 - Social workers and other community providers have relationships with clients (particularly with marginalized populations). However their role is limited in the current system
 - It will be several years before nurse practitioner roles are fully implemented
 - Nurse practitioners have traditionally been the first to be cut - we need to ensure sustainability
 - We need to ensure that action teams represent multiple disciplines and include public participants
 - Teams may need to cross large geographic areas (i.e., should not be geographically defined)
 - **Communication and technology enablers:** Many participants argued that better communications across the system would be a foundational requirement for change. Comments included:
 - E-health will be a prerequisite, including a variety of tactics such as telehealth, patient tracking systems
 - E-health will be a major catalyst for change. We need to help practitioners understand the benefits that e-health offers to them and their patients
 - We must incorporate tracking and communicating measures throughout the system
 - **Include all ages and sectors:** Participants noted that children and youth were not discussed in the South West LHIN's priorities and suggested that priority descriptions be explicit if they include all age groups. Similarly, participants wanted to ensure that the full spectrum of sectors and providers were included in the discussion of linkages and collaboration. Among the comments:
 - Where are the children? We must include children somewhere in the plan
 - We need to demonstrate the importance of links between family physicians and specialists so that patients get the information and resources they need
 - There is a significant cross-over with chronic disease prevention and management; primary health care providers are the front lines for prevention
 - We need to build linkages with allied health professionals - complementary services have an active role to play in primary care and rehabilitation
 - Mental health is very important for the system and connection with primary care practitioners should be enhanced
 - It would be good to see an emphasis on mild to moderate mental illness - there are often not a lot of options currently
 - Be sure to include the role of pharmacists in the community

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- **Partnerships and collaboration:** Many participants highlighted the importance of coordination and collaboration across providers. Some suggestions included:
 - Increase referrals to different primary care contacts in communities and recognition of team based approach to care
 - Role of other practitioners will be important; maximize scope of practice
 - Those in research and academic settings should work with local communities
 - We should create collaborative opportunities to partner between agencies and care providers to provide the necessary care
 - We must leverage opportunities to engage other sectors such as education, social services, and municipalities
 - Build on what is already underway – what will happen to previous commitments and ongoing programs?
 - **Need for further research for implementation:** Participants recognized that the information provided was only a starting point and that much further work would be required by the Priority Action Teams. Some suggestions included:
 - Review the current referral process and referral patterns to identify opportunities for efficiency and to better understand why physicians follow their current referral patterns
 - Look outside of the South West and Ontario for best practices (e.g., Australia and Sweden have similar rural challenges)
 - Ensure that links are made to other priorities of the South West LHIN

2. What specific challenges will we need to overcome?

- **Engaging Physician:** Influencing the behaviours of physicians and involving them in the proposed priority was identified as a significant challenge for implementation of the primary health care priority. Some comments from participants included:
 - Who has influence over solo practice doctors? How will the LHIN influence physicians if they are not funded by LHINs?
 - It will be a challenge to get physicians to collaborate and participate in developing solutions
 - Physicians may not be informed about the LHIN or may not be up to date.
 - Is there physician support for LHINs and/or priorities in the plan? This is key!
 - There is potential for territorial issues (“back yard issues”) as we try to affect change
- **Funding and compensation structures:** Concerns about funding focused on both the need to increase the resources available for primary care, and the need for incentives to participate in renewal models. Comments from participants included:
 - The fee structure is not built to participate in renewal models; compensation is a high priority in renewal models
 - Funding is needed for nurse practitioners
 - Funding should match need, and must match expectations for service provisions
 - Changes to the existing system have cost implications
 - There is no compensation for any providers assisting with system navigation or prevention

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- Funding for prevention is often the first to be cut
 - Fundamentally, there is a shortage of family physicians and other health practitioners
 - **Need for cultural change:** Participants acknowledged that system level changes would require a significant amount of cultural change among all health service providers. Comments included:
 - Cultural change will be required to introduce a “prevention” mindset
 - Current culture in the system is a barrier to the adoption of technology, changing behaviours, working collaboratively, etc.
 - It will require a cultural change to involve and utilize diverse primary care providers
 - **Challenges of access:** Shortages of primary care providers in many areas was a consistent theme across the provider and public engagements. Some other issues of access identified included:
 - Transportation and travel can be a significant barrier to access in rural areas
 - Because of the shortage of doctors, primary care is often the cause of waits in the system and a barrier to access
 - With a shortage of physicians, the LHIN will not be successful in introducing linkages or new service models
 - Socio-economic factors create restrictions for many people accessing services
 - Those deemed “difficult to serve” (e.g., with mental illness or a chronic disease) often find it difficult to get a family physician, because they are turned down by health providers
 - **Information exchange:** Participants highlighted the importance of a strong technology infrastructure, or in its absence, of common communications practices. Some comments included:
 - There are 18 information technology systems for Family Health Teams – why aren’t they streamlined?
 - We need to ensure access to and flow of information between providers (i.e., from hospital to physician practices)
 - Privacy issues will create roadblocks to implementation of e-health initiatives
 - We need to think through how information is exchanged with patients (e.g., there is often too much information for extremely complex patients)
 - **Challenges for implementation:** Participants had questions about how the priority would be implemented, and how they would be kept informed about its progress. Some comments included:
 - How will the Priority Action Teams operate? Who will be involved? Who will be accountable? Will there be overlap among teams?
 - Funding will be needed to execute planned initiatives
 - Priority Action Teams will need to manage the expectations of consumers and providers against resources available
 - How will people learn about the services available to them? How will they learn about the LHIN?

- **Health Human Resources:** The capacity of the current system was an issue of concern for many of the participants, as was the need to appropriately educate and recruit the next generation of providers. Comments included:
 - Movement is needed on resource capacity. We need specific action plans that recognize the time-sensitive nature of the problem
 - Staffing must be available to meet expectations for implementation of the priorities
 - System and service navigator roles need to be staffed and supported
 - More focus is needed on education and educators in the health care system
 - Role clarification is needed (e.g., Who should provide prevention? Who should provide what services?)
 - Education of existing primary care physicians will be difficult because of technology gaps

3. What is currently going on in this area that could be leveraged?

- **Build on the momentum of Family Health Teams:** Many participants saw an opportunity to use the Family Health Teams as a starting point for change. Comments included:
 - Family Health Teams can work in partnership to build on success and achieve consistency and continuity in how they are rolled out
 - Get buy in from physicians through implementation
 - Technology investments are needed in FHTs to ensure consistency
- **Innovative programs:** Examples of successful primary health care programs or initiatives in the South West included:
 - Goderich has a “no-physician” clinic with nurse practitioners already in place.
 - Sauble primary care planning is already underway
 - There are currently six nurse practitioners in Grey Bruce supported by the VON
 - Grey Bruce end-of-life program is developing models of care and measurement indicators, and palliative care teams have physician involvement
 - The Mental Health Alliance of Grey Bruce has an excellent model for mild to moderate mental illness
 - Strathroy Medical Clinic is currently developing a team practice; additional funds are required to move it forward and change the current model
 - South West Medical Centre is bundling various supports in a common place
 - Huron-Perth nurse specialist utilization initiative in palliative care includes case consulting, referrals through several areas (i.e., not physician specific) and specialized case manager/system navigator
 - There are chemotherapy satellites in Wingham
 - Perth County CCAC model has strong partnerships with local Long-Term Care homes
 - Cardiac Rehabilitation Program – Healthy Hearts (self-funded through donations)
 - Healthy Sugars Program
 - Stroke and cancer strategies are models for networking and educating the public

- *In other parts of the province:* Oshawa Primary Care Centre; Wellness Program at Women's College Hospital in Toronto
- **Innovative practices:** Successful new practices identified by participants included:
 - Introduction of dietitian in physician's office
 - Videocare adoption to link hospitals and other providers (a cost effective alternative)
 - Mental health "tune-up" at health fairs to provide information to the public
 - Diagnostics and PACS programs
 - Standardized charting in diabetes care
 - Promotion and quality control of hospices

PREVENTING AND MANAGING CHRONIC ILLNESS

1. Are these the right action plans? Do we need to consider any others?

In general, participants were very positive about the priority as well as the approach described in the action plans. Some of the reasons cited include:

- Chronic illness occupies a large part of acute care, and subsequent costs
- Care paths are not linked
- There is a lack of information on available resources and consumers are often poorly informed
- Providers are seeing a significant increase in mental health and diabetes issues, as well as other chronic conditions

Specific topics discussed included the following:

- **Diabetes is a good starting point:** Most participants agreed with the initial focus on diabetes, although others questioned how the decision was made. Comments included:
 - Diabetes crosses sectors and populations and includes issues of marginalized populations, making it a good target
 - Disease has an impact on the health system over the long term; need to focus on children and youth to prevent disease or prevent complications from arising
 - Lessons from existing diabetes initiatives and networks can be generalized
 - There is concern that implementation of programs for other chronic conditions could be delayed or compromised, and that focusing on diabetes will have an impact locally, and on provincial funding
- **Emphasis on mental health issues:** Participants responded positively to the inclusion of mental illness in the strategy for chronic disease prevention and management. However some people raised concerns about how addiction issues would be considered by the South West LHIN in the IHSP. Comments included:
 - Mental health issues are a growing concern for primary care and providers are seeing significant increases in cases

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- Mental health co-conditions are often not addressed (e.g., Multiple Sclerosis)
 - There is concern that Mental Health and Addictions needs to be a priority on its own, not simply under chronic disease
 - There is debate about whether Addictions belong under the heading of chronic disease; issue is more about chronic conditions *with* addictions
- **Need to involve expertise from all sectors in planning and implementing the action plans:** Participants recommended that the full spectrum of providers should be involved and have a role in implementation of the priority. Comments included the following:
 - There is an important role for CCAC case managers to partner with primary care providers
 - Consider involving non-traditional services or practitioners, recognizing their role in supporting those with chronic illnesses
 - Be sure to learn about and involve existing programs
 - Ultimately helps support physicians and results in positive impact for patient
 - Primary care physicians could be doing more testing earlier
 - Support for primary care physicians will ultimately have an impact on patients
 - Linkage to Public Health is critical. The role should be expanded to address broader community needs
 - Need to engage “super-specialized” expertise in action planning if you want innovation
 - We must include the support system of family and informal caregivers
 - **Need for a strong emphasis on prevention:** A stronger focus on prevention was recommended by participants, for the chronic illness priority as well as for other priorities of the LHIN. Comments focused on two areas:
 - Approach taken by the LHIN needs to focus on risk factors (e.g., obesity) as well as chronic conditions (e.g., diabetes)
 - Prevention will have the biggest long term impact, and the focus of prevention efforts needs to be on children
 - **Need for further research or analysis for action planning.** Participants suggested a number of factors that the Priority Action Teams should analyze as they develop their detailed plans. Suggestions included:
 - Begin with needs not already being addressed in the South West.
 - Explore what we are already doing well
 - Use full determinants of health as a filter to follow through on action plans. Involve health care and non-health care interests as well as a full range of providers (e.g., dietitians, nursing, ophthalmologists, primary doctors, occupational therapists and physiotherapists)
 - Research and adopt existing tools and frameworks to address conditions and risk factors
 - Ensure that there is a mechanism in place for unique patient needs (e.g., not a cookie cutter approach)
 - **Potential chronic conditions to focus roll out of comprehensive CDPM framework:** Participants recognized the need to quickly move beyond the diabetes initiative to a broader



spectrum of conditions (or risk factors). A number of suggestions were made for how to approach this, many of which focused on heart disease and vascular conditions. Comments included:

- Strategy could include number of “chronic conditions” and jointly work through CDPM model. (e.g., renal, cardiac, cancer, and diabetes)
- Focus on determinants of health and start education on prevention early
- Focus on vascular health and cardiac care as it will have widespread impact on other conditions
 - Informatics, reporting, linkages are in place, and there is already an evidence base
 - This is a possible quick start as it is a high risk population. A “secondary prevention” approach could be most effective
- Consider heart disease and high blood pressure as focus areas (would also impact diabetes)
- Start by analyzing where we can have the greatest impact on wellness

2. What specific challenges will we need to overcome?

- **Challenge to “get the message out”:** Participants highlighted the importance of communications planning in order to support change across the system. Comments included:
 - There are technology limitations; we need a central repository of information for programs for clients and providers
 - Existing information repositories are costly to manage and update
 - Communication to consumers and the public will be challenging. Information needs to be simple and direct, as we will face low literacy rates and limited internet access in some areas
- **Adoption will depend on behaviour and culture change:** Participants recognized the need for behavioural changes both by consumers and by providers. Comments included:
 - Changing the focus from illness to prevention will be an uphill battle unless we address risk factors
 - Current education system doesn’t easily allow promotion of healthy lifestyles; we need to educate kids early
 - There is no current mandate among providers to do prevention; often it’s the first area to be cut
 - Raising public awareness is costly and the impact is difficult to measure
 - People who most need to learn about prevention are not those who typically “self-refer”; information brochures will not overcome the problem
 - People often don’t pay attention until they have a condition
 - Providers are geared to “crisis management”; resources often go to crisis or acute care
- **Challenges of measuring success:** Some participants expressed concern about the sustainability of the Priority Action Team’s work and highlighted challenges of measuring or monitoring success. Comments included:
 - Who ensures the plan is sustainable? Who is involved in implementing it?

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- Will funding, performance management and accountability frameworks be in place to ensure success?
 - It will be difficult to measure impact of prevention steps since there will be no immediate impact on outcomes
 - Evaluation will be tricky, particularly for prevention efforts and for managing long term illnesses
- **Complexity of the problem:** Participants warned about the complexity of a comprehensive chronic disease framework, both in terms of dual diagnosis and partnership and collaboration. Some comments included:
 - How do we address several co-morbidities in care paths? We will need realistic care pathways that are practical and can be implemented
 - Many peoples' conditions are complex and have related conditions; how will we measure the outcomes of what we implement?
 - Access to programs is often based on having a critical mass of individuals and sufficient resources. The South West may need to modify best practices, since they are not always transferable from one place to another (e.g., from rural vs. urban)
 - Those with complex needs (e.g., mental health; seniors) are not being accepted by physicians; implementation will depend on linkages with other priorities such as primary care
 - Dual diagnosis often involves many ministries and organizations
 - **Reaching the “hard to reach”:** The challenges of access for “hard to reach” or marginalized people were discussed, as well as the challenges of reaching those who are often in most need of the services. Some comments from participants included:
 - It is challenging to find and reach those who are not managing well or who are so ill that they do not access the services available. (Those who do manage well tend to be vocal and crowd out others.)
 - Transportation barriers can lead to isolation; should they come to us or do we go to them?
 - Rural hospitals sometimes do not have the specialist needed by an individual. The patient may not receive the treatment if they are not proactive
 - Barriers such as low income, culture, education levels can make it difficult to adopt a healthy lifestyle (e.g., fast food socialization)
 - Marginalized individuals often lack a primary care provider
 - **Inter-sectoral collaboration:** Connecting across health sectors and with a broader spectrum of service providers was highlighted by participants as a significant challenge. Comments included:
 - How do we connect the hospital sector and community sector, particularly in the mental health area? Typically community services handle prevention, while hospitals handle treatment
 - We need to balance larger and smaller community organizations. The larger ones tend to receive recognition, while smaller, rural organizations are often left out
 - Physicians traditionally have not involved health practitioners who might be able to further prevention efforts (e.g., Nurse Practitioners)

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- **“External influences” that impact prevention and management of chronic illness:** Numerous factors outside of the traditional health care system were described by participants. These included:
 - Cost of medication
 - Housing and transportation
 - Income and employment (could have an impact on meal planning and access to exercise facilities)
 - Access to rehabilitation and complementary services, which often depends on income/ cost
 - Involvement of different levels of government – provincial, municipal, federal – in addition to non-LHIN-funded health care providers
 - Involvement of multiple ministries - different age groups access different funding sources
 - **Human resource issues:** A range of human resource issues were identified by participants, including:
 - Limited numbers of family physicians in many areas make it difficult to implement any program. Team environments (FHTs, CHCs) will be a good starting place
 - We need to address which providers do what (i.e., physicians are needed for some referrals to services)
 - We must recruit other health providers (e.g., physiotherapy, OT, social work, nurses)
 - Wage differentials, hours of work, and transportation need to be factored in to community care initiatives. We need to look at community, hospital and Long-Term Care settings

3. What is currently going on in this area that could be leveraged?

- **Innovative programs:** Examples of successful programs or initiatives in the South West included:
 - Grey Bruce CDPM model (potential basis for a larger LHIN-wide effort)
 - “PRIISME” Program for diabetes education (funded through the private sector)
 - Healthy Sugars – diabetes education
 - NCSS locally – CSCN network
 - Inter-disciplinary model of FHTs
 - Diabetic education program at CHC (mental health program)
 - WSIB (Toronto) interdisciplinary model – look at the learnings here to apply to our model development
 - Inter-disciplinary team for juvenile diabetes in London
 - VON Meals on Wheels and Foot Care program
 - Diabetes Education Centres (Huron Perth)
 - Ingersoll Cardiac Rehabilitation Program
 - Calgary model – learning could apply to the South West LHIN
 - Betty Cardno Centre
 - End-of-Life Strategy
 - Mental Health and Addictions directory registry

- Smartrisk.com – risk and prevention agency
- **Innovative practices:** Successful new practices identified by participants included:
 - Nursing providers and dietitians in the community
 - Link with the school system to promote healthy behaviours
 - Provider programs such as food banks that go to the user
 - YMCA exercise programs
 - Case management approach to deal with multiple issues (can have case management as a team to focus on the whole person, not the disease)

SENIORS AND ADULTS WITH COMPLEX NEEDS

1. Are these the right action plans? Do we need to consider any others?

In general, there was agreement with the priority and the suggested action plans particularly given the demographics of the South West LHIN and the growing population of seniors in the area. Some specific topics discussed included the following:

- **Consensus on need for improved coordination and system navigation:** Participants were in agreement on the difficulties faced by seniors trying to access services, and on the benefits of more coordinated care for both consumers and providers. Comments included:
 - The system is particularly tough to access for seniors and their caregivers
 - Coordination could reduce pressure on acute care and reduce ALC issues, but will need to involve a full spectrum of services including convalescent, social work, etc.
 - System needs to better manage the “hand- offs”
 - Coordination should lead to putting right resources in right place
 - The public and providers need more information about what is available
 - We need to ensure appropriate follow up for those returning home
- **Improved understanding needed of appropriate roles across the system:** Participants discussed the roles of various providers in the system, today and in the future. Comments included:
 - Look at the potential for a coordinating role to help those most in need navigate the system
 - We need a health human resources plan to capitalize on who should do each function (i.e., who has the best skill set? We should also review equality, wages, full time and part time issues)
 - The role of primary health care providers needs to be evaluated - there are gatekeeper issues when there is a shortage of physicians in a community
 - We need to evaluate criteria for referrals to services

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- **Palliative care opportunities:** Participants highlighted existing programs in palliative care and cautioned the LHIN not to lose the momentum created by these initiatives, given the alignment of goals with the LHIN's priorities. Comments included:
 - We need to support people in the appropriate setting – Long-Term Care, hospital, or home
 - There is an opportunity to learn from provincial initiatives and from local palliative care committees, initiatives that have defined targets and expected outcomes
 - **Need to recognize the diversity of the population being targeted:** Several participants identified the challenges of serving those with complex needs, and drew attention to ways in which this group was different than the seniors population
 - Adults with complex needs are often inappropriately placed in Long-Term Care homes; we need supportive housing
 - Many seniors are well and aging at home - they need to be the focus of prevention efforts
 - Appropriate housing is a key issue for those with complex needs. The LHIN will need to connect with other ministries in order to have a positive impact
 - Transitional housing/respice housing is needed after discharge from hospital
 - **Emphasis needed on developing capacity of community care:** The availability of services in the community was identified as central to the development of a coordinated system. Some comments included:
 - We need to focus on capacity development and strong linkages with our partners in the community
 - Where is the responsibility for recovery? In the hospital? In the community?
 - We must support caregivers and volunteers as well as community agencies
 - What is the role of community care? We need to further strengthen supports in the home
 - We need to keep people in the home and in the community
 - **Implementation may require further focus in order to enable action:** Several participants suggested areas of focus for action planning as implementation gets under way. Some suggestions included:
 - Focus on action – Long-Term Care and rehabilitation – then tackle the continuum
 - Focus on post-hospital recovery period (currently a gap) and transitions across the system.
 - Identify demonstration projects
 - Focus on “difficult to place” clients that are currently in acute care; we need to sort out the misplaced people
 - Develop criteria for the continuum. Consider patient impact and LHIN-wide evaluation
 - **Emphasis on prevention in the continuum, particularly for “well seniors”:** As with many of the other priorities, participants highlighted the importance of prevention, education and health promotion among this population. Comments included:
 - Focus on prevention as well as primary, acute, rehabilitative and community care
 - Focusing on prevention could have a big impact – e.g., falls program or strength training
 - We need to promote healthy lifestyle



2. What specific challenges will we need to overcome?

- **Challenge of coordinating the flow of information:** Coordinating and integrating the flow of information among providers was identified as a significant challenge for implementation of a care continuum. Comments included:
 - Common health record is needed that would be available in a doctor's office as well as the emergency ward
 - We need strong repository of information, updated regularly and linked to thehealthline.ca website
 - Clients need to own their personal information and carry it with them (e.g., a computer chip)
 - We need to address public suspicion about use of technology and privacy issues
 - We need a directory of information about services
- **Awareness about CCACs:** Participants discussed the confusion felt by many people trying to access community services, and highlighted differences across different geographic areas. Comments included:
 - Increased awareness is needed of the capacity within different sectors. We need informed practices regarding sectors, organizations and individuals
 - The CCAC phone number needs to be centralized
 - People need to be educated about services available - not just public but providers as well
 - Constant changes in the system means that people are confused about how to access services
- **Shortage of people providing support in the community:** Participants discussed the role of volunteers, caregivers, and providers in the community and voiced concerns about declining numbers of providers and volunteers. Comments included:
 - Skills are needed in the community to manage complex needs - this area is currently under-resourced
 - Inconsistency of caregivers is a challenge, and many of these people have no voice in the system
 - There is a dwindling number of volunteers; volunteer fatigue is an issue
 - Primary care professionals provide the bulk of care, and there are shortages in many communities
 - Personal Support Workers (PSWs) need appropriate education and pay to maintain consistency. They can have a major impact on quality of life for our patients/clients and provide program support
 - We often do not have a critical mass of people with similar needs in a community to support staffing a position
- **Shortage of appropriate care beds:** Shortages in appropriate settings (e.g., Long-Term Care, acute care, etc.) were identified as a barrier in many communities, particularly in rural areas. Comments included:
 - There are not enough LTC beds and acute care is in crisis

- Many young adults that are in LTC that should not be there
 - Personnel to staff these facilities are often not available
 - Acquired Brain Injury clients are often in acute care since the community cannot accept them. There is very little or no supportive housing in many communities
 - There are no respite services for children and youth
- **Transportation issues:** Several participants identified barriers to access resulting from travel and transportation requirements, particularly in the northern part of the South West LHIN. Comments included:
 - People need outreach services – they cannot access services because of transportation issues
 - Access to ambulances and volunteer drivers is inconsistent
- **Mental health issues:** Participants highlighted mental health issues among the seniors population as an area which needed particular attention. Comments included:
 - We need a specific action plan for Alzheimers Disease and related dementias. How do we better support people in their homes?
 - Awareness about mental health issues is increasing significantly in the sector; we need to address this
 - We need improved access to mental health specialist services – psychiatrists, psychologists, behavioural specialists

3. What is currently going on in this area that could be leveraged?

- **Innovative programs:** Examples of successful programs or initiatives in the South West included:
 - CCAC Seniors Scene book and directory
 - Transition units at Long-Term Care homes, which prevent admissions to acute care and facilitate earlier discharge
 - Current case managers who want expanded role as system navigators in the CCACs
 - Hospice volunteer services and local palliative care committees
 - Alzheimer’s Society
 - Public Health Units’ work on falls prevention
 - Numerous initiatives in end-of-life care in and around London
 - Cancer Care and Regional Stroke Strategy, which have done an excellent job of coordinating services
 - Pathway Group – Grey Bruce Evidence Based Care
- **Innovative practices:** Successful practices identified by participants included:
 - Creative community response for palliative care; end-of-life committees
 - Respite care programs in retirement homes (needs to be expanded, but the Ministry only funds beds)

- “Mobility Van” programs
- Sharing staff instead of money – all you need is a champion
- Grey Bruce educators with a geriatric focus

ACCESSING THE RIGHT SERVICES, IN THE RIGHT PLACE, AT THE RIGHT TIME

1. Are these the right action plans? Do we need to consider any others?

In general, there was agreement with the priority and the suggested action plans. Numerous access issues were identified in relation to this and other integration priorities, most notably access to primary health care, transportation issues and challenges facing rural communities. Some specific topics discussed included the following:

- **Need for analysis of what services are available, where, and by whom:** Most participants agreed that we need to:
 - Add “by the right provider” to the title
 - Complete a detailed inventory and environmental scan of what services are available, key to beginning to identify ‘how’ to address need and linkages of care
 - Focus on measuring priority strategy implementation (e.g., hips and knees)
 - Go beyond inventory and visit provider locations
 - Create an inventory of all of the programs that are under way in various stages
 - Include all age groups and services (e.g., children, rehabilitation)
 - Assess cultural differences and other diversity issues
- **Opportunities to link up rural communities with specialist providers:** Many participants identified transportation challenges and suggested alternatives that would link up providers either through technology or through mobile provider units. Some comments included:
 - We should consider specialists /other practitioners moving to points of care in other areas/rural communities
 - E-Health is a possible enabler of access through linking up providers (e.g., videoconferencing)
 - Telehealth and other services that can assist individuals through their care path
- **Put consumers at the centre:** Participants warned against taking an approach that focused on institutions delivering care and several highlighted the important role for consumers in the system to take responsibility for their own health. Comments included:
 - Patients are responsible for taking care of themselves
 - The plan sounds too institutionally focused
 - Don’t forget the consumer in all the analysis; the plan needs a consumer perspective
 - Cultural change is needed among patients - the message is, take control of your own health

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- **Long wait times have become the norm:** A number of service areas were identified as having extensive wait times in many communities. Examples include:
 - Rehabilitation services
 - Long-Term Care
 - Appointments with a family physician (due to shortages in the community) and referrals to a specialist
 - Psychiatric care, particularly for children
 - Some surgical procedures

Other comments included:

- We need to recognize that specific target services are often associated with specific age categories (e.g., hip and knee)
- Continuum of care problems are important components of wait times -- getting patients in and out at the right time
- Can we better offer and organize surgical services that currently have long wait times?
- Wait times website is a good example of communication strategy

2. What specific challenges will we need to overcome?

- **Transportation:** As with other priorities, transportation was identified as a central challenge for access, particularly for rural communities. Comments included:
 - The cost of non-urgent transportation is a major challenge in the system. We need effective use of available transportation methods
 - Disadvantaged are often the worst hit by transportation issues
 - We need to consider opportunities for services to travel to rural communities or to people in their homes
 - Non-urgent transportation is often not available once a person is in hospital; this has an impact on discharge
 - Transportation - who does what and who pays for what? What services should be available?
- **Availability of services in rural communities:** In addition to transportation issues, participants familiar with rural service delivery identified a range of issues specific to these communities. Comments included:
 - Grey Bruce has become a destination for seniors. Funding allocations need to take into consideration the needs of these communities and plan for Long-Term Care, etc.
 - There are major shortages of mental health services for youth in rural areas. Opportunities for youth in these communities are very limited
 - Funding systems create barriers to bring specific services locally
 - Rural communities often have lower income, education
 - Often difficult to recruit providers to rural communities
 - Organizations in the community are often vulnerable to funding changes
 - Sensitivity is needed when doing analysis to rural issues – “formulas don’t work”

- **Availability of human resources:** Participants saw far-reaching implications of human resource challenges, and suggested the need for change in the areas of education, training and recruitment. Comments included:
 - High workloads mean cutbacks in education and health promotion activities
 - There are challenges motivating younger employees and expertise is leaving the field through retirement
 - Follow-up is a challenge when there is no family physician in a community
 - A shortage of family physicians creates referral delays: primary care becomes the bottleneck
 - There are staffing needs in the community sector across the South West
 - Education system requires changes and updating to reflect today's system and build for tomorrow's system
- **'Competition' among providers:** Participants suggested that there are a variety of areas where providers compete amongst each other. These include:
 - Competition in billing, ability to access funding, volumes, etc. by providers
 - Competing types or models of service delivery (e.g., FHTs verses independent practice)
 - Doctors telling patients they will see them in the emergency room because of more competitive fee structure
- **Education on what is available:** Participants cited challenges in educating both the public and providers on what services are available and how to access them. Comments included:
 - There are no clear channels for communicating with providers
 - There is resistance among some providers to educating their patients or clients
 - The role of providers in education is unclear
 - Who coordinates the Priority Action Teams to prioritize and share information?

3. What is currently going on in this area that could be leveraged?

- **Innovative programs:** Examples of successful programs or initiatives in the South West included:
 - Huron Perth Non-emergency Transport Working Group
 - NSS Initiatives program; RPN program established locally
 - Grey Bruce Care Pathways program for Hips and Knees Network
 - CCAC Information and Referral database; needs to be expanded
 - Cancer Care Ontario's regional care strategy
 - New Directions and Choices – travel to other communities to participate in clinics, see clients, etc.
 - Ontario Breast Screening Program (Listowel) -- enables navigation, uses videocare and involves allied health professionals
 - Diabetic education programs at Huron Perth hospitals
- **Innovative practices:** Successful practices identified by participants included:
 - Alternative care clinics

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- Videocare in hospitals – linking to nursing homes and FHTs, could facilitate discharge planning
 - Diagnostic imaging - need more innovation
 - Cardiac surgery initiatives at the provincial level (wait times, use of specialists)
 - Collaboration in Grey Bruce – there is plenty but it's difficult to sustain (e.g., children's mental health program lost momentum)
 - Mental health agencies/social workers - they do a lot of prevention education but are not often recognized
 - Nursing strategies to increase and learn from current outcomes

IS ANYTHING MISSING?

At each of the sessions the group was asked to reflect on the full list of priorities proposed by the South West LHIN and answer the question, “is anything missing?” Responses made by participants are summarized below:

- Links to the education system and other ministries of the provincial government
 - Children and youth services stopping when they become adults
- Funding issues
 - What is the budget for this?
 - How will the funding filter down? Per capita?
- Children and youth
 - Medically fragile babies (e.g., nursing supports and respite opportunities)
 - Children with complex needs (e.g., mental health conditions)
 - Beds for children
 - Psychiatry services for children
 - Children/paediatrics - waiting lists and gaps in services
 - Young adults with disabilities who are out of school – what programming exists – need a cradle-to-grave view
- More emphasis needed on prevention and health promotion
 - Specific prevention and promotion strategies needed
 - Support for family education
- Acquired brain injury – very difficult to access medical, social and specialist supports
 - Do not fit into the current programs
 - Need day programs, group homes

- Where does convalescent program fit?
 - Difficult to access seating assessment, social work in community
 - ALC impact
- Additional comments included:
 - Rehabilitation services
 - End-of-life care
 - Mental Health (should have its own priority)
 - A focus on transportation
 - Communications action plan
 - First Nations, Amish, Mennonites need a greater focus
 - Why are Public Health and ambulances not included in the LHIN?

3. Summary of Preliminary Discussions with Aboriginal Providers

The South West LHIN held several meetings with Aboriginal and First Nations leaders, and looks forward to working closely with these communities in the future. The following is a summary of input received from a forum held with Aboriginal Providers from across the South West LHIN.

Inter-Jurisdictional Issues

- There was concern that working with LHINs or participating in provincial initiatives would reduce dollars available from the federal government (i.e., that it would be deducted from currently funded programs)
- Current federal dollars are not sufficient to address service needs. Most First Nations communities do not have primary health providers locally

Availability of/ Access to Primary Health Care

- Most communities do not have local access to primary care providers; transportation is a significant issue
- Continuity of care is important to people - they want to see the same nurses and doctors
- Even in family health teams, we need to have the right mix of full-time and part-time staff and need to communicate to consumers who else might be involved in delivering care

Lack of Awareness by Providers about Aboriginal Culture

- Many inefficiencies and access challenges result from a lack of awareness among providers (e.g., prescriptions require additional information from the doctor)
- There is currently no way to flag an individual as Aboriginal or First Nations; the result is poor documentation of aboriginal health
- Lack of sensitivity to cultural differences can have effect on care planning



Opportunities for Improvement:

- An Aboriginal/First Nations liaison in hospitals (Emergency Department, Admissions) to articulate First Nation perspective and support discharge planning
- Education for providers on processes, etc. that can facilitate access for First Nations people (e.g., prescriptions) to avoid inefficiencies

Access to Services

- We need to build trust within communities. People often decide not to seek assistance until they are very ill
- There is no emphasis on diagnosis or overall wellness for those accessing services. This contributes to perception that Aboriginal people do not get the same level of care as others

Access to Services for Seniors and Adults with Complex Needs

- Each reserve has a different definition of seniors – 55, 60, 65
- Aboriginal and First Nations seniors have additional barriers to accessing services, including language, literacy level and cultural sensitivity
- There are dedicated LTC homes or programs for Aboriginal seniors, and no position that liaises with the LTC homes or hospitals to understand unique First Nation needs
- There are extremely long waits for Aboriginal people to get into LTC homes

Diabetes

- A great deal of educational work already being done in First Nations communities.
- We need to consider financial resources of residents
 - Limits access to what they need (transportation to services)
 - Influences lifestyle factors – (e.g., less likely to exercise without access to exercise facilities and less likely to access healthy foods)

Human Resources

- Recruitment to reserves is difficult:
 - We cannot retain student placements (Chippewa Health Centre has students from University of Waterloo)
 - Aboriginal students are not applying for health care programs
 - Reserves cannot offer competitive contracts
 - We must foster links with new northern teaching centre to promote health fields to Aboriginal students
 - We must create opportunities for students to do placements in Aboriginal and First Nations communities

Information sharing

- There is a lack of information or distrust in sharing the information with LHIN. This often limits access to health records and prevents sharing. The result is provider silos



4. Summary of Input from Mental Health Consumers

What needs to work better?

- Challenges with medication and diagnosis
 - Medication needs to be monitored
 - Doctors need to listen to patients
 - Providers need to respect traditional medicine and healers
 - Aboriginal people are often misdiagnosed (e.g., ADD)
 - Many drugs are not covered by ODSB
 - Native people have to pay for own medication when outside of the hospital
 - They tend to go off medication when too costly, then the cycle begins
- Access issues
 - The cost of transportation can be a barrier to participation
 - There is a need for affordable housing; having the basics can prevent chronic illness
 - Aboriginal people need to know where services are (e.g., drop in centres, etc.)
 - There is a need for preventative programs for mildly mentally ill
 - Many Aboriginal people are unable to access family doctor, and doctors often won't take mentally ill patients
 - We need flexibility – some people will take more time than others
 - In smaller communities there are often not enough people to warrant having a service locally (e.g., on reserves or in rural communities, there are no psychiatrists or social workers)
 - Crisis services are available in London, but not elsewhere
 - There are not enough psychiatrists and psychologists, particularly outside of hospitals
 - We need to see too many doctors for too many different conditions
 - After-hours crisis line doesn't always work well
- Stigma experienced in the community
 - Often oppressive principles and values
 - Abuse should be taken seriously; no voice
 - Community needs to be non-judgemental
 - Need additional support for families

What works well?

- Role of social workers in the community
- Inter-faith counselling services and religious support – very welcome; feel part of the community
- Activities – e.g., outdoor activities – “need something to do”
- People/ providers with warmth, trust, acceptance, friendship, information, knowledge, understanding, respect
- Central intake and referral at Parkhill/Strathroy reserve
- Central intake and referral in Middlesex

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- Local meeting places and drop in centres that make people feel welcome - builds trust, then people are willing to share their story
 - Aboriginal Homeless Diversion Project
 - My Sister's Place - 14 community partners available to provide supports - agencies talk to each other, have protocols in place
 - CHCs and Family Health Teams - will be a benefit but we need more
 - CMHA adult recreation program - extremely helpful with peer support, relationships
 - Public Health's free nicotine replacement program
 - Holistic approach – health and other life issues



5. Summary of Input from Immigrant Populations

Three meetings were held in September 2006 to gain input from specific immigrant populations in the London area. In general, most participants had not heard of the LHINs prior to the discussion.

Session 1: Input was received from 34 Immigrant seniors (Latin American and Polish):

- None of the participants knew what LHINs were. They commented several times that if information or advertising is only English they never find out about these things.
- Their comments were as follows:
 - It's an excellent idea; we need someone to make better decisions
 - It's really good to know this thing is coming and we hope it will improve, but we're worried about how to get more information about what it means. Where is more information and is the information available in languages other than English?
 - We have to do something about family physicians because it is so long before appointments and then we wait forever – "Sometimes I think I am going to die before I see the doctor."
 - The doctor will only see me for one problem at a time, so if I have two or more I have to come back next month and then I have more things to talk to him about and he keeps me coming back
 - My blood pressure machine broke down at my apartment and there were 2 nurses on duty on the main floor and I asked if they could check my blood pressure, but they said no because I didn't have an appointment but they were sitting there not doing anything anyway
 - My family doctor only sees one problem at a time. Once he sent me for tests and then took two different appointments to talk about the results because he ran out of time. The hospital called me to see what the doctor said, but I didn't have all the results, so I couldn't tell them. I had to wait a very long time for the appointment at the hospital
 - I had a problem with getting my medicines renewed. When I went to the pharmacy they said I had to go back to my doctor, but the doctor said I had to go to the pharmacy. I was very confused and no one was helping me and my English is not good and I am not sure I understood what I was supposed to do
 - Doctors are too busy – sometimes they don't even eat their lunch!! We have to help them and get more physicians. The doctors from my country are here but no one is helping them become doctors again, so they are working in restaurants



Session 2: Input was received from an engagement at the North East London Community Health Project (drop-in health care partnership with Family Services Thames Valley Health Unit and LIHC). It was a group of 16 people, mostly of Vietnamese or Cambodian descent:

- I have high blood pressure and I already have family doctor. I am worried about people in Vietnam who don't have a family doctor
- I have diabetes and I come to the group at church and they help me with money for food and meds. I also have high cholesterol. Sometimes I don't have money for food and my medications and I feel more sick
- I have diabetes but can't get glucometer because I can't afford it and it's not covered, so I can't check his diabetes every day
- The northeast end of the city doesn't have any doctors, and only one walk-in clinic where you have to wait for hours. Most new doctors ask you to apply, but they always turn down people like us
- We need more doctors, especially in northeast, not White Oaks & Masonville
- I don't have a family doctor and need meds for blood pressure so I feel really bad
- I have no way to travel across city to get them – the bus is really hard and expensive
- Planning only seems to care about people with money
- Sometimes he shows signs of diabetes and high blood pressure so he saw nurse at drop-in and saw them to get meds here - sometimes the nurse is better than the family doctor
- LIHC have nurse or doctor and they are really good but very busy too
- I have a language barrier and can't go anywhere without an interpreter, can't talk to anyone
- Even booking appointments with my own doctor it is hard because I don't speak English so I have to wait for a friend, or a kid, or sometimes when I go to the drop-in and they can help me
- We need help to even book appointments
- Access to medicine is very hard – even Trillium has a \$50 co-payment and that is a lot of money if you only get \$520 a month
- We need more nurses – they can do lots of things
- We need to pay for more supplies for diabetes like pumps and supplies
- I am worried that there won't be beds for seniors when they are sick, especially seniors who don't speak English. Where are they supposed to go?
- There are no mental health services for youth in this area and our kids get no help



Session 3: Input was received from seven peer facilitators at Peer Facilitators for Women Of the World (Croatia, Iraq, Iran, Afghanistan, Columbia and Sudan):

- Prevention is really important, asthma and obesity, the best way to treat is to prevent
- When they go to hospital no one speaks their language, everyone speaks English and there are no interpreters, won't book, people are told to bring friends
- Children are asked to interpret. One woman thought she had depression, but when a friend and adult interpreter spoke to the doctor they were told she was schizophrenic
- Another individual indicated she was offered an interpreter when in the hospital
- Even though hospitals are supposed to provide an interpreter, it is only at the patient request and most of the women don't know that they can ask and it is usually not offered – there needs to be a more consistent policy
- People do not know about other services because the information is only available in English and not in the places that they go
- Neighbourhood Health Centres (with the Middlesex London Health Unit) are closed and that's very frustrating. They had lots of clients and children and were very important for the women and women came to ask lots of questions about their health. Now they have nothing
- There are huge gaps in services when clients can't get a family doctor
- All things very important, believe more in prevention, sooner access to specialist
- It takes a very long time to see a specialist
- Patients time for appointments, not repeat appointments for different issues – what about how much it costs the patient for their time
- Why is chiropractic not covered? My daughter has scoliosis that was treated by chiropractor in Columbia, but here she needs a doctor. She was referred to an orthopaedic surgeon, but the appointment has been cancelled twice with six months in between new appointments. She has started to see a chiropractor on her own and pay for it and daughter has improved 30 grades. She lives on Ontario Works and has no money but has to find this because this is her child
- We need to advocate for these low income families to get the help and supports they need
- When I first came to Canada I had no doctor for six months but nothing is covered even when I had a doctor. I had pain, inflamed, sent for x-ray and ultrasound but nothing there so doctor dropped it and she still has the pain
- Appointment for son with a specialist had a six-month wait, then was cancelled and rescheduled for six or seven months
- No family doctor
- The three-month waiting period for OHIP means they have to pay while they wait and some doctors won't see them
- Post-traumatic stress is not talked about



One participant had talked to her group (Croatsians) and they provided this feedback to her:

- Cambodia has amazing health care system
- Doctors over-worked
- If the family doctor can't see all the symptoms, you schedule another appointment and lose interest to come back until problem is worse again
- There is a lack of information for services that already exist
- Common assessment in employment, should be in health tracking like on computers
- FHT to be formed will do triage (social worker assess all problems in one private place)
- Social workers should do the intake for which provider the patient should see
- In hospitals there are 30 people hearing why you came; you should have to tell your story only once
- Psychomedical social/post traumatic stress in immigrants plays a huge role and not many people talk about it
- There is a need for psychologist services
- There are too many hoops to get recertified. We need a shorter training for foreign-trained professionals. Many programs are only offered full-time, so people can't take them because they have to work to support their family and they aren't eligible to any assistance



6. Summary of Input from the Deaf Community

Recognizing that the Deaf community would find it difficult to participate in public community engagement, the South West LHIN organized a session for the Deaf community, held in October 2006 in the London area. Input received from participants is summarized below.

Accessibility:

- Need for improved access to interpreters
- Billing for interpreters needs clarity
- Build on the Long-Term Care Resident Bill of Rights
- Deaf often have other conditions that make it more difficult to access health services

Education and Awareness:

- Would like the opportunity to educate the South West LHIN and its partners on issues facing the Deaf community
- Voices of parents and families need to be heard
- Ambulance services need professional interpreters via CHS and ambulance attendants need education

Seniors Issues

- Hard of hearing in Long-Term Care homes - staff need to understand aids, technical devices, etc.
- Increased percentage of deaf/deafened seniors; Long-Term Care needs to be flexible

Strengths to build on

- Partnership – Deaf-Blind with Deaf community CNIB-CHS
- Canadian Hearing Society's Mental Health Connect Program – London is one of the only areas in Canada to have a psychiatrist and psychologist who know American Sign Language
- Active volunteer community (Long-Term Care homes could have part-time interpreters or student placements)



7. Summary of Input from the Francophone Community

Overall, the participants agreed that the proposed priorities made sense; however, the primary message delivered by the Francophone Community was that French Language Services need to be available at all levels of the health care system.

1. Overall, do the priorities make sense and which one is most important to you?

- French Language Services Act provides Francophones the right to receive services in French
- Accountability is important to ensure that the needs of the Francophone Community are met
- Francophone staff is needed at all levels of the health system including health promotion, CHC, governance, LTC, and human resources to ensure the delivery of quality French Services
- Adequate funding is required to sustain French Services
- The needs of Francophones who live in non-designated areas must be considered
- A change in corporate culture is required to recognize the needs of Francophones

2. What else do you think we need to add to make this a success?

- Access to services and information in French, 24 hours a day, 7 days a week
- Change the order of the priorities to Access, Prevention, Primary Care, Seniors
- Add prevention, particularly for obesity
- Address all health determinants, not just the medical determinants
- Consider the needs of families and the social context

3. What challenges do you think need to be overcome?

- Housing issues
- Equitable income
- Recruitment of French-speaking professionals
- Identification of adequate French-speaking human resources in place
- LHIN awareness of the needs of Francophones during integration and planning
- Role of public health in promotion and prevention
- Confusion of roles – need clear guidelines/expectations
- Train the trainers
- Always the same people participate – need to get community involved
- Relationship with Erie St. Clair LHIN
- The LHIN should be the catalyst for change

4. What role can you play to make this plan a success?

- Active participation of the Francophone Community at all levels and in all programs
- Regular consultation and distribution of information to the Francophone Community
- Francophones on the Strategic Advisory Group and Board of Directors of health care agencies
- Ensure training of Francophone professionals to know the health care system and facilitate access to services
- Use existing organizations, even in other sectors

8. Results of the Telephone Poll

Methodology

On behalf of the South West LHIN, Leger Marketing conducted a study investigating the opinions and beliefs of LHIN area residents concerning their local health care system. Data collection for the study was conducted via CATI telephone interviewing between August 22 and September 1, 2006. A randomly-selected, representative sample was achieved by inviting catchment residents aged 18 years of age and older to complete the survey. A total of 603 interviews are completed. The margin of error for a sample of this size is +/- 4.0%, 19 times out of 20. In order to ensure the statistical reliability and comparability of regional results, a regional quota regime was employed as illustrated in the following chart. However, the final data are statistically weighted using the most current Census and government data to ensure the results are representative of the actual population of the South West LHIN catchments.

	Sample Size	Margin of Error at the 95% confidence level
Total (South West LHIN)	603	±4.0%
Central	103	±9.7%
North	109	±9.4%
South	391	±5.0%

Summary of Results

Overall, the results of this study show that there is already high, moderate satisfaction with and confidence in local health care in the South West. Notably, unaided awareness of LHINs is low, although half of residents say they are aware once provided with a description. Coupled with this low level of awareness is a resident demand for more LHIN information. Some residents have received informative material in the mail about the South West LHIN. There is strong support for key policy areas, such as access and primary health care. Indeed, residents have high expectations of the South West LHIN, as the majority want to be actively involved in an integrated local health care system that focuses on wellness.

As stated, there is widespread satisfaction with and confidence in the local health care system throughout the South West area. The majority of South West LHIN residents are moderately satisfied with their local health care system. No less than seven-in-ten are satisfied with the overall quality (85%), efficiency (76%), coordination (75%), and accessibility (73%) of their local health care system. Furthermore, a quarter or more of residents are very satisfied. There is also high, moderate confidence in local health care. No less than six-in-ten are confident in the sustainability of the health care system (76%), that it will improve in the future (68%), and in the existence of a plan (60%). In addition, 18% to 25% are very confident in these aspects of the local health care system.



Awareness of LHINs and familiarity with the South West LHIN is modest. Three in five LHIN residents have seen, read, or heard about changes that are being made or will be made to how health care services in their community and across the province are planned, managed, and funded (57%). However, among those who are aware of changes in the health care system, only 12% are aware of LHINs without prompting. With prompting, one-quarter of LHIN residents are aware of LHINs (27%). Once they hear a description of LHINs, one-half of LHIN residents say they are aware (47%). However, only one-quarter of LHIN residents are somewhat to very familiar with LHINs or the South West LHIN in particular (24%). LHIN residents who have seen, read, or heard something about LHINs over the past two years report awareness of a new (16%), team approach (13%), and a move to local control of health care planning (11%).

There is a widespread desire to learn more about the LHIN, as four in five LHIN residents want more information about this health care innovation (81%). Notably, four in five of those who are aware of the LHIN want more information (79%). There has been some success in raising awareness via direct mail. One in five LHIN residents reported receiving information in the mail about the South West LHIN (18%). Moreover, two out of five residents who recalled receiving information about the South West LHIN in the mail found this material to be somewhat to very informative (41%).

The majority of LHIN residents said that all priority areas are very important, and all key priority areas are considered important by at least nine in ten LHIN residents. Nevertheless, three tiers of support were identified from the results. The primary tier of support for key priority areas includes access (32%) and primary health care (29%). This is followed by support for improving health care for senior citizens (22%) as a secondary tier priority, and preventing and managing chronic disease (14%) as a tertiary tier priority. After discussing health care and the LHIN priorities, there was no consensus regarding any missing priorities. Indeed 56% responded “No/Nothing” and the remaining issues mentioned are already addressed by the LHIN’s key priorities tested.

Residents of the South West LHIN have high expectations of their local health care. When it comes to engaging the public, patients want a more active and empowered role in making decisions about their own health care (93%). On a broader scale, three-quarters (74%) of residents think decisions about the health care system are already based on local interests and needs, but only half (55%) think they currently have enough input into health care planning. There is high, strong support for team-based health care provision (97%), integration of the system (96%), and increased coordination of health care services (91%). As well, there is high, strong support for quality standards across the system (95%), and for a new focus on proactive wellness-based approaches (92%).

9. Results of the Online Survey

Responses Received	190
Partial Responses ¹	8

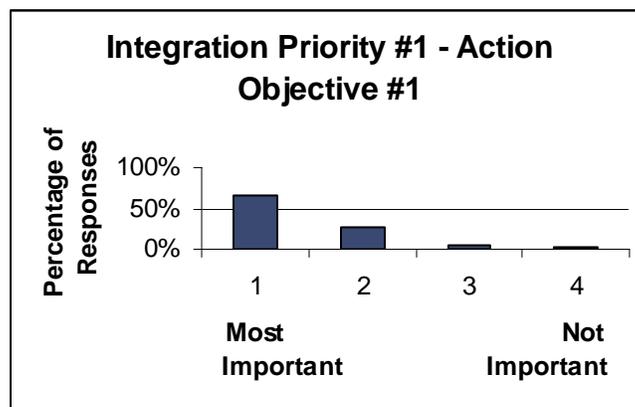
Rating Integration Priorities

Participants rated each integration priority and action objective by its importance. (1 being the Most Important and 4 being Not Important)

Integration Priority #1: STRENGTHENING AND IMPROVING PRIMARY CARE

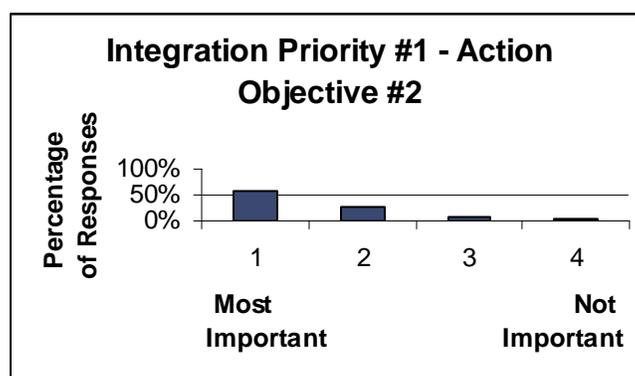
Action Objective #1:

Improve communication and linkages among other health care sector providers and primary care physicians not currently participating in a recognized primary care model.



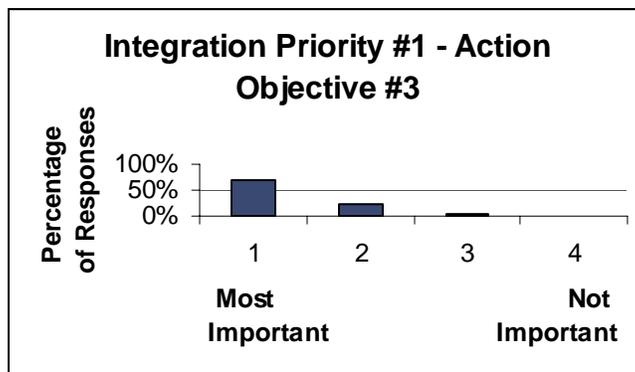
Action Objective #2: QUICK START:

Support the development and evolution of recognized primary health care models.



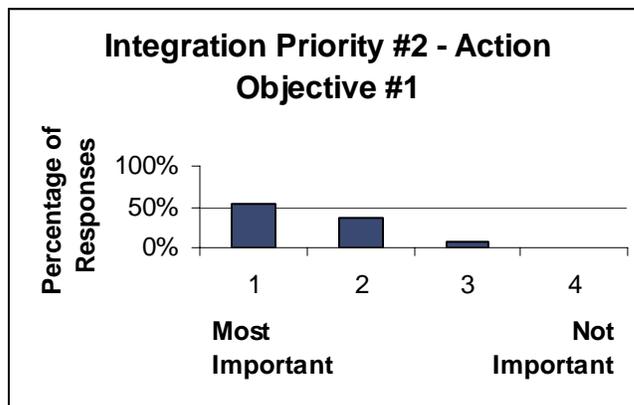
¹ Participants who did not complete the survey.

Action Objective #3: Focus on improving access to comprehensive primary care with an emphasis on early intervention and wellness for people with mental health and addictions conditions.

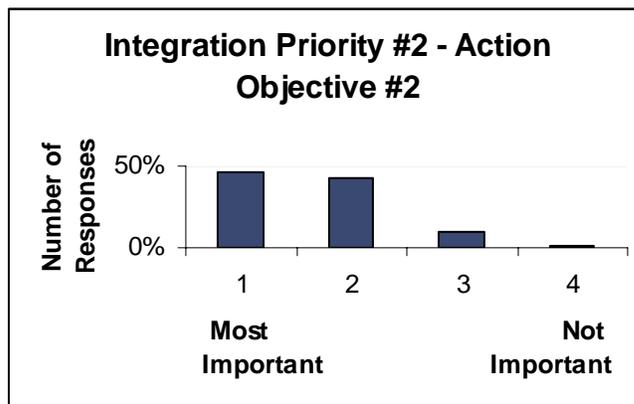


Integration Priority #2: PREVENTING AND MANAGING CHRONIC ILLNESS

Action Objective #1: Develop and implement a comprehensive chronic disease prevention and management program across the South West LHIN.

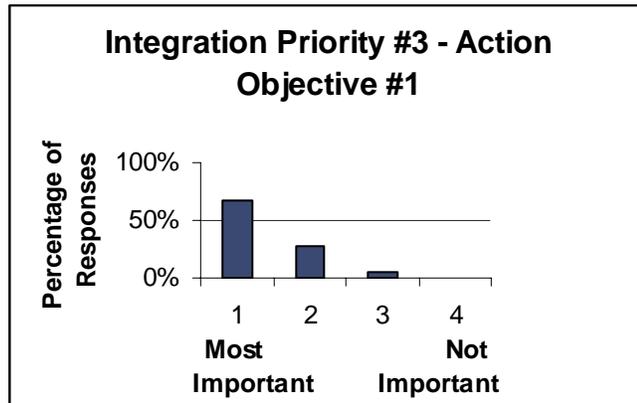


Action Objective #2 (QUICK START): Implement a chronic disease prevention and management program for individuals with diabetes including those with mental health co-conditions, through a selected number of “pilot initiatives” across the South West LHIN.

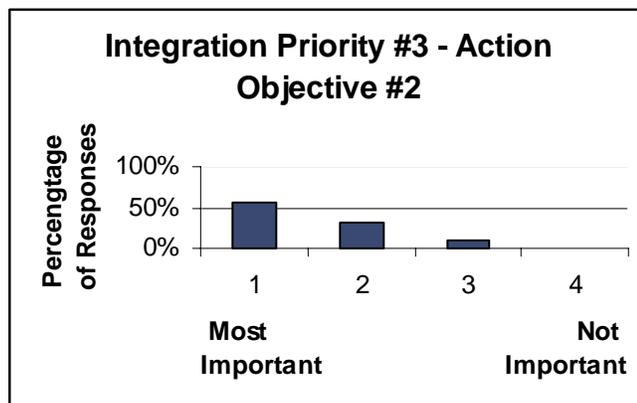


Integration Priority #3: BUILDING LINKAGES ACROSS THE CONTINUUM FOR SENIORS PLUS ADULTS WITH COMPLEX NEEDS

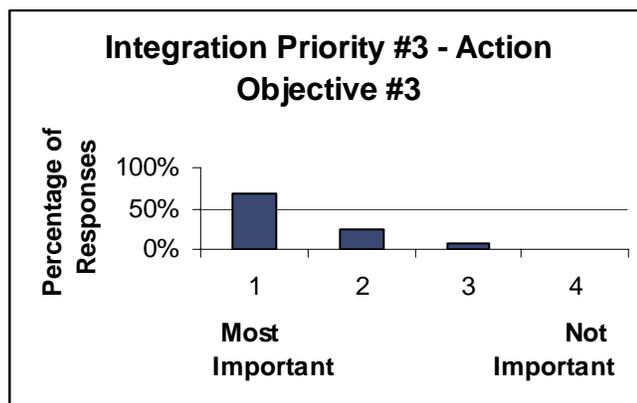
Action Objective #1: Improving the way that service providers work together to ensure that seniors and adults with complex needs receive seamless, timely care from the most appropriate health care provider.



Action Objective #2: Enhancing rehabilitation services for seniors and adults with complex needs.

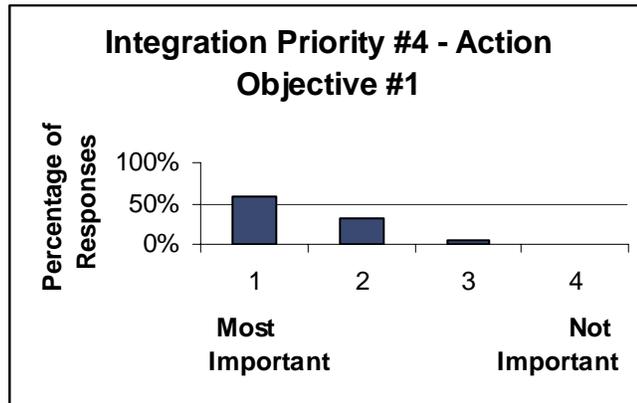


Action Objective #3: Developing a strategy and plan of action to ensure access to Long-Term Care to meet the needs of the South West LHIN.

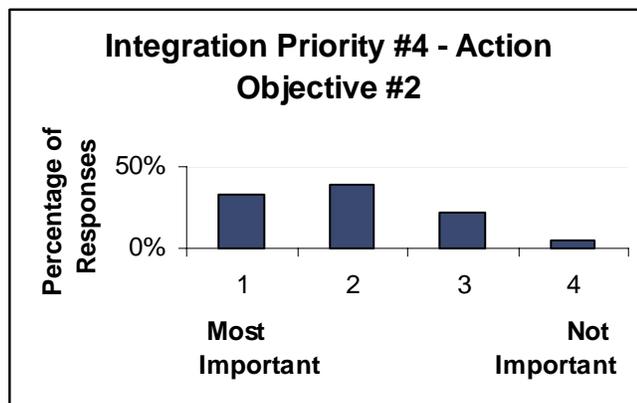


Integration Priority #4: ACCESSING THE RIGHT SERVICES, IN THE RIGHT PLACE, AT THE RIGHT TIME

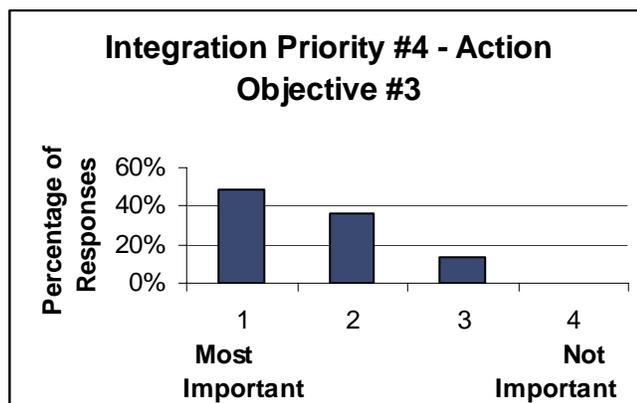
Action Objective #1: Define and strengthen the delivery of equitable, timely and appropriate services; and improve service coordination with a focus on implementing innovative approaches to support rural providers with links to specialized resources.



Action Objective #2 (QUICK START): Promote the Hips and Knees Quality, Utilization & Access Steering Committee to ensure an integrated approach to hip and knee total joint replacements across the LHIN.

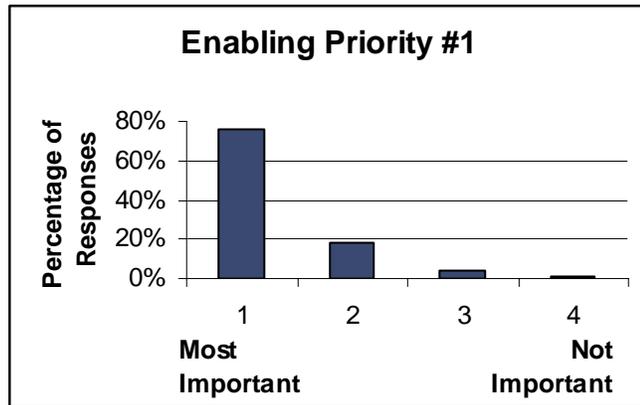


Action Objective #3: QUICK START: Leverage the work of the provincial Critical Care Strategy Group to build critical care capacity and improve accessibility, quality and efficiency of services.

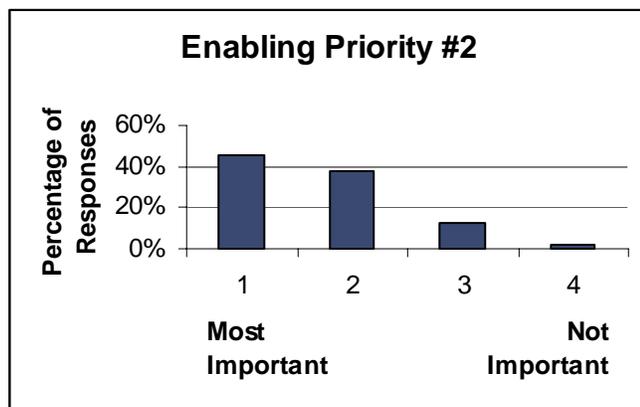


Enabling Priorities

Enabling Priority #1:
HEALTH HUMAN RESOURCES –
SUPPORTING THE PEOPLE WHO
MAKE IT HAPPEN



Enabling Priority #2:
E-HEALTH – NEEDING BETTER
INFORMATION THAT IS SHARED
ACROSS PROVIDERS AND THE
SYSTEM



Rank Order Integration and Enabling Priorities

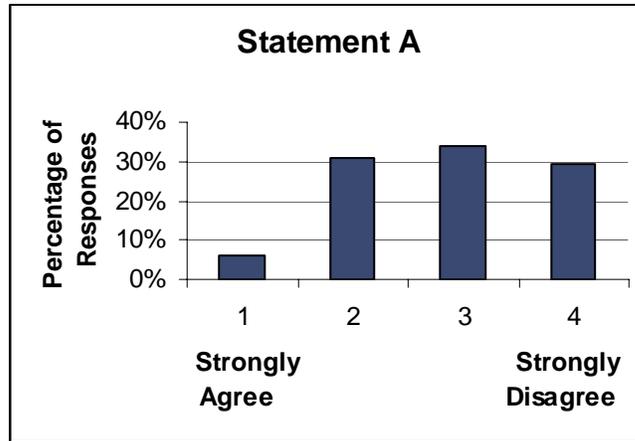
The Integration and Enabling priorities were ranked by participants. (The top priority received a 4 point score, while the lowest priority received a 1 point score.)

	<i>Points</i>
1. Strengthening and improving primary care	533
2. Accessing the right services, in the right place, at the right time	495
3. Preventing and managing chronic illness	399
4. Building linkages across the continuum for seniors plus adults with complex needs	336

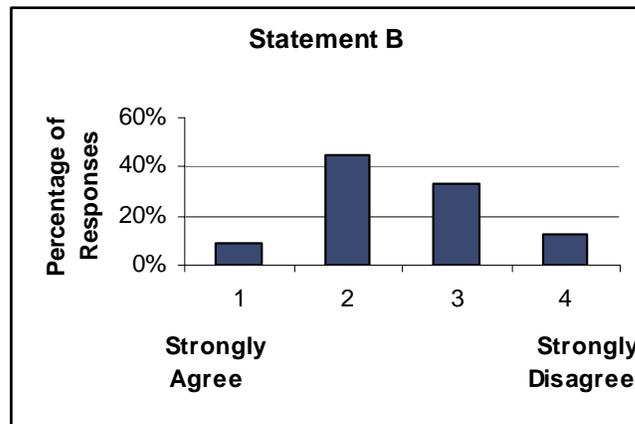
Level of Agreement with Statements

Participants indicated their level of agreement (strongly agree, somewhat agree, somewhat disagree and strongly disagree) with the following statements:

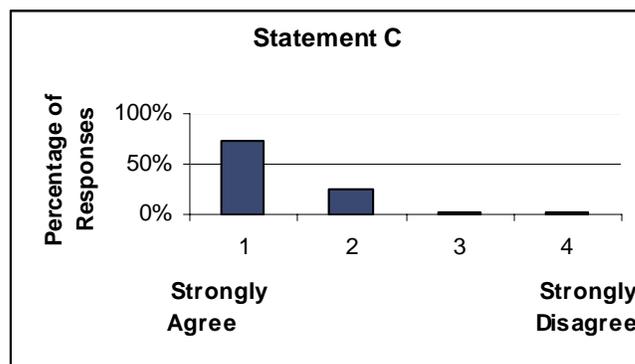
a) I have enough input into how the health care system in my area is planned and managed



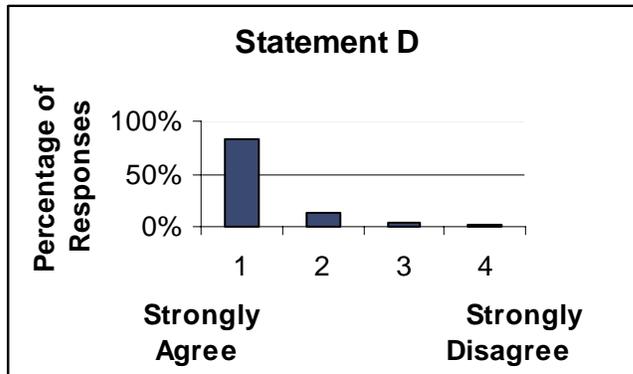
b) The decisions that are made about the health care system in my area are made on the basis of local interests and needs in mind



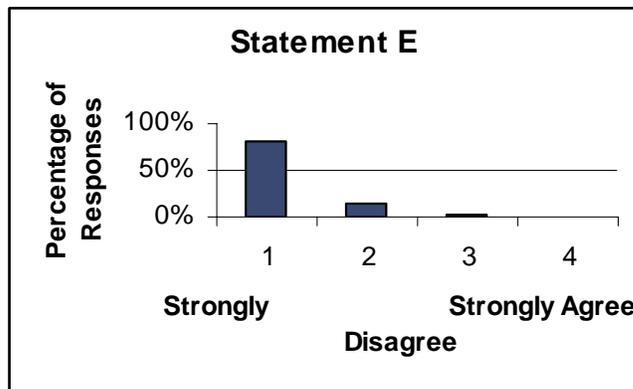
c) The health care system in my area can be significantly improved if the different health care providers and health care networks work together in a more coordinated way.



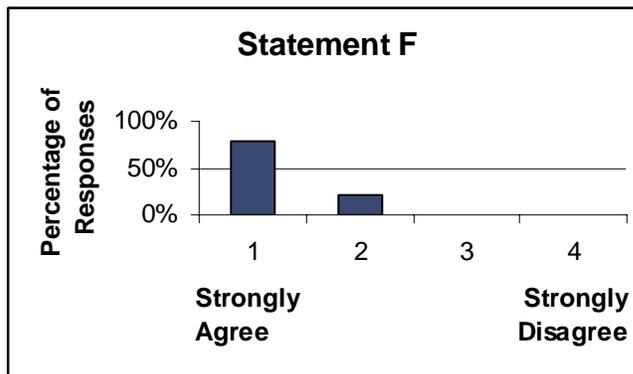
d) The health care system should be integrated to allow people to access it once and then receive all of the services and advice that they need without having to figure out how or where to get these services.



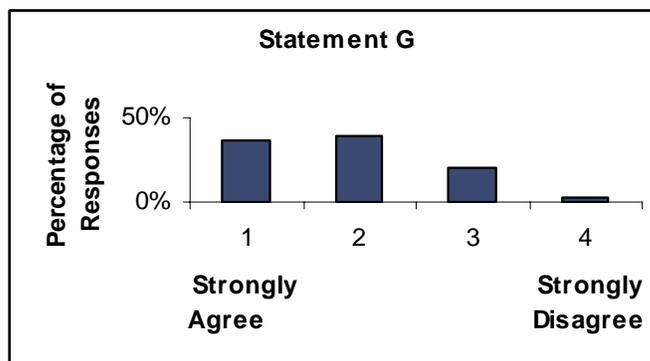
e) Residents should be able to obtain the same quality of health care no matter where they receive health care



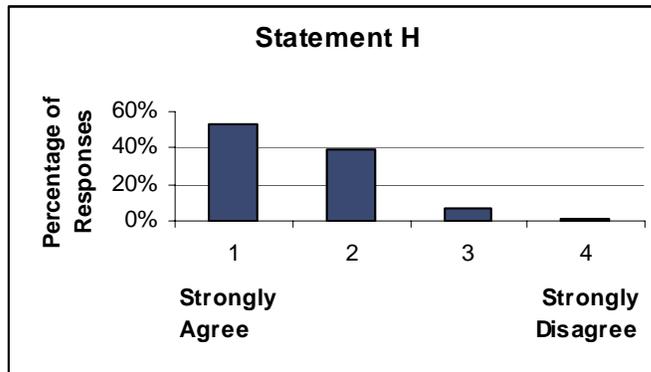
f) Patients should have an active role in making decisions about their own health care



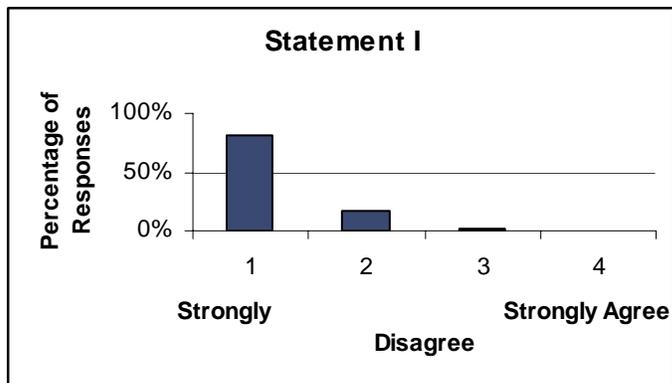
g) The availability for most health care services is considerably farther than the distances traveled to regular shopping areas.



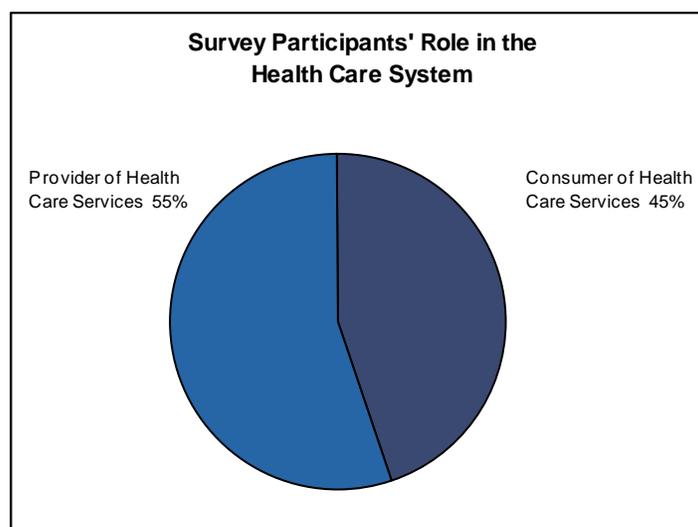
h) The health care system should shift its focus from illness to wellness, and put more emphasis on promoting healthier lifestyles, preventing illness and injury, and assisting early detection of health conditions.



i) The health care system should provide care through teams of primary health care providers - including doctors, nurses, nurse practitioners, dietitians, pharmacists, counsellors and others - so that most appropriate care is provided by the most appropriate provider



Profile of Survey Participants:

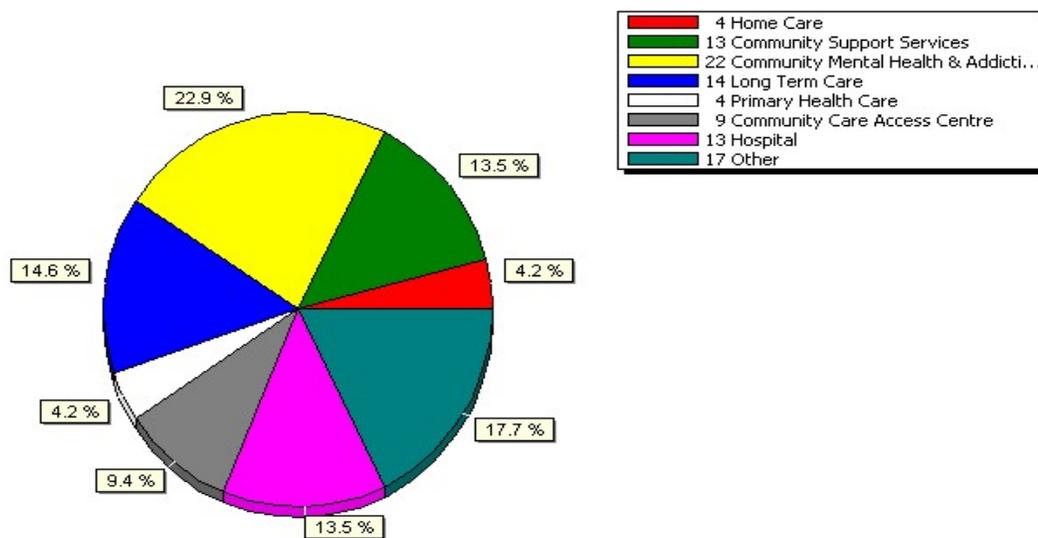


Profile of Health Care Provider

The description which best fits the participants' role in the health system:

Nurse	22
Administration	19
Other ²	19
Support Services	18
Regulated Health Professional	12
Physician/Specialist	6
Volunteer	2
Alternative Medicine	0
Environmental Services	0

Participants provide health care services in³:



Participants provide health care services in the following counties

Middlesex	36
Grey	25
Bruce	23
Huron	18
Perth	17
Oxford	16
Elgin	16
Norfolk	3
Other	3

² Other includes Project Manager in health care system, Medical Secretary, Marketing/Political Affairs Manager, Addictions Counselor and IT Manager at a CCAC,

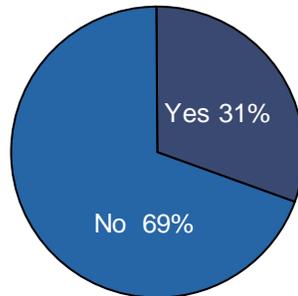
³ Other Services include public health, academic educator/researcher

Profile of Consumers of Health Care:

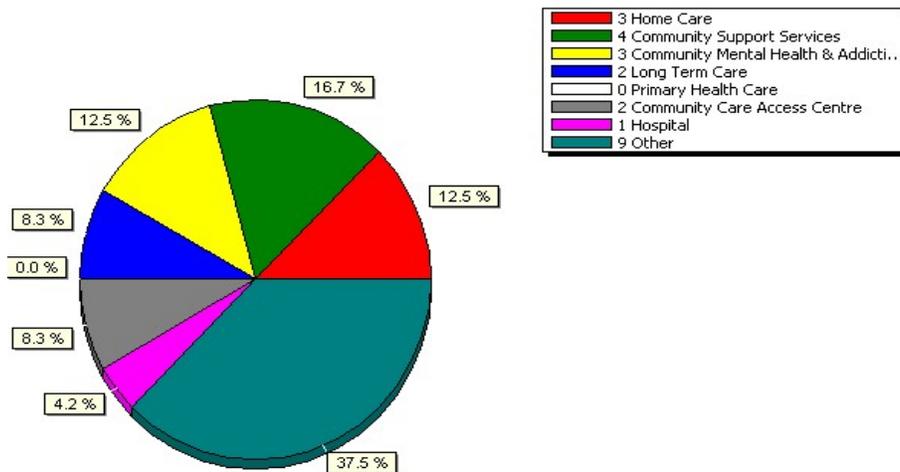
Consumers of health care carry out their daily activities (i.e., place of residence, workplace) in the following counties:

Middlesex	33
Elgin	11
Oxford	10
Perth	8
Huron	7
Grey	5
Bruce	4
Other	1
Norfolk	0

Consumers who are a volunteer in the health care sector:



Consumers who volunteer, are in the following sectors:



Open Response Question Summary

Priority	Action Objective	Thinking about the priority areas, is there any health care service area that is missing from this list that you think the South West LHIN should focus on? Please describe in detail.	Number of Responses	Does it fit into one of the following categories?	No Category Listed - Other
1	1	Other ways to access the health care system besides going through physicians. Nurses could fill the gap and should play a role as gate keeper.	1	Primary Care	
1	1	Building better Family Health Teams attached to Hospitals open 24 hrs eliminates walk in clinics and the 24 hr telehealth network	1	Primary Care	
1	2	The health promotion, prevention and protection services currently provided by Public Health Units need to be tapped in any primary health care strategy (1). Prevention and management of chronic wounds across the continuum (i.e., Pressure ulcer, diabetic foot ulcers and venous leg ulcers) (1).	3	Promotion and Prevention	
1	3	Mental Health. Recognizing and enhancing current addiction services provided, including community care, mental health promotion (1), women's mental health (1), youth and concurrent disorder (1), mental health reduction of stigma (1), increase funding (1), not for profit mental health counseling services (1)	13	Mental Health and Addictions	
1	Other	Birth control education.	1		Mothers and Babies
1	Other	There should be greater focus on maternity and early years care.	2		
2	1	Prevention and Promotion should include the following initiatives : Inflammatory Bowel Disease Management (1), Better access to Nutrition Programs and Registered Dietitians (1), environmental issues that are leading to ill health and chronicity (1), physical fitness (1), classroom instruction (e.g., diet and general wellness)and mandatory regular/daily physical activities (1), accountability for one's health (1), top 5 health issues faced by all demographics in our region (1), Stress management clinics; bereavement clinics (1), Population-Level Screening (1)	8	Community Care	many of the above categories
3	1	Mental health \$\$\$ duplication working in a silo but perceive they are in partnership. Specialized Geriatric Services ministry review greatly needed. \$\$ come from number of referrals to SGS however stats are counted twice as they are already assessed by regional CCAC's	1	Community Care	
3	1	Enhancing services in the home so that the elderly can stay in their homes as long as possible. Not just nursing services but also home support services (1), Homemaking, shopping meal prep - geared to low income seniors and mentally ill (1), Support non-governmental agencies financially such as VON in programs that actively help seniors stay in their own home by providing meals, activity	4	Long-Term Care	Community Care

Priority	Action Objective	Thinking about the priority areas, is there any health care service area that is missing from this list that you think the South West LHIN should focus on? Please describe in detail.	Number of Responses	Does it fit into one of the following categories?	No Category Listed - Other
		programs etc. (1)			
3	1	Culturally appropriate care for the seniors.	1	Long-Term Care	
3	1	Persons with early memory loss and early stage dementia are also "at risk" and require more primary supports. These people need early diagnosis and intervention . The earlier treatment begins the better as medications can delay the progression of the disease and this would save the health care system huge costs in the future. These persons also need consistent primary care providers.	1	Seniors	Mental Health
3	1	The definition of adults with complex needs should include individuals who are severely mentally ill (1) and adults with disabilities as they could be complex in time and age (1), need to define 'complex' (1).	3		
3	1	Need a larger Geriatric Emergency management team . Perhaps we can have a " inform the public campaign " and provide a phone number for seniors/ mentally ill/ families to call for answers to their questions and they can then be instructed on HOW to proceed. They can then go directly to a designated emergency room (or even better, to a separate clinic at a hospital) run by nurse practitioners, who can do an initial screening , and then they are treated or referred faster.	1	Seniors	
3	3	Timely access to long-term beds, with APPROPRIATE funding offered (1), programs for ABI clients (1), Adequate care for residents in LTC. Funding is needed for food and dietary staff to ensure that the resident nutritional status is improved or maintained (1)	4	Long-Term Care	
3	3	Interim care for seniors waiting for LTC home placements. Acute Care capacity. Advocacy groups for seniors are advising seniors and their families to remain in an acute care bed while they wait for appropriate placement. We will see the conflicts between acute care and long-term care come to a head in a legal challenge to the health care system.	2	Other	Systems Issue - Access
3	n/a	Provisions to increase the resources available to support end of life care in the community [especially rural based], increase in respite beds (1)	5	Seniors	Palliative care
3	n/a	Transfer palliative care from acute care facilities to separate residential facilities. It is cheaper in the long run and meets desires of general population.	1	Other	Palliative care

Priority	Action Objective	Thinking about the priority areas, is there any health care service area that is missing from this list that you think the South West LHIN should focus on? Please describe in detail.	Number of Responses	Does it fit into one of the following categories?	No Category Listed - Other
4	1	Transportation to and from Cat Scans/other hospitals etc. - the Ambulance in Perth/Huron Counties service is not adequate (1), transportation or local services to enable access to PHC by Mothers and Babies (1)	3	Other	Transportation
4	1	Local Services , including rehab and in home support (2), Complex needs ADP clinic for adults (1), immediate care of stroke victims, paediatric services by local CCAC (1)	8	Community Care	
4	1	Ensuring that health facilities learn from systemic errors which often lead to death of injury to patients.	2	Acute Care	
4	1	Ensuring communication, collaboration and coordination with other sectors and/or ministries and jurisdictions. Many solutions for service cannot be achieved without this e.g., MCYS/MCSS and Education for children's issues, Justice, Housing for individuals with mental health, ABI etc.	1	Community Care	
4	1	LHINs need to offer services in French to Francophones in the SW. This can be easily achieved by establishing a CHC or family health team for Francophones.	1	Other	Francophone
4	1	Better linkages with providers. Linkages with health clinics that provide blood tests (1)	1	Other	Coordination
4	1	We need to ensure that all individuals have access to primary care that is equitable .	1	Primary Care	
4	1	Support for women abuse (1), early access to long-term sexual assault counseling (1)	2	Community Care	
4	3	wait times in the hospital	1	Other	better coordination of staff
E	1	Emergency Care and enough physicians to do it!	1	Acute Care	
E	1	Increase physicians (4), paediatricians (3), Alternative therapies (2) and chiropractors (1), Orthopaedic surgeons for hips and knees (1), psychiatrists in Grey Bruce (1)	10		
E	1	Utilize nurse practitioners and nurses as these health care providers are grossly underutilized. Have public health nurses and community nurses working in concert with primary care physicians to provide care such as screening, blood pressure monitoring, diabetes care, palliative care and home visiting. This current initiative is very focused on the medical model and nothing will change until there is recognition of the efficacy and work that other health care providers offer.	4	Other	Health promotion and illness prevention
E	1	Need collection of data regarding the shortage of community to psychiatrists to provide the treatment needed in the community	1	Other	mental health and addictions

Priority	Action Objective	Thinking about the priority areas, is there any health care service area that is missing from this list that you think the South West LHIN should focus on? Please describe in detail.	Number of Responses	Does it fit into one of the following categories?	No Category Listed - Other
E	1	Increase funding to hospitals	1	Other	The basic problems of LHIN's.
E	1	Meaford - Thornbury area is in need of a CHC.	1	Primary Care	
E	1	Creating scholarships, opportunities etc. within universities to entice post grad studies in medicine (1). Providing access to free university training for would-be doctors until the shortage crisis is over (1).	2	Other	Building the Medical Profession
Other	Alternative Care	Access to alternative care under the Ontario medical care plan	1	Other	all of listed services
Other	Children	Supports to children and families. Knowledge transfer to all health care professionals (education and re-education) (1), Need to have the same number of pediatric specialists per capita as the rest of the province (1), early intervention (1), school health services (1)	6	Children and Youth	
Other	Individuals with Mental Disabilities	Health care for Mentally Challenged individuals is inadequate. This is due to lack of experience and education for Physicians & Health care providers regarding special needs & conditions affecting these individuals. Long-term health care needs are less apt to be addressed because of this (unless they have a strong advocate speaking for them.)	1	Other	Continuing Care for Mentally Disabled
Other	LHIN	No others; However I have concerns about the LHIN as an organization being capable of providing meaningful results to these excellent aims/goals. Initially they said they would only need a small staff at headquarters to manage LHIN # 2. I believe this is entirely unrealistic and that managing the whole system will require much greater resources, and to prevent poor results I think a realistic report on the plans of how the results will be accomplished is sorely needed. Almost all the 1,000,000 residents of LHIN #2 are waiting to see the changes planned, actually occur.	1	Other	
Other	LHIN	Better education process to explain to Health care workers the role of the LHIN and the relationship between LHIN, CCAC, hospitals, Health Units, and the rest of the health care sector. There is minimal understanding on what is going on and this is creating much angst, & stress re our future roles.	1	Other	This is part of the transition process
Other	LHIN	In the original literature, the LHINs did not have responsibility for Family Physicians, when did this change. Do you see this as a critical mandate for the LHIN	1	Other	
Overall	Performance Measurement	Sustainability/evaluation of healthcare service initiatives	1	Promotion and Prevention	



Priority	Action Objective	Thinking about the priority areas, is there any health care service area that is missing from this list that you think the South West LHIN should focus on? Please describe in detail.	Number of Responses	Does it fit into one of the following categories?	No Category Listed - Other
Other	Performance Measurement / Accountability	Ensuring responsible spending of health care tax dollars by the MOH. The LHIN's should have some influence on the MOH regarding how they are spending tax dollars to prevent unnecessary expenditures. They waste OHIP tax dollars.	1	Other	Fiscal Accountability
Other	Services outside LHIN funding	Cancer	1	Other	on its own
Other	Services outside LHIN funding	Dental care across population levels; birth to senior	1	Primary Care	
Other	Services outside LHIN funding	Specifically people with a vision loss and their frustration at being able to access supports for them to remain in their homes.	1	Rehabilitation Care	
Other	Services outside LHIN funding	Oral health has an impact on general health. Currently many adults are unable to access basic dental services because of financial barriers.	1	Other	access to dental care for all residents
Other	Special populations	Financial support for marginalized populations to ensure they can receive appropriate medication.	1	Other	Mothers and Babies
Other		As we look at enhancing specific services across the LHIN, we need to ensure that services not targeted for enhancement are stabilized.			
Other		Infrastructure - tourist and visitors put demands on services. More building development and presence within communities that carry many transitional people. Regulate the boundaries of health care and note the costs and the rural income levels of local residents versus vacationers who put demands on services.		Community Care	also fits Primary care access.