

# *South East Local Health Integration Network Integrated Health Services Plan*

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## *Appendix A: Findings from the Community Engagement and Stakeholder Consultation Processes*

DISCUSSION DRAFT

July, 2006

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## 1.0 Overview of Engagement and Consultation Process

The project involved an extensive process of public engagement sessions and consultation that involved interviews and discussion groups with stakeholders in communities across Southeastern Ontario.

The goals of the public engagement and stakeholder consultation were to:

- have conversations with communities and stakeholders regarding the strengths of current services, gaps in services and opportunities to coordinate and integrate services.
- ensure that concerns are understood and considered.

Close to 1000 people attended consultation sessions conducted by the consultants.

**Exhibit 1.1: Attendance at Consultation Sessions by Community**

<b>Location</b>	<b>Health Care Attendees</b>	<b>Non-Health Care Attendees</b>
Amherstview	8	5
Bancroft	9	9
Belleville	77	15
Brighton	8	9
Brockville	79	25
Denbigh	1	1
Gananoque	7	9
Glenburnie	3	9
Kingston	283	41
Madoc	9	17
Napanee	37	17
Northbrook	8	8
Perth	52	21
Picton	25	23
Plevna	1	5
Portland	5	5
Prescott	9	6
Selby	4	0
Sharbot Lake	10	19
Smiths Falls	19	4
Sydenham	18	15
Trenton	21	2
Tweed	17	1
<b>TOTAL</b>	<b>710</b>	<b>266</b>

Details of attendance in each community are provided in the appendices.

***Over fifty written submissions have also been received.***

Fifty-seven written submissions have also been received to date and their themes are incorporated here. An inventory of these submissions is found in the appendices.

## ***1.1 Approach***

The approach to the engagement and consultation included:

- Initial interviews with key informants to develop meeting/focus group discussion guide.
- Visiting communities, talking to providers and holding meetings for public input.
- Ensuring a mix of individual interviews, group meetings, and site visits.
- Distribution of a discussion guide prior to meetings with an option to respond by mail, email or fax if invitee was unable to attend at scheduled time.

***Variety of approaches to inviting participation.***

A variety of approaches were used to invite participation. Advertisements were placed in local newspapers to request participation at engagement sessions and written submissions from the public. Local radio stations and the LHIN website also provided information about public sessions. Hospitals, long term care providers, and other health services providers receiving transfer payments from the Ministry of Health and Long Term Care were invited to stakeholder consultations that were generally arranged on dates when the public consultation was occurring in the community. Additional stakeholders, such as municipal governments, unions and academics, were invited to participate.

The process was established to provide flexibility for the communities visited, but generally included the following:

- Public sessions in each community
- Municipal representative(s) – organized by county
- Hospital CEO and Board Chair and/or Senior Leadership Teams
- Physicians
- Mental health and addictions providers, Long term care providers, Community service providers, Acute care providers

- Front-line Staff sessions
- Manager/Director sessions

***A broad consultation process with many opportunities for input provided.***

This was a broad consultation process with many opportunities for input provided, with approximately 1000 people participating.

Although the process was broad, there still may be some perspectives that not enough opportunity for engagement was provided. Future consultation processes will need to include opportunities for engagement of deaf, blind and other handicapped populations.

A meeting for francophone representative stakeholders was convened and conducted in French.

***There is a need to establish a framework for dialogue with the First Nations communities.***

It should be noted that in this initial wave of community engagement and stakeholder consultation, feedback was not provided by the aboriginal communities in the SE LHIN. There is a need to establish an ongoing framework for dialogue with the First Nations and 'off-reserve' communities within the LHIN. It will also be important to establish a dialogue with the NE LHIN regarding services that are provided to their aboriginal populations by the medical community in Kingston, specifically with respect to dialysis services provided to residents of Moose Factory. The provincial Aboriginal Wellness Strategy provides a framework to involve this population in the consultation process.

## ***1.2 Report Format***

***A summary of the perceptions and feedback obtained during the process and provides foundational information for the development of the IHSP.***

It should be noted that this report provides a summary of what was heard during the engagement and consultation process. The feedback to the SE LHIN provides some of the foundational information for the development of the IHSP. Much of what is presented represents perceptions that exist for public and providers.

***Key themes presented first.***

The findings are presented with key themes that were heard across all counties and a summary for each county identifying strengths, issues/gaps, and opportunities for integration and improvement. There is also a section outlining the feedback from the francophone community.

***A summary of the feedback by county is also presented.***

The table following presents the counties and communities in each county in which engagement and consultation sessions were held.

**Exhibit 1.2: Communities by County**

<b>Northumberland</b>	<b>Frontenac</b>
• Brighton	• Sharbot Lake
<b>Hastings</b>	• Sydenham
• Bancroft	• Glenburnie
• Madoc	• Plevna
• Belleville	<b>City of Kingston</b>
• Trenton	• East, West, Central
• Deseronto	<b>Lanark</b>
• Tweed	• Perth
<b>Prince Edward</b>	• Smiths Falls
• Picton	<b>Leeds &amp; Grenville</b>
<b>Lennox &amp; Addington</b>	• Portland
• Northbrook	• Gananoque
• Napanee	• Brockville
• Amherstview	• Prescott
• Denbigh	

## 2.0 *Overarching Themes of Strength in the SE LHIN*

### 2.1 *Strength of Volunteer System*

***The importance of volunteerism in health care.***

A common theme identified in almost all communities that were consulted and engaged was the importance of volunteerism in health care. Most communities acknowledged the strength of their volunteer systems. However, the smaller and more rural communities identified that the system could not be maintained without the large number of volunteer hours being provided in their communities.

***The sense of community and need to “take care of one another” motivates volunteerism.***

Volunteer services were identified in the sessions to be any kind of assistance provided by an unpaid person that is not a family member or close personal friends of a patient. In smaller communities, however, it is not unusual for a volunteer to know the person or persons for whom they are providing services. Some communities identified that almost half of the adults in their community provide volunteer hours, and reported that it is the sense of community and need to “take care of one another” that motivates volunteerism.

***Many community support services are provided almost exclusively by volunteers.***

Although volunteers are being used in hospital and long term care settings, they are being utilized in greatest number in the community. It was reported that many community support agencies, such as transportation services, meals on wheels and hospice services are staffed almost exclusively by volunteers. Volunteer drivers were identified as particularly important in helping people to access necessary medical services. Other volunteer services provided in the community were identified as essential in helping people, and particularly seniors, stay healthy in their own homes. Many volunteers commit multiple hours per week. It was reported that the same group of people that provide volunteer hours often provide financial support for agencies that are required to fundraise parts of their budgets.

***Concern about volunteer “burn out, and that supply of volunteers will not meet future demand.***

Discussion about the strength of volunteerism was usually followed by an expressed concern about the volunteers themselves. It was identified that the majority of volunteers are seniors, and are facing their own health issues. Many communities noted the case of “well seniors helping unwell seniors”. Service providers are concerned that they are “burning out” their current volunteers, and that supply of volunteers will not meet future demand which will be produced by the increasing number of elderly.

## 2.2 *Cooperation and Collaboration between Community Service Providers in Rural Areas*

***Good cooperation and collaboration between community providers, particularly in rural areas.***

Consultation and engagement in all settings revealed the perception of good cooperation and collaboration between community providers. However, this strength was noted most frequently in more rural areas.

***Collaboration between providers allows them to maximize service.***

Cooperation and collaboration between community providers was described most frequently as the sharing of information and resources. Many community agency providers share physical space and resources. Directors of community agencies identified that they are often in contact with one another, and with CCACs, for continuity of care and planning purposes. There are efforts in a number of communities to standardize policies and processes between providers. Addictions Services and Community Mental Health Services in Lennox and Addington County report working collaboratively and have considered merging. Almost all counties identified the use of regular multi-service agency meetings as a forum for communication, education and clinical problem solving. Members of both the public and provider sessions identified that this collaboration between providers allows them to maximize services, and be sure that as few people as possible “fall between the gaps” in the system.

***Cooperation and integration between providers in the various sectors is not equally strong.***

A variety of networks, coalitions and alliances have also been established throughout the region to facilitate cooperation and collaboration between providers in different sectors. An example of this is the Mental Health Alliance, which was formed to address systemic issues related to service planning and delivery across the continuum of care. Although the consultation and engagement process revealed a strength in collaboration amongst local community providers, many were quick to report that the cooperation and integration between providers in the various sectors (for example between hospital and community) was perceived to not be equally strong.

## 2.3 *Emergency Transportation*

Consultation revealed a general, but not strong, consensus that emergency transport services are well provided across the region. Although some very remote communities revealed that they would like increased access to emergency air transport, participants perceive that they typically receive timely ambulance and paramedic services when needed.

Services are adequately developed to allow adherence to time-limited acute services for emergent stroke and cardiac care.

***Typically receive timely ambulance and paramedic services when needed.***

Participants in one community reported that, because they are locals themselves, paramedics are especially responsive to the needs and situations of the people in their own community. When discussing ambulance services, people expressed awareness of the challenges associated with providing emergency transport in a geographically disperse area such as the South East LHIN, noting distance and winter road conditions as particular hardships.

***Transport back when no longer emergent is a particular challenge.***

Participants were quick to note when discussing emergency transportation that while it is relatively easy to get a patient to emergency or acute services, transporting them back from services when they are no longer emergent is perceived to be particular challenge in this region.

## 3.0 *Overarching Themes Related to Issues & Gaps in the SE LHIN*

### 3.1 *Access Issues*

***Difficulty accessing existing resources was the most common challenge identified.***

Difficulty accessing existing resources was the most common challenge identified in the engagement and consultation for all regions within the LHIN.

There were three broad categories of access issues identified. First, difficulty accessing care because of discrepancies between supply and demand for services was identified. This manifests primarily as wait lists for services, and results in a belief that people are not getting timely care, choosing less preferred alternatives to care, or choosing to forgo care altogether. The second access issue related to geographic accessibility. Typically, a service may not be available locally and thus patients are required to travel to access the service. The ability to travel is often a significant barrier to accessing care. Finally, affordability of a service frequently determined its accessibility. This access issue related to uninsured medical services (such as outpatient physiotherapy), uninsured community support services (such as homemaking/house cleaning/laundry/cooking), or the equipment or support a client must pay for themselves in order to receive an insured service (such as the transportation required to get to a medical appointment).

Within these access issues, several common areas were consistently identified.

#### 3.1.1 *Lack of Family Physicians*

***An inadequate supply of family physicians was overwhelmingly identified as a priority access issue in all areas, except Prince Edward County.***

An inadequate supply of family physicians was overwhelmingly identified as a priority access issue in all areas, except Prince Edward County. Challenges with access to family doctors appeared common to all rural and urban locations, all age groups and types of patients.

Many people identified that they simply are unable to get a family doctor. Some communities noted that more than 15% of patients seen in the local Emergency Departments are “orphaned” patients, i.e. patients with no family doctor. It was reported new residents to an area are typically not able to secure a family doctor, and often travel back to their former communities to access their previous family physician. Long time residents who have had a family doctor can also become

orphaned, typically because their family doctor has retired, died or moved away.

Many patients are on long waiting lists for family practices. People in several communities reported being “turned down” or “released” by a family practice. It was noted that they thought this occurred because of the nature or complexity of their problems resulting in them being viewed as “less attractive” patients for doctors with busy family practices.

***Lack of timely care.***

Patients with family physicians also note problems with access to care. Because most family practices are busy and patients usually are required to wait for an appointment, many feel that they do not receive timely care from their doctor. Some people expressed that, because family doctors are pressed for time, the care they receive is rushed and not as thorough as it could be. Others indicated that family doctors appear quick to refer to specialists or other providers, even when it may not be necessary, in attempts to manage demands for their time. Finally, some people indicated that the shortage of a family doctor has resulted in a loss of choice about who provides their care which participants believe is an important personal decision.

***Limited availability of family physicians in the evenings or weekends.***

Another access issue noted mostly in the rural areas of this LHIN was the limited availability of family physicians especially on evenings and weekends. Concern was raised that it is difficult to see a family doctor in the evenings or on the weekends in most communities. Where walk-in or urgent care clinics are available, poor continuity and comprehensiveness of care were identified as areas of concern.

***Escalation of medical conditions that are more difficult, and costly, to deal with.***

There was overwhelming agreement on the problems resulting from inadequate access to family doctors. Concern was expressed that basic medical care is not being adequately received, and there is the perception that very little preventative or wellness care is being delivered. Participants expressed that this likely results in the escalation of medical conditions that are more difficult, and costly, to deal with over time.

***Inappropriate use of other health care.***

The inappropriate use of other health care resources as a result of poor access to family doctors was also reported. Most frequently, inappropriate use of the emergency department was reported. Providers and the public noted that emergency rooms are routinely being used to treat non-urgent cases and to provide prescription medicine refills.

***Inability to receive referrals or access necessary follow up care.***

The inability to receive referrals or access necessary follow up care was identified as a result of the family physician shortage. This is seen as an issue for referral from a family doctor to a specialist. There is a perception that a referral from a family doctor is required to receive homecare services. There are perceived challenges for medication follow-up and monitoring when an orphaned patient is seen in an emergency room.

***3.1.2 Lack of Access to Mental Health Services and Addiction Services***

***Inadequate supply and rationing of services to meet demand, as well as poor coordination of services.***

Mental health services were identified in all communities as a particular access challenge. It was reported that there is difficulty accessing the entire continuum of mental health services and addiction services, from crisis care to chronic community support. Inadequate supply and rationing of services to meet demand, as well as poor coordination of services, were identified as priority health concerns.

***Crisis care was identified as a particular challenge.***

Crisis care services were identified as a particular challenge in many communities. Communities outside of the urban centres of Kingston and Belleville rely on telephone access to crisis psychiatric care. Although providers in Kingston identify that inpatient psychiatric services are readily accessible to the region, there is a perception outside of Kingston that they are not. Many feel that it is essentially impossible to receive the diagnosis required for admission and treatment in an inpatient bed. A shortage of psychiatrists, and poor rationing of psychiatrist services, was also identified.

***Mental health conditions and addictions escalate into bigger medical and social problems.***

Most communities outside of urban centres reported long wait times to access acute mental health and addictions services. Geographic barriers are also a particular concern in accessing this type of treatment. Because “opportunities are missed” by these patients who must wait for services they seek, and because it is too challenging for patients to get to available treatments, many “treatable” conditions escalate into bigger, and more costly, long term medical and social problems.

Addictions patient have difficulty with medication management because of lack of family physicians for follow-up. These patients often have to leave the community to access treatment. There are no local withdrawal management or detoxification options for them locally, particularly in the smaller communities. Transportation is prohibitive for patients who do seek services.

People with long term or chronic mental health problems also identified issues with accessing services. Often, a lack of adequate access to treatment in ambulatory settings was reported. Most frequently, a lack of adequate community support services, such as supportive or transitional housing or needle exchange programs, were identified. This issue was consistently identified in very small, rural settings where few services appear to exist. The same issue was also identified in Kingston, which was reported to be more highly resourced with community support options for these populations. Providers felt strongly that access to adequate community and social support is required to decrease the “revolving door” of demand for crisis and acute care services. Regional providers in Kingston identified a particular concern regarding the adequacy of community support as the plan to eliminate inpatient chronic care beds proceeds.

***Need for speciality services for mental health and for addiction services.***

Finally, access issues were identified as more urgent for certain populations within the mental health community. Although specialty psycho-geriatric services exist in the region, this service was consistently identified as inadequately resourced to meet current and future demand. With the high percentage of seniors in this LHIN, psycho-geriatrics may continue to be a significant and growing challenge.

Addiction services, child and adolescent psychiatry, concurrent disorders, forensics and services for the mentally ill homeless population were also identified as particular access challenges.

***3.1.3 Lack of Access to Specialist Services***

The ability to access specialist physician care was an overwhelming concern in all communities, whether urban or rural. Supply issues, as well as issues of geographic access, were the access challenges identified.

***Specialists are providing primary care, which contributes to longer waits for specialty care.***

It is perceived that the shortage of family doctors is contributing to the challenge of accessing specialist care. Most identified that a referral from a family doctor is required to see a specialist, and this in itself limits access. Some thought that primary care appears to be becoming overly specialized, and that specialists are being used inappropriately as a result of family doctors trying to manage their workloads. In either case, participants believe the demand for specialists appears to exceed the supply. Patients that do get a specialist referral, report that they have long waits to be seen, even for urgent cases. It was reported that specialists appear to be managing follow up and primary care concerns for their

patients in the absence of adequate primary care services and this creates an increased demand for their time, and contributes to longer waits for specialist care.

***Poorly coordinated access to specialists results in inequities.***

Providers and patients report that poorly coordinated access to the limited numbers of specialists in the region results in inequities of service. Because no centralized waitlist management or referral services exist, waits for one specialist may be shorter or longer than waits for another of the same type of specialist. Patients and physicians have been searching, and traveling, to distant providers in order to access services in a more timely fashion. For example, the family doctors in Napanee have started referring to an orthopedic surgeon in Belleville for knee replacements, because the wait list tends to be shorter than the wait lists in Kingston.

***The need to travel becomes a huge barrier to accessing specialist care.***

Geographic access barriers were routinely identified, no matter how near or distant the community from the urban centres where specialists practice. With very few exceptions, patients are required to travel to Kingston, Belleville, Trenton or Ottawa to access specialist care. The need to travel, particularly if multiple appointments are required, becomes a huge barrier to accessing necessary care.

Specialty groups most commonly indicated as in short supply included psychiatry, obstetrics and gynecology, dermatology, rheumatology, paediatrics and pain management.

### ***3.1.4 Physician Coverage Issues***

As expected when a shortage of doctors exists, physician coverage issues were identified by providers in most communities participating in consultation.

***Inability of physicians to take time off of work.***

One issue was the inability of physicians to take time off from work because of difficulty finding coverage for their patients. This is felt to be a major barrier for recruiting and retaining doctors in smaller areas. The hospital in Bancroft reports having to shut down its emergency room due to inadequate coverage when the doctor is away. Doctors in hospitals, who also feel that they are facing a crisis in staffing, find it difficult to get coverage or support from busy family physicians in the community when needed. Communities have difficulty “sharing” doctors when needed because of excessive demand.

***Regional approach to coverage.***

As noted earlier, specialist coverage was also identified as an issue in many communities in the LHIN. Limited supply of specialists over a large geographic area necessitates that some kind of regional approach to coverage be implemented to

improve access across all communities. At this time, no such approach was reported as having been achieved.

### 3.1.5 *Lack of Access to Rehabilitation Services*

Inadequate access to rehabilitation services was identified as a concern in nearly every consultation. Access to speech-language pathologists (SLP), occupational therapists (OT), and particularly to physiotherapists (PT) was noted to be of primary concern.

***Limited funding for inpatient and post-operative outpatient rehabilitation services.***

Issues of access were identified in all sectors. Hospitals noted limited funding for inpatient and post-operative outpatient rehabilitation services. Demand for services, even at hospitals that appear to have well resourced programs, exceeds supply. Consequently, patients are waitlisted or simply do not receive care. It was reported that most hospitals in the LHIN were identified as having neither OTs nor SLPs on staff. It was reported that the hospital in Bancroft is funded for a part-time PT, but has been unable to recruit anyone who is willing to accept only part-time hours.

***Demand for insured in-home rehabilitation services exceeds supply.***

Rehabilitation in the home was also consistently reported as a problem. Again, the demand for insured in-home rehabilitation services exceeds the supply, and patients must wait for care. It was reported that in one jurisdiction post-operative hip replacement patients routinely wait 3 to 4 weeks before being seen by a PT in their home. Although uninsured rehabilitation services should be available through home care agencies, a lack of providers, coupled with the reported inability or unwillingness of many clients to pay out-of-pocket for these services, makes this type of care essentially non-existent. Long term care residents also note that they have minimal to no access to rehabilitation professionals. This may impact opportunities to convalesce, reactivate or even maintain their functional status while in residential care.

***The cost of outpatient rehabilitation severely limits access.***

Access is also limited to outpatient rehabilitation services. In many larger communities in the LHIN, the supply of providers was reported as adequate. However, the cost of the service for patients who are uninsured severely limits access. In smaller communities, outpatient rehabilitation clinics are reported to simply not exist.

***Inadequate access has significant effects on the health care and social system.***

Participants agreed that inadequate access to rehabilitation services may have significant effects on the health and social system. Many felt that many functional problems that result in disability and high patient care needs, such as decreased mobility, could be addressed through better access to

rehabilitative care. Many indicated that rehabilitation could provide alternatives to medical treatments currently being provided by busy doctors. An example that was frequently cited was the use of physiotherapy, instead of medication, to manage disability resulting from chronic back pain.

### 3.2 *Transportation Issues*

***Biggest concern related to non-urgent transportation.***

Issues with transportation were voiced at every consultation session held within the LHIN. The issues in rural communities did not differ significantly from those identified in urban communities. Concerns pertained mainly to non-urgent transportation, and extend to travel both within and between counties in the LHIN. A variety of issues around transportation were identified.

***Options are inadequately resourced to meet current demand.***

Transportation required to access medical care was a primary concern in all communities. Those without their own mode of transportation must rely on other transport options, which are reportedly lacking in most communities. Only the large urban centres have public transportation (bus) options. Very few nursing homes in the LHIN have purchased their own buses or vans for private use. Although medical transportation services and taxis are available in most communities, and some level of transportation is usually available through community support services, these options are reportedly insufficient to meet the current demand.

***Many communities do not have wheelchair or stretcher accessible options.***

Many communities do not have wheelchair or stretcher accessible transportation options, and thus must rely on private medical transportation services to provide transportation.

The perspective expressed was that most transportation options, even volunteer-based driver services, are unaffordable for the majority of patients in the LHIN. Patients and families report that they find themselves waiting long periods of time to be transported, particularly to home from medical care, incurring expenses that are a hardship, or missing or declining appointments because they can't arrange affordable transport. Providers indicate that they waste valuable time and resources when arranging transportation and accompanying patients to appointments. Some hospitals in the LHIN have created arrangements for non-urgent transportation. However, this activity has been funded from their global budgets, which impacts the ability to focus resources where the hospital would choose to. There are also concerns about liability

issues associated with transportation of patients outside the hospital.

***A weakness of the current system is its inability to provide coordination for individual with multiple appointments or for groups traveling from the same geographic location.***

Transportation for access to medical care is an even greater burden for people in rural areas who must travel long distances to access services. Those who must travel frequently for care, including for regular, routine care (such as dialysis) or for multiple appointments, also face challenges. It appears that a weakness of the current system is its inability to provide coordination for individuals with multiple appointments or for groups of people traveling from the same geographic location. Further, transportation options appear to comply to county specific, rather than LHIN based, geographic borders. There are restrictions for municipally-managed medical transportation services that make travel within the region even more challenging.

***Challenges with transportation for non-medical, but health-related, needs.***

Participants in all communities identified challenges with transportation for non-medical, but health-related, needs. There is a desire for more public or volunteer based transportation to allow people, and particularly seniors, to access services even in their own community. Limited transportation options make completing necessary tasks, such as getting groceries or going to the pharmacy, and participating in social and recreational activities that sustain health and wellbeing difficult. The net result is felt to be increased isolation and difficulty aging in place, particularly for residents of rural communities.

### ***3.3 Long Term Care/ALC Issue***

Adequate supply and location of long term care beds was identified as an issue at almost every community engagement and consultation.

***Inadequate numbers of beds for current demand.***

Many communities throughout the LHIN have no long term care beds within their immediate community. Even communities with long term care facilities reported that there are inadequate numbers of beds for current demand. The scarcity of beds puts pressure on people who need placement to accept whatever bed becomes available, even if it is located at a distance from their home. Long term care administrators report that the percentage of emergent or crisis admissions has risen dramatically, increasing pressures for placement in the first available bed. Urban residents that are placed in outlying areas feel isolated from their families and communities. Rural residents resent having to take relocated urban patients into

local long term care beds that they feel should be used for local residents, who might end up being placed at a distance.

***Demand for long term care beds creates problems for hospitals trying to discharge patients.***

High demand for long term care beds creates problems for hospitals trying to discharge patients. Hospitals in Kingston, Quinte Health and Napanee, in particular, report high numbers of alternate level of care patients who “block” beds intended for acute hospital care. Downstream backlogs in the system create significant issues with throughput, and result in poor resource utilization and significant frustration for staff.

***Lack of alternatives such as transitional and supportive housing options.***

Almost every community that discussed a shortage of long term care beds identified the use of alternative levels of housing and support as a viable solution. Most felt that a lack of transitional and supportive housing options, such as affordable retirement homes, and inadequate supportive services through CCACs, create demand for long term care beds that could be avoided.

### ***3.4 Lack of a Regional Approach to Information Systems Management and Communication***

***Effective communication, and tools that facilitate such communication, are critical.***

Communication was identified as a challenge and priority for all providers. Many felt the need for effective communication, and tools that facilitate such communication, are critical given the geographical challenges in South Eastern Ontario.

Essentially every consultation group discussed the need for some kind of electronic health record to make patient information accessible to all providers in the system. Most identified that at present, although gains have been made, no such communication tool exists. Without such an essential tool, participants felt that medical errors, duplication and inefficiencies will continue to occur.

***Fragmented approach to technology within the LHIN.***

A fragmented approach to technology within the LHIN was discussed by most provider groups. A commonly cited example was the purchase of Picture Archiving and Communication System (PACS). Several individual providers have proceeded with purchasing separate, and incompatible PACS. Although this may result in cost savings for the individual provider, it does little to facilitate communication and will cost the region more in the long term. Participants stressed the need for a regional approach to information technology and communication.

### 3.5 *Concern Regarding the Mandate of the LHIN*

Although the goal of the consultation sessions was to discuss health care services, many participants took the opportunity to express concern about the politics behind the LHIN. Rumour and misinformation abound, and participants often seemed to interpret the goal of “integration” as one of “amalgamation”.

***Suspicion over the actions of the LHIN to fulfill its mandate of integration and efficiency.***

Suspicion regarding the actions the LHIN would take to fulfill its mandate of integration and efficiency was noted. Concerns voiced in many sessions included that the LHIN was created to centralize and amalgamate health care and to authorize the contracting out and privatization of health care services. Participants were concerned that the result will be job losses or relocation. There was also a fear of compromised, instead of improved, access to care. Small communities and community support providers were particularly concerned about the potential loss of local sensitivity and personalized care. The majority of participants were of the opinion that the LHIN may achieve efficiencies by amalgamating services and locating them in urban cores, but that it would simultaneously reduce the quality of care being provided. Numerous small communities also expressed their willingness to work with, but not become part of, similar services provided in adjacent communities.

***An additional and unnecessary level of bureaucracy.***

Finally, although many participants supported the formation of the LHIN, many saw it as an additional and unnecessary level of bureaucracy. Not all participants stated a willingness to cooperate with or support the LHIN, stating that the LHIN would need to “prove itself” to gain respect.

## 4.0 *Overarching Opportunities to Strengthen the System & Improve Coordination*

***Overwhelming majority of suggestions called for increasing resources.***

Participants were asked to identify opportunities they thought would improve and coordinate services, address access issues and unmet needs, and strengthen linkages and communication within the system. The overwhelming majority of suggestions called for increased funding, usually in the form of additional funding for human resources and for specific services. Participants were asked to identify alternatives to increased funding and resources. Several key themes emerged from the discussions that were common to all communities.

### 4.1 *Strengthening Primary Care*

***Better primary care will ease downstream burdens for the system.***

Almost every group that was consulted identified the need for improved primary care, including the provision of adequate basic medical care, prevention, chronic disease management and wellness services, as a priority for the system. Essentially, there was consensus that “an ounce of prevention is worth a pound of cure”, and that better primary care will ease downstream burdens for the system.

***The use of alternate providers of primary care with strong support for Nurse Practitioners.***

Although the recruitment and retention of more family doctors was typically identified as the most important way to improve access to primary care services, most participants agreed that a multi-strategy approach would be of value. Of the options identified by participants, the use of alternate providers of primary care was cited most frequently. This included the use of “doctor substitutes”, such as nurse practitioners, when appropriate, but also the use of dietitians, social workers and physiotherapists to enhance and compliment primary care services that are typically sought from physicians. Of note was strong support for Nurse Practitioners as important providers of primary care in a variety of settings, including the community, but also in hospitals, emergency departments, homecare and nursing homes.

***Overwhelming support for team based approaches.***

There was overwhelming support for team based approaches to primary care. Many noted that Family Health Teams and Community Health Centre models appear to offer benefits that make them preferable to traditional physician practices.

***Need to provide extended access to primary care services.***

Participants also wanted extended hours and weekend access to primary care services. Areas that see high seasonal population increases also believe there is a need for walk-in clinics and urgent care centres as options for access.

Most participants saw the LHIN as having an essential role in promoting group practice and facilitating the recruitment and retention of appropriate primary care providers to the area. Others expressed that the LHIN should facilitate new models of primary care in rural areas by recommending and supporting pilot projects. Many felt that the LHIN should mandate and coordinate chronic disease management efforts across provider groups and sectors. Finally, participants frequently noted that the LHIN could have a role in connecting people, particularly new residents, to appropriate local primary care providers and that it should put mechanisms in place by which to do so.

#### ***4.2 Development of a Regional Health Human Resource Plan***

***The LHIN should take a leadership role in HHR planning for the region.***

Consistent with the identified need to improve access to primary care was an awareness of the need for a regional health human resource plan. Most felt that the LHIN should take a leadership role in planning for, recruiting, retaining and developing all kinds of health services providers that are needed in the area. A regional plan is indicated to avoid “poaching” providers from other areas within the LHIN, without any overall net gain.

Many identified that the LHIN should address work-life issues that have been identified and should examine appropriate incentives for providers. Although no consensus was achieved, there appears to be a willingness on the part of providers to begin discussions about expanding AFP models throughout the region, and addressing cross-coverage issues for physicians.

#### ***4.3 Enhancing Community Support Services***

The majority of participants identified the need to improve community support services. This included providing more timely access to existing services and enhancing access by expanding the scope of publicly funded services.

***Need for more home care services, transportation and supportive housing.***

The need for more home care hours and an expanded scope of homecare services (such as homemaking), particularly for seniors was noted by most participant groups. The need for improved transportation and for transitional and supportive housing options, particularly for seniors and the mental health population, was also frequently identified. Hospice, palliative care services, rehabilitation and dental care were also anticipated needs. Advocates felt that the enhancement of community services would improve the health of the population, and help people live outside of institutions and hospitals for as long as possible.

**4.4 *Develop Solutions for Improving Access to Care in a Geographically Disperse Areas***

The need for solutions to providing care in geographically dispersed and rural areas was identified by most participants.

***Improved transport services would create efficiencies in scheduling efforts, missed and cancelled appointment and patient satisfaction.***

Participants often discussed opportunities in the area of transportation, indicating that the LHIN should either provide transportation or, at the very least, facilitate improved coordination and utilization of current transportation resources. Some simply felt that the LHIN should provide funding to providers so that they can purchase vans, particularly accessible vans, and offer transportation at low/no cost to patients. Many suggested that inter-hospital or hospital to county shuttle services could be established. Many felt that the LHIN should facilitate improved scheduling of transportation, so that long term care facilities or communities can transport multiple patients at a time, or so that individuals can avoid multiple trips. All agreed that improved transport services would create efficiencies in terms of scheduling efforts, missed and cancelled appointment and patient satisfaction.

***Reducing the need for transportation.***

There was general consensus that reducing the need for transportation is another viable solution. It was suggested that locating more services in the various communities of the LHIN, either permanently or temporarily, would reduce the need for travel. It was suggested that this could be achieved by establishing satellite clinics and traveling services in outlying communities. For example, the use of a traveling diagnostics service would be useful. Northbrook suggested that locating a dialysis clinic within their long term care centre would eliminate the need for 5 local residents to travel to Kingston three times per week.



***The LHIN should play a leadership role in improving communication in the system.***

Opinions that the LHIN should play a leadership role in improving communication in the system were clearly stated. Many indicated the need for the LHIN to provide clear, open, two-way communication with and between those within its jurisdiction. It was also suggested that the LHIN should enable communication by promoting the development of necessary infrastructure, by ensuring that providers have adequate time for participation, and by providing appropriate incentives to ensure successful integration and communication.

***Ensuring that services work well together and eliminating gaps and duplication of services.***

Finally, many participants commented on the lack of a “body” to oversee and direct the parts of the system as a whole. Most stated that the role of the LHIN should be to coordinate systems activities, ensuring that services work well together and eliminating gaps and duplication of services. An example of this role frequently cited was the opportunity for the LHIN to direct chronic disease management efforts among different sectors and providers.

***Ensuring francophone services in the region.***

There is a need to ensure services are available for the francophone population who has difficulty accessing language sensitive services in this region.

## ***5.0 Francophone Community Engagement & Consultation***

An engagement meeting was convened and conducted in French for francophone representatives in the region. The following feedback is specific to this community.

### ***5.1 What is Working Well***

There was a perception among the participants at this session that in Ontario, family doctors follow up on emergency cases and patient files more rigorously than elsewhere. As well access to specialists, for example, the tertiary center in Kingston, compared to other regions, appears to be better. The new ministry that is focused on integrating children's health services appears to be working well for this population

### ***5.2 Most Pressing Health Needs in SEO***

This group identified the most pressing needs from their perspective in Southeastern Ontario:

- More family doctors
- Long term care
- Home care
- Mental health resources
- Mental health patients lack living accommodation in the community
- Services for the aged
- Services for children
- Need for patients to be understood in French

### ***5.3 Issues/Gaps with Suggestions for Improvement***

#### ***5.3.1 Lack of Health Professionals (Family Doctors, Surgeons, Specialists and Nurses) Who Can Provide Services in French***

This group reported the following issues and concerns and included suggestions for improvement.

- Patients cannot take charge of their health if they cannot communicate their needs.
- Difficulties with communication mean patients cannot easily give their informed consent.

- Communication impacts include: wrong diagnosis, wrong tests administered, wrong treatment plan.
  - An example was given of a child who was given a second dose of sedatives because, according to the nurse, he was not “coherent” when he woke up after an operation, when in fact he was asking for his mother in French.
- Patients who are aged or who have cognitive problems often revert to their first language and can have difficulty communicating, explaining their symptoms. This often leads to misinterpretation of the situation. Language barriers taint the message upon which treatment decisions are made.

*Suggestions for improvement:*

- Bilingual health staff, where present, should be clearly identified so that other health staff will know who can offer the service in French.
- Sites with French-language services should include language capacity as a scheduling parameter so that each work shift has someone designated to deal with francophone patients.
- Health care providers should inquire about the language preference of patients and then assign francophone patients to bilingual personnel.
- Health promotion programs and other public health initiatives could be included in French schools as well as English ones.
- Ensure that health center signage is available in French and English.
- Sensitize hospital administrators to the need for and the impact of French language services.

*5.3.2 Lack of family doctors*

- People who have recently moved to a new place can go months and even years without getting a family doctor in the Southeast.
- Walk in clinics are one form of access, but there are often waiting lists of 3 years to get a dedicated doctor; patients feel it’s a lottery.
- Psychiatric patients are not followed and often do not take their medication.

- Some people use walk-in clinics because it takes so long to get an appointment with their family doctor and the impact is that there is no follow up on patient files.
- People go to ER for no valid reason, band-aid solution and increased use of ER services.

*Suggestions for improvement:*

- Nurse practitioners could be used expand access to primary health care.
- The presence of more bilingual health care professionals would be helpful.

### ***5.3.3 Lack of Mental Health Specialists for Children***

- The lack of mental health services is especially problematic for francophones.
  - An example was given of a father who was in the military whose son had special needs that could not be met in the region; he asked for a transfer to Quebec because he needed access to psychological services in French for his son.
- There is a lack of communication regarding the linguistic capabilities of health care professionals. People do not know who has what language skill.
- Parents in Kingston are going to Toronto or Montreal for specialist services.

*Suggestions for improvement:*

Items noted above for improvement apply to improvement in access to mental health specialists.

### ***5.3.4 Most Significant Issues with Access to Current Services***

- How to access family doctors and services for vulnerable groups.
- Lack of resources affecting home care (CCAC).
- Lack of specialists in mental health.
- Lack of access to francophone health care professionals (especially for matters of patients being able to communicate their problems).

## ***5.4 Priorities for Improvement***

- The French language community would like the creation of more CHCs, with multidisciplinary capability, more

family health teams and which include models for primary care for marginalized/vulnerable patients.

- It was felt that the development and communication to the public of a process for finding a family doctor would be an important development. (E.g. On the Trenton military base, the Chamber of Commerce provides new families with a questionnaire to complete to apply for a family doctor; the process may take up to a year, but it's a process).
- It was suggested that providing incentives for recruiting family doctors/ specialists into certain areas (e.g Kingston has very few resources) would work with universities, medical students and hospitals to help students select where they will do their residency.
- The French language community would appreciate designation of some bilingual positions in the local health care system.
- Nurse practitioners were viewed as good option for the provision of primary health care.
- The “shared care” model, where psychiatrists interact with the patient’s family doctor who will be prime on the patient’s follow-up and file would be a welcome model of care.

#### *5.4.1 Suggestions to Link Health System Parts Together*

- Ministries of health and community social services need to communicate better at their level before they can integrate their services to clients - they cite too many rules which pose barriers to integration.
- Need “one-stop shopping”, a central point of access that will have a sound knowledge of all services available, who does what, and acts as a reference center (instead of having patients bounce from one provider to another, let the patient’s file move around).

#### *5.4.2 Major Changes Desired*

- Promote the role of nurse practitioners as a point of entry for regular health care services.
- Review the role of the family doctor. Previous role of being the coordinator for all services is no longer possible due to volume of cases.
- Public Health and prevention should be an access point to the health care system. This could reduce visits to family

doctors and avoid duplication of services. The processes and structures should be made known to the public.

- Identify and make visible services available in French.
- Promote the specialty of psychiatry and child psychiatry and provide these doctors with support (e.g. need a team of doctors to be able to cope with the demands of the job.)

## 6.0 *County Specific Issues*

Although common themes were identified throughout all areas of the LHIN, consultation revealed issues specific to geographic area and stakeholder groups. The following section briefly details the county specific issues that were identified in the engagement and consultation process.

It should be noted that the inclusion of an issue in this section does not necessarily imply that there was consensus on that issue within the region. In most cases, however, these issues were identified multiple times in each county, and can be considered to be themes.

### 6.1 *Northumberland*

#### 6.1.1 *Perceived Strengths*

- Through strong community support and advocacy, Brighton has been able to establish a new community health centre (not a formal CHC, but a collection of health care agencies collocated near each other), a YMCA and a Family Health Team. These organizations provide access to health and wellness services that have previously been unavailable in this area.
- A large number of private health and wellness and alternative care providers are located here, and have been supported by the community. This demonstrates the community's preference for a wellness, rather than a purely health care treatment, approach to health care.
- Community support services are described as extremely well organized and coordinated. These services are well received by the senior population.

#### 6.1.2 *Perceived Issues and Gaps*

- This county is part of two LHINs. Some providers in this county will serve the residents of two LHINs. Many are concerned about the implications of this, and how cross-boundary issues will be handled.
- Caregiver burnout is a particular concern in this community. Care demands are described as high, both for unpaid caregivers, women and for workers within the system (particularly those working in Long Term Care), which is felt to be a result of inadequate funding and support.

- Increased support for seniors in the community is wanted. This would include the availability of increased homecare supports, but also supportive housing options aimed at keeping seniors out of long term care.
- There is a desire for increased funding to be put into nursing homes. Some staff feel disempowered to provide adequate and appropriate care to this vulnerable population of people.

### *6.1.3 Opportunities for Improvement*

- This community might be receptive to a paradigm shift in the system; from a reactive, health services model of care to a proactive, wellness approach to health.
- The expectations of the health care system of the Baby Boom Generation are very different than prior generations. Boomers may be willing/able to pay for services.
- This community may be receptive to a re-examination of what services are considered “essential” and necessary for supporting the health of the population.
- Early intervention approaches and educational programs targeted at women and caregivers may be well received. These programs teach healthy lifestyle skills, and provide support aimed at decreasing caregiver stress and burden.
- The area would like local clinics and/or traveling specialists to increase access to specialized care, such as dialysis, psychiatry, psycho-geriatrics, dementia care, neurology and cardiology.
- A mechanism for a single point of entry into the system could be considered. Case management or systems navigator assistance, particularly to vulnerable populations might be helpful.

## *6.2 Hastings*

### *6.2.1 Perceived Strengths*

- Satellite services and clinics are located in some communities. This has allowed local access to high intensity treatment such as dialysis and chemotherapy treatment, and has reduced the need for some individuals to travel and arrange transportation.
- Community service provider participation in inter-agency meetings is reported to be well adopted as a mechanism

for communication, joint planning and problem solving within the county.

- Bancroft has a small hospital (part of Quinte Health Care Corporation) which provides local access to numerous emergency, primary and secondary hospital services.
- Several Family Health Teams are being developed across the county. There is strong public support for this model.
- Bancroft has supported the development of a hospice house in the community.
- The Community Health Centre in Tweed is extremely active, and thought to be an asset to the health of the community.
- There is good participation in the Rural Health Sciences Network in this county.<sup>1</sup>
- Providers state that they have a good relationship with Quinte Health Care.
- Efforts are being made for early and improved diabetes and arthritis management. There is a foot care clinic now available for people aged 55+.
- There is an Early Years program available in the region. It appears to be well utilized in providing support to new moms, babies and children.

### *6.2.2 Perceived Issues and Gaps*

- The ability to access mental health services is reported to be particularly problematic in this community. Access to crisis care is perceived to be difficult despite telephone access; there is a reported 2 to 3 month wait for acute mental health services. There is a perception that it is almost impossible to get a patient admitted for inpatient psychiatry, and that community support and treatment are essentially non-existent.
- Capacity for local dialysis services is thought to be poor. Dialysis can only be accessed in Trenton and Belleville,

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<sup>1</sup> The Rural Health Sciences Network for the SE LHIN West is a voluntary organization established in May 2001 by the Access Centre for Hastings and Prince Edward Counties, the Hasting and Prince Edward Counties Health Unit and Quinte Healthcare Corporation. It has a broad based membership from health organizations, institutions, other networks, private sector service providers and consumer organizations. Its purpose is to promote and provide the highest quality health care to the people of Hastings and Prince Edward Counties.

but if these sites do not have available spots or are not able to accommodate complex cases, travel to Kingston is the alternative.

- No local access to specialized cardiac rehabilitation services was described for this area. Patients who have had cardiac surgery have no access to specialized care or follow up within their home town or village.
- Inadequate access to appropriate pain management services, particularly for patients on disability and in palliative care, was described.
- Specialized services for adults and children with disabilities are described as not being available in rural areas.
- Concern was expressed for the youth of the county. Recreation and social programs are limited, and there is concern about rates of teen pregnancy, and alcohol and drug use.
- Personal Support Workers in the community identify themselves as a poorly utilized resource. They feel they have more to contribute to the planning and organization of patient and caregiver care.
- People feel that there are inadequate respite services and options in most of the communities of this county.

### *6.2.3 Opportunities for Improvement*

- Strengthening and coordination chronic disease management efforts, particularly for diabetes, obesity, cardiovascular disease might be welcomed.
- Mechanisms to help both the public and providers navigate the health care system more effectively could be helpful.
- People favour an avoidance or elimination of competition in favour of cooperation.
- An examination of pay equity issues across workers in the health care sectors may result in identification of opportunities for redistribution of the workforce.
- Users of services would welcome enhanced availability of mobile service (lab, diagnostics, specialists clinics like urology, geriatrics and paediatrics).
- Enhanced home care services, to accommodate higher acuity patients that are discharged from hospitals and living in the community, would be welcome.

- Team based primary care practices, recognizing the need for adequate space and equipment in rural locations would be appreciated.
- Expanding nurse practitioner roles to mirror those used in remote northern communities could be a way to expand access to primary health care.
- Telemedicine could be investigated
- After-hours care, and seasonal urgent care to address capacity issues are possible needs. Services such as prescription refills and follow-up for orphaned patients could be explored.
- There is some thought that Ministries of Government could become more integrated (collaboration between Ministries for health, housing, education, employment, child, youth and family services, etc. ). In order to improve the health of the population, it is felt that the Government must do better at acknowledging the social determinants of health model.

### ***6.3 Prince Edward***

#### ***6.3.1 Perceived Strengths***

- Prince Edward County distinguishes itself from other areas in the LHIN in terms of feeling no shortage of family physicians. Picton, for example, has more than 20 family doctors working in their family health team.
- The county feels that the local hospital (part of Quinte Health Care) is an asset and that the services at the hospital have been instrumental in attracting physicians to the community.
- The dialysis unit at the hospital is a welcome part of the local health care system.
- The community is very proud of the large numbers of volunteers associated with many of the community services and with the hospital as well.
- Community care for the elderly, day hospice services, and Alzheimer's Society are all highly spoken of organizations in the community and are reliant on volunteers.
- The collaboration among the community agencies is reported to be excellent.
- The community is proud of the local FHT and the availability of Nurse Practitioners was a welcome addition.

The FHT will be locating in the hospital and Quinte Health Care has been supportive of this development.

- There are plans to have CCAC case managers co-locating with FHT in the hospital to facilitate access to home care.
- The hospital emergency department is valued by the local population although many would like to see a major upgrade in the physical features of the department.

### *6.3.2 Perceived Gaps and Issues*

- There is concern that the hospital may be eliminated and the community feels there have been no assurances from Quinte Health that the hospital and its services will remain. There are several examples of recently reduced services that have displeased the local community (physiotherapy, laboratory, Complex Continuing Care). It was discussed that it will be problematic if the traveling mammography clinic is ended or if there is closure of the special care unit. The centralized booking system implemented by Quinte Health was described as not allowing local hospital services to be well utilized, bureaucratic, difficult to get through, and resulting in greater travel for patients.
- Reduction in hospital laboratory outpatient services has shifted reliance to a private laboratory with fewer hours of operation. There is no public transportation and reliance on volunteers is limited for travel to clinics at Belleville and the cancer clinic in Kingston.
- There are no local physiotherapy outpatient services. Residents travel to Belleville where services are reported as being very limited.
- There is a perception of a lack of outpatient clinical nutrition, occupational therapy, social work, audiology and preventative / maintenance services in general. There is a desire to balance health services between acute/chronic/prevention and health maintenance.
- A limited availability of home care services, particularly personal support services, is felt to exist. The travel schedule of the home care workers is seen to use a great deal of their time.
- There is a desire for the FHT and the hospital work closely together in terms of clinic offerings, overhead and sharing the services of health professionals.

- There is a desire for more availability of specialists: Dermatology, Rheumatology, Urology, Psychiatry.
- Mental health services were generally seen as having poor availability.
- Generally, the county is felt to have a lack of supportive housing / hospice type care of any kind (mental health, vulnerable populations, elderly, developmentally handicapped, neurological disorders, stroke victims). The local adult day program run by VON was lauded as being ‘great’, but needing to increase in size.
- There is a desire to update the local hospital capital infrastructure.

### *6.3.3 Opportunities for Improvement*

- Mechanisms to increase awareness and sharing of resources that exist within the community would be welcome.
- If the resources of the hospital are under-utilized there could be investigation about how to share hospital resources among all providers so that services can be maintained (e.g. sharing of allied health professionals between hospital, FHT and community providers; sharing of capital).
- It was suggested that a focus on drug monitoring and interactions within the aged population could help all provider agencies.
- A single intake mechanism for local services could facilitate knowledge of what is available and local access.

## *6.4 Lennox and Addington*

### *6.4.1 Perceived Strengths*

- Northbrook is proud of its Long Term Care facility. They indicate that it offers high quality care, and would like to see its services expanded.
- A new municipal Long Term Care Facility has been established in Napanee. There is great satisfaction with the new building.
- Construction is beginning on a significant hospital expansion in Napanee.
- The small hospital in Napanee provides a large number of services, including a variety of ambulatory care clinics.

They have also become a new provider for cataract surgery. Surgery and urology services were also noted to be provided. The laboratory service (blood clinic) is also considered to be an excellent resource for the community.

- Telemedicine is being used in this county. For example, the hospital accesses the telestroke program at St. Mary's on the Lake hospital.
- The hospital has established multiple partnerships with other providers. (e.g. the hospitals-in-common lab program, the Rural Health Science Alliance).
- The southern part of the county feels that it benefits from its proximity to Queen's University. They have established linkages and partnerships with the medical and allied health schools at Queen's that are thought to enhance their ability to deliver high quality health care services.
- A representative from the local CCAC is on site at the Napanee hospital to merge hospital discharge planning services with access to CCAC services. Staff agree that this eases the transition to home, and creates efficiencies in the use of hospital and homecare resources.
- Napanee Hospital is using a Nurse Practitioner in its emergency department. This model has been well received.

#### *6.4.2 Perceived Gaps and Issues*

- Residents of this county, particularly those in the northern part of the county, are required to travel to access services for dialysis, lab and diagnostic imaging.
- Hospital physicians indicate that they are overworked trying to cover hours for patient care. They are feeling that Family Health Teams and other models of group practice being put in place actually exaggerate the siloed approach to healthcare. They want community based family physicians to assist with hospital call and care for their patients in hospital.
- A perception of a shortage of respite beds and services, such as day programming availability, was indicated in this county. Palliative care, frail seniors, physical and mentally disabled and the acquired brain injury populations were reported to be in particular need. The funded in-home respite program has a waiting list.

- Municipal government expressed its concern about the pressures it faces in providing funding for health care services funded by municipalities, either historically (e.g., public health, long-term care) or through “downloading” (e.g., ambulance services). They are unsure that they will be able to maintain the tax base required to deal with these costs.
- Non-urgent transfers are reported to be an increasing problem as the population ages.
- Concern was expressed by municipal officials regarding who will be responsible for cross-boundary ambulance transportation.
- Participants in northern areas of the county indicated that they prefer to seek regional care in Renfrew or Ottawa, which is outside of this LHIN. They expressed concern regarding their continued desire and ability to access care across LHIN boundaries.
- Physicians in Northbrook, both in family practice and the medical advisor for the nursing home, are approaching or beyond retirement age.
- Residents between 18 and 55 years old see themselves as being under-serviced. There are specialty programs targeted at seniors and children, but these people, who face challenges of unemployment, drug and alcohol problems, excessive stress, etc., feel they fall between the cracks.

#### *6.4.3 Opportunities for Improvement*

- Continued expanded use of nurse practitioners and interdisciplinary teams as a solution to doctor shortage and difficulty with access to primary care is a desired approach.
- It was suggested the LHIN consider implementing a hospitalist model in Napanee, in order to assist with patient throughput. It was recognized that this model may not be as preferred for continuity of care.
- Suggestions to locate additional and necessary health care services, such as a dialysis, lab, respite and a physiotherapy clinic, at Northbrook’s Long Term Care Facility were made.
- The communities expressed a willingness to use foreign trained doctors with provisional licenses. It was felt that the LHIN must provide assistance in attracting health human resources to the area.

- A demand for systems navigation options was prevalent. The system is seen to be difficult to manage. Complexity was seen as heightened for small communities that are served by multiple providers in multiple settings. It was suggested that specialized roles for this, rather than expecting all providers to provide case management services was a preferred model.
- Chronic disease management is wanted for arthritis, diabetes, renal failure, obesity and chronic pain.
- Health service models where primary, preventative care and screening can be accessed without a referral from a family doctor are desired (For example, breast screening and blood sugar testing, or a no-family doctor clinic).
- More sharing of resources, including infrastructure, equipment, policies and procedures, etc., between regional and local providers could create efficiencies and result in beneficial standardization. An example cited was the creation of a shared, regional formulary.
- Early intervention programs within schools and targeted at parents and families, could prevent downstream problems.
- Efforts to eliminate paperwork and administrative requirements for providers would be well received, and may allow more time for direct patient care.
- The LHIN was requested to support the social determinants of health model by assuring that basic social and personal needs are provided for all residents.
- The LHIN was advised to continue to pursue the use of evidence based approaches. Evidence of best practice, should be used in resource allocation decision making.
- Participants indicated that a two-tiered health system exists in Ontario. They supported the idea of private sector involvement, for both support services and management of health care services, to gain efficiencies while still maintaining the ideals of the Canada Health Act.

## **6.5 Frontenac**

### **6.5.1 Perceived Strengths**

- Nurse practitioners are being used in several settings within the county.

- Residents feel that the family health team in Sharbot Lake offer excellent services and create much improved continuity and access to care.
- Organizations in the County report that they are working well together.
- The family physicians in Sharbot Lake (an emerging Family Health Team) have a long history of monthly meetings with community-based agencies involved in service development.
- A Mental Health Team has been meeting weekly in Sharbot Lake to discuss mutual problems, prioritize and consult on referrals and learn psychiatric skills so that fewer referrals are needed. Psychiatrists are seen to be meeting the needs of the teams' practice population, rather than serving just those who get referred to them. Mental Health counselling is also available in the office or in homes through Northern Frontenac Community Services.
- Residents have options for local hospital care in Perth, Smiths Falls, Napanee and Kingston. GPs feel that residents enjoy better and faster specialty service in orthopedics, general internal medicine, urology, gynaecology and general surgery in Perth than Kingston.
- A high quality of care received at Hotel Dieu Hospital, St. Mary's on the Lake and through CCACs was seen to exist.

#### *6.5.2 Perceived Gaps and Issues*

- It is felt that there is poor access to long term care beds, particularly in northern part of county.
- Many healthcare staff working in the rural areas of the county are reported to be at or beyond retirement age. This is creating a concern over the quality of care they are providing, the quality of their work life, and the availability of providers in the future.
- The cottage area creates seasonal demand on the health care system.
- Residents with 'no fixed address' are not able to get a health card and access publicly funded health care services. These residents report going without care, and costing the system a considerable amount of money in health and social support.
- Rural residents feel that providers from urban areas do not understand how things work in the county. For example, many people in northern areas of the county still have

party phone lines and no internet access. Provisions to increase the recruitment and training of rural residents as providers of care in these areas are desired.

- Many reported problems with non-urgent transfers.
- Waits for consultant services are seen to be problematic: Gastroenterology, Neurology, Rehabilitation services in Perth.
- A high morbidity pattern associated with poverty in this county was reported.
- Many low-income seniors reported being unable to afford to purchase services not funded by government. For example, there are reports of 50 long term care like patients in private homes without subsidy because the County Home for the Aged is an hour away in Glenburnie.
- Municipal government expressed its concern about the pressures it faces in providing funding for health care services funded by municipalities, either historically (e.g., public health, long-term care) or through “downloading” (e.g., ambulance services). They are unsure that they will be able to maintain the tax base required to deal with these costs.
- People reported problems with access to mental health services.
- Northern Frontenac Community Services’ unit costs are high reportedly because of low client density and large catchment area. They reportedly run many programs on a cost recovery basis; clients may forego these services in order to afford shelter or food. Because only direct contact hours are funded under the Client Intervention and Assistance Program, the extent to which the agency can get involved in crisis intervention is reported to be limited.
- Advocacy to reduce elder abuse and ensure that they have resources for daily living is desired to parallel resources available to the developmentally handicapped.
- There are concerns about losing the laboratory services in the small hospitals.
- Internal markets or competitive bidding on community care, orthopaedic procedures, and lab services is felt to contribute to disintegration of the system and add unnecessary costs to the health system. Concern was expressed about what is perceived to be an increased role of the private sector in the health system.

- The shift from one home care agency (VON) based in the Sharbot Lake Clinic to 3 agencies based outside the community is reported to have disrupted communication and continuity of care. Nurses coming from Sydenham and Kingston are not seen to always meet urgent requests, with a reported use of unnecessary hospital visits. Finding nurses who will travel to Sharbot Lake for regular services can create staffing problems.
- A lack of residential settings for younger people with physical disabilities was described. These people may be inappropriately placed in nursing homes or retirement facilities. A system of attendant care is desired.

### *6.5.3 Opportunities for Improvement*

- Mechanisms to support seasonal demand for health services are wanted.
- Outreach clinics in small communities that provide routine care and eliminate the need for travel is wanted.
- Alternate levels of support and housing that delay the need for long term care placement could be provided. Building small, residential homes in outlying communities may be effective. Also, providing homemaking assistance may help people stay in their homes.
- More integration of services for seniors is needed amongst long term care, community care access centres and private homes, many of which support complex care patients is wanted. More rationalization of who is in a residential home and who is in a nursing home is a potential improvement.
- CCACs are thought to be able to play a bigger role as repositories of information about service availability and as system navigators.
- Team-based primary care and walk-in clinics in the community would be a welcome development.
- A community health centre could be a base for access to multi-disciplinary services and serve as a clearing house for information about various support groups. It could have a resource library with high-speed Internet access (only dial-up access exists at present).
- Using the Internet to create accessible databases of available services by community is seen as being a useful knowledge brokering tool.

- The ideal system is seen as having information from every provider shared electronically.
- The LHIN must understand the challenges of rural life. Delivery of every service that Northern Frontenac Community Services offers is felt to be affected by their ability to arrange transportation.
- A budget for a low income subsidy could allow flexibility to better align resources with needs. For example, subsidized home maintenance and in-home respite might enable more seniors to stay in their homes as long as possible.
- Enhanced access to primary care is a common demand in this area. Situating health professionals (nursing, dietetics, dental) in the school system might help overcome the challenges associated with geography.
- A mechanism to fund pilot projects to evaluate models for health delivery in rural settings may be helpful.

## *6.6 City of Kingston*

### *6.6.1 Perceived Strengths*

- The MOHLTC has provided support for some primary care initiatives.
- Regional Paediatric services offered through Hotel Dieu Hospital are perceived to be a strength.
- The three hospitals in the Kinston region report working to streamline services and eliminate duplication. The respective roles have been clarified, and administrative redundancy is reported as being reduced.
- There is cooperation and collaboration between long term care facilities in the region.
- Diabetes education and breast screening programs are run out of the Kingston Hospitals.
- A Regional stroke strategy has been implemented.
- Use of Nurse Practitioners in long term care is seen as effective.
- The Community Health Centre model is seen to have been effective in improving the health of the population in North Kingston.
- Mental Health and Addictions services are present. For example, there are ACCT and high intensity teams in the

community, programs for dual diagnosis and geriatric mental health.

- Hospitals have trialed the use of advanced practice physiotherapists as a substitute for orthopedic surgeons in pre-operative assessment for orthopedics. This approach is reported to have improved patient throughput.
- The direct funding program (where clients receive funding to hire and manage their own help) has been adopted in this county.

#### *6.6.2 Perceived Gaps and Issues*

- Hospitals in Kingston have a significant problem with ALC days.
- There appears to be a disconnection between perceptions of service availability, coverage and access within Kingston and outside of Kingston. Providers in Kingston perceive that services are more available than do outside providers.
- Concerns were expressed about the ability to continue to train family doctors from this LHIN in communities outside of the LHIN boundaries. A need to continue to be able to do this was expressed.
- Specialists express that, because of the lack of family doctors, they are required to provide primary care and follow up care as part of their service. They feel that this is an inappropriate use of specialist time.
- Psychiatrist services are not well rationalized within the system. Psychiatrists are available, but they do not see patients in hospital or emergency, creating issues with access to crisis and acute care.
- A problem in communication between hospitals, family doctors and providers in the community was identified.
- There is a reported need for a comprehensive system to deal with chronic and complex pain issues.
- Concerns were expressed about a decreased quality of care of patients being treated in hospital. Care of the elderly from nursing homes while in hospital was reported as a particular concern.
- There is no common approach to electronic health records or use of PACS within the region.
- There is a perception that, although specialist clinics have been arranged for outlying areas, these clinics are

sometimes cancelled. This has created problems for patients outside of Kingston, and places an additional demand on resources in the long term.

- There is high demand for diabetes care, GI function testing and colon screening that existing programs are seen as not being able to meet.
- Ministry funding for diabetic pumps has been positive; however, services that were reported to be needed to support this program have not received similar funding, thus meeting demand for service is felt to be challenging.
- There is a demand for more chronic home care.
- Dementia care services are felt to have coordination needs.
- There is a perceived need for improved forensics services within the mental health umbrella, in light of the high number of prisons within this county.
- Needs of patients in long term care are seen to be changing, but funding models may not reflect this change. For example, it is felt that patients are higher acuity than in past, require more emergency admissions, greater numbers of young patients with physical disabilities are present, and more dementia and acquired brain injury patient are present.
- New non-smoking regulations are seen as being problematic for long term care homes that will not be building isolated smoking rooms.
- Municipalities are concerned about the effects of LHINs on the local economy. Specifically, they are concerned about job losses and downloading of health related services to municipal budgets.

### *6.6.3 Opportunities for Improvement*

- Providers are willing to discuss processes to improve physician cross-coverage issues. A willingness to consider a regional on-call approach is evident.
- Inter-LHIN benchmarking of health services is seen as an important development.
- If the LHIN decides that not all services can provided within the LHIN, there should be the ability to contract out services to other LHINs.
- Support and guidance to facilitate improved medical transportation within the region is felt to be an important

development. Transportation issues are felt to need systemic solutions.

- Although fee-for -service physicians do not fall under the jurisdiction of the LHIN, it is felt the LHIN should establish processes for communication with them in order to continually improve the health care system.
- Chronic disease prevention and management strategies to manage obesity and diabetes would be welcome as a priority.
- Centralized waitlist management strategies could improve access, and create increased equity, for specialist services.
- Opportunities to offer primary care outside of traditional practice models would be welcome. For example, develop “no family doctor” clinics in community.
- The creation of an umbrella of coordinated services for seniors in the region would be useful.
- A LHIN communication plan that includes municipalities, providers, the public and hard to reach groups, such as homeless and nursing home populations would be useful as developments begin.
- A social harm reduction strategy that includes the provision of shooting rooms and needle exchange for addicts has been suggested.
- Community supports specific to those with chronic mental health and psychiatric problems, particularly in anticipation of closure of inpatient psych beds are seen as an important part of the local system.
- An ideal system is felt to include processes and structures for coordinated intake and discharges between different parts of the system.

## **6.7 Lanark**

### **6.7.1 Perceived Strengths**

- The CCAC placement system has been seen to be very effective in helping make effective and timely placements into long term care facilities.
- Portland has a community health centre that is viewed as effective in improving the health status of its local population.

- Merrickville provides primary health care outreach to surrounding communities. This is felt to have created access to services that were previously not available.

### *6.7.2 Perceived Gaps and Issues*

- Poverty, low income and socioeconomic status are seen as a barrier to accessing care in this county.
- Residents of this county travel to access many specialty services.
- Residents in this county also receive services in the Champlain LHIN. Providers in this county also serve residents in the Champlain LHIN. There are concerns about being a cross-boundary area and its implications on access to services were voiced.
- The Perth community uses the “Hospitals-In-Common Lab Partnership” and is concerned about inadequate funding and loss of service.
- Access to mental health and addictions services were identified as poor in this county.

### *6.7.3 Opportunities for Improvement*

- Doctors’ incentive systems are felt to be possible. Provision of salaried funding across primary health care delivery models to eliminate competition for general practitioners would be beneficial to this county.
- Simplifying the process for allowing foreign trained physicians to practice in Ontario was suggested as one solution to the doctor shortage.
- Changing the catchment boundaries associated with the Community Health Centre in Portland, to better align primary care access with natural and established geographic pathways could be considered.
- Mandated coordination of services across providers could improve how effective chronic disease management is provided.
- An expansion of the scope of homecare services that are provided might allow people to stay safely at home for longer periods of time. For example, providing homemaking, including meal preparation and light housekeeping, both for chronic homecare patients and for post-operative/subacute patients was seen to be a possible beneficial development.

## **6.8 Leeds and Grenville**

### **6.8.1 Perceived Strengths**

- Processes to reduce waits for MRIs have been implemented.
- Referrals to local specialists are reported to be managed effectively. Where no local specialists exist, such as in Brockville, referrals are felt to be more of a challenge.
- The regional stroke program has provided access to primary PCI treatment.
- A group of privately owned Long Term Care facilities have purchased and share an access bus as a solution to transportation challenges for their residents.
- Community support service workers are collaborating to improve standardization of processes and services across the county.
- Community based providers offer mobile and in-house services, such as dental care, for residents of Long Term Care facilities in Gananoque.

### **6.8.2 Perceived Gaps and Issues**

- Many residents of this county prefer to seek regional services in the Ottawa area, outside of the Southeast LHIN, and are concerned that the establishment of LHINs may curtail this activity.
- Concerns about the closure of public laboratory services were expressed.
- The hospital in Brockville describes limited surgical throughput of patients as a result of operating room capacity.
- Limited or no access to local, short term psycho-geriatric care is described as happening.
- A shortage of available and affordable respite care, both in home and inpatient settings is reported.
- Funded rehabilitation services were described as being available only through inpatient services at the Brockville hospital.
- There are different standards and qualifications required for EMS personnel in Ottawa and Kingston, both of which serve this county. Cross-boundary issues such as this may need to be resolved.

- Although diagnostic services are available, people want faster access.
- There are different planning regions for lab services within the county. Again, this may need to be resolved between LHINs.

### *6.8.3 Opportunities for Improvement*

- There is support for expanded use of nurse practitioners in various settings.
- A regional health human resource plan possibly coordinated with other LHINs for cross-boundary locations like Leeds and Grenville county could be a difficult but important development.
- Formal networks for comprehensive chronic disease prevention and management such as for diabetes, congestive heart failure and obesity are pressing demands.
- Determination of which services will be delivered at local hospitals, and which will be available only at tertiary hospitals to avoid duplication and inappropriate utilization is something the LHIN is urged to do.
- Alternatives to fee for service models for physicians as well as incentive models could be considered.

*Appendix 1:*  
*Meeting Types and Participants by Community*

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Community and Meeting Type	Attendance (Provider)	Attendance (Non-Provider)
<b>Amherstview</b>		
LTC - combined Admin. and Frontline staff	7	0
Public meeting	1	5
<b>Bancroft</b>		
All Staff and Physicians	2	0
Combined LTC & Comm. - Front-line staff	3	0
Family Health Team	1	3
Public meeting	3	6
<b>Belleville</b>		
Hospital Board Chair & CEO	4	1
All Physicians	5	0
All Staff	45	0
Mental Health & Addictions - Admin. staff	4	1
Mental Health & Addictions - Front-line staff	2	0
LTC - Combined Admin. and Front-line staff	4	1
Community services meeting - Admin. staff	6	1
Community services meeting - Front-line staff	6	0
Public meeting	1	11
<b>Brighton</b>		
LTC and Comm Services - combined Admin. and Front-line staff	7	1
Family Health Team	1	0
Public meeting	0	8
<b>Brockville</b>		
Mental Health & Addictions - Combined Admin. and Staff	6	0
Hospital Board Chair & CEO	1	1
Hospital Managers and Directors meeting	11	0
Hospital Front-line staff	12	0
Community services meeting - Combined Admin. and Staff	7	0
LTC - Combined Administrators and Front-Line staff	8	0
Municipal Meeting	2	6
Physician Meeting	16	2
Public meeting	16	16
<b>Denbigh</b>		
Public meeting	1	1
<b>Gananoque</b>		
LTC and Comm Services - Combined Admin. and Front-line staff	6	0
Public meeting	1	9
<b>County of Frontenac (Glenburnie)</b>		
Municipal Meeting	3	9
<b>Kingston</b>		
Municipal Meeting	0	3
Mental Health & Addictions - Admin. Staff	13	0
Mental Health & Addictions, LTC - Front-line staff	17	0
Community service - Admin. staff	17	0

<b>Community and Meeting Type</b>	<b>Attendance (Provider)</b>	<b>Attendance (Non-Provider)</b>
Community service - Front-line staff meeting	9	0
Front Line Meetings	63	1
Admin. and Director Meetings	35	2
Program Administrative Leads and Managers	9	0
Patients Council	11	0
Board Members & Senior Staff	15	4
Physicians	27	0
LTC - Admin. meeting	4	0
LTC - Front-line staff meeting	40	0
Family Health Teams	2	0
Francophone Meeting	8	0
Public meeting (Central)	3	12
Public meeting (West)	8	10
Public meeting (East)	2	9
<b>Madoc</b>		
Municipal Meeting	0	13
Community service - Combined Admin. and Staff	6	1
Family Health Team	2	2
Public meeting	1	1
<b>Napanee</b>		
Hospital Managers and Directors meeting	3	1
Hospital Front-line staff meeting	9	1
Physician Meeting	5	0
Combined LTC, Comm Services & MH - Admin. staff	4	0
Combined LTC, Comm Services & MH - Front-line staff	7	0
Municipal	0	5
Public meeting	9	10
<b>Northbrook</b>		
LTC and Comm. Service - Combined Admin. and Front-line staff	2	5
Public meeting	6	3
<b>Perth</b>		
Physician Meeting	7	0
CEO/ Board of Directors	1	1
Managers/Dept. Heads	10	0
Hosp - front-line staff session	14	0
CAO/Municipal	1	6
LTC - Combined Admin. and Front-line staff	9	0
Comm Serv. - Combined Admin. and Front-line staff	3	5
Public meeting	7	9
<b>Picton</b>		
Combined LTC and Comm. Service - Admin. staff	6	0
Combined LTC and Comm. Service - Front-line staff	6	0
Family Health Teams	5	0
All Staff and Physicians	4	0

<b>Community and Meeting Type</b>	<b>Attendance (Provider)</b>	<b>Attendance (Non-Provider)</b>
Municipal	1	7
Public meeting	3	16
<b>Plevna</b>		
Public meeting	1	5
<b>Portland</b>		
Community Service	4	0
Public meeting	1	5
<b>Prescott</b>		
Combined LTC, CC and MH - Admin. and Front-line staff	5	0
Public meeting	4	6
<b>Selby</b>		
Combined LTC and Comm. - Admin. Staff	4	0
<b>Sharbot Lake</b>		
Family Health Team	3	0
Community service - combined Admin and Staff	4	0
Public meeting	3	19
<b>Smiths Falls</b>		
Combined Administrators LTC & Comm Services	10	0
LTC & Comm. Care - Front-line staff	8	0
Public Session	1	4
<b>Sydenham</b>		
Community service - Combined Admin. and Staff	6	0
Ontario Health Coalition	2	0
Public meeting	10	15
<b>Trenton</b>		
LTC & CC - Front-line staff session	5	0
Combined Administrators LTC & ED VON	8	0
All Staff and Physicians	6	0
Public Meeting	2	2
<b>Tweed</b>		
Community Health	17	1
	<b>710</b>	<b>266</b>

*Appendix 2:*  

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*Inventory of Written Submissions from the  
General Public*

Letter #	General Public	Community	Themes
1	X	Amherstview	<ul style="list-style-type: none"> <li>♦ Population in Loyalist Township has increased but they still have only eight (8) doctors.</li> <li>♦ Since signing on with LHIN, their doctor is only available to registered patients 21 hrs./week making it difficult to obtain timely medical appointments, so they have to go to the after-hours medical clinic.</li> <li>♦ "LHIN is just empty words in Amherstview"</li> <li>♦ Lab blood work results used to take a day or two, but now take up to a week.</li> <li>♦ When test results are needed as soon as possible, they travel to Kingston HDH.</li> </ul>
2	X	Godfrey	<ul style="list-style-type: none"> <li>♦ Shortage of GP's</li> <li>♦ Queen's University does not provide health services for its faculty or staff, only students – needs to be addressed.</li> </ul>
3	X	Belleville	<ul style="list-style-type: none"> <li>♦ Mentally ill are not followed up with support services once they are released from hospital, often leading to violence in the home.</li> <li>♦ More nursing homes need to be built – long waiting lists</li> </ul>
4	X	Belleville	<ul style="list-style-type: none"> <li>♦ More time should be spent on keeping people healthy prior to becoming ill.</li> <li>♦ Need for a diagnostic centre.</li> <li>♦ High cost of prescription drugs escalating – resort to utilizing more natural materials.</li> <li>♦ Have a library system available to all practitioners with all the newest literature so they can be aware of the latest developments, techniques and equipment, reducing the number of operations being incurred.</li> <li>♦ Would it not be cheaper to train someone to be skilled in a special surgery rather than a full-fledged doctor then a specialized surgeon.</li> </ul>
5	X	Lyn	<ul style="list-style-type: none"> <li>♦ Long wait for care</li> <li>♦ Nothing being done about "problem" staff and afraid to say anything in case their loved one suffers for it.</li> </ul>
6	X	Brockville	<ul style="list-style-type: none"> <li>♦ Stop privatizing.</li> <li>♦ Stop doing P3 hospitals.</li> <li>♦ Population aging.</li> <li>♦ Doctor population aging.</li> <li>♦ Difficulty in accessing psychiatric services.</li> <li>♦ Loss of outpatient lab services at BGH.</li> <li>♦ Importance of rehabilitation services.</li> <li>♦ LHIN is another layer between the Minister and us.</li> </ul>
7	X	Unknown	<ul style="list-style-type: none"> <li>♦ Patient should be given copy of billing that goes to OHIP.</li> <li>♦ No accountability in the system.</li> <li>♦ Central booking system needs to be shut down.</li> <li>♦ Doctors should be charged for the use of hospital services and operating rooms.</li> <li>♦ Hospital food has deteriorated.</li> </ul>
8	X	Brockville	<ul style="list-style-type: none"> <li>♦ Shortage of doctors.</li> <li>♦ Health card should be easier to obtain and without an expiry date.</li> </ul>
9	X	Brockville	<ul style="list-style-type: none"> <li>♦ Permanent health card brought back – that doesn't expire.</li> </ul>
10	X	Perth	<ul style="list-style-type: none"> <li>♦ Documentation re. closure of HICI outpatient labs in spite of signed (3,000) petition.</li> </ul>

Letter #	General Public	Community	Themes
11	X	Belleville	<ul style="list-style-type: none"> <li>◆ Environmental aggravators given too easy a time, contributing to higher cancer rate in area, putting strain on cancer treatment facilities.</li> <li>◆ Chronic illness such as cancer on the rise.</li> <li>◆ Environmental Health Clinic essential resource but funding no longer designated.</li> <li>◆ OHIP does not cover treatment for above issues.</li> </ul>
12	X	Kingston	<ul style="list-style-type: none"> <li>◆ Walk-in clinics don't provide follow-up and are limited in what they can do.</li> <li>◆ Shortage of physicians critical.</li> </ul>
13	X	Kingston	<ul style="list-style-type: none"> <li>◆ Need to include alternative health care approaches within publicly-funded health care system.</li> </ul>
14	X	Brighton	<ul style="list-style-type: none"> <li>◆ Has had positive experience with local health care.</li> <li>◆ Nurses follow up on blood tests, didn't have to wait long for bone density test, good follow-up after test.</li> </ul>
15	X	Picton	<ul style="list-style-type: none"> <li>◆ Detailed account, outlining their experience with health care following a stroke - physio.</li> </ul>
16	X	Unknown	<ul style="list-style-type: none"> <li>◆ More focus on prevention and education of children &amp; youth</li> </ul>
17	X	Belleville	<ul style="list-style-type: none"> <li>◆ Detailed account, including various letters and photos, of spouse's experience with healthcare services following a brain hemorrhage.</li> </ul>
18	X	Prescott	<ul style="list-style-type: none"> <li>◆ Concerns about patients without family physicians left out of Family Health Teams</li> </ul>
19	X	Kingston	<ul style="list-style-type: none"> <li>◆ The importance of home care now and for the future</li> <li>◆ The lack of coordination of home care services</li> <li>◆ Burden on the family caregiver.</li> </ul>
20	X	Kingston	<ul style="list-style-type: none"> <li>◆ Strengths at PCCC St. Mary's on the Lake: Wheelchair repair services, dental services</li> <li>◆ Changes needed: Accessible bus; meals; stipend increase; new wheelchair; more trained RNs &amp; RPNs; trust</li> <li>◆ Kingston Whig Standard editorial re: funding for disabled persons.</li> <li>◆ Copies of Correspondence with MOHLTC</li> </ul>
21	X	Kingston	<ul style="list-style-type: none"> <li>◆ Health Care – What's wrong with this picture</li> </ul>
22	X	Perth	<ul style="list-style-type: none"> <li>◆ Concern re: predominance of health care workers at the public meeting</li> <li>◆ Validity of public consultations given attendance</li> <li>◆ LHIN's perceived lack of effort to provide information to the media</li> <li>◆ LHIN boundaries</li> <li>◆ Most pressing health issues: nutrition, health education, and proper distribution of funding so younger generations can be assured of proper healthcare</li> <li>◆ Health education as an essential part of the system</li> <li>◆ Lack of addiction treatment in the community</li> <li>◆ Transportation, the working poor and nutrition as the top 3 issues</li> </ul>

<b>Letter #</b>	<b>General Public</b>	<b>Community</b>	<b>Themes</b>
23	X	Kingston	♦ Concern about drug and alcohol use in children and teens
24	X	Kingston	♦ Recommend allocation of funds for assessment, treatment and counselling of youth who misuse and are addicted to drugs and alcohol

*Appendix 3:*  

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*Inventory of Written Submissions from  
Organizations*

Letter #	Organization	Community	Submission/Themes
1	Hospital	Kingston	<ul style="list-style-type: none"> <li>♦ Written submission in response to discussion guide.</li> </ul>
2	University	Kingston	<ul style="list-style-type: none"> <li>♦ Need for health practitioners with expertise in chronic disease.</li> <li>♦ Need to educate public.</li> </ul>
3	The Health Pursuits Reading and Study Group	Bath	<ul style="list-style-type: none"> <li>♦ Piloted a reading group approach to dealing with chronic illnesses resulting in reduced doctor visits, reduced medications required, reduced need for surgeries and taken on more responsibility for their health.</li> <li>♦ Encloses brochure.</li> </ul>
4	Gateway	Tweed	<ul style="list-style-type: none"> <li>♦ Need for after-hours service.</li> <li>♦ Physiotherapy.</li> <li>♦ Seniors services.</li> </ul>
5	Prince Edward County (2)	Picton	<ul style="list-style-type: none"> <li>♦ Comments following community engagement session</li> </ul>
6	Hospital (radiation therapy dept)	Kingston	<ul style="list-style-type: none"> <li>♦ Access to treatment.</li> <li>♦ Support for smoking cessation.</li> <li>♦ Screening for colorectal cancer.</li> <li>♦ Education regarding screening for breast and prostate cancer.</li> <li>♦ Cancer population needs to be addressed.</li> <li>♦ Shortage of radiation oncology professionals.</li> </ul>
7	Queens University - Dept. of Medicine	Kingston	<ul style="list-style-type: none"> <li>♦ Funding directed toward ensuring the optimal long term management of chronic disease.</li> </ul>
8	Family Health Team	Madoc	<ul style="list-style-type: none"> <li>♦ Health Needs Assessment for Centre Hastings Medical Centre – Summary Report and Full report dated August 2002.</li> </ul>
9	Prevention Awareness for Life	Kingston	<ul style="list-style-type: none"> <li>♦ Youth needs are unmet (substance counselling, mental health and addiction).</li> <li>♦ Waiting lists.</li> <li>♦ Prevention education not funded by government</li> <li>♦ Integrate community support services.</li> </ul>
10	District Health Council	Leeds and Grenville	<ul style="list-style-type: none"> <li>♦ Health Care: Community Action plan for Leeds and Grenville.</li> </ul>
11	The Ontario Rural Council	Guelph	<ul style="list-style-type: none"> <li>♦ A non-profit organization established to serve as a “catalyst for rural dialogue, collaboration and action”.</li> <li>♦ <u>Note</u>: Enclosed proceedings were not attached to paperwork given to Hay Group.</li> <li>♦ Expressing interest in being involved and provided link</li> </ul>
12	Ministry of Community and Social Services	Toronto	<ul style="list-style-type: none"> <li>♦ MCSS is interested in building upon its collaborative relationship with MOHLTC ensuring that relative MCSS service providers are included in LHIN local community engagement process and development of Integrated Health Service Plans.</li> <li>♦ List of community network of specialized care members</li> </ul>

Letter #	Organization	Community	Submission/Themes
13	North Hastings Family Health Team	Bancroft	<ul style="list-style-type: none"> <li>Business and Operational Plan prepared for the Ministry of Health and Long-Term Care – March 2006</li> </ul>
14	North County Community Health Centre	North Lanark County	<ul style="list-style-type: none"> <li>July 2005 Community Health Needs Assessment specific to the catchment area of the North Lanark County CHC.</li> <li>Community Health Needs Assessment Results Presentation to LHCS Board of Directors October 2005</li> </ul>
15	Hospital	Perth & Smiths Falls	<ul style="list-style-type: none"> <li>Summary of Emergency Services, Anaesthetic and Surgical Procedure volumes</li> </ul>
16	Hospital	Brockville	<ul style="list-style-type: none"> <li>CEO responses to consultation questions, as included in meeting notes</li> </ul>
17	SAIL	Gananoque	<ul style="list-style-type: none"> <li>Program brochures regarding programs &amp; services offered by Services to Assist Independent Living</li> </ul>
18	St. Mary's on the Lake – Medical staff	Kingston	<ul style="list-style-type: none"> <li>Responses to consultation questions, as included in meeting notes.</li> </ul>
19	Central Frontenac Community Services Corp	Sydenham	<ul style="list-style-type: none"> <li>2006 Annual Plan and catalogue of programs and services and community profile</li> </ul>
20	Kingston Health Coalition	Sydenham	<ul style="list-style-type: none"> <li>February 1, 2006 Submission (regarding local control) to the Standing Committee on Social Issues Regarding Bill 36</li> <li>Literature references that address the issues of for-profit vs. not-for-profit provision of health care.</li> </ul>
21	Hospital	Kingston	<ul style="list-style-type: none"> <li>Link to Government of Manitoba press release re: Director of Patient Access role.</li> </ul>
22	Hospital	Kingston	<ul style="list-style-type: none"> <li>Stroke Strategy of Southeastern Ontario</li> </ul>
23	Care Connections	Napanee	<ul style="list-style-type: none"> <li>Information about a business being established that links people willing to provide room/board and assistance to senior who are no longer able to live on their own.</li> </ul>
24	Hospital Professionals of Ontario Public Service Employees Union Local 466	Perth and Smith Falls	<ul style="list-style-type: none"> <li>LHIN process has not been transparent or democratic</li> <li>Concern that LHINs are a front for privatization; jobs and services will be lost as they are privatized, patients will no longer have access to services</li> <li>Services may be moved from local communities, putting pressure on patients to travel to access services</li> <li>Please consult the working members of hospital and health care system before imposing change.</li> </ul>
25	Family physicians and community specialist physicians	Brockville	<ul style="list-style-type: none"> <li>Submission in response to discussion questions for stakeholder consultation session</li> </ul>
26	North Frontenac Community Support Services	Frontenac County	<ul style="list-style-type: none"> <li>Submission in response to discussion questions for stakeholder consultation session</li> </ul>

<b>Letter #</b>	<b>Organization</b>	<b>Community</b>	<b>Submission/Themes</b>
27	Rural Visions Centre	Kingston	<ul style="list-style-type: none"> <li>• Documentation of relationship between Rural Visions and the Arthritis Society.</li> </ul>
28	Country Roads Community Health Centre	Rideau Lakes	<ul style="list-style-type: none"> <li>• Brochure</li> <li>• Newsletter</li> <li>• Annual Report, 2004-5</li> <li>• Schedule F, program overview</li> <li>• Strategy map</li> </ul>
29	Health Care Network for SE Ontario	Kingston	<ul style="list-style-type: none"> <li>• Discussion paper on acute and specialized psychiatry resources for the SE Ontario adult mental health system</li> </ul>
30	Memo from Leeds & Grenville Medical Society	Brockville	<ul style="list-style-type: none"> <li>• Notes of meeting with P. Huras</li> </ul>
31	Ontario Community Support Association	Toronto	<ul style="list-style-type: none"> <li>• Key messages regarding LHIN legislation</li> </ul>
32	Radiation Therapy Dept at Queens	Kingston	<ul style="list-style-type: none"> <li>• Correspondence re report to follow</li> </ul>
33	MPP - Dombrowsky		<ul style="list-style-type: none"> <li>• Submission in response to discussion questions for stakeholder consultation session.</li> </ul>