

The North West LHIN
“Share Your Story, Shape Your Care”
Initiative: Themes and Issues



Centre for Rural and Northern Health Research
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Initiative: Themes and Issues

**Prepared for the
North West Local Health
Integration Network**

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THE NORTH WEST LHIN PROJECT

The North West Local Health Integration Network (LHIN) launched its “Share Your Story, Shape Your Care” project in January 2009. This community engagement initiative allowed residents of the North West LHIN and health care professionals to participate in a dialogue about priorities for the regional health care system. Results were used to inform the North West LHIN’s 2nd Integrated Health Services Plan, which was published in November 2009.

The “Share Your Story, Shape Your Care” initiative received over 800 contributions from people across our region; this included “Choicebook Responses” and separate “Story and Ideas Submissions” that were submitted in either online or paper versions. People of all ages took part in the project; about one-quarter were aged 34 and under; one-half between 35 and 54; and the rest 55 and older.

Two-thirds of respondents were members of the general public; the remainder were physicians, nurses, and members of other regulated health professions. Overall, slightly more than one-half of participants worked in the Health Care Sector, about one-tenth in each of the Government, Education or Service sectors; others were employed in Forestry, Mining and Manufacturing. Reflecting Northwestern Ontario’s population distribution, 52% resided in the City of Thunder Bay; an additional 11% lived in Thunder Bay District; 9% in Rainy River District; and the remaining 28% from Kenora District.

Their stories, ideas and suggestions gave the North West LHIN insights into the specific health challenges faced across the region. People also identified their health care priorities, shared their opinions about health strategies that are being implemented or proposed, and offered suggestions about various ways of addressing health challenges.

THE STUDY

This study responds to the North West LHIN's interest in conducting an additional thematic analysis of submissions from the "Share Your Story, Shape Your Care" initiative. Specifically, it was designed to explore major themes and issues raised regarding health needs and the delivery of services across the North West LHIN. The goal was to achieve a fuller understanding of the extent to which the population of the North West LHIN experiences specific health problems and the factors which facilitate or impede their access to appropriate care.

Objectives

The primary goal of this project was to conduct an in-depth analysis of data from the "Share Your Story, Shape Your Care" initiative. Key objectives included: (a) exploration of themes related to the North West LHIN's eleven major service priorities; (b) examination of factors (geographical, economic, social or cultural) contributing to positive and negative experiences; (c) description of service issues experienced by at-risk populations (seniors, Aboriginal peoples, and economically challenged communities); and (d) identification of overall themes and issues that are unique to Northern communities.

Approaches

The report presents an in-depth review of narrative data from the "Share Your Story, Shape Your Care" initiative, encompassing 850 items from the "Choicebook Entries" and "Story and Idea Submissions." All materials were entered into a common database and analysed using Nvivo N8 software. The researchers independently coded the data then consensually validated findings to identify recurring themes and their relationships with one another. Ongoing consultation

with the North West LHIN ensured that the review addressed the most relevant topics.

This Report

For ease of reading, the report has been organized around the eleven issues identified as priorities by the North West LHIN: (1) Emergency Department Wait Times; (2) Primary Care; (3) Specialty Care and Diagnostic Services; (4) Chronic Disease Prevention and Management; (5) Long-Term Care Services; (6) Mental Health and Addictions Services; (7) Aboriginal Health Services; (8) French Language Health Services; (9) Health Human Resources; (10) eHealth; and (11) Integration of Services Along the Continuum of Care.

Each section begins with a brief description of issues, including a summary of the number of respondents citing each service issue and subthemes as areas of specific concern. The report concludes with a summary of the major themes and subthemes found within each section. For further information on the North West LHIN “Share Your Story, Shape Your Care” project, please visit the North West LHIN website at: <http://www.northwestlhin.on.ca>.

(1) EMERGENCY DEPARTMENT WAIT TIMES

- ***200 references***
- ***Key Issues included: Long Wait Times (60),
Need for Enhanced Triage Services (26)***

There was general agreement that long delays in obtaining care through hospital emergency departments across the North West LHIN were largely due to the fact that many of the region's residents lack access to primary health care and are therefore compelled to use emergency departments. Addressing emergency department concerns also requires consideration of triage issues and, for individuals with chronic illness or mental health problems, enhanced care options.

Long Wait Times

Although there was agreement that the triage process in emergency departments worked well for patients with serious problems requiring immediate attention, it was not uncommon for patients with less serious health problems to wait up to "5 or 6 hours" at emergency departments before receiving care; in some hospitals, "wait times could be as long as 8 to 10 hours."

Compounding the problem, the volume of cases meant that emergency room physicians could not spend much time with clients, which was another source of frustration: "Sent to emergency room with a severe migraine by health nurse ... sat for 3 hours ... before seeing a doctor, which lasted [for] a few minutes." Several examples were provided of adverse events which had occurred as a result of long emergency room waits. In one instance, a patient's appendix had ruptured, causing complications:

I went to emergency with abdominal pain ... and waited for several hours ... during this time my appendix ruptured. Because of the prolonged wait in the Emergency Room, my surgery, length of hospital stay and recovery were much more difficult than they needed to be.

People became equally frustrated when emergency room staff referred them back to primary care or walk-in clinics for follow-up care. Often, there was no one at the clinic that could see them, so they were forced to go back to the hospital for care. Relating her frustration about having to use the emergency room for her son who had an ear infection, a mother said:

The doctor is so overbooked ... they tell you to go to emergency because some things can't wait a month or two. Yet you feel that it is not an emergency; however, you can't wait so you go to the hospital and they get mad for wasting emergency room time for ear infections ... I took my son to the emergency room and the doctor there said 'follow up with family doctor in 3 days.' [I] can't get in [to see my doctor] for a month!

Need for Enhanced Triage Services

Having better triage in emergency departments was seen as a measure which could reduce physicians' workload and expedite access to care. It was suggested that "the triage process itself should be re-examined ... to ensure more timely care." As a health provider pointed out, "given the evidence that other professionals are able to triage at the level of medical doctors ... it's short-sighted to not seriously consider alternative models for triage to limit wait times." Once initial triage had been completed, care also could be expedited by delegating tasks to health care providers other than physicians. There is a role for nurse practitioners, for example, "to assess and deal with minor ailments." Adding "social workers or mental health workers" to emergency departments might assist in care of clients with mental health or addiction issues, by ensuring that they are "assessed and sent to the appropriate program" for supportive care.

(2) PRIMARY CARE

- **312 references**
- **Key Issues: Family Physicians (191),
Walk-in Clinics (95),
Enhanced Role for Allied Health Professionals (43)**

Access to primary health care is an area of great concern for residents of Northwestern Ontario. While having everyone enrolled with a Family Health Team was acknowledged to be the ideal, at the present time the necessary complement of health care personnel is unavailable. Themes discussed under primary health care included the shortage of family physicians and suggestions around an enhanced role for allied health professionals. There also was awareness that, with prompt access to primary care, health care issues could be detected sooner, leading to a healthier population.

Shortage of Family Physicians

Throughout the “Share Your Story, Shape Your Care” initiative, citizens commented on the shortage of family physicians and the number of individuals who did not have a family doctor. They also were concerned about long wait-times for appointments: people who were enrolled with a Family Health Team, for example, had to wait anywhere from “4 weeks” to “4 months” for an appointment.

Those whose family physician had retired or moved away or those who moved into the North West LHIN typically found themselves without any access to primary care. As one family caregiver said: “My family doctor recently retired ... now me and my father are stuck with no doctor because they’re aren’t enough in the region ... to provide for everyone.” People who relocated to the North West LHIN from other parts of Ontario or other provinces were equally discouraged with

attempts to find primary care. As an individual who had moved into the province said: “I moved ... five months ago and still am not able to find a family doctor. If I need to see a doctor for anything, I have to go the emergency room.” Another caregiver who had relocated to Northwestern Ontario from another part of the province said:

Ever since I moved to [named community]¹, I have been without a family doctor. My family and I have simply learned to live with various ailments such as influenza, chronic back problems, [and] arthritis. The level of health care is unacceptable and inequitable compared to the rest of Ontario.

Walk-In Clinics

Although walk-in clinics are much appreciated where they are available, most are associated with particular Family Health Teams and therefore not accessible to the general public. Several people recounted their frustration at going to a walk-in, only to find that they couldn’t access the services because they weren’t enrolled with the Family Health Team. As one individual remarked, “My wife was refused care at the walk-in clinic ... because she did not have a family doctor there even though she has [seen] specialists there and has been a patient there for [many] years.” Another person commented: “Family Health Teams are great, until your doctor retires -- and then you lose access to the clinic altogether!”

The locations of walk-in clinics, their limited hours and restricted services were also problematic. Some clinics were situated in outlying neighbourhoods and were difficult to access when people did not have private transportation. Relocating walk-in clinics to centrally-located shopping malls or pharmacies was desirable. As a citizen pointed out, in communities with public transit “malls are well served by transit systems, and as a result, are great locations.”

¹ Names of communities and health care organizations have been removed to protect the privacy of respondents.

Limited hours for walk-in clinics were viewed as another barrier to care. “Walk-in clinics are a great idea, but again they are only open Monday to Saturday for a few hours.” Speaking about difficulties in getting prescriptions renewed at a walk-in clinic, a health professional said: “most of us can’t take time off from work to wait in a walk-in clinic for hours to get a script renewed, so we go without them.” Extended hours for walk-in clinics would ensure “24/7 access” to primary care: “Walk-in-clinics are a great idea and must also be opened for longer hours including evenings and weekends.”

As a further issue, preventive care or referrals to specialists often were not available at walk-ins. Due to time constraints, physicians at walk-ins sometimes would not do preventive “check ups” or “physicals.” There also were difficulties around referrals for specialist care, because at “walk-in clinics ... some of the doctors will not do referrals or follow-up for a person who is not their client.” The limited services available through walk-ins were an especially serious constraint for seniors who did not have a family physician and were wholly dependent on the clinics for care. Relating her elderly mother’s experience, a family caregiver said:

My mother ... went to a walk-in clinic and received a referral to a specialist. It's been over a year and she has heard nothing ... She sees different doctors each time she goes ... She is on high blood pressure medication and does not get regular check ups ... She will never be able to get a physical done because they don't have time.

Enhanced Role for Allied Health Professionals

Considering the shortage of family physicians, enhanced roles for allied health professionals were recommended. Suggestions were made about expanding the roles of nurse practitioners, paramedics or physician assistants. In some locations, nurse practitioners already “play a huge role within physician offices and where there are physician shortages.” They also deliver “outreach care” to rural communities and remote First Nations. Additionally, suggestions were made that

nurse practitioners could assume a more active role in primary care with Family Health Teams: “Nurse practitioners are a wonderful addition to the health care team ... [and] should be allowed to treat stable patients and consult with physicians when necessary.”

Citing examples of programs delivered in Manitoba and the Maritimes, some respondents saw potential for using paramedics for home-based primary care. For example, they could deliver “home visits for seniors, immunization programs, health monitoring and other outreach programs” which were seen as being “beneficial to our rural areas.” Similar roles might be assumed by “physician assistants” who could function as “service multipliers” for busy physicians.

Many participants in the “Share Your Story, Shape Your Care” initiative also saw potential for improving care by employing nurse case managers. Seniors and people with disabilities, for example, could benefit from on-site nursing supports: “Having RNs or RPNs in as many senior apartment complexes as possible ... would assist seniors who needed to take medication.” Case managers could also help clients with complex mental health conditions “by advocating for them and communicating with other health care providers.”

As one person said, the ideal was to have “A full health team ... a wide range of services and practitioners, all working from a holistic view of the client.” At the same time, it was recognized that it would be difficult to find staff to fill these roles. As a manager reported, “We have been searching for two nurse practitioners for our Family Health Team for almost two years and the community is recruiting for five nurse practitioners.” Another person said:

A clinic that includes a variety of doctors and nurses would be great, if you can recruit them. Being able to have everything coordinated on site is nice, but my concern is where are all these doctors and nurses going to come from?

(3) SPECIALTY CARE & DIAGNOSTIC SERVICES

- **286 references**
- **Key Issues: Wait Lists for Specialist Appointments (62), Team Based Outreach Care (30) and Telemedicine (131), Transportation Barriers (135) and Travel Grants (24)**

Respondents to this initiative identified several concerns about specialist care and access to diagnostic services: specifically, wait times, the need for team based care, and the use of telemedicine. An additional issue was the transportation barriers encountered by clients who must travel to access specialist care.

Wait Lists for Specialist Appointments

The lack of specialists in the North West LHIN has translated into significant waiting lists for all but the most urgent care. There was a perception that non-urgent patient cases are delayed and clients who would benefit from preventive treatment are not getting timely care. The result is that the “not so urgent patients of today will soon be the urgent patients of tomorrow.” Several examples were provided of delays, postponements or rescheduling of appointments with specialists, diagnostic tests or surgery. Recounting his experience, a man said:

I had a referral to see [a specialist] ... made in September of 2007 and the first available appointment was in April of 2008. It has been cancelled and rescheduled three times since then (by the physician's office for various reasons) and my appointment is not until April 8, 2009 (so far), more than one and one-half years later!

The effects of delays in getting specialist care were especially apparent when clients were placed on wait lists for surgery. Several examples were provided of conditions which had worsened during the time a client was on a surgical wait list.

One individual said: “My kidney stone problem was not acute [so] my surgery kept getting postponed. I had treatment for infection and my situation became acute. Earlier intervention could have prevented this.” Another client recounted the effects of delays in care for an ankle injury: “Because of the delay I am scheduled for an ankle replacement. Could this have been avoided? The doctors were ready to perform the surgery when I fell five years ago but the hospital would not accept me.”

Many respondents emphasized that specialist resources must be augmented and referrals expedited to allow faster treatment of less urgent cases “without jeopardizing the rest of the wait list.” Some thought that patients placed on wait lists for surgery and other specialist care should be given the option of “an out-of-town referral” so they could access care elsewhere. A few advocated adoption of a two-tier system where people could pay privately to see specialists.

Team-Based Outreach Care and Telemedicine

Team-based outreach care, combining consultation with specialist physicians, diagnostic testing and preventive care, along with telemedicine supports for follow-up care, was seen as an attractive option for improving specialist care across the North West LHIN. It was suggested that specialists, such as “internists,” “cardiologists,” “dermatologists,” or “orthopedists” could visit outlying communities on a rotating basis. Portable diagnostic equipment would also expedite access to care:

A top priority is to get diagnostics and specialists out into the region. How long is it going to take to ... realize if you bring the service to the outlying region wait times would be significantly reduced? Portable CT scanners and possibly even MRI units need to happen. Specialist clinics in the region need to be continued and even increased.

Telemedicine, already available in most of the North West LHIN towns and remote First Nation communities, was seen as having great potential for improving access to some types of specialist care. Several examples were given of telemedicine

being used to facilitate “follow-up assessments,” “patient education,” “mental health counselling” and “professional education.” Clients who had been able to take advantage of telemedicine consultations, as an alternative to travelling to Thunder Bay, Winnipeg or Toronto, were very appreciative of the convenience.

There was recognition, however, that telemedicine had its limitations. Wait times for telemedicine could be equally as long as for a conventional appointment. As one client said, “I waited to see a specialist through telemedicine for almost a year.” Health care providers also acknowledged that “not only does an appointment via telemedicine take much longer to organize, it takes longer to work through.” Some types of specialist consultations, furthermore, had to be conducted in-person. As a health care provider said, “telemedicine is a help but patients and professionals have to meet face to face some of the time.”

Transportation Barriers

Given the geography of the region and the fact that specialists are located in urban areas, transportation barriers represent serious impediments for clients from rural and remote areas who need specialist care. Several examples were given of patients who had to travel from rural communities or remote First Nations to Thunder Bay or Winnipeg several times within a period of a month or two for consultations and diagnostic tests. This was “very disruptive, not to mention expensive.” While transportation barriers affected individuals of all ages, they were especially detrimental to seniors, who sometimes found travel so difficult that they refused care:

Much travel is necessary to access specialist care but for older people, this is particularly arduous, especially in the winter. I have an elderly mother that just refuses to travel in the winter and I know of other elderly people who have refused follow-up appointments ... because of travel.

There was a need to “build the coordination to suit the patient not the other way around” to reduce travel burdens and provide more timely care. Several examples were provided of “extra trips” which had resulted when coordination of care was poorly done. In one case cited, a client drove 5 hours to see a specialist, only to find out that his local clinic had not forwarded requested information. He said: “My trip was pointless, I had to come back home, have the blood work done, get all the information from the clinic and go back. It was very frustrating as I had to take time off work and drive all that way!” Another individual emphasized:

With our technology and computers, these specialist visits absolutely need to be coordinated so they are either all on the same day or at least the next day. Our [patients] have repeatedly spoken about this need. They do not have the energy or other resources to do these repeated visits yet they are expected to do so continually.

Travel Grants

Given the economic problems being experienced throughout Northwestern Ontario, families were having difficulty finding resources to travel for specialist care. “When people face tough economic times, travel for medical appointments in larger centres puts an additional stress on individuals and families.” There also were problems with the Northern Travel Grant program. Reimbursements often took “months at times ... causing financial hardship.” Patients who lived in outlying communities without access to inter-city bus services also found that the grant “doesn't cover costs” of travelling by private automobile to Thunder Bay or Winnipeg. Considering these difficulties, a health professional suggested the travel grants program should be modified: “Give people the travel grant before they travel; many of our clients don't have the money *up front* [to pay for travel and] to wait to get reimbursed.”

(4) CHRONIC DISEASE PREVENTION & MANAGEMENT

- **247 references**
- **Key Issues: *Emphasis on Preventive Care (132),
Need for Team-Based Approaches (20),
Benefits of Peer Support (23)***

As an ongoing concern, the issue of chronic disease is a pervasive one. Respondents from across the North West LHIN commented on their experiences with chronic disease from both health care provider and client perspectives. The need for enhanced preventive care, as well as team-based chronic disease management was strongly supported.

Emphasis on Preventive Care

Because one's actions can lessen the burden of certain health conditions, there was widespread agreement "the prevention of disease should be a much larger focus of the LHIN." Similarly, it was pointed out that many of the most prevalent chronic conditions in Northwestern Ontario, such as diabetes or heart disease, are actually highly preventable. "Many of these issues could be ameliorated through appropriately focused prevention," according to a health provider. Patients who have had success dealing with their chronic conditions also underlined the importance of preventative action: "[We must] keep well before we come down with disease: eat healthy and exercise!"

Other people who took part in "Share Your Story, Shape Your Care" expressed concern about their inability to access family physicians for preventive care. One person with diabetes, for example, reported difficulties getting "routine foot screening, foot care and preventative education" through his local primary care clinic. Other individuals reported challenges accessing cancer screening services

locally. As a woman noted: “Some family doctors do not do any regular screening including breast exams, pap smears, etc. unless the patient asks for it to be done. In some cases it needs to be demanded.” She added: “These types of tests for prevention should be done automatically. It should not matter what doctor you go to. ... I wonder how many chronic diseases could be prevented?”

Several people who commented on difficulties accessing preventive care suggested that access to services could be enhanced by mobile clinics that delivered comprehensive screening, preventive care and education. As one person suggested: “Why not have a ‘travelling van,’ much like the breast cancer screening van, that can visit outlying communities once a month or so to see these patients.?” A health care provider who was familiar with mobile clinics that were used in other provinces and in the United States suggested that a range of services could be delivered this way:

Add to the vans: Skin cancer screening van (this is done in the States).
 Eye vans that will go up the [secondary highways]. Colonoscopy vans.
 Foot care vans or foot care nurses coming to the clinic. Dental hygienist vans with dentists on board. The visiting van thing works absolutely fantastic, but they can't be scared to go up the most northern highways.

Need for Team-Based Chronic Disease Approaches

Throughout the “Share Your Story, Shape Your Care” submissions, there were numerous examples of personal or family difficulties coping with chronic disease. Expressing frustration around the lack of easily understood information, a client said: “Provide me with clear useable information specific to my chronic disease and I will be far better able to manage it independently!” A family caregiver also was given very little information on how to deal with a relative’s diabetes. She was told “it was just trial and error for awhile” and felt “there should be a better way.”

It was thought that a multidisciplinary team-based approach would address many of these concerns, allowing “clients’ care to be well managed” and “provide a wide variety of resources.” It was suggested, for example, that nurses would do

“routine screening and assessment;” pharmacists would monitor compliance with “standard medications;” and physiotherapists and other rehabilitation staff would support “health promotion.”

Summing up the advantages of team-based chronic disease management, a participant said, “hands-on team work, consistent steps, helps to build a healthy routine for clients.” As well, the “one-stop” approach was highly recommended: “Seeing multiple professionals at one time is a really good way of maximizing assessment and treatment time for professionals and decreases the burden on the clients in having to come back.”

Benefits of Peer Support

Respondents described a variety of positive benefits stemming from experiences in peer support groups. They liked the opportunity for sharing, listening, reflecting, and receiving support from others who had the same chronic condition. Those who had taken part in “self-management programs” for people with chronic pain, rheumatic disease, multiple sclerosis or stroke, reported similar benefits from the knowledge gained. The friendships started in the groups, over discussions of common health issues, also helped them to improve their ability to manage their illness. A person with multiple sclerosis, for example, spoke highly of their monthly meetings: “I can't say enough how the group has helped me. I don't mean help with emotional problems, but just on coping day to day with different symptoms and solutions.” Another patient declared that:

Weekly sessions to manage my chronic illness ... have provided me with confidence and knowledge to move forward in less fear of chronic illness. The sessions have also provided me with a place to voice my concerns.

(5) LONG-TERM CARE SERVICES

- **313 references**
- **Key Issue: Wait Lists for Existing Services (21)
Need for Supportive Housing (96),
Home Care for Seniors and People with Disabilities (70)**

Across the North West LHIN, long-term care was affected by shortages of care providers, restricted service availability and lack of supportive services. Specific issues of concern included: long wait lists for services; inadequate supportive housing; limited home care for seniors and adults with disabilities; and supports for family caregivers. It was thought that providing adequate supportive housing, along with additional home care services and respite for caregivers would go a long way to ease the stress on seniors and people with disabilities and their family caregivers.

Long Wait Lists and Limited Resources

Given the aging population in Northwestern Ontario, concern was expressed about the limits in the long-term care available. Respondents cited numerous examples of lengthy wait lists that clients experienced for nursing homes, supportive housing and home care services. The feeling was that “our system will remain overtaxed, as the area population keeps aging, and many children now have to leave area to find jobs and cannot help with home care.” There was worry that long wait lists meant that those who needed care could not access services in a timely manner. As one person said: “Resources are very limited and currently all wait lists are long. Timeframes are a barrier and people fall between the cracks still.”

Need for Supportive Housing

The need for supportive housing was a priority requiring immediate attention. Most of the smaller communities had “no supportive housing” at all. In larger communities, where supportive housing was available, wait lists were unacceptably long, “sometimes up to five years.” Other options, such as private retirement residences, were unaffordable: “The wait list to get into a supportive housing unit is horrendous and because of our demographics (First Nation, immigrant, low-income) our seniors simply cannot afford [private retirement residences] in Thunder Bay. This only gets worse in the district.”

There were “endless heartbreaking stories” of seniors from outlying communities who had to relocate to Thunder Bay to access supportive housing, leaving their families and familiar settings behind. As one individual remarked: “It is imperative that seniors, who do not require long-term care can stay in an environment that enhances their quality of life, not deteriorate it.” Similar stories were shared about persons with disabilities who had to move into long-term care facilities because of the lack of assisted living spaces in their home communities.

As a health care professional noted, there are persons with disabilities “that are young, 20-30 years old, [who are] forced to stay in a hospital setting when supportive housing would be wonderful.” There also was a lack of supportive housing for “hard-to-serve” populations, such as individuals with mental health or behavioural problems.

Community housing alternatives with links to agencies and “greater flexibility of services” were viewed as a partial answer to these deficits. There also was agreement that “supportive housing would alleviate some of the alternate level of care issues and pressures on nursing home beds” that are currently being experienced across the region.

Home Care Services for Seniors and Adults with Disabilities

Although it was recognized that most “seniors and adults with disabilities would rather stay in their own home if they got help,” the limited availability of home care services placed people at risk of requiring placement in long-term care facilities. Some people also reported that problems with staffing in home care agencies contributed to discontinuities in care: “Working conditions [are] so poor that the good workers leave and the family has to train new workers.” Another person believed: “To provide quality care in the home, health care workers must be paid wages comparable to the long-term care sector.”

Several strategies were suggested that might “improve assistance for the elderly or infirm in the home and activate the *Aging at Home* policy.” Many seniors and people with disabilities who were not currently eligible for home care, for example, could benefit from “practical help ... with appointments, personal care, groceries, and medications.” As a family caregiver emphasized, her relative “did not need to be bathed; she needed someone to drop in once a week to see how she was doing, i.e., eating and taking her pills.” Persons with serious physical disabilities, on the other hand, often required “attendant care for three hours daily” as well as homemaking supports. Individuals with “multiple physical and mental health needs” required flexible services; without such supports they “end up in hospital or long term care as they cannot do the instrumental activities of daily living.”

Strengthening home care through augmenting volunteer supports was seen as equally beneficial. Seniors and people with disabilities were highly dependent on the supports provided by organizations such as “Meals on Wheels ... the Canadian National Institute for the Blind, Canadian Hearing Society, Hospice Northwest, HAGI Community Services, [or] Wesway.” Family caregivers also relied heavily on volunteer-supported respite care programs; without access to these supports, caregivers “become exhausted and [their relatives] become hospitalized as alternate level of care patients or are admitted to long-term care homes unnecessarily.”

(6) MENTAL HEALTH & ADDICTIONS SERVICES

- **206 references**
- **Key Issues: *Delays in Care (22),
Coordination of Mental Health Services (20),
Mental Health Education and Awareness (42)***

The particularly sensitive nature of mental health issues is a continuing concern for health care professionals and those who experience these conditions in their lives. “Accessibility” was generally seen as the key to improving mental health and addictions services. Particular emphasis was placed on timely diagnosis and treatment, crisis supports and continuing care. Better coordination of care across the entire spectrum of services also was a priority, since this population is often forced to live marginally and experience significant unmet needs. As a health care provider observed:

Mental health is a concern. There needs to be care that is accessible and ... along the continuum [of care]. This population needs lifelong support for incidences of relapse and reoccurrence. Sometimes the issues involving crisis have nothing to do with an acute health care problem but rather are more social in nature.

Delays in Care

As with mainstream medical care, any delay in the care of mental conditions or addictions can lead to serious results. Many respondents reported an unacceptable amount of delay in either being seen or being given access to appropriate care. One participant described the experience of going to a hospital emergency room for crisis care and having to wait for an indeterminate amount of time, during which the condition worsened:

At emergency we arrived and checked in with the nurse and receptionist who said the wait could be 4 hours ... 4 hours later my partner went up to the receptionist and said I wasn't doing so well and asked how much longer. Then she said I would have to wait longer.

Health care workers who participated in “Share Your Story, Shape Your Care” suggested that patients with mental health illnesses are placed at high risk, if access to care is significantly delayed. Although the consensus was, if “someone is willing or ready to access the services, we cannot make them wait,” it was widely acknowledged that community mental health programs had “absurdly long wait times.” A family caregiver, for example, was told that the “wait list at a particular centre was 8 months.” Meanwhile, both family and patient “desperately needed education, support and counselling on coping strategies”.

Poor Coordination of Mental Health Services

People observed that mental health services are numerous and designed for specific populations, with few linkages between them. Knowing which service to access or how to access a particular service is challenging, for health care providers and clients alike. As a health care provider said: “Mental health services are so split up that no one knows who to refer an individual to ... it really needs to be organized in a very different way.” There also were gaps in the services available, particularly in the outlying areas. While smaller communities may have mental health counselling available, there typically are no addictions services available. As one individual suggested: “It would be nice to see rehabilitation programs set up in small communities ... there are many substance abuse problems but it is illogical for some people to travel hours away, leaving their families behind, for treatment.”

All of these services require coordination so a minimum number of calls are required to access appropriate care. Ideally, there would be “a single point of entry for mental health services” with close follow-up to ensure that a client “does not fall through the cracks.” A number of options were suggested for improving mental

health services, across the spectrum of care. These included “shared mental health programs in every family medical clinic,” “24 hour on-call mental health and addiction workers in emergency rooms” and “school-based early intervention programs.”

Follow-up care was also mentioned as being crucial to the delivery of effective mental health services: “It is not enough to refer people to services; sometimes they need the clinician to pick up the phone and make the initial contact to ensure the person will be seen.” Additionally, access could be enhanced if mental health and addiction programs, which currently operate independently, were merged. As a health care provider observed:

Some teams will not work with clients who have concurrent disorders i.e. active addictions and possible psychiatric concerns ... Too much is left to chance ... People are better served by effective advocacy and a coordinated approach.

Improved Mental Health Education and Awareness

Given the complex nature of mental health and addictions, continuing education was a recognized priority. Health professionals, law enforcement personnel and social service providers, along with the general public, must have information “about places where people with mental health and addictions problems can get help.” A pilot study carried out by the Canadian Mental Health Association was cited as an example of an effective program designed to increase public awareness:

Training cab drivers, hairdressers, bartenders, etc. to do active listening and to provide information on available services ... People who work in the community ... may be the sole point of access for a number of vulnerable people who may not ever visit a health care facility.

(7) ABORIGINAL HEALTH SERVICES

- **177 references**
- **Key Issues: Need for Aboriginal-Specific Services (23), Cultural Content and Language Issues(24), Bridging Jurisdictional Barriers (24)**

Those who participated in the “Share Your Story, Shape Your Care” project recognized the challenge of meeting the unique health-related needs of Northwestern Ontario’s First Nations and Métis communities. Key recurring themes described by respondents included: need for additional Aboriginal-specific services and more Aboriginal health care providers, addressing cultural content and language services, and bridging jurisdictional barriers.

Need for Aboriginal-Specific Services

Aboriginal-specific health clinics and services in small towns and the regional centre were identified as a need, along with adequate funding to support them. As well, hospitals and other health care organizations need to establish “partnerships with the indigenous communities” to improve the delivery of care to First Nations and Métis clients. Preventive programs that incorporated their traditional heritage and customs were equally important. It was suggested, for example, that the development of programs with cultural content, including healing and mentoring initiatives directed towards younger Aboriginal generations, would improve health.

One of the most compelling and frequently-mentioned issues raised by respondents was the small number of Aboriginal health care professionals educated in the region. There was a perception that physicians and nurses of similar heritage will better understand what their patients were going through and be able to explain diagnoses and treatments in a more relevant way since they would possess a “fuller

understanding of [their clients' cultural] background." There was repeated emphasis on the importance of "encouraging Aboriginal people to train in the health care field," with one respondent suggesting that it would have "a snowball effect."

Cultural Content and Language Issues

The fact that many health care workers' have limited knowledge about Aboriginal culture was a concern. This was generally attributed to an absence of Aboriginal cultural content in health education programs "in the nursing and medical schools." For example, one respondent stated: "When we went for our training in college, we had no cultural courses." She added: "Cross cultural training is a must. The Aboriginal culture is a unique and strong culture. Most barriers I have seen include language and the general misunderstanding of the culture."

There was also a need for continuing education to improve non-Aboriginal health care providers' ability to deliver culturally-competent care to their Aboriginal clients. A practitioner emphasized this point: "So many of [First Nations and Métis] cultural norms are different than ours, we can't just make them adapt to us because that is what works." Specifically, suggestions were made to "integrate more Aboriginal culture into practice and certificate courses" that were offered to health care providers throughout the North West LHIN. Similar suggestions were made around the need to include Aboriginal content in "in-service" training sessions.

Bridging Jurisdictional Barriers

The delivery of services to First Nation clients, on and off-reserve, involves a complex array of jurisdictional responsibilities, local, provincial and federal. Effective health care strategies require a bridging across these jurisdictional boundaries. This was identified as a priority by clients and health care providers alike, from across the North West LHIN. They wanted: "all levels of government to

assist in Aboriginal health care [to] reduce the 'we aren't responsible for that' thinking by federal and provincial levels." As a professional observed:

I find that there is so much red tape around Aboriginal Health and non-Aboriginal Health. Certain services cannot go onto a reserve, but individuals can come to them. I think it would be great to 'reach out and work closely.'

Suggested strategies were made around enhancing outreach and follow-up care to Aboriginal clients, in both on-reserve and off-reserve locations. In terms of outreach care to First Nations, there should be an "increase in the mobility of services to Aboriginal communities ... using personnel who have a comfort level and knowledge in working with this culture." As for follow-up care, better communication between hospitals and First Nations would ensure more timely connections for patients being discharged, when they require "further services, such as from the [First Nations] Home and Community Care Program."

Specific suggestions were made around improving access to health care for Aboriginal peoples residing in the region's towns and cities. Translation services would help people who spoke Ojibwe, Oji-Cree, or Cree: "Aboriginal persons accessing health care services should have a translator available *via* phone, teleconference, or in person." Outreach initiatives were equally important for Aboriginal families and youth who have recently relocated: "Outreach programs, street patrols ... would help to connect people to appropriate programs." Another suggestion was to improve "continuity of services" for clients who received care from both Aboriginal and mainstream primary care organizations.

Several individuals spoke about the significance of greater involvement of Aboriginal communities in the planning of health services across the North West LHIN. As one individual said: "We need to directly approach Aboriginal people to try to work out a plan to better serve their needs." Another person emphasized the need to engage the leadership of Aboriginal organizations in the strategic planning process, to "make sure that Aboriginal people are included in the dialogue."

(8) FRENCH LANGUAGE HEALTH SERVICES

- **98 references**
- **Key Issues: Need for French-language Services (55),
Publicizing Multilingual and Translation Services (18)**

As expected, the limited number of French language health services available across the North West LHIN was a concern for a fair number of respondents. Recruitment strategies designed to attract additional Francophone health professionals to Northwestern Ontario, as well as the provision of French and multilingual services were also cited as needs.

Need for French-Language Services

Respondents repeatedly emphasized the importance of offering services in both official languages. Several examples were provided of difficulties that Francophone clients had in finding health care services in their own language. One individual described a challenging family experience at a hospital in northwestern Ontario where “no one at the hospital spoke French” saying: “This is one of my greatest concerns for ... the population in the Northwest of Ontario which are French speaking and do not understand the medical terminology as well in English.”

The need for additional Francophone services and recruitment of Francophone professionals was seen as priority. Several people pointed out that Francophone patients often will relate more effectively to physicians and nurses whose native language is French than they would to physicians or nurses who have been using a translator, however effectively. Thinking about these issues, a citizen gave the following advice to health care organizations: “Don’t forget to work on recruiting professional French speakers who can give services to French speakers.”

Moreover, hospitals, clinics, community care and long-term care organizations which had Francophone staff should make an effort to ensure that the public was aware of French language services and supports which were available. Several respondents emphasized their frustration at finding out, after the fact, that Francophone services were available: “It should be well indicated if professionals can speak French and how to access that service.”

Publicizing Multilingual Services and Translation

Given that the North West LHIN population includes significant numbers of citizens whose first language isn’t either official language, but Objiwe, Oji-Cree, Ukrainian, Finnish or Italian, multilingual services are highly desirable. This applies to ASL (American Sign Language) translation services as well. People who commented on language issues emphasized that, depending on the population served, there was a widespread need to ensure that appropriate translation services were available. Throughout the health care system: “What is really needed ... is translators to aid in communication and thus help provide more effective treatment; communications is so essential and the frustration at all levels hinders care.”

Specifically, there was a call for improving public awareness of multilingual services such as translation through “a central telephone or Internet-based system containing lists of languages available.” Publication of health promotion materials in languages other than French or English was viewed as being equally important. Another individual suggested that the North West LHIN itself should consider publishing “official LHIN statements and documents” in other languages, reflecting the ethnic and linguistic diversity of the region’s populations. “ Special attention also needed to be given in ensuring that materials were available in a number of audiovisual formats, including online and print versions. As one person observed, “Not all people have access to computers ... [and] an online resource only meets the needs of a few.” Another person added, “a website is a great idea but a brochure or telephone service may help some [people] more.”

(9) HEALTH HUMAN RESOURCES

- **219 references**
- **Key Issues: *Shortage of Health Professionals (53), Support for Educating Health Professionals (40), Fostering Team-Based Care (125)***

The overarching theme of health human resource shortages and the need for recruitment of additional professionals is one of the most significant issues facing Northwestern Ontario. There were candid evaluations of deficits in the health workforce, descriptions of the challenges faced by human resource departments, and suggestions to encourage future recruitment and education of health professionals.

Shortage of Health Professionals

Throughout the “Share Your Story, Shape Your Care” submissions, a recurring concern was the shortage of family doctors that was being experienced throughout the region, along with the difficulties that citizens had in accessing care as a result of these deficits. Lack of family doctors was an unfortunate reality in nearly all locations and numerous examples were provided of the problems that individuals faced in trying to find a family physician. Those who did have family physicians found that it was often “difficult to ... get an appointment within a reasonable timeframe.” Care challenges also occurred when organizations could not fill allied health professional positions. Issues recruiting nurse practitioners, audiologists, dietitians, pharmacists, physiotherapists, occupational therapists, and psychologists were reported. Health care providers also voiced frustration over the difficulty retaining colleagues when their organizations experience chronic understaffing: “It’s hard to get good people to stay when the workload is overwhelming and access to other services is so difficult.”

Given this situation, “recruitment and retention should continue to be a priority focus to improve access to primary care and specialty care.” Current recruitment incentives, however, were generally believed to be insufficient to attract new professionals to communities in the Northwestern part of the province. Many people mentioned the variety of incentives that might be offered, including “monetary incentives” for additional “years of practice,” guaranteed “research grants,” “paid relief time,” and “continuing education.” Collectively, such incentives could counteract the elevated costs of living and sense of isolation that often deter professionals from practising in northern communities. Health care organizations who were in need of additional staff should also look at creative solutions:

Look at job sharing scenarios. This would be most effective for individuals who would like to semi-retire or work part time. Promoting the assets of our region such as [recreational opportunities] to those individuals may help attract newcomers.

Support for Educating Health Professionals

A variety of incentives could also encourage students in the health professions to practice in the region after their training is completed. According to some respondents, possible solutions to ongoing health workforce problems could be found by investing in infrastructure to support medical students, along with medical residents, foreign-trained medical graduates and various allied health professionals in the Northwest: “Having more capacity for students will help us to ‘grow our own’ and improve the care we provide.” Communities and health care organizations could consider supporting the education of local students with the understanding that they will practice at home for a certain number of years of service after graduation. As one individual suggested: “Provide free tuition and books or incentives similar for post secondary education as long as the student provides three or more years service in a Northwestern Ontario community.”

Other respondents pointed out that foreign-trained health care professionals, who now reside in our region, should be given additional supports to access retraining programs that would permit them to practice here. This was a common lament: “I find it unthinkable that so many immigrants, [who] are health care professionals, are not allowed to practice.” Another person said: “There are great numbers of immigrant doctors not doing medical jobs when they could be ...ready to practice the skills they learned in their homeland.” She added: “This is an untapped resource.”

Fostering Team-Based Care

Regardless of the setting, there was agreement among those who submitted information to the “Share Your Story, Shape Your Care” initiative that “team-based care” was the ideal way to deliver health services. People emphasized the necessity of valuing all health care providers for their own unique strengths, across the entire continuum of care. As a health care professional said: “We have to get away from the old way of thinking that a solo physician is the answer to everything and concentrate on developing true high-functioning collaborative teams.”

While acknowledging the decision-making capabilities of physicians, there was a sense that the skills of nurses and other health care professionals were often under-utilized. As a health care provider said: “We have a lot of good health care professionals. We are just not using them wisely.” Facilitating access to a full range of health professionals, including nurse practitioners, physiotherapists, occupational therapists, psychologists and social workers, could ease part of the “burden” of physicians, thus contributing to an improved professional atmosphere:

I strongly believe that 'task-shifting' from doctors to nurses, nurses to 'health educators', etc. is hugely important in increasing access to health care and optimizing the existing health human resources.

At the same time, it was recognized that specialized supports often were required to help health care organizations move towards more collaborative models of practice. People who commented on this issue suggested that the team approach could be fostered through “mentoring programs,” “increasing use of nurse practitioners,” and “videoconference continuing education sessions” to ensure that all health care providers have opportunities for “keeping current.” Team functioning would be further enhanced by “re-examin[ing] scopes of practice to clearly determine if some local health professionals can actually handle practices typically delegated to larger health care facilities.”

Several people who discussed team-based care approaches underlined the importance of having a diversity of health care services within one setting. They saw primary health care organizations, such as Family Health Teams or Community Health Centres, as providing the ideal “one stop” location for a variety of programs offering “support and assistance to managing ones health.” As one individual emphasized, “such services would improve collaboration between various health care providers and optimize patient care.”

Co-locating services to address common combinations of chronic illnesses, for example, “diabetes and high blood pressure,” could be an effective way of improving care. Combined clinics would also make it easier for staff to deliver required client education and preventive lifestyle interventions. Such initiatives might also alleviate the long wait times that frequently occur in the primary care sector. As a health care provider observed:

Maybe increasing the amount of programs along these lines will help. Sometimes, I think physicians get bogged down with the chronic patient who returns every two weeks. Maybe weekly clinics for chronic disease would be more effective. e.g., high blood pressure clinics, diabetic foot clinics, obesity clinics, etc.

(10): eHEALTH

- **166 references**
- **Key Issues: Confidentiality and Privacy Issues (39), Ensuring System Effectiveness (23)**

As a relatively recent, albeit significant development in health care delivery, the issue of electronic health records is inevitably a controversial one. Respondents expressed a range of opinions about eHealth, from the hesitant to the positive. There were concerns that eHealth systems were not equally accessible in all communities and across all health care sectors. General themes included: the benefits associated with sharing of medical records, increased levels of communication, as well as concerns regarding data loss and client privacy, along with questions about overall system effectiveness.

Benefits of Sharing Medical Records

Sharing of clients' medical records was strongly supported by some study participants; the sentiment was summed up by one respondent, who said: "I would love to have my health records shared between health workers." People who supported eHealth initiatives felt that medical records should be available anywhere to "any authorized medical practitioner" so that they have a reliable reference when dealing with clients.

The availability of such records could enhance clients' access to care at walk-in-clinics and avoid duplication of diagnostic tests and procedures. In one example given, a woman was sent to a walk-in clinic where her medical records were not available. While she was well looked after, there were test duplications that could have been avoided if her medical records had been accessible. As a family caregiver

said: “This is a waste of money that could easily been avoided if records were readily available to all.”

Confidentiality and Privacy Issues

Privacy and access to sensitive information, however, were serious concerns that made some people cautious about more widespread use of eHealth systems: “I feel that e-sharing could be risky...a patient's confidentiality may be lost.” There also were concerns that clients who have “conditions that can lead to discrimination, such as mental health disorders or sexually-transmitted diseases, would be reluctant to participate in a system that makes this information broadly available.” As one respondent said, “to protect privacy, records would need to be “properly encrypted” and access to the information strictly controlled. Furthermore, a patient must consent to the sharing of any information and health professionals must maintain confidentiality:

Clients should have the right to control access to sensitive issues; for example, a client [in the hospital] for surgery may not want all of their health care providers reading about treatment for mental health issues that are not relevant to their current illness.

Some individuals also were concerned about data loss and security issues and the necessity of having paper records to back up electronic information: “Be very, very careful with electronic health records -- so much risk of catastrophic data loss, security problems, etc.” If these criteria could be met, however, there should be no concern for privacy issues and the goal of providing better health information and ultimately better care could be achieved. As one individual said, eHealth “would make it easier for health care professionals to have the information they need with less delay.”

Ensuring System Effectiveness

To make eHealth work, respondents suggested a number of strategies that might increase efficiency and decrease costs. A provincial eHealth system, which would allow connectivity and data sharing between and among all types of health care organizations, was viewed as being the ideal solution. As a province-wide system was believed to be some time in the future, however, people placed priority on improving the eHealth systems that were in place throughout the North West LHIN so they share data and inter-connect. At present, this was not possible: “Currently the system we have ... cannot communicate with [tertiary care centres] ... [which is] a waste of time and duplication of work!”

Connectivity and communications would be improved if common data management software was introduced across the North West LHIN. Ideally, organizations across the spectrum of care, from primary care, through home care, long-term care and hospitals should be able to “compare the same data, entered in the same software, the same way.” “Improvements in the connectivity from area First Nations” and the eHealth systems available in mainstream health care organizations also was seen as important. Summing up these issues, a health care provider said that sharing of records would also eliminate duplication of efforts that occurs when “people show up in other communities and are unable to relay medical history ... staff would not have to repeat tests, etc.”

From a patient perspective, people who were familiar with the systems used in other provinces said they would like to have access to their “personal medical records” or “their test results” via e-mail or a website. They also recognized that eHealth would “be a big time saver for both sides and the health care worker would have full access to my medical background.” Both clients and health care providers were generally in favour of any innovative new system that would expedite patient diagnosis and treatment: “Freedom of information in this regard would inform better care and proper diagnosing and certainly benefit the patient.”

(11) INTEGRATION OF SERVICES ALONG THE CONTINUUM OF CARE

- **240 references**
- **Key Issues: *Need for Integrated Services (34), Success Stories of Well-Integrated Care (30)***

The submissions collected through the “Share Your Story, Shape Your Care” initiative identified the improved integration of health care services as a dominant issue. “Better integration of health care services as a whole” was considered essential for efficient delivery of health programs. This position was supported by both positive and negative experiences, which show the high degree of diversity that exists across the North West LHIN, depending on the circumstances, settings, and locations.

Need for Integrated Services

The term used by many respondents to describe the apparent separation of health care services was “silo,” meaning that many departments and organizations function independently of one another and with minimal communication between. This was summarized well by one professional who stated “The single most important building block [towards health care integration] is to abolish the idea of working in silos and make people work collectively and collaboratively, and make people accountable to this ideal.” Emphasizing the need for better integrated care, another provider said: “We are all responsible for clients regardless of how they land on our doorstep. It is all of our responsibility to ensure that people are connected to proper services.”

Moves to integrate various health care services, however, were viewed as contingent on addressing the health human resource gaps which existed in the present system. Given the staffing shortages experienced across the region, some individuals held a generally negative view of the possibilities for integration: “It is unreasonable to think that one can form an efficient and coordinated system with professionals spread so thin.” Other individuals displayed more optimism about the potential to “grow our own regional health professionals” and provide “better integrated care.” Additional staffing would free up physician time, allowing practitioners to focus on “entire individuals rather than illnesses.” In return, greater attention to client care would allow health care organizations to run more smoothly and efficiently, thus becoming an attractive feature for recruiting new professionals.

While the challenges are great, those who took part in the “Share Your Story, Shape Your Care” project recognized that health care organizations and providers had developed a number of successful strategies for delivering care to individuals and families. These included examples of integrated services in primary care, hospitals, long-term care and mental health and addictions.

Primary Care

Some health care organizations were commended by a number of respondents for keeping integrated health care high on the list of priorities for clients. Family Health Teams that included a range of services and supports were widely appreciated: “Patients can visit our hypertension management clinic, the dietitian and the pharmacist all in the same visit and in the same place... patient satisfaction is increasing exponentially!” Another person cited an example of a comprehensive primary care clinic staffed by physicians, nurses and mental health counsellors:

At the health clinic ... I was able access and make appointments at times that fit my busy schedule. There are also other practitioners available such as nurses, counsellors, etc. ... and all my tests have been easy to get

to. My doctor was able to spend 30 minutes with me to discuss my signs and symptoms ... and prescribe a medication.

Community Health Centres and Aboriginal Health Access Centres also were cited as examples of integrated primary care. Their outreach initiatives to both urban and rural populations were viewed as being especially effective. A community health centre, for example, used mobile vans to deliver a comprehensive geriatric primary care services to seniors who resided rural communities. Other centres delivered outreach services in small towns and urban areas, for example, supporting street patrols and special clinics for youth and the homeless. Aboriginal Health Access Centres also provided “culturally-sensitive” primary care, prevention and health promotion programming to Aboriginal peoples. All of these were viewed as “successful models to provide care for these populations.”

Other programs strengthened linkages between primary care and specialist care. Preventive chronic disease clinics that were offered throughout the region, for example, gave people access to both primary care and specialized services that otherwise would not be available. In one example, a stroke survivor who was without a family physician attended a prevention clinic, was quickly assessed by a nurse practitioner in terms of cardiovascular issues and given tests and medications, along with instruction on preventive care from a dietitian. In this instance, “follow-up was prompt, care was integrated and risk factors addressed and managed.” In another example, an outreach team linked clients and their primary care providers to telehealth-facilitated stroke and cardiac rehabilitation and education supports.

Hospital-Based Services

Although concerns were expressed over emergency room wait times, many respondents reported positive hospital experiences, ranging from children being quickly assessed in the emergency room and immediately seen by an asthma specialist, to a successful transition from broken bone diagnosis to surgery: “all was handled quickly and efficiently, and without question. This is the way it should be.”

Successful coordination of care also occurred when patients were referred from their community hospitals to tertiary care centres for treatment. A client who lived in one of the smaller communities, for example, was admitted to his local hospital “on a Monday night with chest pain,” transferred to a tertiary care centre for an angioplasty the following day” and “was back [in town] Wednesday evening.” As a family caregiver said: “This was a picture perfect example of the integration of Ontario’s health care system.”

Integrated hospital-based services for cancer, renal and stroke patients were also cited as examples of effective care. Clients who attended the clinics liked the range of services offered and the convenience, particularly the fact that they could access supports from specialists and a range of other health care professionals during a single visit. In one of these clinics, “patients see their doctor and allied health professionals at one appointment [and] a native liaison worker is also present to assist when dealing with patients of First Nations ancestry.”

Hospital-based programs, with support from local physicians and nurses, also successfully deliver care to clients in outlying communities. In one example cited, a client who lived in a remote location was able to complete his entire course of treatment at home, with “initial appointments *via* telehealth ... and occasional, scheduled visits to see the specialists.” As a health provider emphasized, “in some instances, [the system is] already providing well-integrated care to our patients; this is just something we need to do *much more* of.”

Long-Term Care

Groups with particular needs, such as seniors and younger persons with disabilities, also benefit from integrated care approaches within the long-term care sector. A successful example of team-based care in a long-term care facility was described as follows:

Quarterly meetings or care conferences on each patient in the facility.
The inter-disciplinary team all meets as well as the patient and their

family members. They discuss medications, physiotherapy and occupational services, the nursing services and dietary needs ... this plan works very well in long-term care because it is a more holistic approach to care ... The patients enjoy this as well because they can have their needs met and be more autonomous in their care. It promotes quality of life for people living in long-term care.

There also were examples of effective in-home care being provided to seniors or people with disabilities. Access to a full spectrum of services, including primary care physicians, nurses, support workers and respite care was essential to allow people to remain in their own homes, as was “good communication” among the organizations providing care. Relating an elderly relative’s experiences with end-of-life care, a family member said:

Our family doctor was able to see him for emergency issues the [same] day. He was able to access home care services from the Community Care Access Centre for nursing and homemaking ... through Veterans [Affairs] coverage ... It was also well- coordinated for him to stay in his own home with end-of-life care.

Mental Health and Addictions

On the issues of mental health and addictions, respondents pointed out that Northwestern Ontario health care organizations must cooperate to ensure that individuals with mental disorders are not “falling through the cracks” that exist in the regional network of health and social services. Several experiences in this area were cited as examples of effective ways in which this vulnerable population has been or could be assisted in accessing needed health care services and supported in daily life.

One respondent praised the work on older adult mental health that is being done in some of the North West LHIN’s small towns, as an example of potential approaches that could be used elsewhere in the region. “We need to link things like older adult mental health . . . to share resources, assessments, consultation and

training with each other ... pull together all of these services, networks etc. and arrange them in sensible way.” Another professional described staff team meetings as an excellent opportunity to examine and revise care plans for such clients:

Goals of care are looked at, and revised. This ensures the client is getting the care that is needed, and that there are objectives that staff can easily see ... the next round for the client is scheduled at an interval fit for the type of concerns that were discussed.

There also was recognition that some clients with serious mental health and addictions issues did well in programs which offered case management. Such supports were especially effective for people with co-existing mental health and medical problems, such as diabetes. As a health care provider reported: “These clients do best with intensive case management i.e., with a nurse that helps them manage their psychiatric illnesses and medical illnesses ... and communicating with ... physicians ... as they cannot do this themselves.” Another individual suggested that the patient navigator approach, which has been used successfully in hospital-based renal, cancer or stroke programs, could be adapted to assist clients with mental health and addictions issues:

Having someone to help a client through the system, and having someone to call when there are snags makes sense in getting people the care that they need. The navigator should also be able to cross barriers. A mental health professional should be able to help a client get help for a physical issue, just as someone working with a client with chronic disease should be able to help them access counselling services or help for social issues.

SUMMARY OF ISSUES

The diversity of issues raised by respondents throughout the “Share Your Story, Shape Your Care” project echoes the wide range of issues at the forefront of health care in Northwestern Ontario today. These issues, summarized below, represent the priorities of both citizens and health care providers, who shared a joint concern that health care across the region be delivered in a more effective and efficient manner:

- One frequently repeated area of concern, throughout the North West LHIN, was the issue of wait times. A delay in access to health care is an overwhelmingly negative influence on any patient’s condition, both mentally and physically. Regardless of the context, in primary care, emergency rooms, specialty care, long-term care, or community-based programs, lengthy wait times were mentioned as a significantly negative experience for all concerned.
- Geographic distance and lack of transportation continue to be a significant barrier to accessing health care, particularly for seniors and Aboriginal people. In smaller communities, the lack of local services and the difficulties of accessing specialist care at a distance also limits some peoples’ ability to maintain their health.
- Comments categorized under both “primary care” and “health human resources” were mainly centred around the difficulty in recruiting both family physicians and nurse practitioners. The need for other health professionals, including audiologists, dietitians, physiotherapists, occupational therapists, and health educators were also identified, especially in organizations serving smaller towns, rural areas and remote First Nations.

- Considering the shortages of health care providers experienced across the North West LHIN, respondents spoke out on the fact that both recruitment and retention should continue to be a priority. Some people felt that the situation would ease in time, if medical and nursing school enrollments and supports were increased. However, more immediate practice incentives were required to counteract the costs of living and sense of isolation that health care professionals experienced in northern communities.
- In hospital settings, respondents suggested more efficient triage in emergency departments, along with teams that include nurse practitioners and social workers to ensure more timely access to care. Much of the long wait times reported in emergency rooms was thought to be associated with the fact that a large proportion of the North West LHIN lacked a family physician and didn't have access to walk-in clinics and therefore were forced to use the emergency room as a first point of access to care.
- As well as making suggestions for dealing with health care challenges, respondents shared stories about the success that they had experienced in health care settings. They were particularly enthusiastic about integrated health care, with a strong appreciation for a "one-stop" approach to accessing care. Many saw great potential in Family Health Teams and Community Health Centres, for example, as central points for accessing care. They also appreciated the efforts that hospitals, long-term care and mental health organizations were making to more closely integrate care. There was equal recognition that successful integrated care programs, developed in outlying communities or in Thunder Bay, could be "could be piloted and then adapted and rolled out across the region."