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North West LHIN Health Service Provider Engagement in the District of Kenora IDN

November 20, 2014

INTRODUCTION

In the fall of 2014, the Health System Design and Development (HSDD) team led five community engagement sessions with LHIN funded health service providers (HSPs) across the region. These sessions were designed to:

- Share information regarding the current planning initiatives and receive feedback from stakeholders
- Engage in dialogue related to local health system issues to build the 4th Integrated Health Services Plan
- Build relationships between HSPs and LHIN planning consultants in each integrated district network (IDN)

MEETING DETAILS

The HSDD team provided brief presentations highlighting current planning initiatives followed by time for questions and answers. The presentation outlined current planning initiatives in the areas of:

- Chronic disease prevention and management (CDPM)
- Access to care
- Mental health and addictions
- Seniors and palliative care

Following the presentations, a world café knowledge sharing forum was hosted by the HSDD team titled, 'The Harvest Café'. Participants were invited to rotate between three discussion tables hosted by the senior consultants. Table themes included chronic disease prevention and management, access to care and mental health and addictions.

The HSDD team invited various local health care providers from the District of Kenora IDN to the engagement session on November 20, 2014. The session was held at the Best Western Lakeside Inn in Kenora.

In order to set the stage for the discussion, participants were invited to reflect on the Café's central question:

How are we going to move health care forward in our region?

The following questions were posed to each group to guide the discussion:

- What successes can we acknowledge?
- What challenges might come our way and how might we meet them?
- If our success was completely guaranteed, what bold steps might we choose?
- How can we support each other in taking the next steps (LHIN vs HSP)? What unique contribution can we each make?

Qualitative data in the form of notes from each table's discussion were collated and examined for common themes using content analysis. The following themes and points of discussion were the key findings resulting from the District of Kenora IDN engagement session.

MAIN THEMES ARISING FROM HARVEST CAFÉ

Chronic Disease Prevention and Management

Several key themes were brought forward in the discussion of chronic disease prevention and management that extended beyond specific disease into comprehensive approaches to service provision:

Approaches to CDPM service provision

- Self-management and patient education have been big successes in the IDN as they help people live better by understanding the illness they have
- Self-management is reasonable for a certain demographic but has limited impact for others. This may be determined by age, mental capacity, culture etc.
- Taking a 'paternal' approach to chronic disease management is not helpful. The approach needs to include self-management and group appointments
- Health care providers should be encouraged to become involved in Community Care Access Centre's (CCAC) self - management programs
- Family health teams (FHTs) host the majority of chronic disease management in the IDN
- Physicians choose to refer patients to Thunder Bay for chronic disease management instead of Kenora or Dryden which may be more convenient for patients
- Waasegiizhig Nanaandawe'iyewigamig Health Access Centre (WNHAC) takes a proactive approach to chronic disease management by increasing access to services through home visits and flexible appointment times
- Education is often the focus of chronic disease management but people already know what they need to do and are not successful in making change. This focus needs to change

- A model of care for chronic disease management might include front line workers who can provide diabetes education at various access points. This may include pharmacy or emergency department (ED) nurses however a coordinator is necessary to make this work
- Currently care is where funding is; not where the patient is
- Mobile teams are needed to enhance access to care
- A mobile wound care program is needed
- A client's medical condition may be a symptom of underlying issues related to social determinants of health

Diabetes care

- Dryden diabetes program provides care in First Nation communities which has been successful
- Diabetes services at WNHAC are easy to access as they are in proximity to each other
- Diabetes education needs to shift from focusing on teaching to addressing the clients' issues

Geographic constraints

- Kenora IDN has the most geographically dispersed population in the region and the demographic in each community varies (ie. Red Lake has a young population vs Dryden which has a significantly aging population)
- Large geography makes access to services a challenge
- The diverse population dispersed across the IDN makes it difficult to develop a single Health Links proposal that is representative of all communities

Collaboration

Collaborative successes were identified in the discussion along with new opportunities:

- Creation of the Kenora substance abuse and mental health task force led by local police has been successful in bringing stakeholders together
- An interdisciplinary approach to chronic disease management focusing on where the patient is currently at would be beneficial
- Care is often fragmented and needs to be wrapped around the client
- Inter-ministerial collaboration to reduce the duplication in services should be encouraged
- Partnerships are the key to success. Information related to partnerships needs to be shared with front line workers
- There is an opportunity for health service providers and public health units to work together in managing chronic disease
- Physicians need to work closely with health service providers and LHIN but it is challenging when they are not funded by the same source

- Locally based management for regional organizations is needed to ensure partnerships at a local level are made
- Cross sector partnerships need to be encouraged
- Crisis intervention has proven successful in decreasing ED visits
- Collocation of human resources in the region is needed

Community based services

- There are concerns regarding the gap between the time of discharge and when community supports are coordinated for a client
- It may not be possible to offer all services in each community due to the need for economies of scale

Access to health services

- The hospital is viewed as an institution and may be a deterrent for some to access
- Wait times for access to specialty care are long. There are delays in the referral process within the IDN
- Weekend discharges lead to patients getting lost in the system as health care providers are not aware of the discharge
- Access to primary care after office hours is needed. Evening and weekend walk in clinics or physician office hours should be considered
- Weekend and evening access would be beneficial for chronic disease management to reduce access to ED for non-urgent issues
- Health Care Connect is helpful in connecting people to primary care services
- The FHT has restricted access to foot care to only those living with diabetes
- Ostomy nursing support is available in home but not after hours or on weekends if there are issues
- People with dementia are slipping through the cracks. Primary care needs to incorporate regular screening for symptoms of dementia as a standard of care for routine appointments
- Early onset dementia is increasing but services are restricted to seniors. The criteria needs to change to meet client needs
- Norwest Community Health Centres (CHC) has evening/weekend walk-in hours. Could WNHAC adopt a similar model?
- Awareness and education of existing wound care services is needed to decrease the number of clients travelling to Thunder Bay when service is available locally
- WNHAC comes to the hospital to see clients
- Service providers under one roof is successful as demonstrated in the CHC model in Ignace

Children and Youth

- Access to a mental health worker at school has been implemented though the role is more administrative than clinical
- The transition from youth to adult for those living with diabetes is challenging. Young people in Kenora want access to peer support groups
- Youth under the age of 18 may have access issues due to age of consent
- There are long wait times for paediatric mental health services. Adolescents and teens are increasingly needing access to services to address suicide and stigma associated with mental health issues
- Youth mental health programs related to chronic disease are needed. Supports in college/university setting should be considered

Prevention

- Prevention efforts need to be expanded and should begin at an early age
- An approach that is patient centered and preventative is more successful
- Prevention efforts to engage the community would be helpful. The CHC in Ignace is addressing social determinants of health by coordinating a community garden, local food bank and building partnerships with local organizations
- Health promotion might be a component of chronic disease prevention and management that expands across all sectors

Clinical integration

- Standardized tools for the region would enhance service delivery
- There are many screening tools available for mental health – a more standardized approach is suggested
- A regional standard for data collection and interpretation across the province would support provincial comparisons

Mental Health and Addictions

The prevalence of mental health and addictions issues was identified as high in the District of Kenora IDN. Several key themes emanated from the discussion:

Approaches to care provision

- A bundle of core mental health services are needed from prenatal to end of life
- Similar to CDPM, a self-management component should be introduced in mental health and addictions to empower people and teach life skills
- Difficulty in obtaining an appropriate diagnosis may inhibit people from accessing the services they need
- A definite diagnosis may limit the types of services an individual can access due to the limitations of an organization's mandate
- Transitional services from youth to adult are not well established in the region. There needs to be less focus on age and more focus on the person
- Early intervention and prevention could alleviate the burden on mental health and addictions downstream

Behavioural supports

- There is minimal behavioural support for people with dementia as this population grows
- Long term care homes are challenged to provide the appropriate behavioural supports
- Brain Injury Services of Northern Ontario (BISNO) is offering housing to people from Kenora once they are stable and this is working well

Children and youth

- Children and youth do not have access to necessary services. Upstream investments in service will reduce the burden later
- Youth suicide is a concern for many First Nation communities and different approaches are being undertaken to raise awareness
- Children's services are fragmented. Ministries need to come together to work collaboratively on a common agenda to provide seamless care
- Access to hospital based crisis support in ED for children under the age of 16 is lacking
- A stabilization unit/services are needed for children in crisis or those with behavioural issues
- There is a gap in paediatric and adolescent mental health and addiction services especially in the ED
- There is a lack of crisis support for children in the IDN

Collaboration

- Inter-ministerial planning would better coordinate services and identify gaps
- Information and work is being shared across multiple organizations
- Planning might occur across sectors and ministries
- Partnerships among HSPs are crucial to distribute services appropriately
- A complex care committee was established in Kenora with success
- WNHAC is exploring a model of integration wherein direct service agreements are established with multiple HSPs to provide services in First Nation communities
- There is cross sector collaboration and discussion through the provincial mental health and addictions strategy
- One ministry and one funding model would be ideal

Access to mental health and addictions services

- Alcohol addiction is a significant issue in the IDN and appropriate addiction programs are needed to meet this demand
- Stigmatization still plays a role in accessing care
- Services need to be brought to where people are at – 'right in the bush'. Mobile services need to be considered
- Counseling support services are currently being provided through OTN
- Maslow's hierarchy of needs is the ultimate driver in accessing services
- Outreach in First Nation communities is offered in the IDN. A change in service hours occurred to better meet the needs of the clients
- People need to be seen sooner than they are currently being seen
- There are no crisis supports available on the weekends
- People want choices rather than one location
- Reduction in wait times for initial assessment has been observed in Red Lake
- Services and supports for marginalized populations, including stabilization units are needed
- Wait lists are lengthy for addictions services and residential treatment programs are needed
- There is limited access to primary care for individuals with a history of mental health issues and it is often difficult for these clients to be rostered to a primary care provider

Health human resources

- Competitive salary and retention are health human resource challenges in the IDN

Technology

- Telemedicine/telehealth could be leveraged but may not be appropriate for children and some adults
- There is need for telepsychiatry but it doesn't necessarily meet the need or access is limited
- There are limited options for addiction supports. Telemedicine exists but it is not widely accessible
- Tele-mental health coordination is happening for children

Access to specialty care

- Psychogeriatrics is a growing concern
- A methadone program in Red Lake would be helpful in meeting client need
- Forensic psychiatry services may be beneficial
- Access to psychiatry in Dryden is challenging as the primary care provider must make a referral to specialized care
- There is need for managed alcohol programs like the one in the city of Thunder Bay

Community based services

Both successes and opportunities in community based services were identified in the district in meeting the local needs of clients.

- Firefly and CCAC nurses for mental health and addictions have improved access to services and local linkages
- OPP campaigns on anti-bullying and the Drug Abuse Resistance Education (DARE) program are showing promise
- Alzheimer's society is facing challenges in meeting demands and needs related to dementia
- Kenora Association for Community Living (KACL) has a wellness program to support healthy living. It is primarily funded through donations/grants and therefore is an insecure program
- Housing subsidies are an issue
- Only those with appropriate private coverage get their transportation paid for
- The assertive community treatment (ACT) team in Kenora does not see all mental health and addictions clients such as dual diagnosis. Knowledge transfer and capacity building need to occur
- Homeless populations who are struggling with addictions cannot access shelter if under the influence
- Housing is needed for everyone especially those struggling with mental health and addiction issues
- Substance abuse and housing are significant issues

Access to Care

Discussion on 'access to care' was framed as access to the emergency department, specialty care, ALC and imaging. However participants were encouraged to bring forward additional items for discussions. The key themes that were discussed included:

Specialty care

- There may be a difference in specialized procedures offered between Winnipeg and Thunder Bay (For example, mastectomy and breast reconstruction are two surgeries in Thunder Bay but one procedure in Winnipeg. Another example is paediatric orthopaedics, there is a specialist in Winnipeg but not in Thunder Bay)
- There is an apparent surge of psychiatric and social issues for adolescents and youth, and a need for psychiatric acute care facilities for this age group
- If specialty equipment were put in place at a hospital in each IDN, a visiting specialist would be able to conduct procedures for patients in their home communities
- If specialists travelled more often to IDNs and experienced the capacity and challenges in remote communities, ensuing relationships would foster referrals

Technology

- Telemedicine systems are being utilized well to provide greater access to specialty care
- The telemedicine nurse/coordinator is integral in ensuring patients are comfortable using the technology for interactions with care providers
- Telemedicine systems help health service providers stay in contact with specialist teams and facilities based in Thunder Bay
- Child and adolescent psychiatrists are accessed through the telemedicine systems
- Telemedicine and telehomecare are beneficial, but the health service provider often does not have an IT person on staff to help with technical issues

Transportation

- Community-based and volunteer-based services, such as the Red Cross or the Lions Club, are available in some communities to drive patients who need to travel for specialist care. These organizations often front the cost themselves and access the Northern Ontario Travel Grant for reimbursement

Geographic constraints

- Access to MRI services is difficult because of travel distances to either Thunder Bay or Winnipeg
- The Ontario health system encourages referrals to specialist care in Thunder Bay, but many patients in Kenora IDN prefer to access care in Winnipeg because they may have family and friends in Manitoba, and it is the same time zone as Kenora (2 hour drive vs. 6 hour drive)
- Travelling to Thunder Bay or another destination for specialist care often requires the time of a family member, who must take time off of work without compensation

Access to health services

- Marginalized persons, such as the homeless, have poor access to services, go undiagnosed and often present at the emergency department for care. Furthermore, there is difficulty connecting persons presenting at the emergency department with supportive and social care upon discharge
- If home care was managed by the hospital corporation, there would be an incentive to provide a high quality service to avoid the consequence of increased emergency visits and ALC days

Local challenges

- The senior population of Kenora IDN is rapidly growing, and there is a corresponding increase in cases of dementia. This has implications for long term care and patient transport
- Supportive housing could be offered in smaller communities to prevent people moving to Kenora or Thunder Bay for access to supportive housing

SUMMARY

- There was open and strong participation during the group discussions. While some participants knew each other, others did not and this provided the opportunity to network with people in the district
- Participants valued the opportunity to share their experiences and ideas during the Harvest Café with a diverse group of HSPs
- The format of the Café received positive feedback from the participants however participants indicated the need for allotment of additional time during the discussions
- Participants expressed appreciation towards the LHIN for making the effort to travel to the District of Kenora IDN and taking the time to meet with stakeholders
- A follow up summary document of the Harvest Café discussion was of keen interest to the participants and they were assured that this would be provided

The goal of the session was achieved. Health service providers from the District of Kenora IDN embraced the opportunity to share their lived experiences and provide insight into how patient health care experience can be improved as planning the next IHSP takes place.

APPENDIX

Summary of Attendees Evaluations

1. Overall, did this session meet the stated objectives? Yes (9) No (-) Unsure (-)

2. What was your overall level of satisfaction with the following:

Please mark one rating per line, either **X** or ✓	**Highly Dissatisfied**	**Dissatisfied**	**Satisfied**	**Highly Satisfied**
Content of session			**6**	**3**
Group Discussion		**1**	**4**	**4**
Use of Your Time		**1**	**5**	**3**
Opportunity to participate			**3**	**6**

3. What was your overall level of satisfaction with this session?

	Highly Dissatisfied	**Dissatisfied**	**Satisfied**	**Highly Satisfied**
Please mark one rating only		**1**	**5**	**3**

4. What did you like best about this session?

- Opportunity to share information (Harvest Café) (4)
- Mixing up the small groups for a different perspective
- Meeting the LHIN staff and discussing the Northwest vision (2)
- Sharing successes and challenges
- LHIN presentation

5. What are one or two things that would have improved this session?

- Long-term care representation
- More discussion time, equal time for different sectors (3)
- Larger room for comfort
- Representation from marginalized populations, homeless and addictions
- Mix up the small groups so they don't travel together to each table (create a more varied conversation)

7. Was the Harvest Café was an appropriate format to engage in group discussion?

	Highly Dissatisfied	Dissatisfied	Satisfied	Highly Satisfied
Please mark one rating only			**5**	**4**

8. Other comments:

- A good job in planning and facilitating, look forward to future meetings (2)
- Thanks for the opportunity to contribute
- The group worked together to address common issues, goals, gaps, and vision to move forward
- Unfortunate that some people dominate the round table discussions
- More in depth comments could have been provided in a survey rather than a full day