Integrated Health Services Plan 2010 – 2013 (IHSP-2)

Themes and Findings from Phase 3 Consultations

Final Summary
October 29, 2009

Summary

Later in 2009, the Toronto Central LHIN will release its 2nd Integrated Health Services Plan (IHSP-2) covering the period from 2010/11 through 2012/13. In September 2009, the LHIN circulated two consultation documents and associated surveys: one targeted at health service providers and one targeted at community members and health care consumers. This document summarizes the results of this survey process. Overall, surveys were completed by 356 health service providers and 110 community members.

The health service provider (HSP) survey and consumer survey asked somewhat different questions with the HSP survey being more detailed.

The document is organized as follows:

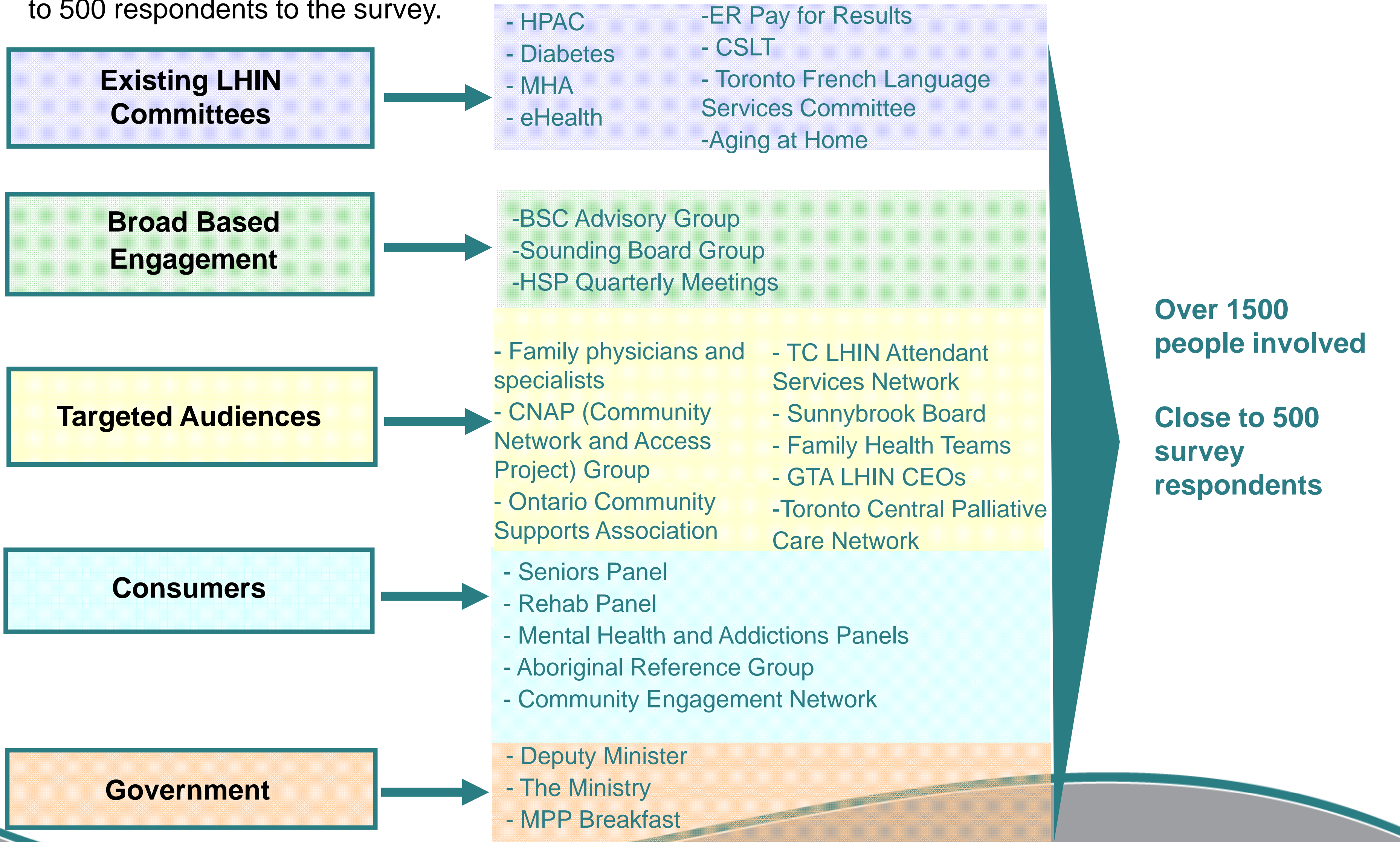
- *Phase 3 Consultation Approach and Response Rates*
- *Overall Results*
- *ER/ALC*
- *Diabetes*
- *Mental Health and Addictions (MHA)*
- *Health Equity; eHealth*
- *Feedback on Outcomes / Value to the public*
- *Most essential / Least essential System Function in next 3 years*
- *Overall Comments*

Section 1

Phase 3 Consultation Approach and Response Rates

IHSP-2 Community Engagement: April – October 2009

In total, the IHSP-2 process has engaged over 1500 people through a variety of forums and there were close to 500 respondents to the survey.

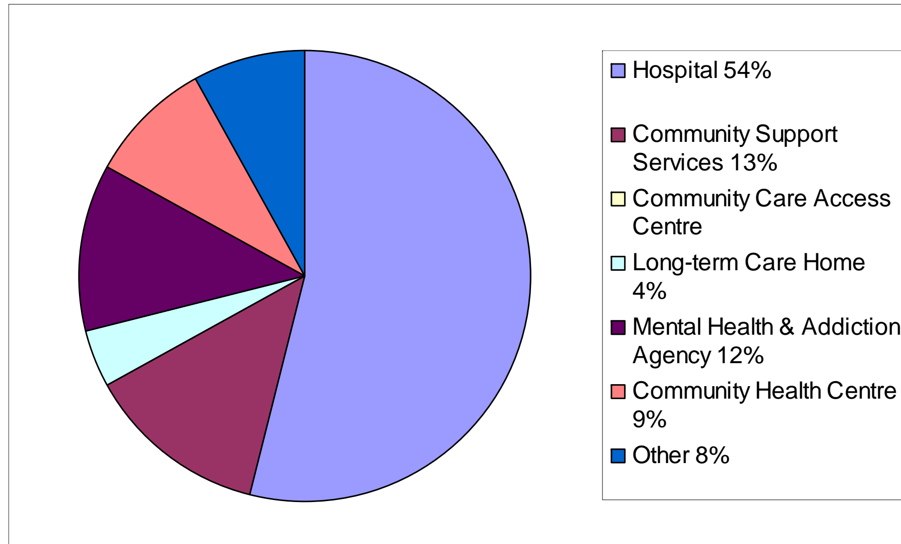


Profile of IHSP-2 Survey Respondents:
Health Service Providers

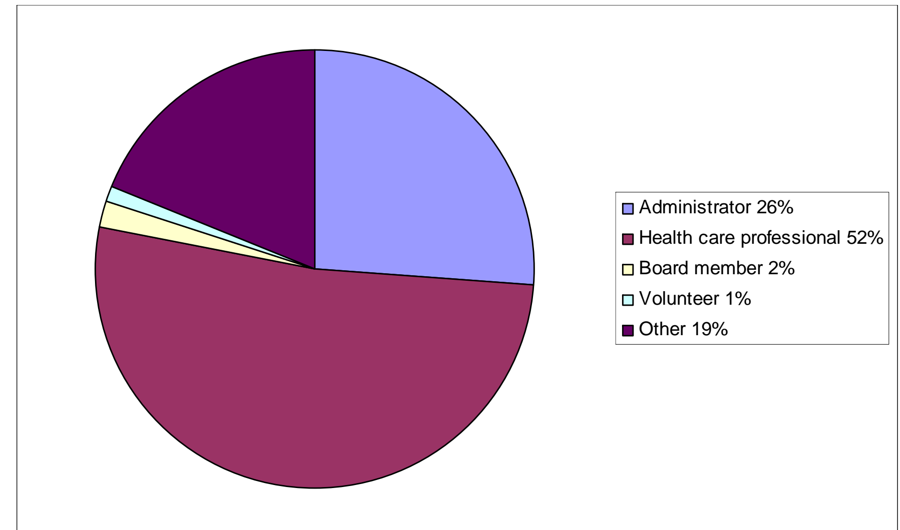
Of the 356 surveys received from health service providers, the largest proportion of surveys came from hospitals and health care professionals were the largest provider group completing the survey.

N = 356

Sector representation



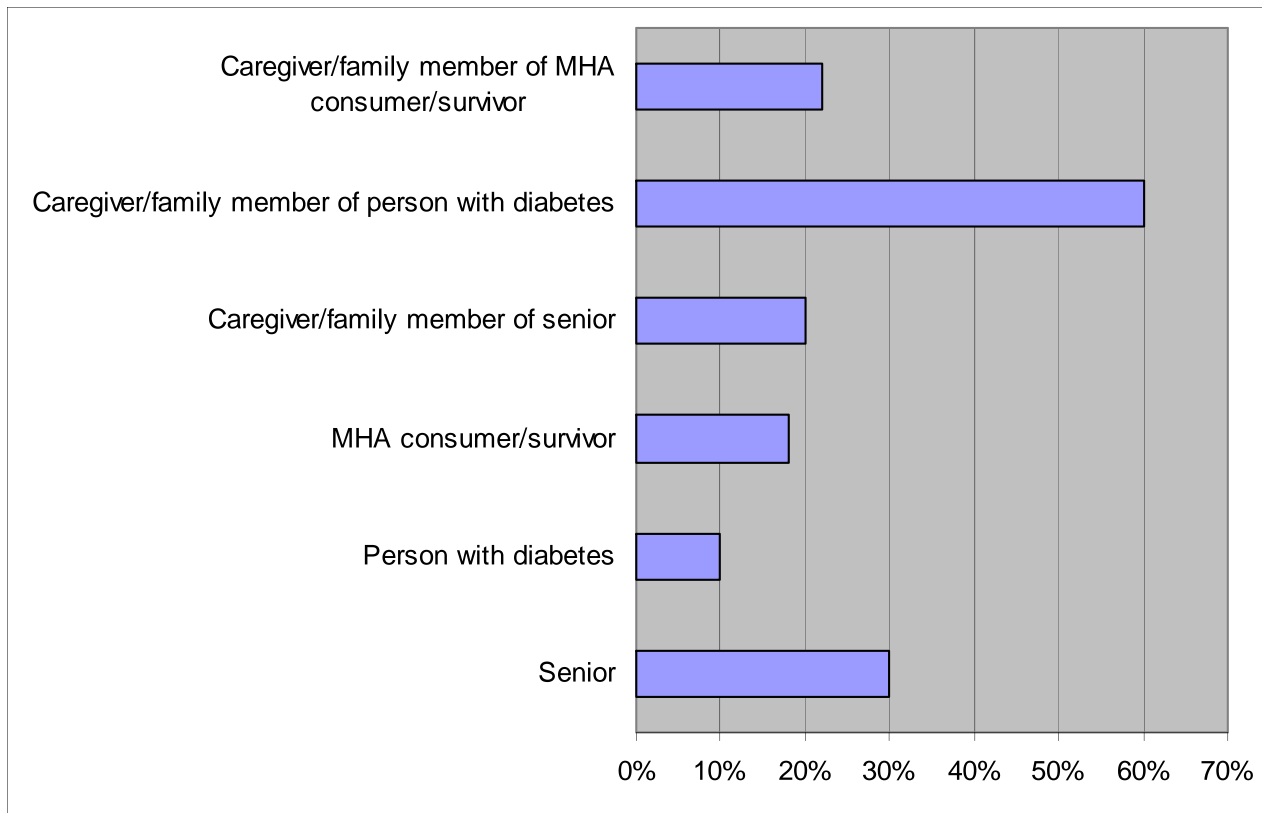
Provider type



Profile of IHSP-2 Survey Respondents:
Community Members

Of the 110 surveys received, the largest proportion of surveys came from people who identified as caregivers or family members.

N = 110



Overarching Themes

The themes described here reflect the most prominent feedback received from the community, health service providers and consumers in Phase III in both the formal survey as well as multiple face-to-face consultations. Respondents were most interested in:

- ***Transitions in Care*** - navigation, discharge planning, better links between providers
- ***Focus on Vulnerable populations*** - persons with dual diagnosis, homeless
- ***Quality and Safety*** - patient satisfaction, more standardization
- ***Prevention and Social Determinants of Health*** - particularly housing
- Need for more investment in ***community services –*** especially in-home and close to home supports
- ***Health Human Resources*** - dissemination of best practices, more training
- ***Information sharing***: clinical information and availability of services

Notable Themes from Providers and Consumers

A handful of additional themes emerged that were unique to the provider and community members

Themes Common to Providers

- Increased accountability between providers, and accountability for deliverables
- Cross-LHIN linkages
- Focus on primary care

Themes heard from Community Members

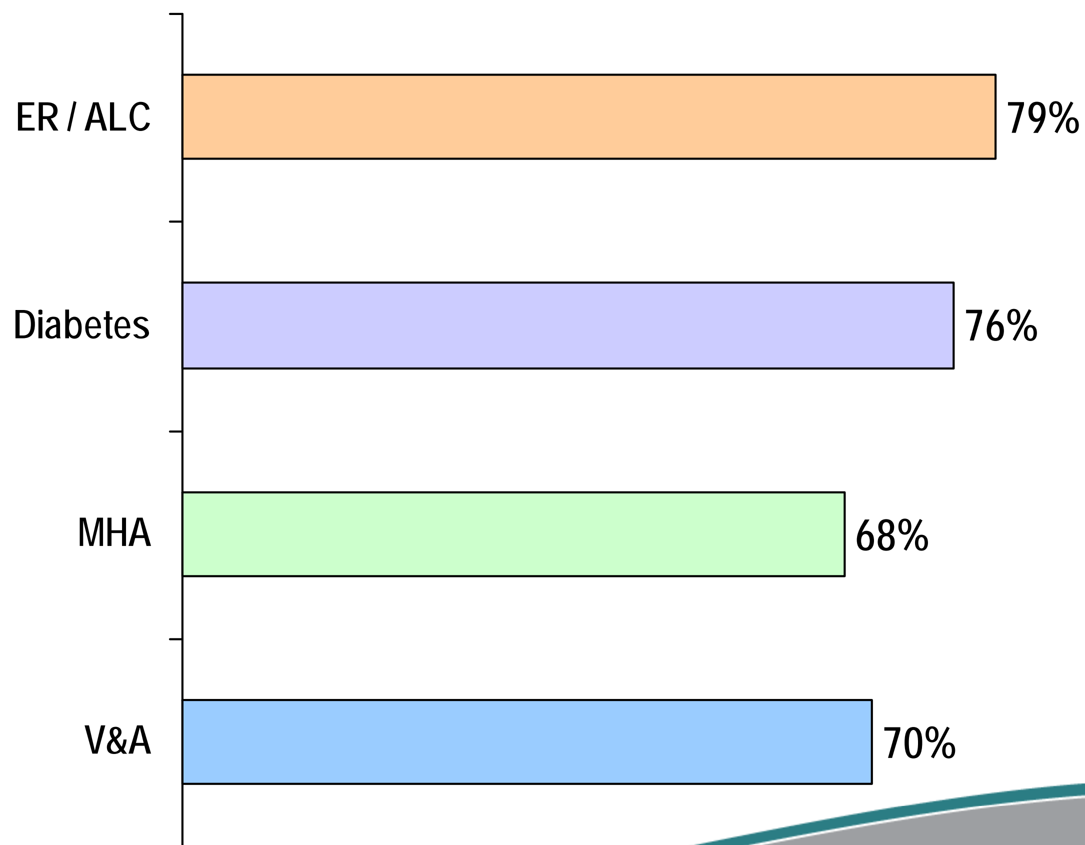
- Focus on caregivers/families
- Primary care - including ER alternatives (e.g. after hours clinics, house calls)
- Health Equity – culturally sensitive and competent services, language interpretation and translation, peer support services, access to care

Support for IHSP-2 Action Plans: HSPs

Health service providers, in general, showed support for the IHSP-2 action plans .

Question: The activities described in the action plan are the right activities on which to focus in order to accomplish the goals for this strategic priority

% Agree or Strongly Agree

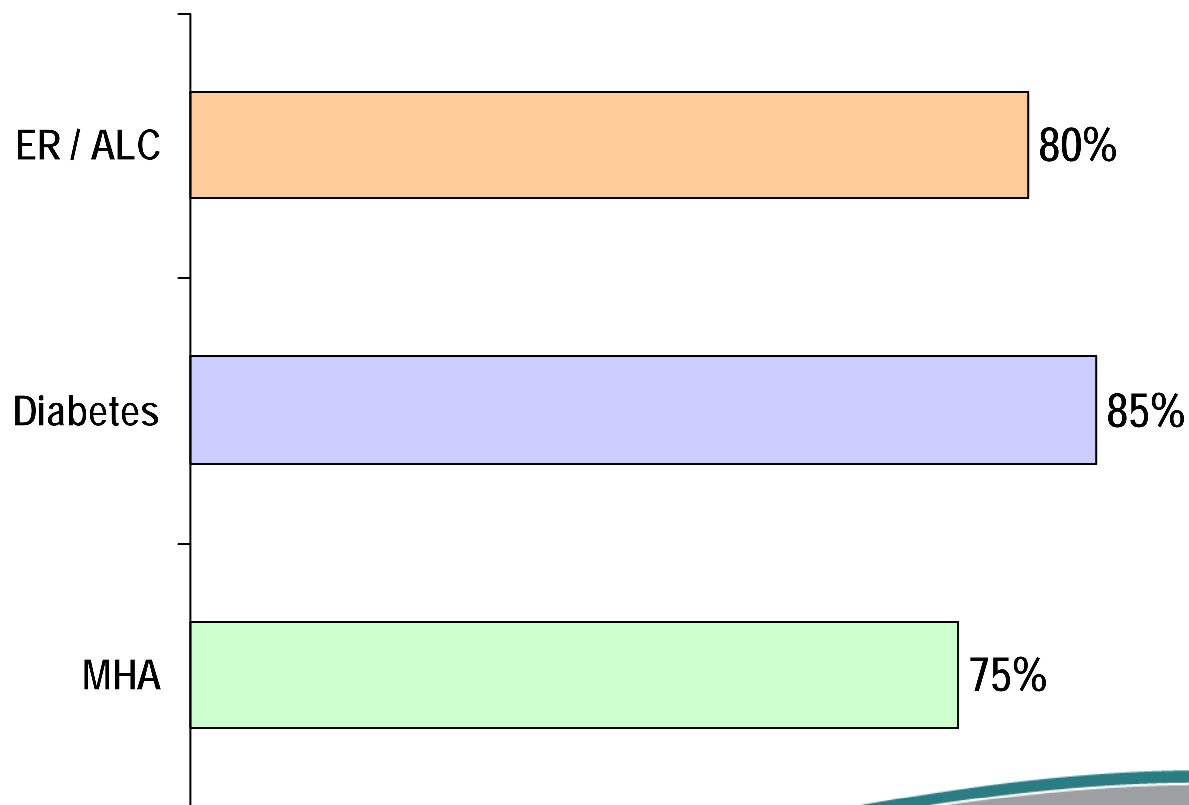


Support for IHSP-2 Action Plans: Consumers

Consumers also showed overall support for the IHSP-2 action plans.

Question: Based on your own experience, are these activities (described in the action plan) **moving in the right direction?**

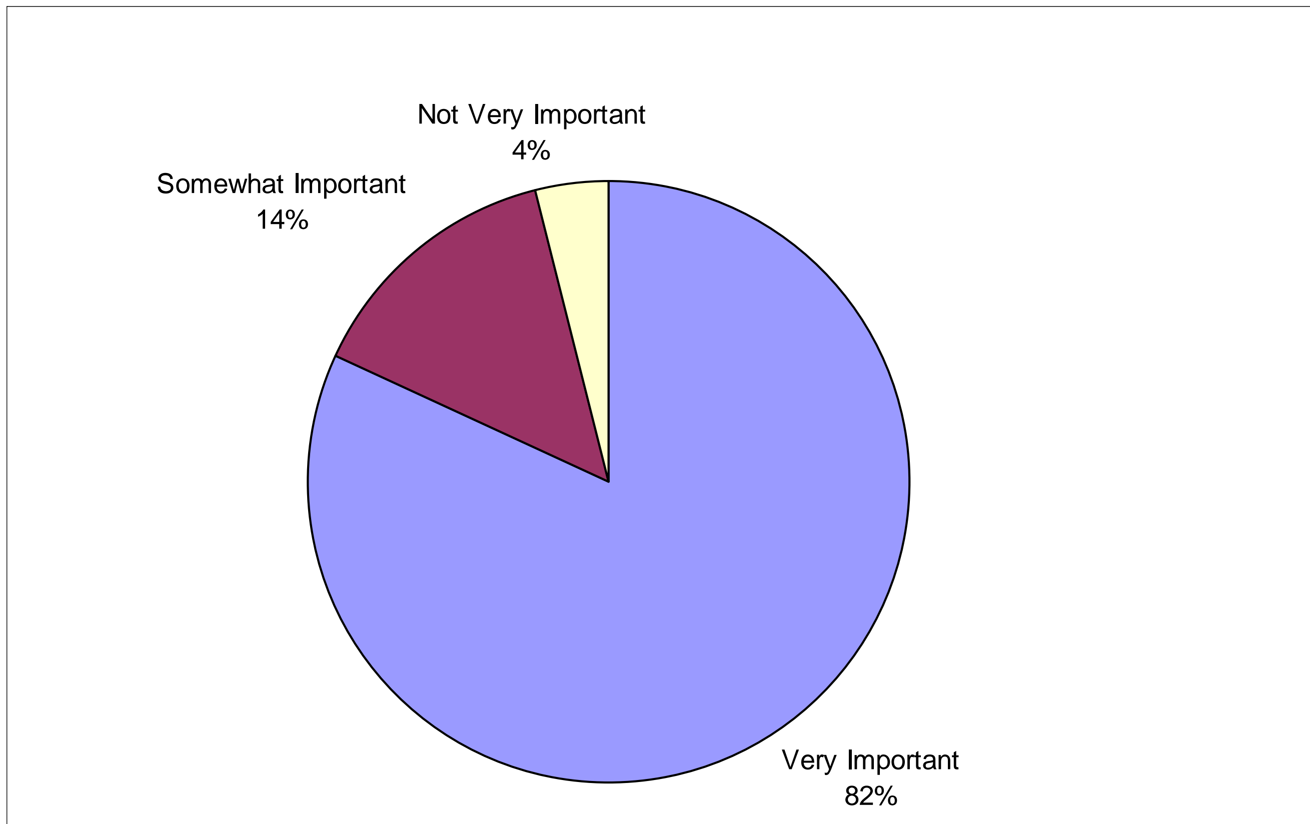
% Agree or Strongly Agree



Support for Value & Affordability – Consumers

Consumers are overwhelmingly supportive of the LHINs focus on increasing the value and affordability of services.

Question: How important do you think it is for the LHIN to focus on finding ways to increase the value and affordability of health care services?

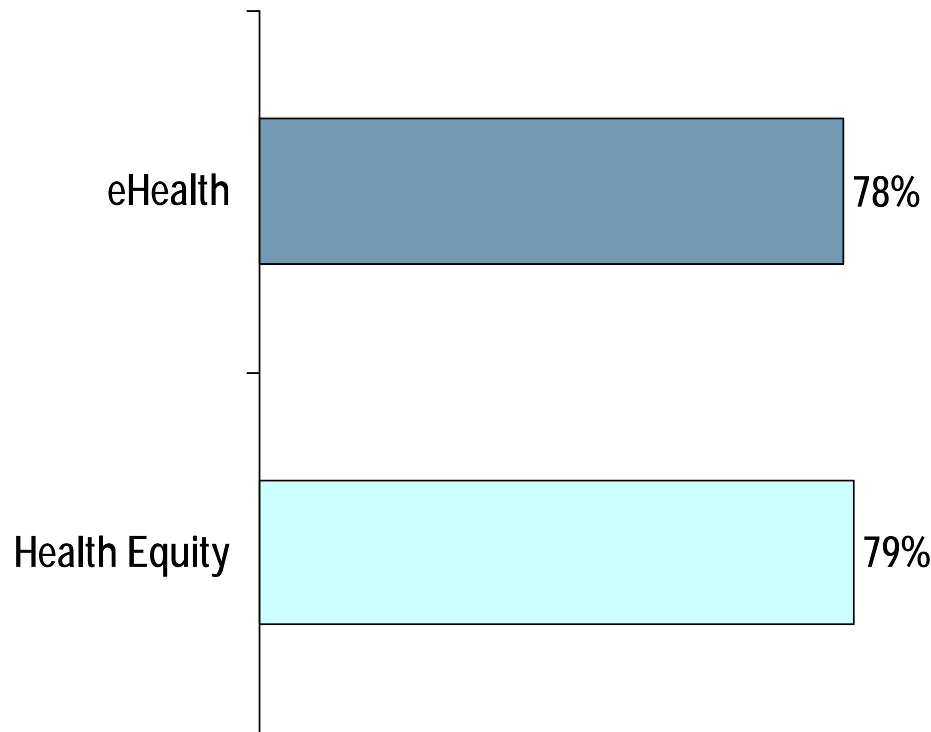


Support for eHealth and Equity: HSPs

Health service providers agree that Health Equity and eHealth are important enablers in supporting the five IHSP-2 priorities over the next three years.

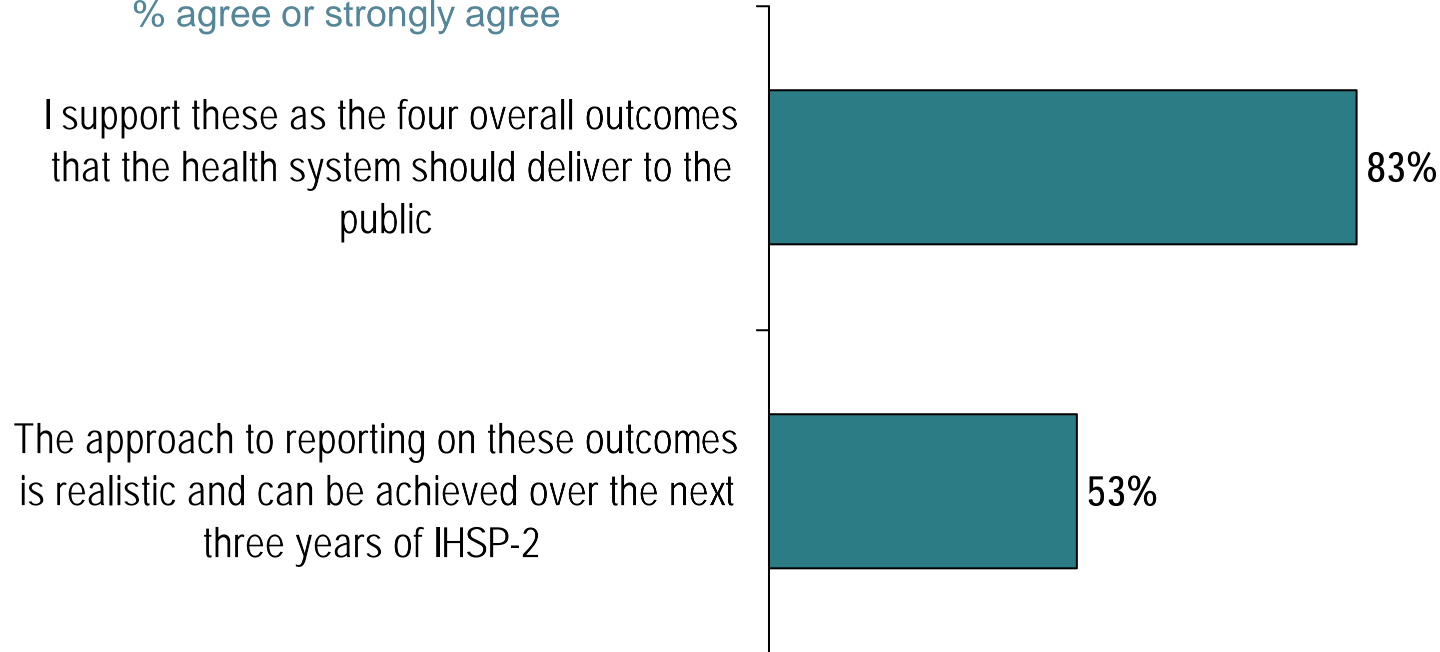
Question: _____ is an essential enabler in supporting the five IHSP-2 priorities

% Agree or Strongly Agree



Support for the Overall Outcomes

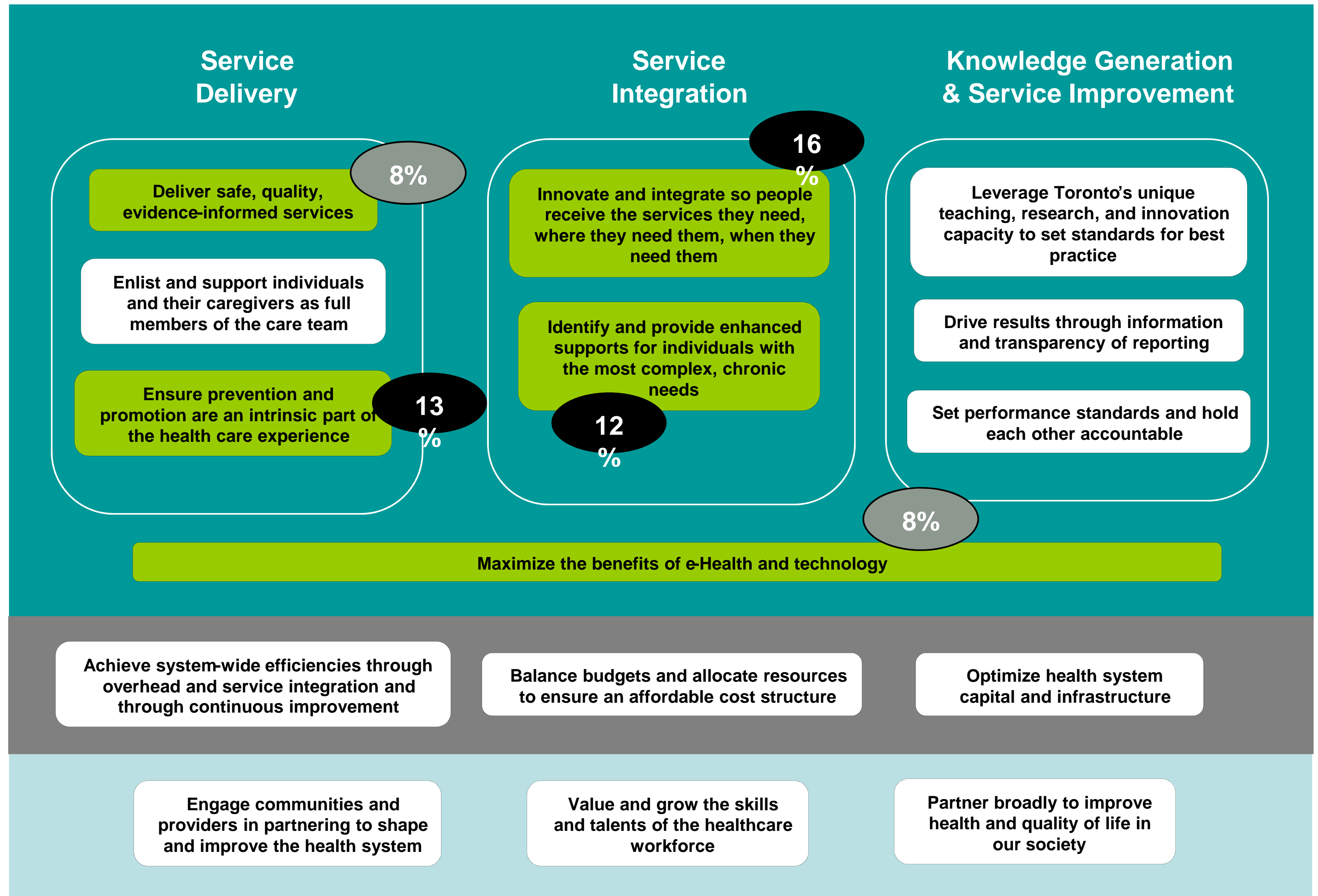
The last section of the Health Service Provider survey asked for feedback on dimensions of the overall TC LHIN strategy map. The first set of questions asked for feedback on the four "outcomes" or dimensions of value to the public that are shown at the top of the strategy map. HSP respondents showed strong support that for these four overall dimensions – but were much less confident in the proposed approach to how the LHIN will measure performance against these dimensions.



Most Important "System Functions"

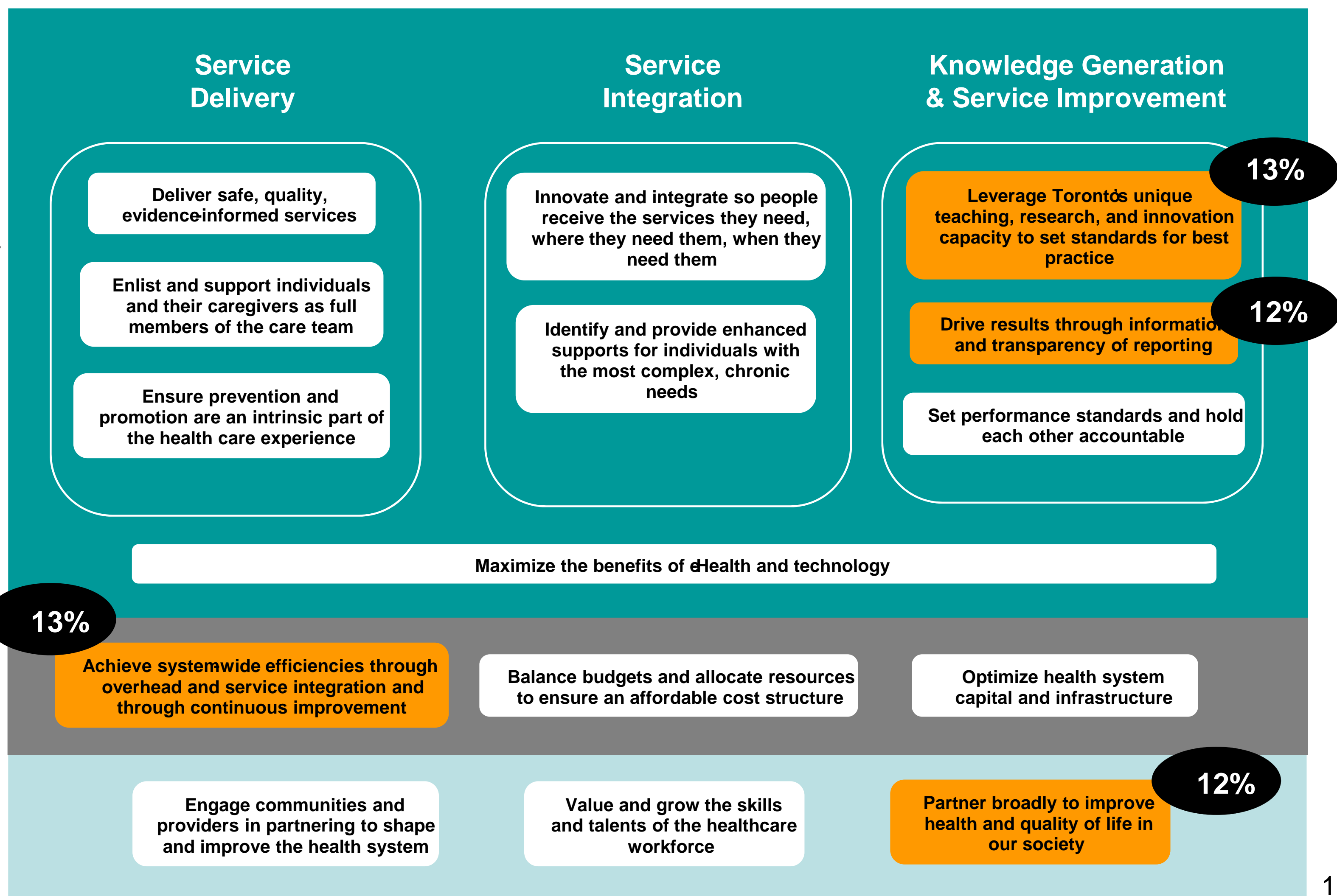
The HSP survey also asked respondents to rank the fifteen "system functions" in the strategy map in order of "most essential" *to making progress in the next three years..* The diagram below shows the highest ranked functions.

Question: Select the three health system functions that you believe are the most essential to making progress in the TC LHIN *in the next three years*



Least Important "System Functions"

The "least essential" functions are shown in orange.



Section 2

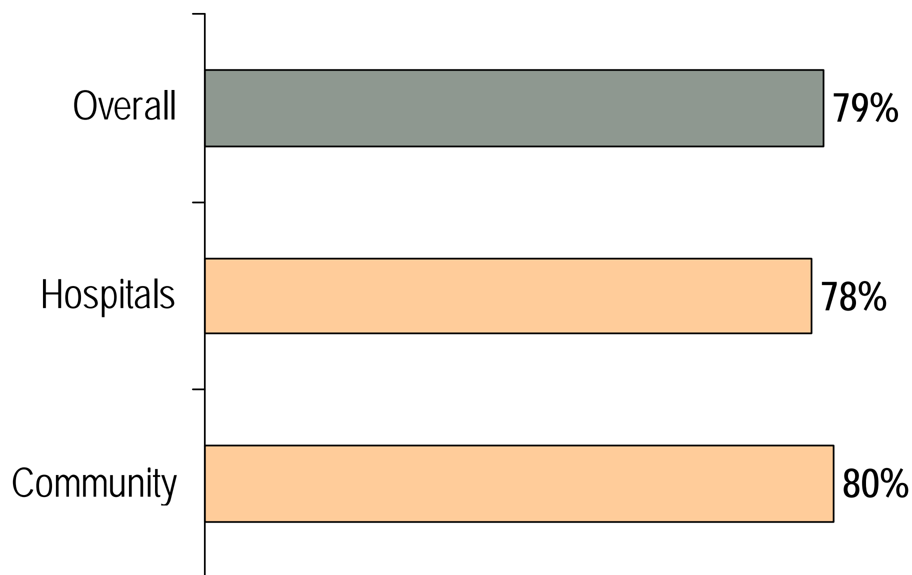
Results for the ER/ALC Action Plan

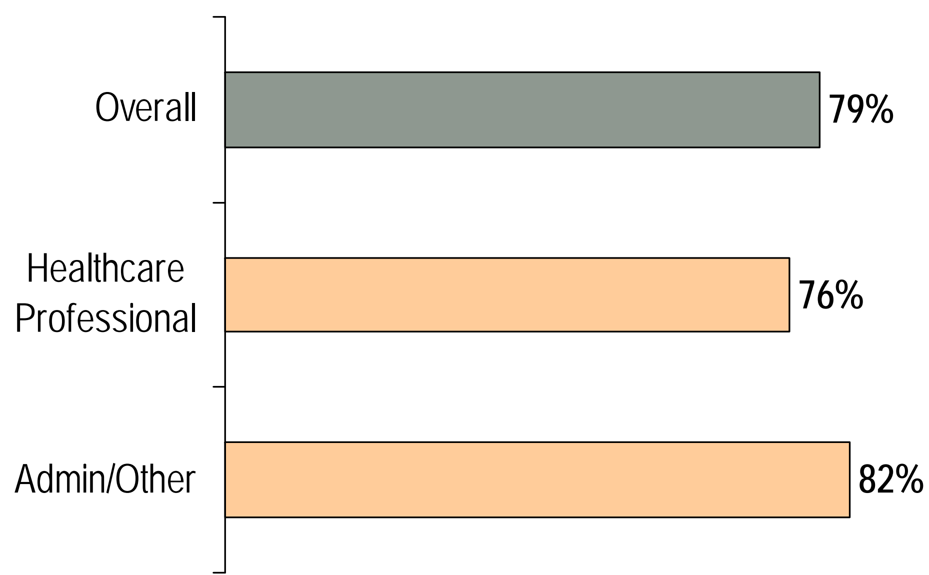
ER-ALC

Overall Support for the Action Plan: HSPs

Support for the ER/ALC action plan among health service providers is consistent.

% agree or strongly agree

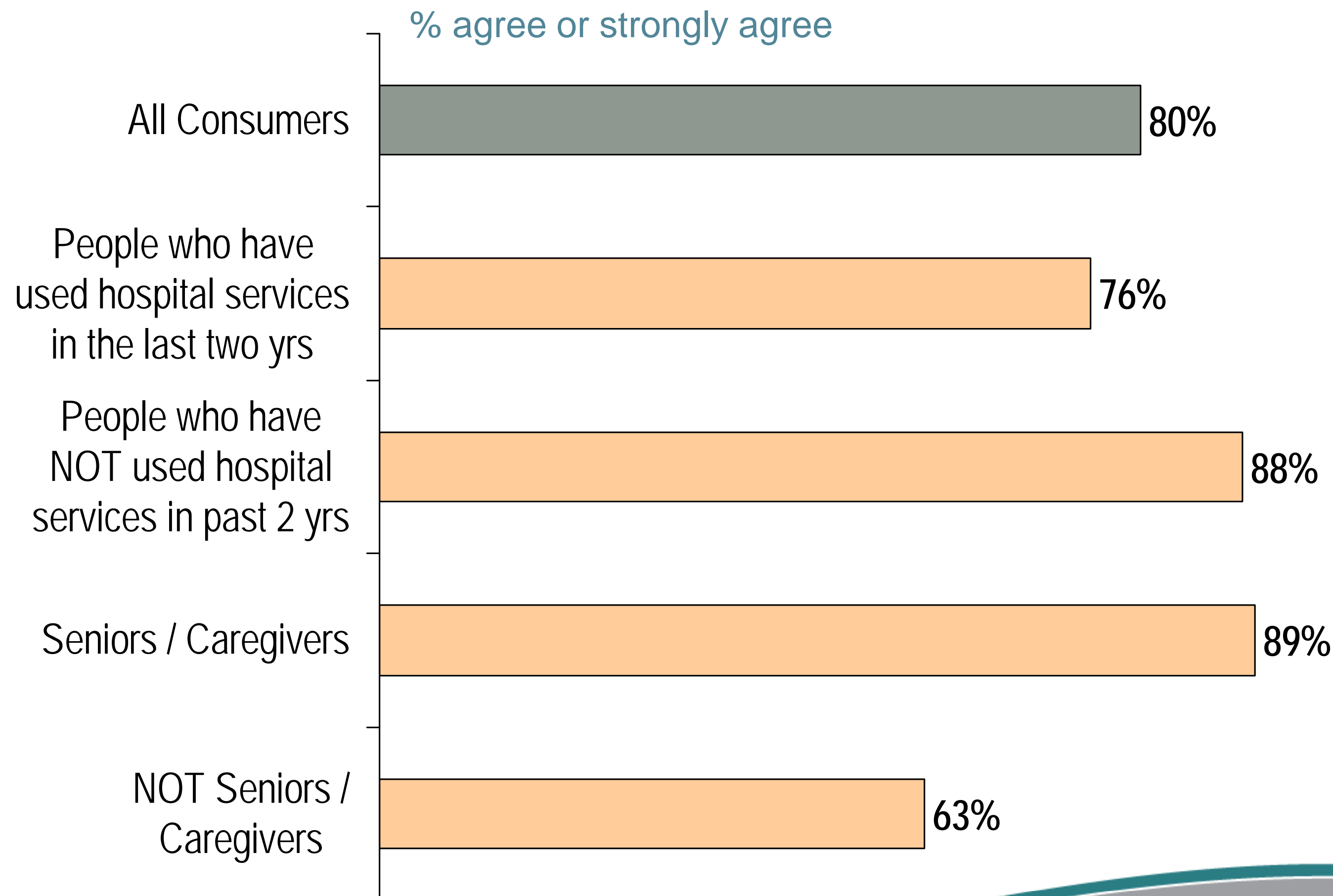




ER-ALC

Overall Support for the Action Plan: Consumers

There were notable variations in level of support for the ER/ALC action plans among consumers with seniors and people who have not used hospitals services in the past two years showing the strongest level of support.



Proposed Changes to the Action Plans from Health Service Providers
ER/ALC

Number of Comments	71

Population focus	Seniors are not the only vulnerable group to consider, people having a dual diagnosis are also part of the percentage of those in ALC beds. As an Emergency Physician with a particular interest in Care of the Elderly, I keep observing that high-quality care of an older person in the Emergency Department is often a highly effective, cost-efficient activity. Having increased resources and improved training for ED staff in the particular challenges of caring for older people is a high priority... While reducing ED wait times is in general a good idea, I would argue that in some/many cases a longer ED stay for an older person is frequently beneficial. The primary groups presenting are: The frail elderly, those with no primary care physician, the economically disadvantaged ,the sick. This plan does not target any of these!
Community capacity	Focus on building up the number of beds for senior and vulnerable citizens in the community FIRST. The enhancing community based programs including those with addictions sounds great, however there are a large number of folks without homes or with unsafe housing who require addiction services; in particular withdrawal management in a hospital type Although I see these are urgent areas to be attended to, increasing alternative/community service, both crisis and ongoing care, availability is crucial.
Specialized services	General support for community services, but specialty care/complex continuing care are the really difficult & resource-intensive needs experienced in-hospital - the ER/ALC action plan may not crack the toughest nut. Emphasize importance of specialized rehab/CCC and LTC as an enabler to reducing acute-care ALC
Process improvements	Intake processes (CNAP) are not well funded for their mandate - they require significant resources to do this well including specific issues eg. palliative care, mental health etc. but the program is not set up for that much detail. "Hiring any ""flow nurses"" or/and administrators for these purposes (ER/ALC) are a waste of funds in most hospitals because these roles have no incentive to improve efficiency of care Many pts attending the ER, should be elsewhere, but have no family MD or local clinic. I would locate such clinics adjacent to the busiest ERs and refer such patients there
More investments	Given the current status of financial budgets within hospitals, which is fixed - or modestly diminished, the amount of resources available for patient care is limited. Thus, new initiatives such as ER wait times will likely result in a new layer of bureaucracy within each organization to monitor and collect data for reporting. Thus, the amount of available resources for a new initiative will need to come at the expense of existing programs. Broad ideas have been given in the Action Plan, however, the logistics requires increased health care spending, hiring of human resources and increasing physical space/beds for ALC residents

Indicator Advice from Health Service Providers
"If the LHIN only tracked one measure of success"
ER/ALC

Number of Suggestions	92

In general, there was not a wide range of variation across the 63 responses.

New indicators	Focus on ALC not ER since there are other variables affecting LOS in the ED, not just ALC. From those listed, I would select "Total ALC days" but it is the timely transfer to Rehab/CCC from acute setting that is crucial. If emphasis is on community solution, some community-based indicator must be tracked - currently absent.: ALC placement from hospital to suitable community setting. Reduction in ALC beds Hospital readmission rates Number of occupants waiting to be transferred from acute care centers and the average # of days. Number. of days ALC patients stay in hospital Time from registration in ER to admission Proportion of hospital days spent by non-acute care patients Percent of people who present at an ER who are not connected to any community based supports. Patient satisfaction with care in the ER
Comments related to measuring wait-times	Wait times are in-vogue but have NEVER been shown to impact health outcomes in the population. Do we really want to just look good or actually improve the health of the population? Wait time should not be measured just in ER's. How about wait times for mh and/or addictions, for seniors supportive housing
Other	Numbers of patients served who got the care (ie resolved the problem they sought care for) they came to the hospital for and the cost to do this.

Advice from community members, consumers and families on what is working well in the system and where there are gaps in care

ER/ALC

Number of Suggestions	55

Suggestions for new services	Transportation services to dentist, doctors appointments. Urgent care walk-in clinics for events that happen in the evening or on weekend but that do not need a hospital (e.g. requiring stitches) If they had one doctor who makes house calls, it would make a lot of difference. Phone consultation with a medical expert (who has good clinical diagnostic skills) on specific medical or health conditions. Continuing training for the personal support worker in areas of nutrition, first aid. Use Telehealth as a resource.
Valuable home services	Services for items such as physiotherapy after surgery are delayed due to waiting lists and only available quickly if you are able to pay. Some members of my family have been very appreciative of the good community language interpreters that have been provided and they notice such an important difference in quality and the confidence they have in professionally trained interpreters versus the model of having people bring relatives that speak English and the target language
Information/ coordination of services	I don't know how to find out what health care services and options exist for you or your family in the community. There is confusion over what is covered by OHIP. Often you only find out when something isn't covered after yu have used the service and it's time to pay. More education around this would help in my community. There is also confusion over eligibility when trying to access mental health/addication services. You often have to go to more than one agency to find the right one. It would be great to integrate services that are similar so that consumers can go to any mental health agency and find out which place offrs the right service for you. Or atleast have someone experienced work with you to navigate the complex system.
Other	I am able to access them, however many seniors have difficulty making the initial contact with home services (which does not provide help anyway) or community service agencies. Appalled at lack of timely services.

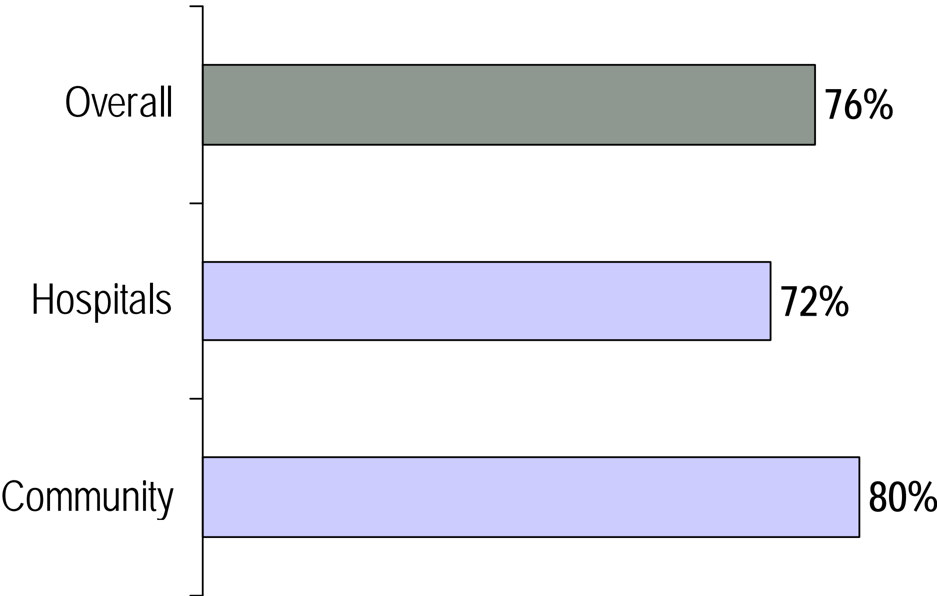
Section 3

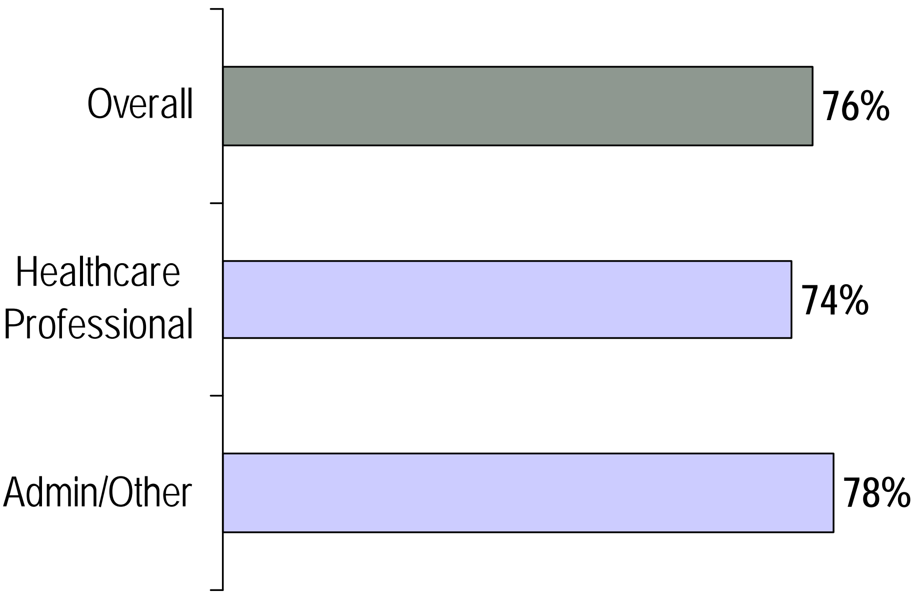
Results for the Diabetes Action Plan

Diabetes

Overall Support for the Action Plan: HSPs

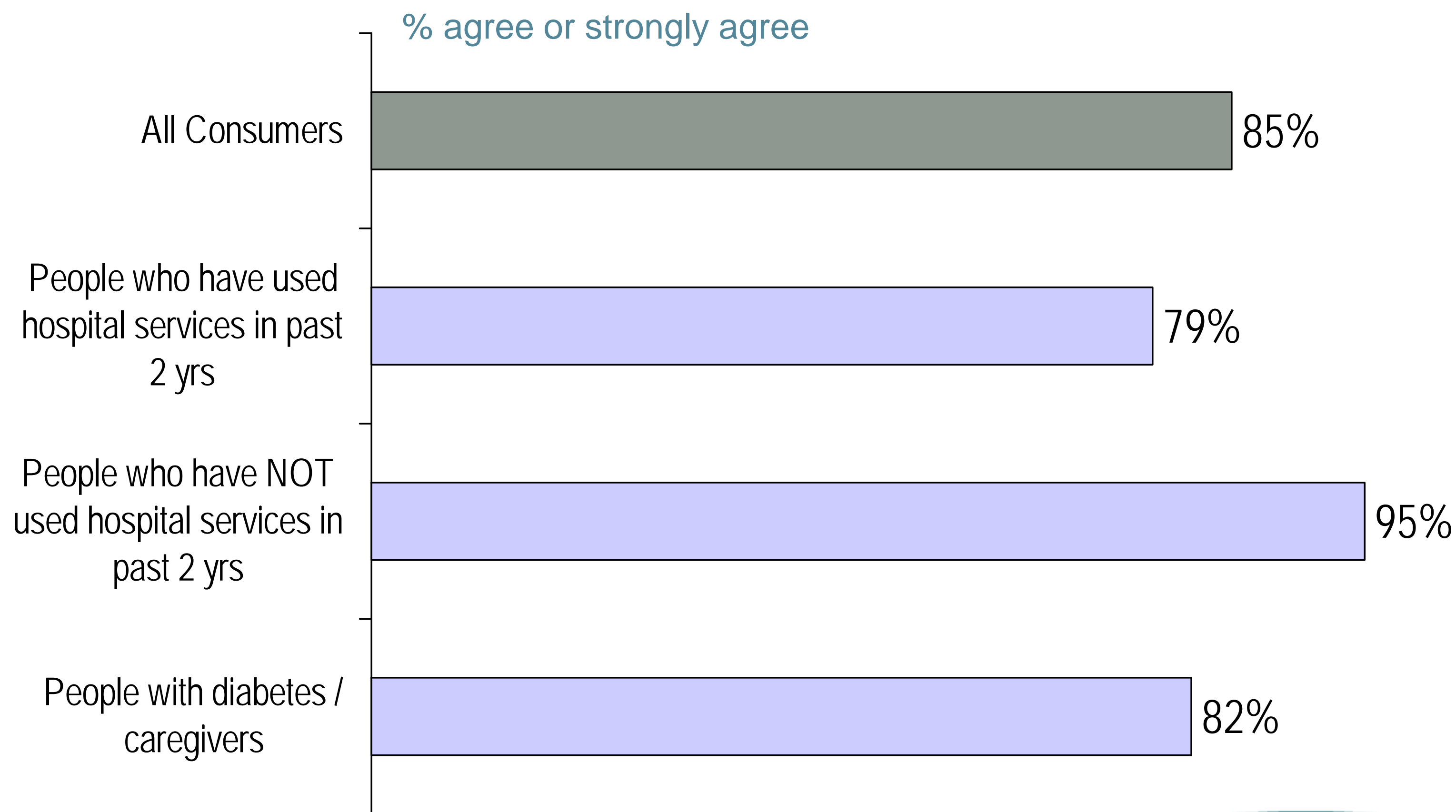
Overall, health care providers were supportive of the diabetes action plan.





Diabetes
Overall Support for the Action Plan: Consumers

As with the ER/ALC, people who have not used hospital services in the last two years expressed more overall support for the plan. People living with diabetes and/or caregivers of people living with diabetes showed high overall support for the plan.



Proposed Changes to the Action Plans from Health Service Providers

Diabetes

Number of Comments	63

Prevention	I support addressing diabetes as early intervention can significantly impact the trajectory of the disease and reduce overall costs in the long run. Add initiatives and activities that focus on the social determinants of health e.g. income supports, access to healthy food, education. Need to build a comprehensive prevention strategy. There should be specific activities that assist with diabetes management and prevention [in high risk populations]; activities like improved eating (shopping, cooking, food preparation)
Access to specialists	There is a greater role for specialists to be played in the roll out of this strategy than is suggested by the plan. Many patients with diabetes are complicated, and many of them fail to have routine testing As more cases are indentified the resources to endocrinologists will need to be increased Need early involvement of diabetic foot care teams that include vascular surgery
Culturally relevant care	It would be helpful to reach out to communities, but how are you deciding which communities and in what way? Need to take into account cultural differences. We really need to consider more consolidated services for diabetes care - these services also need to be responsive to cultural issues. Integrate the need for interpretation "\
Centralised, coordinated services	Ensure there is a full-continuum strategy: acute, CCC, rehab, LTC, community. Establish linkages between primary care and diabetes education centre through a regional diabetes coordinating centre. Need more consolidated services for diabetes care – services need to be responsive to cultural issues. Create screening centers (like service stations) where pts with DM go and have the panel of tests done, the results of which are sent to their primary care clinic. Diabetic management centres will not work as they separate diabetics from their primary health care givers. People are more than a diagnosis, and need all their health care needs to flow through a single entry point.
Access to information	Make the Diabetes Registry available across sectors, including rehab, CCC and LTC Early referrals to CSS that focus on complications or risk factors of Diabetes e.g., Heart and Stroke, Kidney Foundation, CNIB. Inclusion of information regarding these organizations in Diabetes Education and media programs.

Indicator Advice from Health Service Providers
"If the LHIN only tracked one measure of success"
Diabetes

Number of Suggestions	63

In general, there was not a wide range of variation across the 63 responses.

Clinical-based indicators	The glycemic priority for diabetes management is not evidence-based. glycemic control is important, but priority should be on blood-pressure control. # of new patients and their HgBl A1C at 3 and 6 months Rate of diabetic foot infections which are suggestive of poor diabetes control and poor follow-up in community
Process-based indicators	the number of dialysis admissions per ##(10,000) of high risk group number of cases drops over a longer period of time % of people getting evidence-based tests according to best-practice guideline s# of people with diabetes who are not attached to primary health care who become attached to a primary care physician Hospitalization rates for complications of diabetes

Advice from community members, consumers and families on what is working well in the system and where there are gaps in care

Diabetes

Number of Suggestions	47

Prevention	Seems to be an emphasis on providing treatment; concern that the public health/prevention aspects are not given same attention. If you do not have a family doctor, do not get regular check-ups, do not get your blood tested, how are you to know you have diabetes? When you do, it could be too late for treatment. More could be done to prevent diabetes by educating people on life style choices that may adversely affect their health.
Education and information	There is a lot of patient education available for diabetes and excellent medical practitioners to attend to this patient population. For me some connections into the education about diabetes worked well but I do think that there needs to be more information available to people in general. Perhaps more local community groups for support and information. I think one of the things that could be improved is the information about the symptoms of other complications or diseases that come with diabetes Hospital based workshops that deal with living with diabetes - education reduces hospital admissions.
Reduce complications	Increased prevention programs to help prevent the onset of diabetes and the possibility of kidney disease as a complication of the diabetes.
Quality of care	Need continuity in service: all medical help is gone once the first education and visit is done Teaching is poor. I continually run into people in the store who have taken hospital based classes and still do not understand what to do.

Section 4

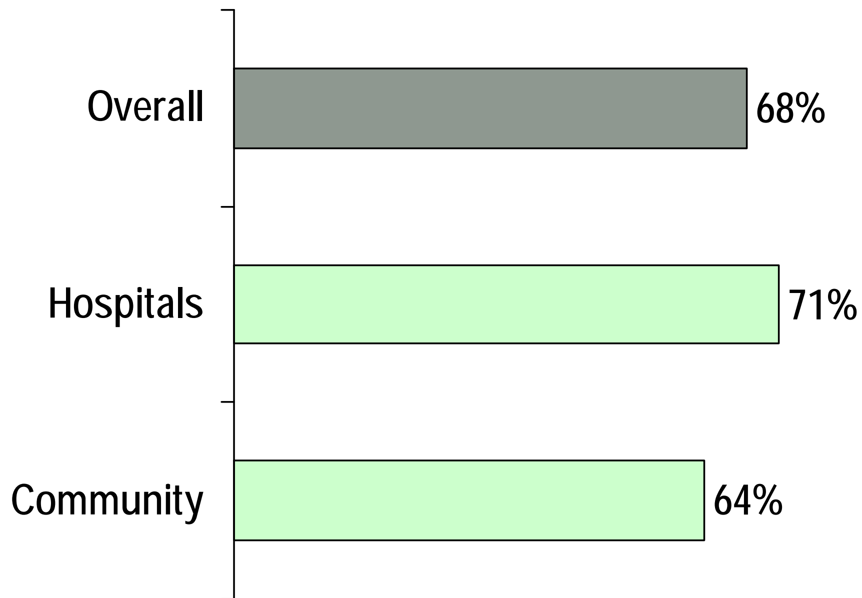
Results for the Mental Health & Addictions Action Plan

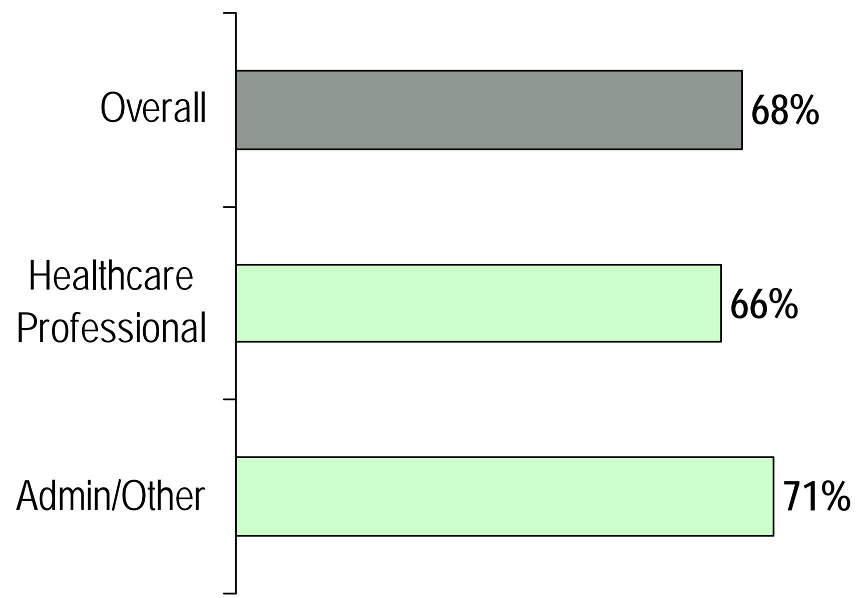
MHA

Overall Support for the Action Plan: HSPs

In general, health service providers were supportive of the Mental Health and Addictions action plan.

% agree or strongly agree

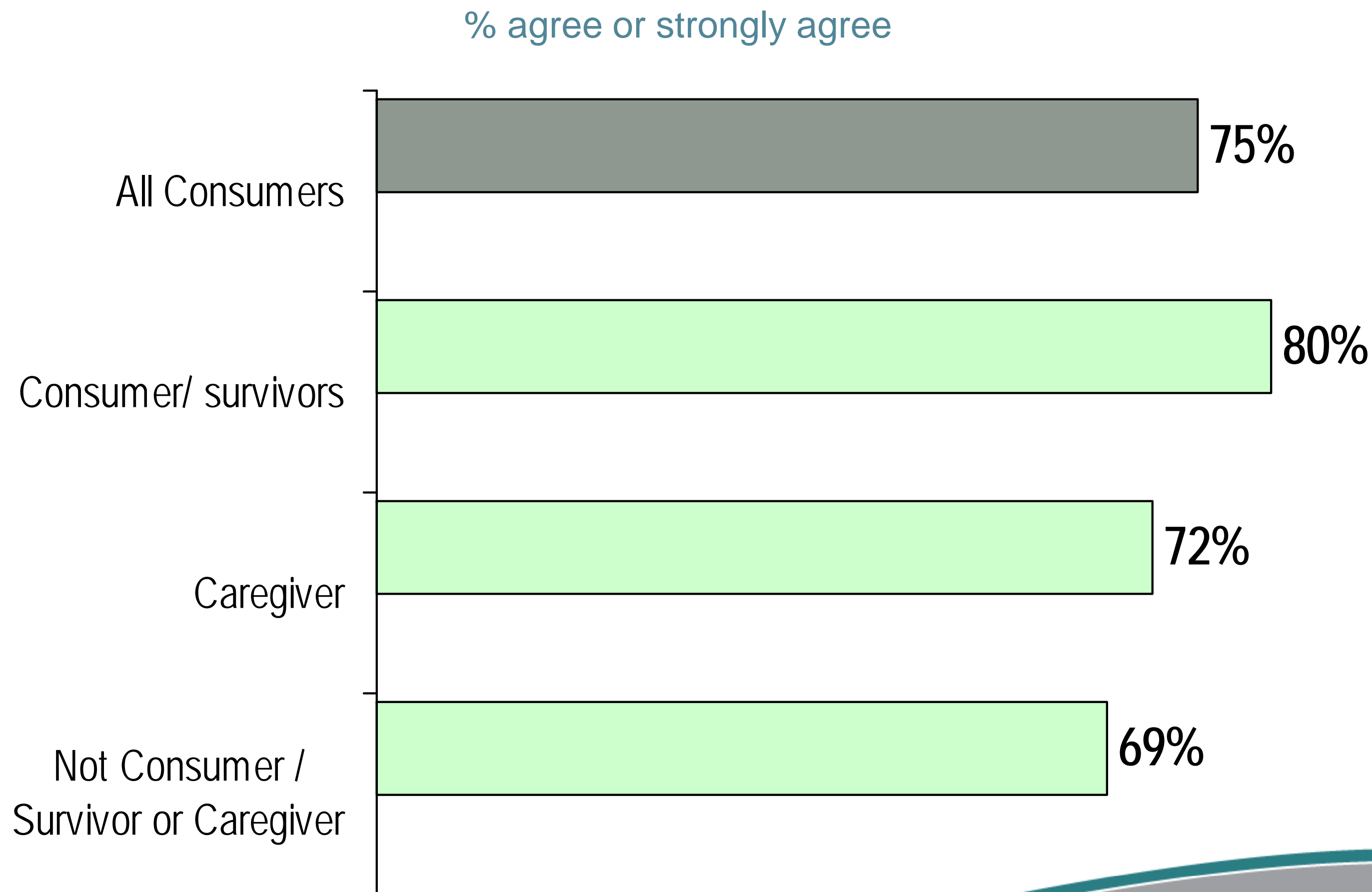




MHA

Overall Support for the Action Plan: HSPs

People who are direct users of Mental Health and Addictions services – either as consumer/survivors or as caregivers – express stronger overall support for the MHA action plan than those without direct experience with these services.



Proposed Changes to the Action Plans from Health Service Providers

Mental Health and Addictions

Number of Comments	66

System capacity	There is a tremendous dearth of mental health professionals. Most patients wanting to receive OHIP-covered mental health services face a long wait. We need more long term counseling services available to the low income population that frequently has mental health issues and cannot afford psychologist fees. Social workers that provide counseling services usually only do so on a short term basis. More emphasis on human resources -- it is virtually impossible to get a psychiatric assessment of an adolescent in a timely manner unless they are suicidal Need targeted investments in housing, 24/7 community programs, diversion from ER, tertiary care backup. More peer support for people in crisis. Build more shelter and mental health shelter with appropriate counselors and caretakers for the mentally ill citizens.
Priority populations	Dual Diagnosis policy guidelines - include this population in the priority population as they represent the best example of the worst things that happen in the mental health and addiction sectors Develop and implement targeted strategies for vulnerable populations....this should include Acquired Brain Injury (and by this I mean Brain Injuries related to stroke, SAH, SDH etc... not just head trauma) There is hardly any mention of children and youth. Children and youth mental health does not get the attention that is needed. Many adult mental health professionals will not see children.
Primary Care	I don't see explicit mention of how the family physician office will be aided as they try to coordinate the complex mental and physical health problems in any given patient.
Training for providers	Increased ED staff training regarding the particularities of geriatric mental health problems (delirium, dementia, depression, substance use) is essential Enhance geriatric MH&A training for care pr Enhance outreach programs that include training for external service providers as clients in the community may have dual diagnosis.
Waiting times	Detox wait times are anywhere from 1/2 a day to several days. There are NO youth or senior specific detoxes.
Holistic and continuous care	Invest in partnership initiatives that support holisic care - ie supportive housing; stronger linkage of MHA services with primary care. Ensure of continuum of care. If a person is admitted as a resident to LTC, discharging facility needs to create plan for follow up in consultation with admitting home, provide discharge summary, circle of support contact info, etc. none

Indicator Advice from Health Service Providers
"If the LHIN only tracked one measure of success"
Mental Health and Addictions

Number of Suggestions	62

In general, there was not a wide range of variation across the responses and several respondents agreed with the proposed indicator.

Proposed new indicators	The reduction of ER repeat users where the main diagnosis is Mental Health and Addiction % reduction in Er visits for mental health or addiction correlated to persons use of supports or housing Reduced wait time for medical withdrawal management. count connections between psychiatric services and primary health care givers client satisfaction with accessibility of services access and wait times: needs to be equal across SES
ER use is not an accurate indicator	It can be a successful outcome to have people living with these issues access ER. Identify a way to distinguish when utilizing ER is a problem vs. a success." The example given - a % reduction in visits - is a misleading because % ER MH&A visits can decrease in relation to higher volumes of other visits, even as MH&A visits remain the same or increase."

Advice from community members, consumers and families on what is working well in the system and where there are gaps in care

Mental Health and Addictions

Number of Suggestions	53

System capacity	There is a lack of coordination of services and there is not enough services (ie housing). There is also a lack of services available for family members/caregivers - family members require emotional support, psycho-education about their loved one's illness/addiction, treatment options, etc. More housing supports. We cannot continue to dump people into housing and expect them to do well.
Access	I envision CAMH running a daily drop-in clinic, 4-7 pm where teens aged 12-18 could go and just drop in to talk to someone. The only entry gate into the mental health system is through a family doctor referral or an ER referral. Why not set up "drop in" sessions in communities that have a mental health professional on-site once a week for a couple of hours where people can go to find out if they need to see a professional? Mental health services are not accessible to those with other physical or communication disabilities.
Navigation and continuity of services	More follow up to track what happens to the individual affected. Have a system that can help people navigate the different mental health and addictions agencies. Have a way to compare eligibility criteria so that the consumer doesn't have to go to each agency and find out that they don't qualify.
Continuous programming	Some people need supervision forever at some level and not be dropped after a period of time....mental disease is treatable but usually not curable though the funders seem to think otherwise.... I was in treatment for survivors of childhood abuse, but the program only went on for six months. After that, you must find other specialized supports and pay out of pocket for them. I am not able to afford this.
Educating health service providers	Family General Practitioner simply would not refer family member to a specialist or the necessary medical facilities necessary. The attitude seemed to be..."In her 80's, why bother?" I think an overall understanding and appreciation of each others' approaches, - service providers, families and consumers, and respect and willingness to accept other people's perspectives even if they are different from one's own views. This could be included in service providers' educations.
Importance of peer support	Networking with other survivors in a non-medical setting is important and there should be opportunities for this in our system. An information help line which could introduce someone, both consumer and family to the system… including how to find a doctor or other medical help, a list of books available, and self-help peer support organizations for both family and consumer.

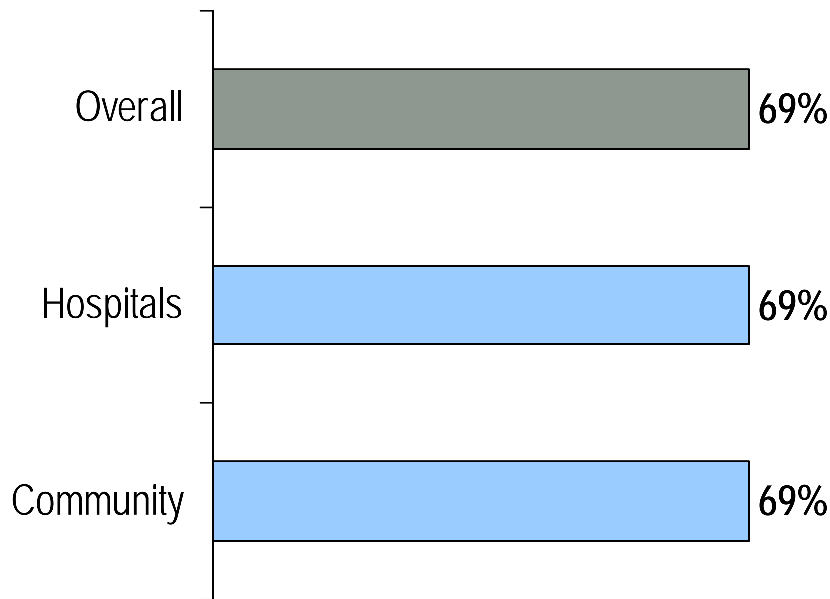
Section 5

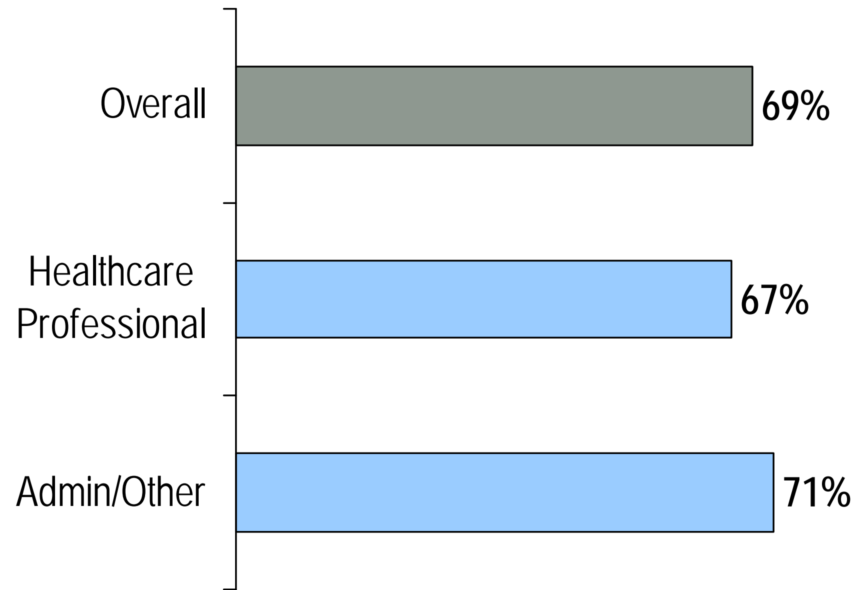
Results for the Value & Affordability Action Plan

Value & Affordability

Overall Support for the Action Plan: HSPs

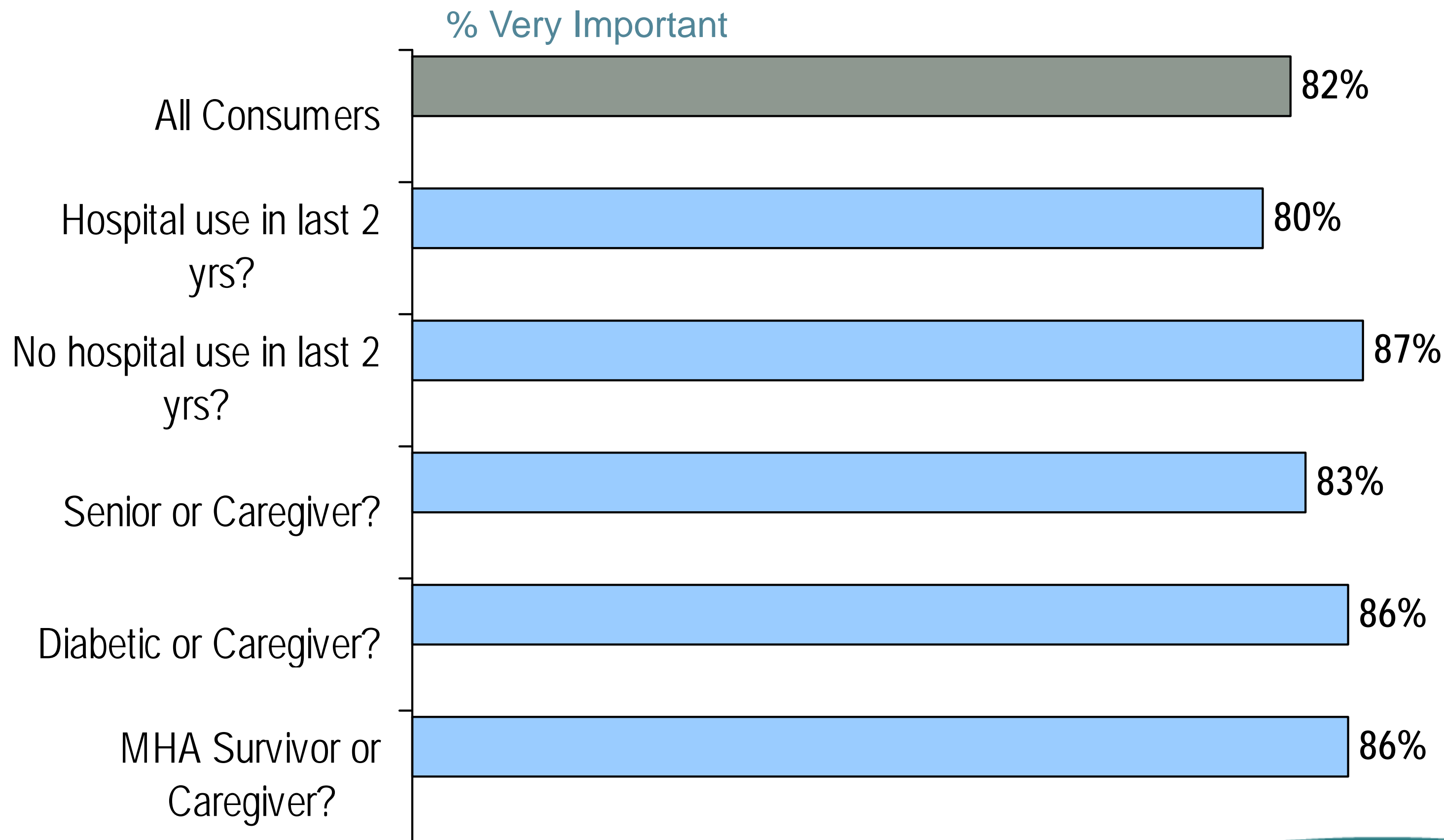
Respondents in hospitals and community express similar levels of support for the Value & Affordability action plan with healthcare professionals showing slightly lower support than administrative and other respondents.





Support for Value & Affordability – Consumers

The number of consumers who view finding ways to increase the value and affordability of health care services to be "Very Important" is high among all consumer groups with some interesting variations between groups.



Proposed Changes to the Action Plans from Health Service Providers

Value and Affordability

Number of Comments	41

Incentives for Providers	If you want people to start paying less then start incenting people to work together. Increased budget accountability of hospital based physicians
Cost effectiveness	A greater emphasis needs to be put on expanding services that are cost-effective or even cost-saving, and reducing services that are not cost-effective, or simply ineffective. Once this is in place, it is more reasonable to look at which hospital or institution is implementing most efficiently.
Community, not just hospitals	"Shouldn't just be hospital related. Why can't the smaller organizations benefit from economies of scale with the hospitals?" Your volumes may be higher in hospital but the costs are considerable in the community when there is no common standardization of equipment and supplies
Balance efficiency and effectiveness	I worry when we focus too much on money. Some things are necessary and important despite the cost. I support the concept however I am concerned that we remember that it is possible to be efficient and not at all effective. I would like clarification on the health outcomes we are working towards. If a particular health outcome is currently not that good
Caution on data comparisons	'Benchmarking' between hospitals is only meaningful if the services provided are sufficiently similar. Currently our hospital uses 'benchmarking' by comparing on cost alone, with no attention paid to the patient population served by the comparator hospital
Demand management	Actually calculate the cost of services rendered to those who actually need them vs. those who do not. Impact of self management strategies. ....improvement in housing and supervision will mean less hospital visits...pay now or pay later Need initiatives that involve health promotion e.g. well baby programs, child care, nutrition supports, housing and education.
System design	Increase the involvement of primary health care givers in all aspects of the hospital; make a seamless interface between primary community health care and hospital care. Instill a respect for the family doctor as an essential and critical part of hospital Impact of system navigations and coordination of services. More resources and programs need to be available at the community level, provided by community organizations.
eHealth	IT portals should be mentioned in this category as a key method to increase coordination, decrease duplication, enhance health care delivery and meet targets in a more timely manner. Information technology is crucial to cost containment and to date, Ontario lags behind to an embarrassing extent.

Indicator Advice from Health Service Providers
"If the LHIN only tracked one measure of success"
Value and Affordability

Number of Suggestions	43

A lot of endorsement of the concept of a ratio of services delivered to budget spent	Some sort of ROI calculation, similar to what it being proposed (Ratio of Services Delivered to Resources) Increased service with no increase in overall cost ratio of services delivered to resources invested remains the same or better
Efficiency measures	Cost per weighted case
Buying Groups / Group purchasing	Several comments endorsing % group purchasing as measures; others cautioning that this is a narrow measure of "value and affordability"
Other Ideas	% Admin … "The amount of money spent on people who do not have direct patient care as part of their work per in-patient day in acute care facilities. The amount of money being used on data acquisition and IT per patient day." Some kind of measure of waste / duplication a formula that will equate preventitive medicine visits to more urgent visits that otherwise would have been preventable, and less costly, ie how many urgent costly visits will one prevetitive medice visit save us Quality of Life Years hospital deficit tracking and disclosure of the highest paid professionals in the system all organizations are independently audited and accredited
General comments	I am not sure any of the proposed indicators adequately measure value. They seem to measure doing things more cheaply but not necessarily effectively. Value in my mind,as a concept, includes doing things well and within in budgetary limitations. This is exceedingly difficult to measure.

Section 6

Results for Key Enablers: Health Equity and eHealth

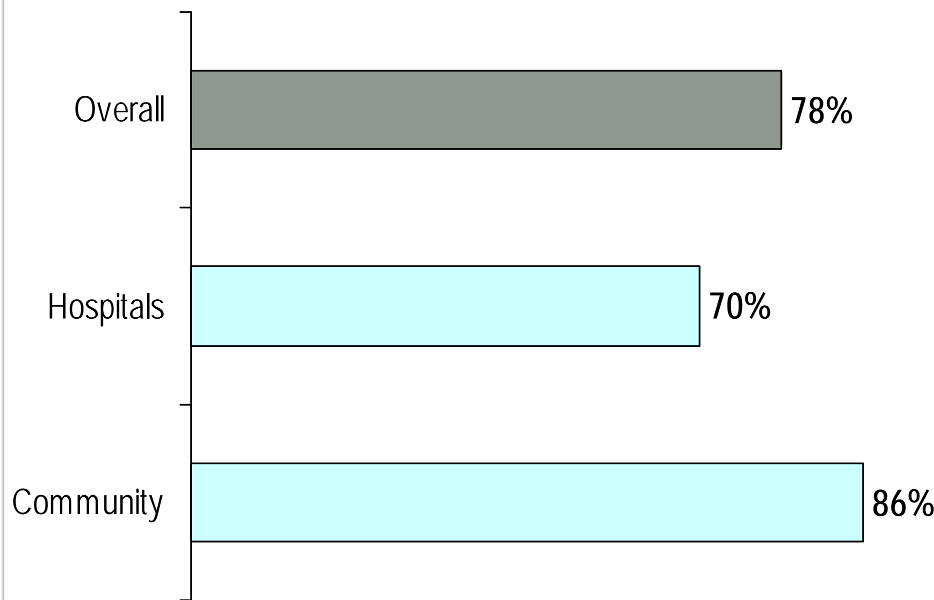
Health Equity

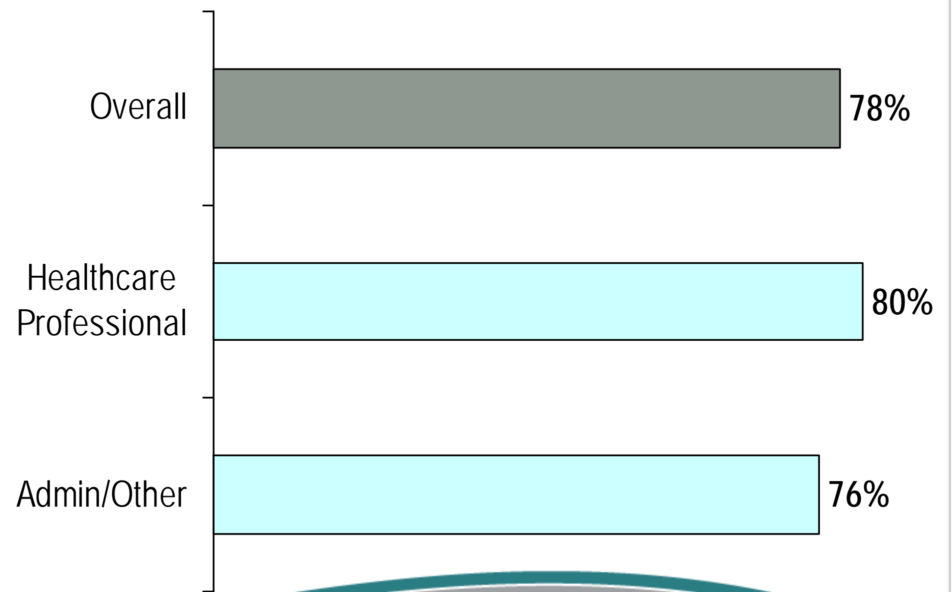
Overall Support for the Action Plan: HSPs

Health equity is important to all health service providers with healthcare professionals showing the highest level of support.

Question: Health equity is an essential enabler in supporting the five priorities described above

% Agree or Strongly Agree





Proposed Changes to the Action Plans from Health Service Providers

Health Equity

Number of Comments	46

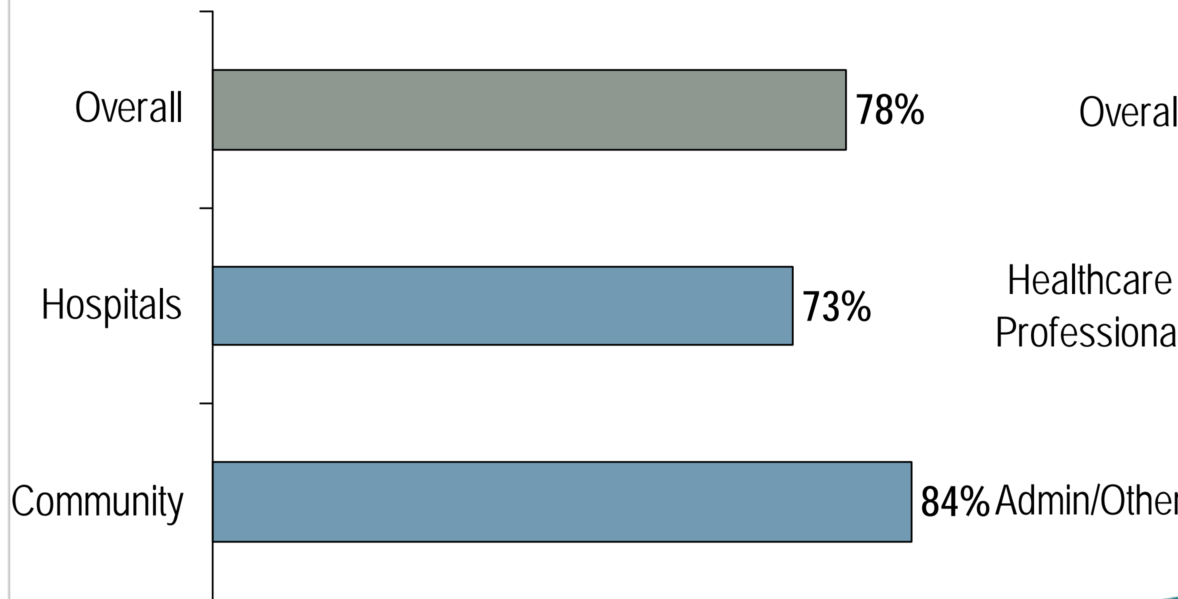
Equity as a new concept	Equity as access may make the concept more familiar, but doesn't necessarily address more fundamental issues of fairness, of service/commitment to vulnerable and marginalized populations. What will the expectations/requirements to serve marginalized (difficult and expensive) populations/individuals? Treating them reduces efficiency because they are so difficult. Recognizing that equity is a 'value' that will take time to integrate into the psyche of individuals and organizations. It is not complete with the development of a plan
Language issues	Interpretation services - This is a frustrating area working in an outpatient clinic where we see hundreds of patients a day and usually don't know in advance when an interpreter will be required. Translating facilities, allowing our multicultural community to access our excellent health care system. Have centralized translating services accessible by speaker phones so that when a patient and their health care provider require help, it can be accessed by telephone, for as long as it is needed. Need a LHIN-wide language and interpretation model, for its potential to yield tangible results within a reasonable time frame
Expectations and accountability	Guidelines and Expectations re: shifting resources in order to increase Health Equity practices (e.g. cost of interpretation, paying community members to do outreach, escorting clients / patients to appointments, recognizing that equity practices take longer than other approaches and therefore cost more, hiring staff with other languages who have the skills but may need additional training) There needs to be system-wide expectations and accountability. The LHIN needs to establish a minimum set of standards for health equity and require hospitals to demonstrate implementation and show results. Building obligations to promote health equity into accountability agreements starting with Hospital Service Accountability Agreements in 2009/10
Measure health equity	Identify a common set of hospital and system-level data to measure, develop and evaluate strategies to address health inequities; timely access to Interpretation and Translation Services. Common measurement and understanding would assist in creating more health equity. As it stands, I doubt that there is much measured in this area Common set of data to measure develop and evaluate strategies and their outcomes

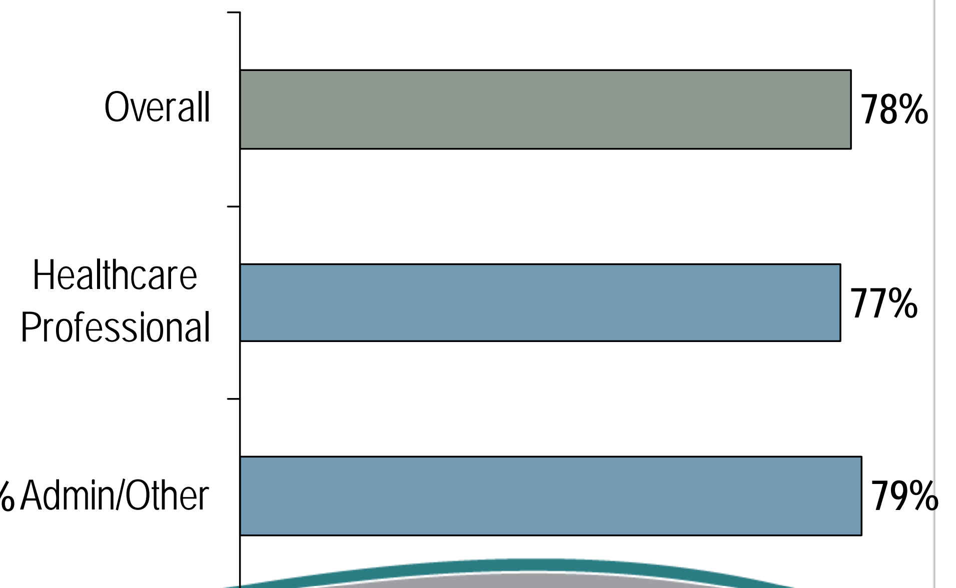
eHealth
Overall Support for the Action Plan: HSPs

Overall, health service providers agreed that eHealth is an essential to system change.

<u>Question</u>: eHealth is an essential enabler in supporting the five priorities described above.

% Agree or Strongly Agree





Proposed Changes to the Action Plans from Health Service Providers

eHealth

Number of Comments	67

System wide implementation	Interoperability across different systems Integrating patient records from various organizations and common referral or wait list info. More aggressive alignment between organizations
Accountability and timelines	Ensure increased accountability Setting firm timelines for transition to electronic health records. This is an access issue and a patient safety issue as, within the hospitals, a patient can have separate files in multiple departments which are never integrated. Making it happen without busting the budget, not sure why it cost so much when it can easily be done by cheaper means. This measure is a good measure not sure why the timelines have not yet been met.
Privacy concerns	I have concerns about centralizing patient registries / information as this runs a high risk of negatively impacting client confidentiality, and client direction over his / her care. I believe that pieces will missed and people will be left aside. Also, where is the human connection. What will happen to confidentiality? Ensure that advantages in technology enhancement are not offset by problems with client trust and confidentiality concerns that will create further barriers to people receiving care.
Crossing LHIN boundaries	Connecting the GTA - RM&R will not achieve what is sets out to do in absence of integrating referrals to major centres in Toronto, many of which originate from or are repatriated back to centres outside of the TC LHIN A single patient record which could be accessed by all in the system would reduce the duplication of effort and ensure that pertinent information is available to all health care providers.
User-friendly	While an important and useful enabler it has the potential to backfire as it can overload smaller agencies. New tools need to be simple, user friendly and well supported in order to be useful and manageable for us. Developing a flexible and responsive system without excessive bureaucracy allowing simple access for all stakeholders.
Other	EHealth can be an enabler but to say it is essential means we cannot do it without eHealth. That is something I disagree with completely. Ontario is pathetically behind other jurisdictions (provinces, countries) with eHealth -- there is no excuse for why we do not have a single province wide system, instead of the 14 or so systems that are in partial use across the province. Enablers do NOT provide better access to care. In TC-LHIN the advent of the MSK central registry for TJR has NOT provided better access to care. There are many patient portals already in existence in TC LHIN - why are you re-inventing and producing a pilot?

Section 7

Results for Outcomes / Value to the Public

Support for the Overall Outcomes

Overall, respondents were supportive of the following system outcomes: improved health, timely access, trust and confidence in the system, equity and access in outcomes.

I support these as the four overall outcomes that the health system should deliver to the public

% Agree or Strongly Agree

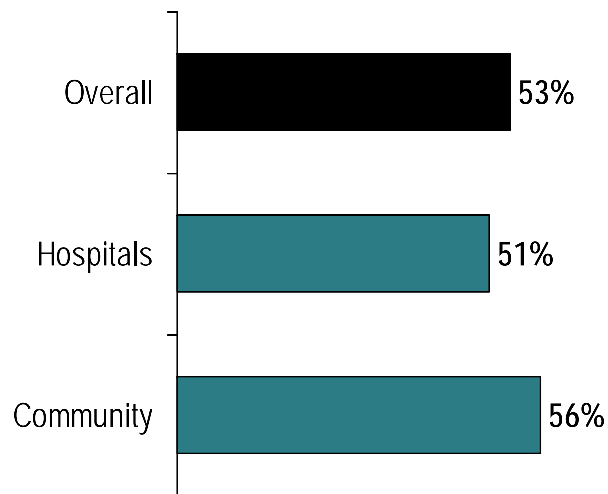
Support for the Overall Outcomes

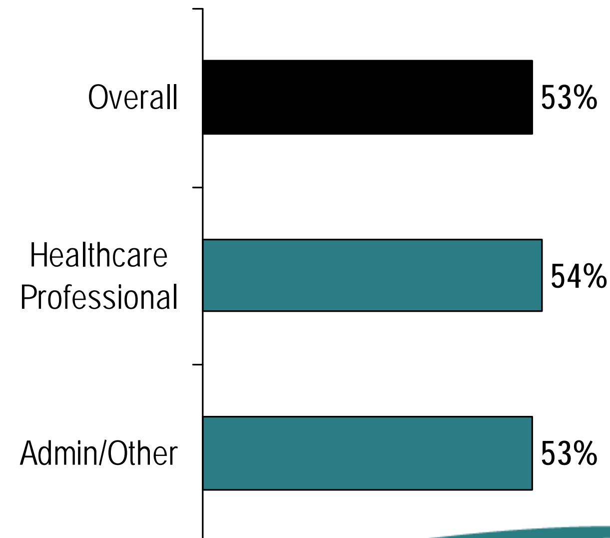
That meet the public's needs for ...

Health care providers were not convinced that the approach to reporting on the success of these outcomes is realistic.

The approach to reporting on these outcomes is realistic and can be achieved over the next three years of IHSP-2

% Agree or Strongly Agree





Comments on the Four “Outcomes to the Public”

Number of Comments	15

Access	Suggest consideration of a focus as well on access indicators to post-acute services, not only MRI, CT, etc. If a key goal is to reduce ALC then need to track access to post acute services which is not listed
Population-specific	Make sure there are some outcomes that relate to children and youth.
Challenges with “Improved Health”	As can be seen with the initial spread of H1N1 in "disadvantaged" populations, the spread of diseases and ill-health needs to be addressed through the determinants of health as well as through treatment and traditional prevention.
Efficiency / Sustainability	Improved efficiencies in terms of costs would be something the public would be interested in while ensuring high quality services in terms of safe, timely, effective, efficient care.
Time horizon for outcomes?	Health, access and trust cannot be improved in the time frame targeted. It will take 5-10 years to see these outcomes. Lengthen your horizons or change your outcomes to something simpler. Overall the outcomes are too large and complex to be achieved in this short time
General	Success in reporting these outcomes will depend upon agreement on the outcomes and definitions by numerous HSPs which span from local community health centres to large academic hospitals. I also believe we are just beginning to look at integration more seriously, outcomes such as "improved health" will take time. As for Trust and Confidence in the health system, that will most likely rely on timely access to the ED. With ALC numbers actually rising (not decreasing), this outcome will not be possible without addressing the ALC issue head-on and adding additional capacity that cannot be achieved through process re-design and resource matching initiatives alone.

Section 8

Results for Most Essential / Least Essential System Functions

There was overwhelming support from health service providers to focus efforts on ensuring that clients get services where they need them and when they need them – and also for the functions relating to quality and prevention. Other "top three" functions showed notable variations between groups.

Health System Functions that are most essential to make progress in the Toronto Central LHIN over the next three years

System Functions	Overall Ranking	Overall Ranking by organization Type		Overall Ranking by Provider Type	
		Hospital	Community	Healthcare Professional	Admin/Other
Innovate and integrate so people receive the services they need, where they need them, when they need them	1	1	1	1	1
Deliver safe, quality, evidence-informed services	2	2	4	4	4
Ensure prevention and promotion are an intrinsic part of the health care experience	3	3	2	2	2
Identify and provide enhanced supports for individuals with the most complex, chronic needs	4	6	3	6	3
Maximize the benefits of e-Health and technology	5	4	7	3	5
Engage communities and providers in partnering to shape and improve the health system	6	14	5	9	8
Set performance standards and hold each other accountable	7	5	6	5	6
Value and grow the skills and talents of the healthcare workforce	8	8	10	8	11
Enlist and support individuals and their caregivers as full members of the care team	9	12	5	11	9
Leverage Toronto's unique teaching, research, and innovation capacity to set standards for best practice	10	7	12	7	12
Optimize health system capital and infrastructure	11	15	15	15	15
Achieve system-wide efficiencies through overhead and service integration and through continuous improvement	12	10	13	10	14
Balance budgets and allocate resources to ensure an affordable cost structure	13	11	14	13	13
Drive results through information and transparency of reporting	14	9	9	14	7
Partner broadly to improve health and quality of life in our society	15	13	11	12	10

There was greater variation in response to what functions are “least essential” to making progress in the next three years with the main area of consensus relating to the function of “partner broadly to improve health and quality of life in our society”.

Health System Functions that are least essential to make progress in the Toronto Central LHIN over the next three years

System Functions	Overall Ranking	Overall Ranking by Organization Type		Overall Ranking by Provider Type	
		Hospital	Community	Healthcare Professional	Admin/Other
Partner broadly to improve health and quality of life in our society	1	1	3	2	1
Drive results through information and transparency of reporting	2	2	4	1	6
Achieve system-wide efficiencies through overhead and service integration and through continuous improvement	3	4	1	3	5
Leverage Toronto's unique teaching, research, and innovation capacity to set standards for best practice	4	7	2	6	2
Optimize health system capital and infrastructure	5	5	6	5	4
Maximize the benefits of e-Health and technology	6	8	5	9	3
Balance budgets and allocate resources to ensure an affordable cost structure	7	3	11	4	10
Set performance standards and hold each other accountable	8	6	9	7	9
Value and grow the skills and talents of the healthcare workforce	9	10	7	10	7
Enlist and support individuals and their caregivers as full members of the care team	10	9	10	8	14
Engage communities and providers in partnering to shape and improve the health system	11	11	8	11	8
Identify and provide enhanced supports for individuals with the most complex, chronic needs	12	12	13	13	12
Ensure prevention and promotion are an intrinsic part of the health care experience	13	13	14	15	11
Innovate and integrate so people receive the services they need, where they need them, when they need them	14	15	12	14	13
Deliver safe, quality, evidence-informed services	15	14	15	12	15

Section 9

Overall Comments

Health Service Providers

Overall comments on the Action Plans and the Indicators

Action Plans:

"I support addressing diabetes as early intervention can significantly impact the trajectory of the disease and reduce overall costs in the long run; I also understand this is helpful as a first step in managing other chronic conditions."
While I understand the limitations in available funding, the changes that are required will only be partially obtained through standardizing tools and enhancing data collection. The MH&A system was underfunded for a protracted length of time and it will take time and some investment to address this. I think it is important to acknowledge this and articulate and champion innovative ways that move treatment and service and funding from hospitals into the community.

Indicators:

Cautions with focusing on a limited set of indicators"	Stop trying to find one indicator. Acknowledge the complexity of the problem." agree that collecting data and providing outcomes measures is important to seeing how we are doing and what needs to be done. However, you should also keep in mind that by focusing on specific wait times, other wait times may increase - for instance, focusing on hip and knee replacements may mean that spine surgery is delayed or harder to book in favour of your targeted measure. And that truly would be inequity. I don't think that this can be measured with only one
Data challenges	More discussion with agencies re: ability to report. Data is collected differently, there is no consistency re: data collection currently, inadequate data collection system makes reporting very difficult.