Toronto Central **LHIN REPORT** | NOVEMBER/DECEMBER 2008 EDITION

Homeless Seniors
start to create their own community

They were one week away from living on the streets when the call came from Neighbourhood Link Support Services. "This place is everything to us," says Kristina Atanasov. "We were so scared. We didn't know what we were going to do."

Kristina and her husband Nicola are just two of the 26 seniors in one building on the Danforth to benefit from Toronto Central LHIN funding to Neighbourhood Link Support Services as part of the LHIN's Aging at Home Strategy. The Atanasovs came to Canada three years ago from their native Bulgaria. They had only tiny pensions from Kristina's work as a laboratory technician and Nicola's job as a teacher. When their son and his wife, who had sponsored them, had jobs transferred to the United States, the

Kristina and Nicola Atanasov

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Ontario
Local Health Integration Network

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Atanasovs found themselves unable to follow and without an affordable place to live as their family moved away. Without strong English language skills or friends in this country, they realized that they were in trouble.

Neighbourhood Link Support Services came to the rescue. It has partnered with Toronto East General Hospital and COTA Health on this project that has created supportive housing services to help homeless, or marginally housed seniors as well as seniors with mental health and addiction issues or living in abusive relationships. Helping these seniors to maintain their health and independence relieves pressures on long-term care homes and emergency departments.

"In this building we have an apartment we can afford, a place to come to meet with others, and free language classes, which is very important," says Nicola. "Here in the lounge there is a television that we can watch as we don't have one, and a computer with an Internet connection. This week I was able to come down to check my email account, send a message to my son and get a response right away. It lets me stay connected with our four-year-old grandson." The broad smiles on their faces let you know how important this is to them.

Like the other seniors who live in their Danforth Avenue building, the Atanasovs now have access to two personal support workers and a geriatric

Shirin Yilmaz, community health worker, East End CHC and Darlene Ross.

mental health case manager. The staff provide assistance with activities of daily living, life skills coaching and recreational and other activities that create social bonds and decrease isolation. There are 24-hour emergency services available to all residents as well as friendly visiting, security checks and telephone reassurance. And access to other Neighbourhood Link Support Services are facilitated.

Darlene Ross is another of the new seniors to benefit. She also suddenly found herself with no where to turn after a difficult family situation suddenly left her homeless.

"I was so grateful to find this place, it was a god send," she says. "When your immediate needs are met – like having a safe place to live – the pressure is off and you can breathe again and start to work to put your life back together.

What I like is that everyone who lives here is asked what they can contribute to the community – there's a responsibility to give back. I like to garden, so that was something I could do. It's important to your dignity to contribute."

Darlene was able to find a job at a grocery store through the seniors' employment services at Neighbourhood Link Support Services and has appreciated the help to get back into socializing.

"Without this lounge and the encouragement, we'd all be alone in our apartments. But you can come down here in the morning for coffee or tea, or for the lunch or dinners that they hold during the week. It's really homey, it brings a sense of comfort to everyday life. I've got neighbours sharing the newspaper with me and now people are bringing books to the lounge and we're watching movies in the afternoon and doing different activities together.

"What I really like is that here you are treated like you are human. Since I don't have anyone in the city to look in on me, the safety checks make you feel cared for and cared about. No one ignores you. You get to live life as you want to live it; you're not ostracized or treated like a number. It goes beyond existing to really living."

As of September 30:

- **12 unscheduled emergency department visits have been avoided in the Danforth building due to staff assistance and the 24-hour on-call service.**
- **Five clients at potential risk for falls had arrangements made to protect their safety.**
- **Four clients who expressed a need for a primary care provider have been linked with either a provider or a clinical service.**
- **The Tenant Advisory Group (which includes 6 clients) reports that the quality of life for all residents has improved and the support provided has had an impact on clients' physical and social well-being.**

Across the LHIN, other new or expanded supportive housing service projects that are part of the Aging at Home Strategy have also started or are getting underway. At the Overlea in Thorncliffe Park, for example, exercise classes, blood pressure/blood sugar monitoring and falls prevention sessions and foot care clinics got off the ground on November 7 at Friday Health Clinics.

All projects regularly report on clearly defined performance indicators so that the LHIN can ensure that they are resulting in high quality services for clients and, at the same time, improving the local health care system.

Home at Last

Part of the Aging at Home Strategy

Creating smooth transitions for frail elderly individuals is just what the Home at Last project funded by the Toronto Central LHIN is about.

The safety net:
the 16 health service providers of the Home at Last project:

Project Lead:
St. Christopher House

Community Support Services:
Community Care East York
Mid Toronto Community Services
Neighbourhood Link Support Services
SPRINT
Storefront Humber
St. Clair West Services for Seniors
West Toronto Support Services
Woodgreen Community Services

Hospitals:
Mount Sinai
St. Joseph's Health Centre
Sunnybrook Health Sciences Centre
University Health Network
Toronto General Hospital site
University Health Network
Toronto Western Hospital site
St. Michael's Hospital
Toronto East General Hospital

Toronto Central Community Care Access Centre

Part of the Aging at Home Strategy, led by St. Christopher House, Home at Last is a partnership between the Toronto Central Community Care Access Centre, nine community support service agencies and seven Toronto hospital sites (see sidebar for complete list of participants). The one-year project is designed to:

- facilitate safe and timely discharge of clients from hospital
- improve the discharge experience for the client and improve health outcomes
- improve client access to ongoing community support services.

What the 17 partners do by working together is ensure that vulnerable older people who don't otherwise have someone to help them don't end up being readmitted to hospital because they haven't eaten properly, haven't taken their medications or injure themselves because they can't manage on their own.

By offering a ride home on discharge day, with someone to pick up medications from the pharmacy and do some homemaking, the project makes sure that people are safe and supported for the first few days at home.

The project helps link people with the care and support they need at home, which improves his or her health status and quality of life. Ultimately the project will help to improve patient flow through the health care system, reducing the number of days that patients remain in hospital when they don't really need acute care services. This in turn will provide more access to in-patient beds to those who are waiting in emergency rooms for admission and reduce waiting times for those needing emergency care.

Home at Last by the numbers:

Number helped to September 30, 2008	84 new clients
Target number to be helped by March 31, 2009	475 new clients
Discharge satisfaction rate to September 30, 2008	100% of seniors who completed satisfaction surveys rated Home at Last "very good" or "excellent"

Health Equity:
Caring for those with the greatest needs

As the LHIN with the most diverse population, realizing health equity is an enormous challenge in Toronto Central, but also a necessity if we are to improve and sustain the health care system. The facts linking social and economic inequities and health outcomes are striking. For example:

- Diabetes is twice as high in low income versus high income neighbourhoods
- New immigrants are more likely to have cardio-vascular disease because of language and other barriers to getting appropriate health care
- More low income people are living with pain and disability because they are receiving 60% fewer hip replacements than people with higher incomes.

The Toronto Central LHIN's success in improving the health care system will be measured in terms of whether everyone, particularly those in greatest need, has access to the right care, at the right time and in the right place.

The LHIN is also asking the health service providers we fund to be accountable for reducing health disparities. Last fall, the LHIN announced that hospitals will be submitting Health Equity Plans. The LHIN is starting with hospitals but will also be requesting plans from community providers in the future. To kick start the plans, the LHIN partnered with a group of hospitals already focused on health equity. The group, called the Hospital Collaborative on Marginalized Populations, created and presented an outline for the plans to the Toronto Central LHIN board in November. The plans will be completed by early 2009; they will:

- Provide a baseline of health equity activity in hospitals across the LHIN
- Show how health equity may be addressed in accountability agreements
- Enable more collaboration among hospitals
- Inform equity plans from community providers.

Over the next two years, our attention will be on health issues that disproportionately affect marginalized populations (i.e., chronic diseases starting with diabetes and mental health and addictions). There is much to do. But, by taking action with local hospitals and community providers, we will achieve a more equitable health care system.

The Toronto Central LHIN's 2007-2008 Annual Report is now available.
Visit **www.torontocentrallhin.on.ca** to download a copy.

Local Health Integration Networks = Performance Management

By Matt Anderson, CEO, Toronto Central LHIN

Among his many wise maxims, Albert Einstein said "everything should be made as simple as possible, but no simpler." After my first six months as CEO of the Toronto Central LHIN, I have distilled the LHINs down to a singular concept: LHINs = Performance Management.

By now, health system providers and the consumers and residents who are engaged with the Toronto Central LHIN understand that the LHIN's job is to improve the health care system by enabling the coordination, integration and continual improvement of local health care services. The next important questions are:
1) how are we creating a health care system
2) how do we know if we are succeeding?

Here's my simple answer. The LHIN's primary function is managing the performance of the local health care system. This idea was, of course, not invented by the Toronto Central LHIN. It is codified in the *Local Health System Integration Act, 2006*. It is the foundation of the LHINs' accountability agreements with the government and the accountability agreements between the LHINs and the health service providers (HSPs) they fund.

To put this concept into action, the Toronto Central LHIN is developing a robust performance management program.

The goal is to improve local health system performance while ensuring that people living with chronic diseases – particularly mental health, addictions and diabetes – have the services and support necessary to stay healthy.

I have heard consistently from providers and community members and learned since I arrived at the Toronto Central LHIN that we need to concentrate our efforts on a few key areas in order to impact people's health care sooner and to change the health care system. A clear focus becomes all the more essential when tackling a system as large and complex as health care.

It is not surprising that mental health and addictions and chronic disease management are local priorities as well as being top government commitments. Currently 31% of residents in the TC LHIN have at least one chronic disease and chronic diseases account for 25% of hospitalizations.

Diabetes is a good place to start building a chronic disease management system because of the impact of the problem on an aging population and on entire the health care system. Twenty-five percent of all people with diabetes in Ontario live in Toronto.

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Currently 8.8% of people in Ontario have diabetes, 25% of whom live in Toronto. Diabetes contributes to 32% of heart attacks, 30% of strokes, and 70% of amputations. In the Toronto Central LHIN, one in five people will experience mental illness in their lifetime. The prevalence is two to three times higher among people who are homeless. An aggressive effort in these areas will have a particularly significant effect on the health of marginalized and under-serviced populations who are disproportionately affected by these conditions.

The Toronto Central LHIN is defining appropriate performance indicators and targets both for the LHIN and for health care providers. And, under the leadership of Diamond Watson, Director of Performance Measurement, and Bill Manson, Senior Director of Performance Management at the Toronto Central LHIN, we are creating a process to collect, measure and, most importantly, use data to improve local health system performance. For example, the LHIN has created a quarterly scorecard to monitor the aggregate performance of the LHIN as well as the performance of individual providers. A Clinical Service Lead Team, made up of recognized clinical leaders within the LHIN, assists us to interpret the results. To close the loop, the LHIN works with health service providers who do not meet targets to uncover and resolve underlying issues.

As we go forward, we will be subjecting our performance management program to continual improvement. This includes fine-tuning the LHIN's performance indicators. Indicators will only be effective when they are backed up by a clear plan of action and the right incentives to produce results. There needs to be a data collection system that is reliable and informative. And we need to be able to hold specific organizations accountable for improving on specific indicators.

There is an impatience in the Toronto Central LHIN to see the health care system improve. I share this sense of urgency. At the same time, I am convinced that the only way to achieve this scale of change is by investing time and effort up front to understand the problems that need fixing.

Season's Greetings!

On behalf of the Board and team at the Toronto Central LHIN, we would like to wish you a happy holiday. We would also like to thank the dedicated people working in our local health care system for the care that they give to people everyday and for their personal contributions to improving health care. This holiday season allows us to take time out to spend with family and friends, and to relax and recharge. We look forward to more partnerships and progress in 2009!

Mohamed Dhanani
Chair, Board of Directors, Toronto Central LHIN

Matt Anderson
CEO, Toronto Central LHIN

Appointments announced to *Health Professionals Advisory Committee*

At its October meeting, the Board of Directors of the Toronto Central LHIN approved appointments of 13 registered health professionals to its Health Professionals Advisory Committee (HPAC).

HPAC is an important body for the LHIN to seek advice from health professionals and a clinical perspective to support the implementation of local health system initiatives, including health human resource planning and innovative models of care. HPAC members will be an important link to a range of health professional groups that practice in the Toronto Central LHIN. Required to be established in each LHIN by the *Local Health System Integration Act, 2006*, the HPAC has a mandate to provide the LHIN with advice related to:

- patient-centred care
- implementation of the Integrated Health Service Plan (IHSP)
- strategic initiatives

The Terms of Reference set by the Ministry of Health and Long-Term Care require12-15 members, comprised of the following registered health professionals:

- 4 Physicians (including 1 physician who practices family medicine in the community and 1 physician who practices specialty medicine inpatient in a hospital)
- 4 Nurses (hospital, community, long-term care and a Registered Practical Nurse)
- 1 Dietitian
- 1 Pharmacist
- 1 Occupational Therapist or Physiotherapist
- 1 Psychologist or Social Worker
- 3 additional members

Requests for expressions of interest were distributed widely to health service providers, other LHIN stakeholders, and professional associations and colleges. A Toronto Central LHIN board member, a member of the senior team, and at least one staff member interviewed candidates who proceeded to the selection phase.

In selecting candidates, a diversity of perspectives was sought in terms of gender, ethno-cultural background, sector, neighbourhood of practice and experience in LHIN areas of focus.

All candidates have now been appointed, with the exception of the Registered Practical Nurse and the Dietician. HPAC will be convened with its current members, while the LHIN continues recruitment to fill these roles.

The following have been appointed to the inaugural Toronto Central LHIN Health Professionals Advisory Committee:

Profession	Name
Physicians	**Dr. S. Lawrence Librach** is the Director of the Temmy Latner Center for Palliative Care (largest palliative care program in Ontario). He has extensive planning experience including working with the Toronto Community Care Access Centre and others to develop the Palliative Care Network. He has also been involved in developing national standards for palliative care.

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Appointments announced to Health Professionals Advisory Committee continued from page 9

Profession	Name
Physicians *continued*	**Dr. Andrew McDonald** is currently a staff emergency physician at Sunnybrook Health Sciences Centre. He is also the team leader in its Trauma program. Dr. McDonald completed his Masters in Health Administration. Currently he is the Chair of Quality of Care at Sunnybrook working on process improvement throughout the hospital and in relation to its community partners. **Dr. William Watson** is a family physician at Department of Family and Community Medicine St. Michael's Hospital. He has over 30 years experience as a physician. He is the recipient of numerous awards and honours including the "2008 Family Physician of the Year" award for the Toronto region awarded by the Ontario College of Family Physicians. He teaches at University of Toronto and has a strong clinical focus on inner city health issues. **Dr. Pauline Pariser** has worked as a family practitioner in the Toronto core for over 26 years. Currently she is the physician lead for the Taddle Creek Family Health Team (FHT). She serves on the Physicians Leaders Group for the MOHLTC as well as the GTA Health Information Access Layer (HIAL) & Provider Portal committee. She has also taught at the assistant professor level at the University of Toronto, Department of Family and Community Medicine.
Nurses	**Christine Daglish** is currently the Director of Operations at Responsive Health Management. In the last 17 years she has worked with seniors in various capacities, including as a front-line staff member, nurse manager, administrator and director of care in a long-term care home. Key areas of expertise include: health human resources, patient-centred care, utilizing Emergency Department best practices, and reducing transfers from long-term care & Emergency Departments. **Rani Srivastava** has worked at the systems level through both the College of Nurses of Ontario and the Registered Nurses of Ontario and has been involved in the development of practice standards, policy, and best practice guidelines. She has a strong focus on diversity and equity in health care both clinically and as a researcher and educator. She is currently Deputy Chief of Nursing Practice at the Centre for Addictions and Mental Health. **Marianne Surbek** is a nurse practitioner at the Southeast Toronto Family Health Team. She has extensive experience as a nurse with at-risk and marginalized populations, including Aboriginal people and street involved youth. She has a long history working in an interdisciplinary environment.
Registered Practical Nurse	*Vacant*

Profession	Name
Social Worker	**Linda Jackson** is currently the Director of Social Work and Community Services at Baycrest Geriatric Health Care System. She is responsible for the provision of social work services across the continuum of services offered at Baycrest and is also involved with community partnerships to support system-wide improvements.
Physiotherapist	**Giancarla Curto-Correia** is currently Patient Care Manager, Ambulatory Care Centre at St. Joseph's Health Centre in Toronto. She also holds a Masters in Health Administration. As a rehabilitation practice leader, she has worked on various strategic projects that have resulted in improved system coordination and resource utilization. She has participated in several local health system initiatives, and served on committees of the Total Joint Network, Southeast Toronto Regional Stroke Network and the Professional Practice Network of Ontario.
Dietitian	*Vacant*
Pharmacist	**Norman Umali** is a community pharmacist working as a home visiting pharmacist with the Toronto Central Community Care Access Centre (CCAC). His primary clinical focus is high-risk patient populations, particularly the elderly with multiple chronic conditions. He develops proactive relationships with family doctors and Family Health Teams to optimize patient care from the perspectives of medication compliance and improving patient self- management.
Other – Regulated Health Professionals	**Paul Cornacchione** is currently the Manager of Medical Imaging at the Toronto General Hospital and was previously the Manager at the Princess Margaret Hospital. At Princess Margaret, Mr. Cornacchione was extensively involved in a LEAN project to improve booking for MRIs. Mr. Cornacchione also championed developing a job shadowing program to increase inter-professional education among technologists within medical imaging. **Deborah Bonser** is currently the Head of the Division of Midwifery at Toronto General Hospital and also a founding partner of the Midwives Clinic at East York - Don Mills. She serves on the Maternal/Newborn Council and Maternal/Newborn Executive Committee with obstetricians, paediatricians, nurses, social workers and other professionals. **Rex Banks** is currently the Director of Hearing Healthcare. His responsibilities include providing clinical supervision and management for the Audiology and Hearing Aid Programs through Canadian Hearing Society, which involves nine locations and 20 audiologists and hearing aid dispensers.

Toronto Central LHIN's Two New Directors Complete Board

The Toronto Central LHIN welcomes two new members to the Board of Directors, Lloyd Komori, Chief Risk Officer (CRO), Ontario Power Generation (OPG) Inc. and Stephanie Coyles, Senior Vice President & Chief Strategy Officer, Alliance Data Systems, LoyaltyOne Division.

With the addition of Lloyd and Stephanie, the Toronto Central LHIN board has a full complement of nine members, further strengthening the breadth and depth of perspectives, experience and expertise on the board of Ontario's most populous and diverse LHIN. Lloyd and Stephanie bring a wealth of executive and corporate leadership experience.

As Chief Risk Officer for OPG, Lloyd Komori provides the vision and leadership that drives OPG's implementation of effective risk management activities across the corporation. As CRO he impacts an expansive range of activities across OPG including the prudent management of the corporation's significant pension and nuclear funds and the oversight of major hydro and nuclear asset development projects. In addition, Lloyd is the OPG's Chief internal Audit Executive, responsible for evaluating and reporting on management's compliance with an array of internal governance and regulatory standards.

Prior to joining OPG, Lloyd spent 24 years focused on managing risk and opportunity in corporate/investment banking, derivative trading and investment management industries. His experience also includes the development and leadership of a risk management consulting practice for one of the world's largest consulting firms.

Lloyd is a member of the advisory board of the Strategic Risk Council, a Chartered Director, Audit Committee Certified, a standing member of the Committee of Chief Risk Officers, and has been a faculty member of the Director's College since its inception.

Stephanie Coyles is a member of the Executive Committee at LoyaltyOne (formerly Alliance Data Loyalty Services) that works with more than 100 of North America's leading brands in the retail, financial services, grocery, petroleum retail, travel and hospitality industries to profitably change customer behavior.

Stephanie is responsible for enterprise development strategy (including M&A), product innovation, corporate branding and knowledge development and dissemination.

Stephanie was previously a senior principal with McKinsey & Company. In nearly two decades with the firm's Canadian consulting group, she tackled strategic challenges and helped boost bottom-line results for a wide array of North American retail (grocery and soft goods), financial services, telecom and consumer packaged good companies. Her other achievements include establishing McKinsey's Canadian health care practice and publishing ground-breaking research on consumer loyalty.

Stephanie holds an Honours Bachelor of Commerce Degree from Queens University and a Masters in Public Policy from Kennedy School of Government at Harvard University.