Toronto Central **LHIN REPORT** | July 2009

Supporting vulnerable populations with *Diabetes Care*

When Kandiah Saravanapavan walked into the South Asian Diabetes Prevention Program (SADPP) held on a Wednesday morning in April, at the Oriole Community Centre, he did not know exactly what to expect. Kandiah, a Tamil originating from Sri Lanka, has been in Canada since 1984. While his English is strong, this pre-diabetes screening program allows Kandiah to access care in his first language and in his own community – something he has learned not to take for granted.

With the Toronto Central Local Health Integration Network providing over $125,000 in funding through its Aging at Home program, Flemingdon Health Centre (FHC), in partnership with the Social Services Network, established the SADPP in January 2009. This initiative enhances access to diabetes prevention services for the South Asian communities in North East Toronto. Expanding on the existing Mid-Toronto Diabetes Education program at FHC, SADPP offers language-specific and culturally relevant services that allow for early detection of diabetes.

The SADPP team consists of a Registered Nurse, Registered Dietician, Project Coordinator, Project Manager and three outreach workers. As Neil Stephens, SADPP's project coordinator, explains: "This program reaches out to the South Asian communities where members are tied by their affinity to languages such as Tamil, Farsi, Urdu,

SADPP Registered Nurse with a client

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Ontario
Local Health Integration Network

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Gujarati, Hindi and Bengali. We cut across religious lines by visiting mosques, temples, churches and community centres within the Flemingdon Health Centre catchment area."

Maya Kandiah, President of the Senior Tamils' Service, joined today's pre-diabetes screening to show his support for a program that he believes is "very important for all of us to live a healthy life." Having lived with diabetes for 12 years, Maya admits that a large number "of the South Asian community have diabetes, but this program helps to raise awareness, teaches seniors how they can prevent further diabetes complications and take precautions to avoid the onset of diabetes."

According to research done by the Institute for Clinical Evaluative Sciences (ICES), certain ethnic groups are at greater risk for diabetes, particularly people from Africa, Asia, Latin America and South Asia. The number of Ontarians with diabetes has increased by 69 per cent over the last 10 years – and is projected to grow from 900,000 to 1.2 million by 2010. One in four Ontarians with diabetes lives in the Toronto Central LHIN. Besides the sheer number of people affected, diabetes puts people at significant risk of disease and disability. Diabetes contributes to 32 per cent of strokes, 30 per cent of heart attacks and 70 per cent of amputations. Treatment for diabetes and related conditions costs Ontario over $5 billion each year.

Toronto Central LHIN and diabetes

Fast Facts:

- 31% of Toronto Central LHIN residents have at least one chronic disease;
- 25% of Ontarians with diabetes live in Toronto;
- 1 in 10 people in the Toronto Central LHIN are living with diabetes. That number climbs to 24.4 per cent of men 65 and over and 21.6 per cent of women 65 and over.

A typical pre-diabetes-screening session involves three stations and a workshop: registration and initial assessment; anthropometric measurement taking (taking measurements of the body, i.e. height, weight); blood/glucose level testing; and a workshop on healthy living by the Registered Dietician. Under the leadership of Peter Yue, FHC's Executive Director, Heba Sadek, head of the health promotion department at FHC, is the visionary behind this program. A foreign-trained physician and a health promoter, Heba acts as the project manager for SADPP. Her goal is to establish SADPP as an example of a best practice approach to diabetes prevention. "We want to provide a meaningful service and highlight an innovative approach to delivering this type of care. This could be developed into a 'best practice model' that could be applied to other communities and different chronic conditions."

At Station One, Kandiah meets an outreach worker who facilitates an initial assessment using the FHC pre-diabetes screening tool. This is an evidence-based tool developed by the SADPP team that is tailored for the South Asian population. It also serves as a risk calculator and includes an in-depth questionnaire designed primarily to identify those at risk of diabetes.

Kandiah moves along to Station Two for a visit with the Registered Dietician, Indubala Shekhawat. At any given screening session, Indubala calculates the Body Mass Index (BMI) for approximately 30-45 at-risk adults and seniors. Today is no different. Kandiah steps onto a scale and has his height and weight measured. Arriving at Station Three, Kandiah meets with the Registered Nurse, Zeemen Kabani. Zeemen reviews the assessment tool thus far and looks at Kandiah's family history and BMI number. With this information in hand, she administers a prick test with a glucometer in order to measure Kandiah's blood/sugar level – a test that is extremely important for both people at high risk of diabetes and those who have already been diagnosed. After visiting all three stations, the nurse can provide a comprehensive

assessment and conclude whether Kandiah is at-risk for pre-diabetes. At-risk patients are referred to the Mid-Toronto diabetes clinic, while those patients without a family physician are provided resources to connect them to primary care. In addition, follow-up workshops are scheduled with the same pre-screened group to ensure full-circle care.

Reflecting on today's session, Zeemen smiles proudly, "this is what I love about this program. We don't scare them. We tell them this is good news! You can do something about this [high blood/glucose reading]. The fact that we are doing pre-diabetes testing is the best because it means that we are giving them a second chance."

With three or four screening sessions a month, the mobile SADPP team is always ready to service their community. Kandiah for one is happy he came to the screening program. "I thought it was important for me to come and check my blood/sugar. This is a very good service and it's systematically done. Sometimes this group of seniors doesn't have access to this type of service, so it's good to come here. I go to a family doctor once every three months, but here I get a blood test, they take all the measurements and it's more convenient. You meet with a dietician and a nurse and then you go home and you feel better with the knowledge you need to lead a healthier life."

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The SADPP team from left to right: Neil Stephens, Nalayni Ravinranath, Nelli Jutha, Peter Yue (Executive Director), Sajeda Khan, Zeemen Kabani, Heba Sadek, Indubala Shekhawat.

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The Ontario Diabetes Strategy

Fast Facts:

- Ontario is investing $741 million in a comprehensive four-year diabetes strategy to prevent, manage and treat diabetes.
- Key elements of the strategy include:
  - Improving access to insulin pumps and supplies for more than 1300 adults with Type 1 diabetes
  - An online registry – an electronic information system that will allow health professionals to keep track of and communicate with patients and provide individuals with diabetes better access to information and educational tools
  - Expanding chronic kidney disease services
  - Expanding bariatric surgery
  - Educational campaigns about diabetes prevention targeting high-risk populations, including Aboriginal and South Asian communities
  - Increasing access to team-based care closer to home
- The Toronto Central LHIN received funding from the Ministry of Health and Long-Term Care (MOHLTC) to:
  - Create a map of current diabetes services in the LHIN to expose gaps and inequities in accessing diabetes services
  - Engage with the LHIN's health service providers, health professionals and consumers to create options for improving access to team-based primary care diabetes services
  - Develop a work plan for a pilot project to improve diabetes management in the Aboriginal population
  - Provide recommendations for diabetes registry pilot sites
- The Toronto Central LHIN's Diabetes Steering Committee is chaired by Dr. Lynn Wilson, Dr. Bernard Zinman and Lynne Raskin, and brings together health service providers, clinical diabetes experts and a regional chair of the Canadian Diabetes Association to provide recommendations about implementing the Diabetes Strategy at the local level
- The Toronto Central LHIN consulted over 300 organizations, health professionals, including primary care physicians, and people with diabetes in developing its recommendations to MOHLTC

Towards a Common Vision for the LHIN

By Matt Anderson, CEO, Toronto Central LHIN

2008/09 marked my first full year as CEO of the Toronto Central LHIN and I take great pride in being part of an organization on the move and a health care system that is improving care for millions of people who receive services in our LHIN.

As I take stock of the year just passed, there have been a number of important improvements in the local health care system – many small and a few large. In my estimation, the most significant are: 1) shifting into action mode by concentrating on a select number of priorities; 2) strengthening the LHIN's performance measurement **and management capabilities; and 3) incorporating the promotion of health equity into all of the Toronto Central LHIN's work.**

Since my arrival at the LHIN, one of the pieces of advice that I receive most is to focus on a limited number of priorities and avoid the temptation of trying to solve all problems at once. We took this advice and identified three top priorities where we believe we can have the greatest impact for the people we serve:

1) improving the performance of the system, of which the main strategy is reducing Emergency Room (ER) wait times and Alternate Levels of Care days (ALC); 2) chronic disease management, starting with diabetes; and 3) mental health and addictions.

Community engagement, performance measurement and management and eHealth are the key means by which we will accomplish these health system improvements.

In 2008/09, Toronto Central LHIN programs and projects directly benefited some 6,700 individuals and indirectly touched the lives of many more families, caregivers and communities. The LHIN led the implementation of two major health care initiatives, Aging at Home and the ER Pay for Results, designed to expand home and community-based care for seniors and to reduce ER wait times.

ER wait times began to steadily trend downward last year. While this is an early trend (data from April to December 2008), it reflects the concerted efforts being taken by all providers to tackle this pressing issue.

In 2008/09, all 18 hospitals in the Toronto Central LHIN signed Hospital Service Accountability Agreements (HSAA) and ended the year in a balanced position. At the same time, every hospital in the LHIN developed a Hospital Health Equity Plan, identifying equity issues and the steps that must be taken to reduce health care disparities in Toronto.

And 100 per cent of the LHIN's 149 community support service and mental health and addictions agencies signed their inaugural Multi-sector Service Accountability Agreements by March 31, 2009, a defining moment in the evolution of local community health services.

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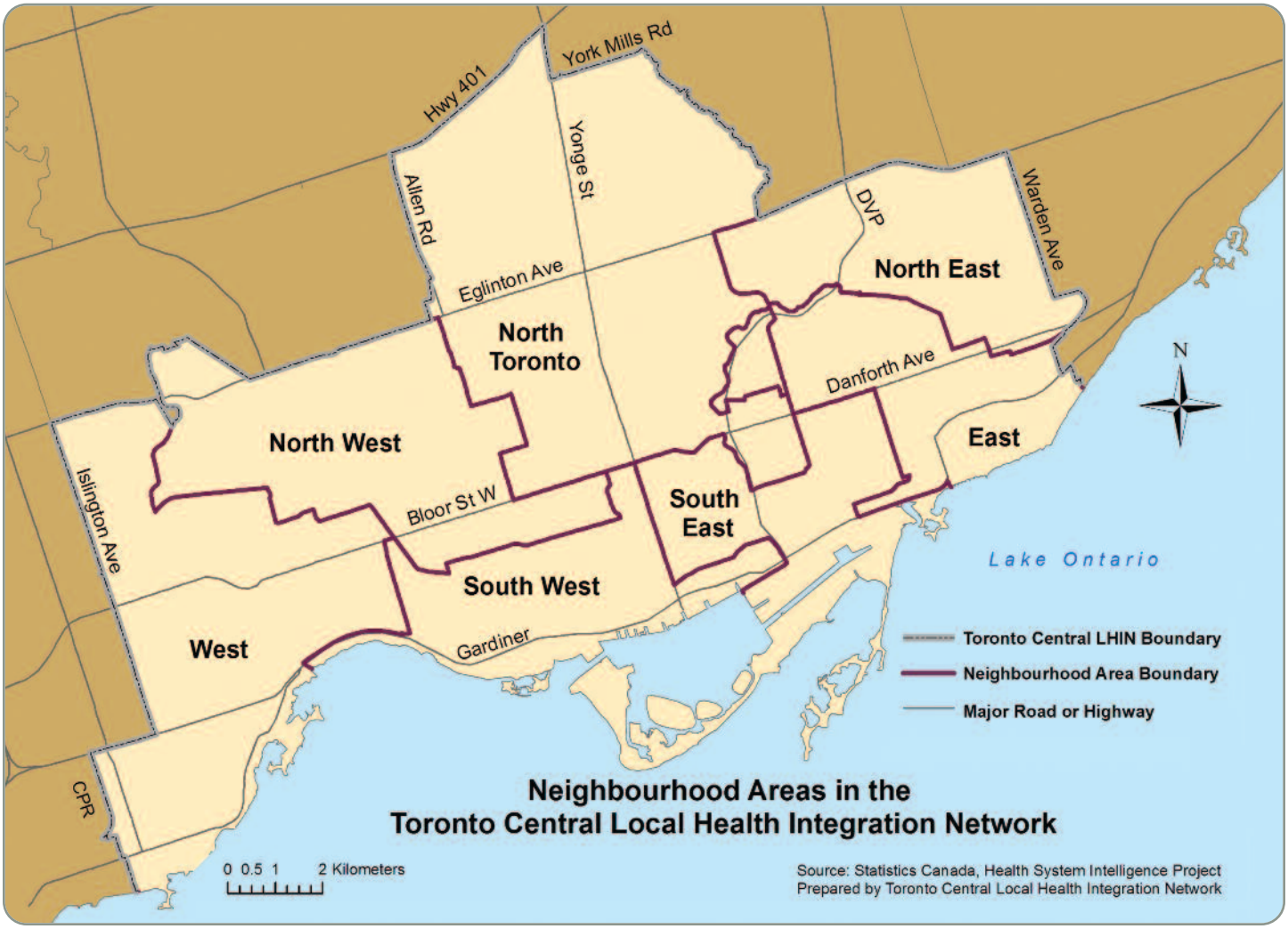
Towards a Common Vision for the LHIN continued from page 5

At the end of 2008/09, the Toronto Central LHIN is closer to becoming the kind of health care system our communities rightfully expect. But, there is a still much more to be done. This is where the next Integrated Health Services Plan (IHSP-2) comes in.

IHSP-2 builds on the progress made since 2007. It will be an action-oriented plan for the entire health care system – not just the Board and staff of the Toronto Central LHIN. It will reflect the provincial government's health care priorities and describe the specific actions that need to be taken now at the local level to address these important health care needs. IHSP-2 will also set out key steps towards a local health care system that maximizes the value delivered for the public dollars spent. And the LHIN will set out clear goals and targets so that everyone will know how much progress is being made.

During the spring, or Phase I of the IHSP-2 development process, the LHIN engaged our health service providers, LHIN committees and consumer panels and a reference group of experts about the vision and overall strategy for the Toronto Central LHIN.

Over the summer and fall, the LHIN will branch out and engage health service providers, health professionals, patients/clients and local residents to help design specific actions to improve health care in Toronto. Visit the Toronto Central LHIN's IHSP web section for updates, including a report on Phase I of IHSP-2: **http://www.torontocentrallhin.on.ca/**



2008/09 – A Year of Action at the LHIN

Over the past year the Toronto Central LHIN, together with local health service providers and stakeholders, have made measureable progress toward a health care system that is more accessible, accountable and equitable for the people it serves. But there is much more to be done as the LHIN develops the next Integrated Health Services Plan to address an ever-increasing demand for services in uncertain new economic realities. Here are some highlights of actions and achievements in 2008/09:

Reducing ER Wait Times and Alternate Level of Care (ALC)

Long ER waits are symptomatic of a system that is not working the way it should. ALC – a term that means patients who are stuck in hospital beds waiting to be transferred to a more appropriate setting – such as home care and supportive housing – is the greatest contributor to ER wait times in the Toronto Central LHIN. The Toronto Central LHIN has two main strategies to reduce ER wait times and ALC: ER Pay for Results (P4R) and Aging at Home.

Emergency Room at St. Michael's Hospital

Results

Between April 2008 and February 2009, ER wait times progressively improved for all patients. The LHIN will continue to closely monitor this trend to determine the impact of Aging at Home, ER Pay for Results and other investments.

a) ER Pay for Results (P4R)

The ER P4R program provides financial incentives to seven hospitals to achieve ER wait time reduction targets. Last year, the Toronto Central LHIN allocated $8.6 million to Toronto General Hospital, Toronto Western Hospital, St. Joseph's Health Centre, St. Michael's Hospital, Sunnybrook Health Sciences Centre, Toronto East General

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Hospital and Mount Sinai Hospital. During the first year of the program, hospitals primarily focused on improving the performance of emergency departments. However, the LHIN and health service providers recognize that the key to reducing ER wait times is to improve access to care options outside of hospitals including community based care and primary care.

Community support organization meeting the transportation needs of a client

The Toronto Central LHIN's ER P4R Executive Committee, comprised of the CEOs of the seven hospitals, the Executive Director of the Toronto CCAC, Toronto Emergency Medical Services (EMS) and the CEO of the Toronto Central LHIN, developed a collaborative system-wide action plan. This includes initiatives to prevent unnecessary ER visits and help people stay independent and healthier in their homes and communities.

In 2009, the Toronto Central LHIN announced an investment of over $7.9 million in the seven ER P4R hospitals to build on the program's success so far.

b) Aging at Home

Last year, the Toronto Central LHIN provided $6.2 million to support 17 locally-driven initiatives to expand access to home care, community services and supportive housing for older adults.

In its first year, Aging at Home initiatives directly benefited just under 2,500 seniors. And they are creating a ripple effect by improving the well-being of caregivers, families, and communities.

The 2008/09 Aging at Home projects did four things:

1. Improved coordination of services for seniors.
2. Expanded supportive housing. Last year, 301 more people received supportive housing services in the Toronto Central LHIN.
3. Enhanced access to team based care, including mobile outreach teams helping seniors with mental health and other complex needs.
4. Promoted prevention and wellness including six community development projects that benefitted 1,350 seniors.

In May 2009, the Toronto Central LHIN announced $15.4 million for Aging at Home initiatives for 2009/10, an increase of $9.2 million over 2008/09. This includes $5.3 million for five new initiatives, and $10.1 million to enhance projects that began last year.

Mental Health and Addictions

Last year, the Toronto Central LHIN invested in and supported various initiatives for people living with mental health and addictions issues.

Highlights include:

- 150 people with mental illness and addictions benefited from the new supportive housing units funded by the LHIN.
- Outreach services to support seniors with mental illness and/or addictions to remain in the community and avoid crises.
- 32 mental health and addictions agencies from Toronto Central and other GTA LHINs are collaborating to coordinate client access to supportive housing.
- Expanding an electronic medical record for the homeless – Client Access to Integrated Services and Information (CAISI). Last year, 37 agencies used CAISI and 3,946 homeless clients across the city were supported through this system.
- A transitional unit was established to prepare seniors, hospitalized with mental health issues, for a return to the community.
- Tools to help ER staff to identify and assess seniors in ER with mental health and addictions issues, and link them with appropriate post-ER care.

eHealth

As part of its joint three-year eHealth strategy with the Central LHIN, the Toronto Central LHIN launched two key eHealth programs that are changing the way health care is delivered to local residents.

Resource Matching and Referral (RM&R)

Resource Matching and Referral (RM&R), an electronic referral system, will transform the referral process by linking patients/clients with available services based on a standardized assessment of the patient's needs. RM&R will reduce ALC by moving patients more rapidly out of hospital beds and into the level of care that best meets their needs.

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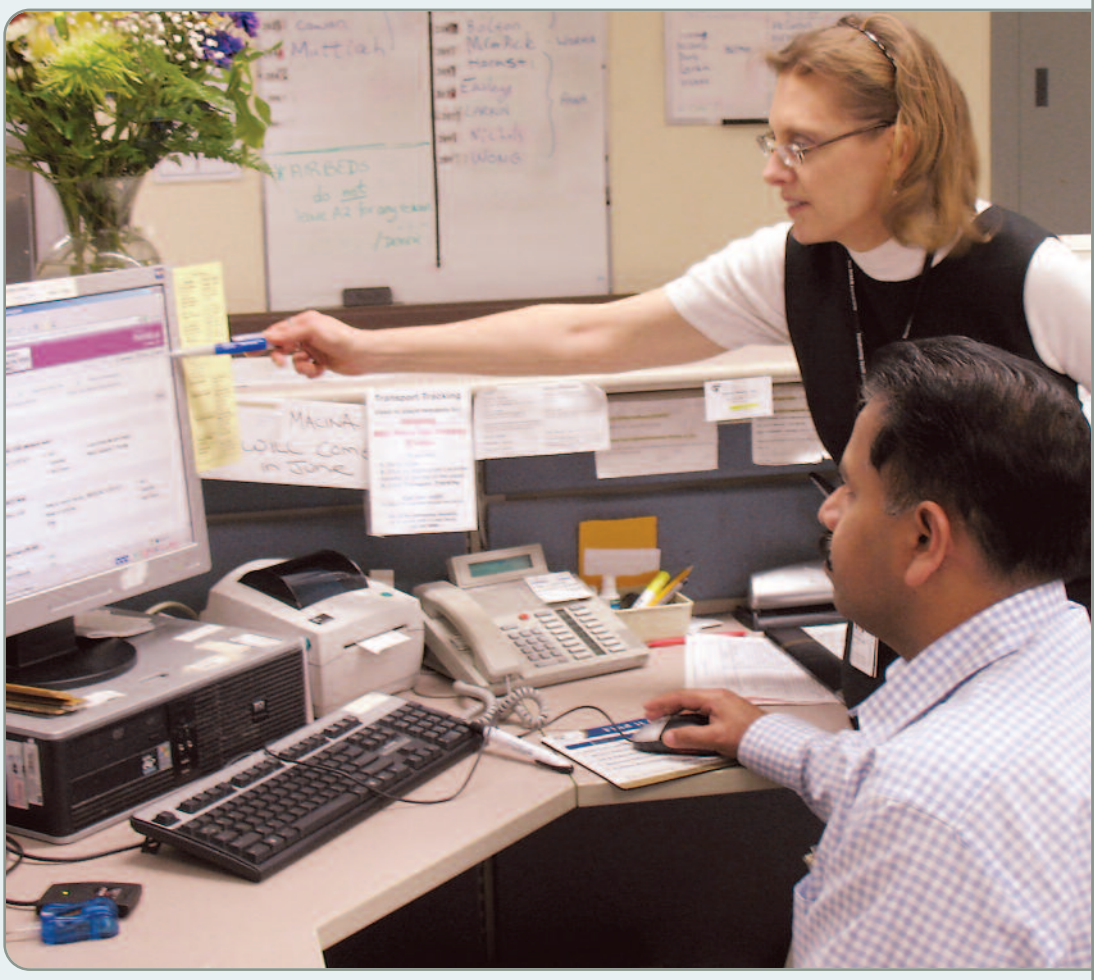


Photo of Analyst Shelley Macmillan training Sajimon Joseph, social worker at Toronto East General.

2008/09 – A Year of Action at the LHIN continued from page 9

To date RM&R is being used in:

- eight acute care facilities
- eight rehabilitation and complex continuing care facilities (Rehab/CCC)
- the Toronto Central CCAC
- 12 long-term care homes within the Toronto Central LHIN

In the next several years, The Toronto Central LHIN's goal is to have all referrals done electronically. Starting in 2009/10, RM&R will be expanded to an additional 26 long-term care homes. Groundwork is also being laid for implementing RM&R in mental health, addictions and community support service agencies across the LHIN.

ConnectingGTA – Health Integration and Access Layer (HIAL) and Provider Portal

ConnectingGTA is a joint initiative of the five GTA LHINs (Toronto Central, Central, Central East, Central West, Mississauga-Halton). A key component of the Electronic Health Record being developed in Ontario, HIAL links data systems and sources such as patient or disease registries, lab results and drug information. The Provider Portal provides health professionals with user-friendly access to vital health information about their patients/clients. Over 46 health service providers and 20 clinicians worked with the Toronto Central LHIN and the other GTA LHINs to identify the business, technical, privacy and governance requirements associated with the HIAL and Provider Portal.

System Performance

This past year the Toronto Central LHIN developed tools to analyze, report, and, most importantly, use information to improve local health system performance.

Four times a year, the LHIN's Board reviews a scorecard on the performance of the LHIN and health service providers. A Clinical Services Leadership Team, made up of leaders from different health professions, provides clinical insights about the results. The LHIN then works with hospitals to uncover and resolve underlying issues.

In 2008/09, 100 per cent of the LHIN's hospitals signed Hospital Service Accountability Agreements (HSAA) and ended the year in a balanced position. Each of the 149 diverse community support service and mental health and addictions agencies and the Toronto Central CCAC signed accountability agreements with the LHIN, committing to a new standard of accountability and transparency.

Health Equity

Health equity is woven into everything that the Toronto Central LHIN does. Here are a few highlights:

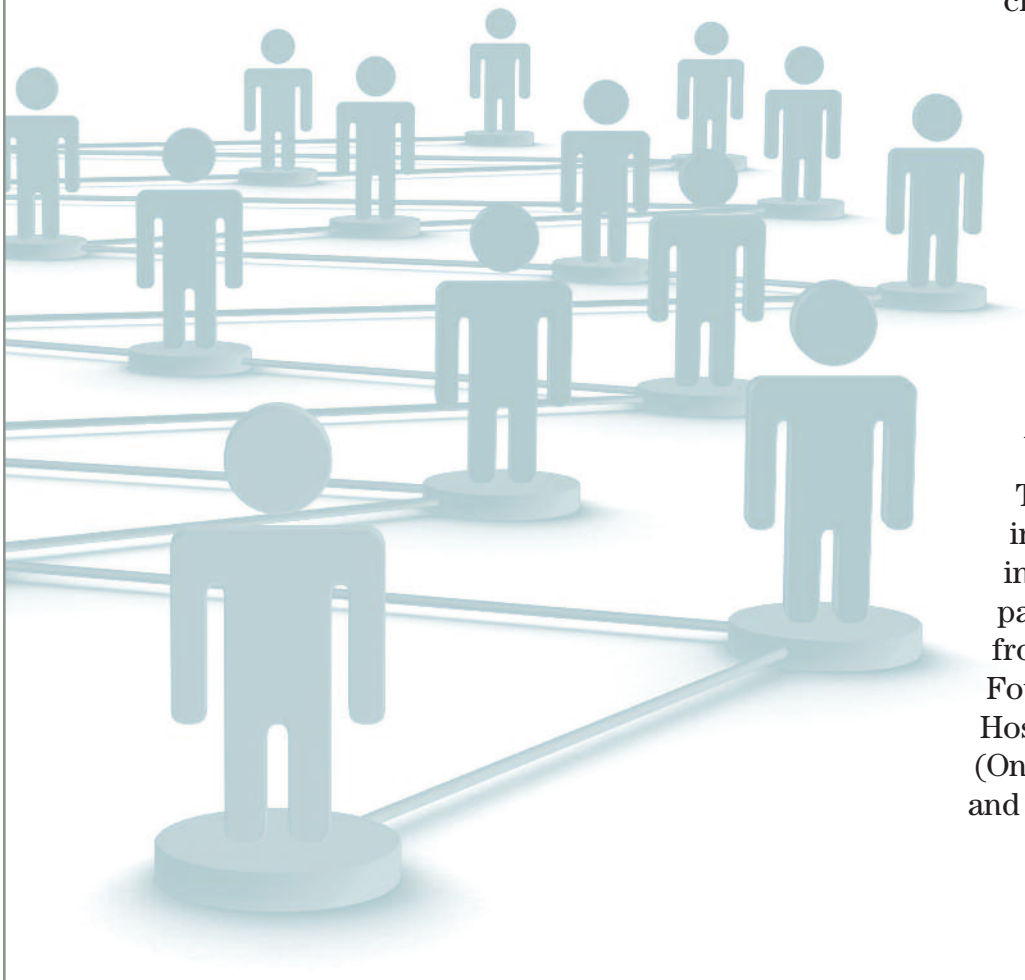
The Toronto Central LHIN worked with the Hospital Collaborative on Marginalized Populations drawn from the LHIN's 18 hospitals to develop Hospital Health Equity Plans. All 18 hospitals submitted plans that were signed by hospital CEOs and Board chairs, signifying a commitment at the highest levels to improving health equity.

The June 2008, "Healthy Connections" conference brought together front-line workers, administrators, policy-makers, consumers and families to learn about the realities of and strategies to address health inequity.

Partnership for Service Improvements

– Transforming Health Care at the Local, Community Level

Earlier this year the Toronto Central LHIN launched Partnerships for Service Improvement (PSI), an initiative to promote a more efficient and effective health care system by reducing costs and duplication.



PSI encourages Community Care Access Centres, Community Support Services agencies, Community Mental Health and Addictions agencies, hospitals, long-term care homes and Community Health Centres within the LHIN to partner on projects in the areas of back-office (i.e. human resources, legal services) and clinical support services (i.e. infection prevention and control, pharmacy services).

Fourteen PSI proposals – involving 50 health service providers/agencies – were submitted and reviewed by an independent expert panel made up of representatives from government, hospital, community, academic and the LHIN.

The LHIN used a rigorous and independent evaluation process involving a six-member selection panel with senior representatives from Community (Trillium Foundation); Hospital (Ontario Hospital Association); Government (Ontario Buys); Academic (Rotman); and the Toronto Central LHIN.

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Partnership for Service Improvements – Transforming Health Care at the Local, Community Level continued from page 11

The five successful PSI Demonstration Projects are:

1) Back Office Solutions – Human Resources/Legal Services

This project will facilitate and enable integration of specific human resources, occupational health, and training and development programs between multiple health service providers within the LHIN.

- **Benefits –** Improved staff training, leadership development, recruitment efficiencies and a reduction in staff turnover.
- **Partners –** Community Care East York, COTA Health, Neighbourhood Link Support Services, Solutions – East Toronto's Health Collaborative and Toronto East General Hospital.

2) Infection Prevention and Control (IPAC) eLearning in the Community

This project will provide an eLearning module designed to drive consistent IPAC best practices among community workers and volunteers.

- **Benefits –** Reduction in community acquired infection rates, savings in education costs, avoidance of hospital admissions, and reduced staff sick time.
- **Partners –** Nisbet Lodge, Community Care East York, Neighbourhood Link Support Services, Solutions - East Toronto's Health Collaborative, Toronto East General Hospital, and George Brown College.

3) Shared Pharmacy Services

This project will integrate clinical pharmacy services across hospitals.

- **Benefits –** Improved drug distribution, enhanced patient safety, and improved quality of care.
- **Partners –** Four hospitals representing acute care and complex continuing care/rehabilitation: St. Michael's Hospital, Providence Centre, Bridgepoint Health and Toronto East General Hospital.

4) Tech Accord – IT Integration

This project will integrate IT services among community mental health and addiction agencies to promote standardization, simplified vendor and contract management, and shared training.

- **Benefits –** Increased efficiencies and cost savings in the purchase of hardware and software, implementation, maintenance and training.
- **Partners –** Houselink Community Homes, Mainstay Housing and St. Jude Community Homes.

5) Toronto Healthcare Interpretation Services

This project will create a model for sharing translation and interpretation services among *seven* health care providers through shared technology solution and a pool of freelance interpreters.

- **Benefits –** *Significant contribution to health equity, avoidance of one-time costs of setting up separate dispatch systems and pools of freelance interpretation staff, and annual cost savings from staff recruitment and retention.*
- **Partners –** University Health Network, St. Joseph's Health Centre, Toronto Rehabilitation Institute, Women's College Hospital, Hospital for Sick Children, St. Michael's Hospital, and Access Alliance.

These projects are just the start of an important initiative to bring greater efficiency and improvements in the way we provide care in central Toronto. The LHIN plans to use these demonstration projects as models that can be expanded to other health service providers.

Congratulations to all the partners involved in the five PSI Demonstration Projects and to all the HSPs who collaborated on proposals.

For more information about PSI, visit: www.torontocentrallhin.on.ca

LHINs Connect Aboriginal Community with *Spirit of Partnership*

Aboriginal engagement strategies ensure open, inclusive dialogue with Aboriginal organizations

Aboriginal people face many serious health-related challenges, such as high rates of chronic and contagious diseases and shorter life expectancy compared to other Canadians. Currently in Ontario, 76.5% of Aboriginal peoples live off-reserve, with the largest urban Aboriginal population in Canada residing in the GTA. Despite having the highest concentration of health service providers in Ontario, there is a persistent disparity in the health status of Aboriginal peoples, compared to the non-Aboriginal population.

One of the ways that the LHIN has addressed this disparity is to work with Aboriginal health champions in Toronto. One such organization is Anishnawbe Health Toronto, an Aboriginal health access centre with three locations in Toronto's downtown core, and a leader in urban Aboriginal health practices, combining primary care services, supportive programming and traditional medicine in order to address the physical, mental, spiritual and emotional needs of its clients.

Anishnawbe Health Toronto's Executive Director, Joe Hester, is a critical link for the Toronto Central LHIN. Through his work on many projects, Joe provides invaluable insights and advice to the LHIN about the ongoing and changing needs of the community.

When asked to identify the biggest health priority areas, Hester indicated that diabetes is still one of the major health concerns in Aboriginal communities, occurring at least three to five times more often in Aboriginal peoples than in non-Aboriginal peoples.

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Roger Obonsawin facilitates the March 3rd Aboriginal Engagement Forum at the Native Canadian Centre of Toronto; The Visiting Schools Program performs traditional dance

LHINs Connects Aboriginal Community with Spirit of Partnership continued from page 13

Hester added that GTA LHINs and health service providers need to mount a major long-term collaborative effort in order to achieve more positive results in the prevention and management of the disease.

"We have to deal with the social determinants of health – poverty has a huge impact," he said. Hester also sites broad mental health concerns, particularly concurrent disorders, as being a high priority as well.

In early 2008, the Toronto Central LHIN joined forces with the four other LHINs that border the City of Toronto – Central, Central East, Central West, and Mississauga-Halton – to hold a forum on community engagement with local Aboriginals and agencies. The unmistakable conclusion was that the GTA LHINs need to collaborate together and with Toronto-based Aboriginal groups in order to improve access to services for Aboriginal people in the GTA.

According to Hester, one of the key areas of collaboration to address the challenges faced by the urban Aboriginal population is to develop a comprehensive health assessment that provides a picture of the health status of urban Aboriginal peoples. "It is imperative to proceed on this, even if it takes a year or two, the picture is lacking," he said.

This approach is necessary to ensure that the LHIN has its "ear close to the ground," Hester says, adding that the LHIN and the Aboriginal community

must have an open level of communication that embodies the true spirit of partnership.

In addition to the community engagement forum, in the past year the LHIN and Aboriginal agencies in the GTA worked together on several initiatives, including the development of an Aboriginal Diabetes Pilot Project work plan, and a culture-based community feast, to promote a greater understanding of Aboriginal culture, and the health and wellness needs in the Toronto Central LHIN.

Fast Facts:

- According to the 2006 Census, 26,575 people self-identified as Aboriginal in Toronto. This number is thought to be greatly under-represented, and is estimated to be closer to 70,000 (Toronto Aboriginal agencies estimate).
- Heart disease is 1.5 times higher in the Aboriginal population
- Aboriginal people living off-reserve are 2.5 times more likely to be obese compared to other Canadians
- Suicide amongst First Nations Peoples is 3 to 5 times the Canadian rate
- Type 2 diabetes is 3 to 5 times higher among First Nations people

PERSPECTIVES – A Profile of Health Care Leaders

Dr. Robert Howard, President and CEO, St. Michael's Hospital

Please describe your current role, training and relevant background.

More than 25 years ago I came to St. Michael's Hospital as a resident. I had no way of knowing then that I was at the beginning of a long term relationship with an incredible hospital. I have had a number of roles over the years as a cardiologist, researcher, teacher and administrator. A few years ago, I earned my executive MBA from the University of Western Ontario. What sustains my enthusiasm is the strong spirit of St. Michael's and the limitless energy of our people.

I have been fortunate to combine several professional passions in all my roles including the opportunity to teach young physicians, discover new therapies, learn innovative techniques and develop and encourage leadership qualities within myself and others. However, even as my administrative knowledge and responsibilities grew, I continued until very recently to see patients, and I think this kept me grounded. All of my work at the Hospital has immersed me in its priorities of research, education and patient care – in a very intimate way. My breadth of experience drives my commitment to keeping St. Michael's Hospital the leading academic health sciences centre that it is.

As incoming President and CEO, what is your vision and main priorities for St. Michael's Hospital and for the surrounding community?

Since the Sisters of St. Joseph founded the Hospital in 1892, St. Mike's has been committed to caring for the sick and the poor. Many of our best clinicians and researchers chose to come here in part because of this promise. It's one of the reasons I became President and I will keep it.

My vision for St. Michael's Hospital is to sustain and expand our role as a centre of excellence within our Local Health Integrated Network, our region and the world. We will do it without compromising our values and traditions, or breaking the bank.

Our Inner City Health Program (ICH) is a shining example, the only program of its kind in Canada. Since 1999, the program has not only provided excellent care, but has also developed a strong academic program through research and education. One marvelous initiative from ICH is the Baby and Me Passport. The passport is a health information tool for homeless or underhoused pregnant women that rewards them for healthy practices like keeping medical appointments. I will continue to encourage more projects like this one.

St. Mike's is also a leader in providing complex and highly-technical treatment. For example, we treat some of Ontario's most serious trauma patients who arrive by helicopter. Another example of our commitment to excellence includes our technology-assisted programs, including capabilities in heart and vascular that can allow patients to avoid undergoing major open heart surgery. We serve as a system-wide resource for the Toronto Cardiac Care STEMI program providing rapid treatment and saving precious minutes for heart attack patients.

The Li Ka Shing Knowledge Institute at the corner of Shuter and Bond Streets will open in 2011. The Li Ka Shing Knowledge Institute is so much more than a building! It will usher in a new era not just for the Hospital, but for health-care education and research beyond our walls. We are bringing together excellent researchers and educators, where they can speed the latest discoveries into medical practice and serve downtown Toronto health needs in faster more efficient ways.

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PERSPECTIVES – A Profile of Health Care Leaders

Dr. Robert Howard, President and CEO, St. Michael's Hospital continued from page 15

To successfully navigate the road ahead requires new partnerships with healthcare, educational and community organizations. We want to work together building a unified health system that provides the best care and learning environments for our community.

In your opinion, what are the main challenges and opportunities to improve access to care within the Toronto Central LHIN?

We need to keep innovating access to care. I have seen how the changing urban population in Toronto pose health care challenges including caring for the elderly, addictions, mental health, caring for new Canadians, poverty and homelessness issues. Our new care and outreach models need to strike the balance between home, community and hospital care that serve our marginalized populations. We must also preserve and enhance programs that treat the critical patients in the GTA and ones transported to us from across Ontario. We value the ongoing engagement and partnerships with our community to ensure the best care available.

Ensuring that patients get the care they need and in the most appropriate health care setting is a priority for the provincial government and the TC LHIN. How is St. Michael's Hospital tackling this challenge?

We strive to provide the right care in the right setting with four interdisciplinary family practice units located in south east Toronto. These teams of primary care providers treat a disproportionate number of lower income patients and many with complex health needs and chronic diseases.

We have a group of 35 physicians who work in local homeless shelters and provide care to disadvantaged patients where they are located, including a clinic at Canada's largest homeless shelter for men, Seaton House. And thanks to new funding from the Toronto Central LHIN, we are creating a community-based geriatric/psychogeriatric program, with other community partners.

We also share a special partnership with long-term care providers Bridgepoint Health and Providence Healthcare that has enabled us to concentrate on providing the best care, while improving capacity and the flow of our patients.

As a downtown hospital that serves many marginalized populations, how do you ensure that St. Michael's Hospital provides health care on an equitable basis?

Health equity is our priority. The Inner City Health Program, our largest, works closely with community partners to create special programs and services to care for those who are poor, homeless, have severe mental illness, and those living with HIV/AIDS. We constantly adapt our medical models to serve our patient populations.

In addition, our Centre for Research on Inner City Health, also unique in Canada, focuses on finding new ways to address the needs of marginalized populations. We are also partners with other LHIN hospitals in the Hospitals Collaborative on Marginalized Populations. This network also develops system-wide methods to improve health equity. We share best practices, coordinate approaches to care and create equity performance indicators that can be measured over time.