Toronto Central **LHIN REPORT** | June/July 2010

2009/2010 – A Year of *Progress and Collaborative Action*

2009/10 represents the last year of the Toronto Central LHIN's first Integrated Health Service Plan, and this past year the Toronto Central LHIN, together with local community members and health care providers, made measureable progress towards a health care system that is more accessible, accountable and equitable.

This report spotlights some of the key achievements that have been made by partners throughout the LHIN during this past year. Reflected within the data and the stories is something less tangible – a culture within the health care community in the LHIN which is clearly changing for the better. Organizations that only a few years ago never had an occasion to sit in the same room together are now partnering on some of the most pressing health system issues. There is a heightened level of transparency as organizations and health professionals share performance data and provide the public with an unvarnished view of where the health system is working and where it is failing.

Highlights

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

Each day, hundreds of patients visiting Toronto Central LHIN ERs wait longer than recommended to be treated or admitted to hospital. While there are various and complex reasons for these delays,

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Ontario
Local Health Integration Network

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one key reason why emergency departments get backed up is that the hospital beds needed by ER patients are occupied by ALC patients who are waiting to be transferred to an alternate place of care that will better meet their needs.

Nine out of 10 patients waited 20 per cent less time to be treated in the ER in March 2010 compared to March 2009.

The Toronto Central LHIN's ER wait times and ALC strategy's two main programs are ER Pay for Results and Aging at Home.

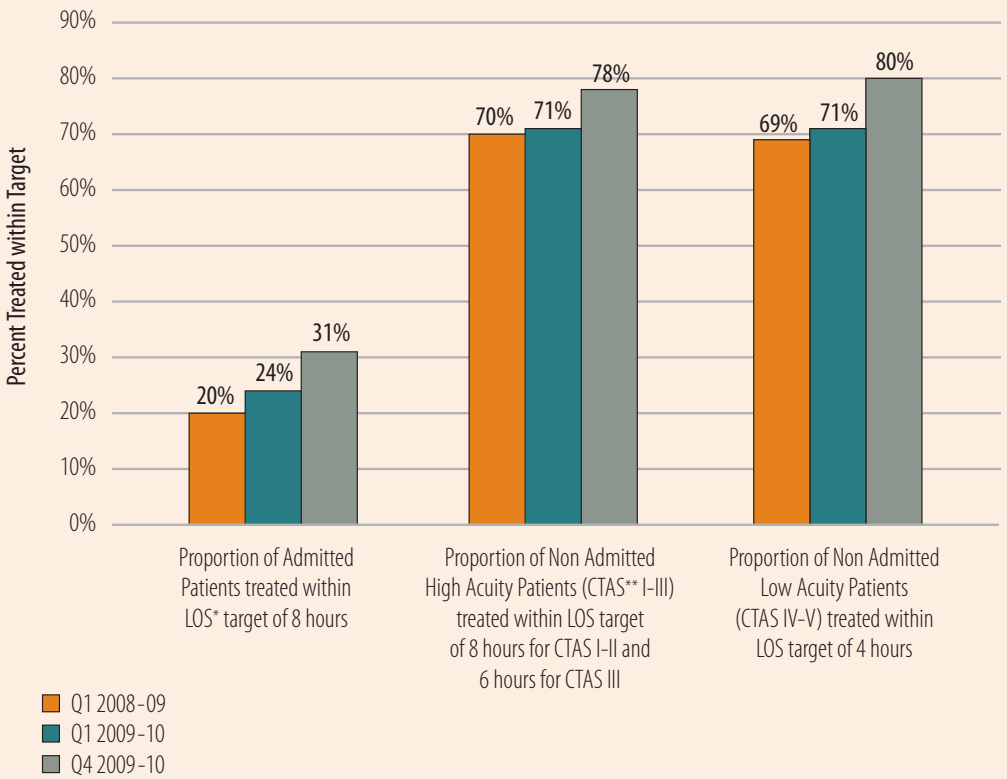
ER Pay for Results (P4R)

ER P4R provides financial incentives to seven hospitals in the Toronto Central LHIN to meet ER wait time targets. In 2009/10, the Ministry of Health and Long Term Care allocated $7.9 million to Toronto General Hospital, Toronto Western Hospital, St. Joseph's Health Centre, St. Michael's, Sunnybrook Health Sciences Centre, Toronto East General and Mount Sinai Hospital to reduce ER wait times.

The P4R program encourages hospitals to look beyond their four walls, learn from each other and pursue collaborative solutions across hospitals, community services and other sectors. Recognizing the importance of addressing ALC and supporting patients to transition from hospital to home, community and long-term care, the Toronto Central Community Care Access Centre (CCAC) is also a standing member of the P4R working group.

In 2009/10, ER P4R built on the strengths of the program's first year and focused on improving patient flow and process within the ER and hospital; increasing hospital capacity including human resources; and investing in information technology.

Over the program's first two years, the Toronto Central LHIN hospitals made great strides in reducing ER wait times, with gains accelerating in 2009/10. The graph below shows the steady improvements made on all three ER P4R targets.



* Length of stay

** The Canadian Triage & Acuity Scale (CTAS) is a tool that enables Emergency Departments (ED) to triage patients according the type and severity of their presenting signs and symptoms

Aging at Home

Aging at Home is a three-year strategy designed to expand seniors' access to care options at home and in the community, and to create locally-driven approaches to enhance seniors' independence and health. In 2009/10, Toronto Central LHIN invested $15.4 million to support 22 initiatives. The program emphasized supporting marginalized and high-need seniors, specifically those with dementia, mental illness and/or addictions, by diverting seniors from avoidable ER visits, where appropriate, and supporting seniors as they transition from hospital to a level of care that better meets their needs.

Aging at Home initiatives directly benefitted approximately 8800 seniors in 2009/10.

- 1,738 patients were assessed by Geriatric Emergency Management Nurses in the ER and 1360 were safely discharged to a more appropriate care setting.
- Over 3000 new client referrals done using the Community Navigation and Access Project's standardized intake form, simplifying navigation and quickly connecting seniors with community services.
- 588 more people received supportive housing in the Toronto Central LHIN.

Mental Health and Addictions

In 2009/10 the Toronto Central LHIN's mental health and addictions strategy focused on three main areas: 1) enhanced services targeting key populations, including supportive housing intensive case management and integrated care; 2) better service coordination through client referral, intake and assessment tools; and 3) enhancing mental health and addictions data to enable performance improvement and evidence-informed decision making.

HIGHLIGHTS

- **Expansion of supportive housing units – of the 588 clients served by the new supportive housing units, 337 clients (or 57 per cent)** are living with mental illness and/or addictions, including dementia and related conditions.
- **Outreach services to help seniors** with mental illness and/or addictions stay in their community. James Town Outreach Program (STOP) has helped over 110 clients maintain their housing and get connected to services in the last year.
- **A transitional unit** to help hospitalized seniors with mental health challenges return home.
- **One common wait list and application form for all 28 mental health supportive housing providers – comprising nearly 100 per cent of the Toronto Central-LHIN funded units for mental health** – through the Coordinated Access Supportive Housing (CASH) program.

"STOP is about meeting people where they live, which helps us to identify problems, including health issues, and putting them in touch with the health services and community support they need."

Karen Edwards, outreach worker with the Community Resource Connections

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- **Specialized tools and education materials** to help ER staff identify and assess seniors with mental health issues, and to link them with the post-ER care options.
- **An integrated model of care** through the Toronto Community Addictions Team that helps clients with problematic substance use or a concurrent disorder (a person with a mental illness and a substance use or gambling disorder) get connected to the right care options for them.
- **Improved outcomes for people with concurrent disorders** by enhancing the knowledge and skills of mental health and addictions agency staff.

Diabetes

One of the priorities of the Toronto Central LHIN is to improve the prevention, management and treatment of diabetes in the local population and to contribute to the success of the provincial Diabetes Strategy.

HIGHLIGHTS

- The Toronto Central LHIN Diabetes Strategy Steering Committee **developed a model of care** for diabetes management with input from the community and health service providers. It has been incorporated into a proposed regional coordinating centre model that the Ministry will be implementing.
- **Provided expert advice** on the implementation of the provincial Diabetes Strategy, including recommendations for diabetes registry pilot sites.
- **Implemented two outreach and screening programs.** The South Asian Diabetes Prevention Program (SADPP) at Flemingdon Community Health Centre expanded in 2009/10. Building on the success of SADPP, a second program – Live Free – for Caribbean and Latin Americans communities got underway last year, with a third program being planned for urban Aboriginals.

- The Toronto Central LHIN Diabetes Steering Committee developed a work plan for a **pilot project to identify diabetes care gaps and needs within the Aboriginal community.**

Value and Affordability

Increasing value in publicly funded health care requires making the best use of existing resources to deliver the best results possible.

In 2009, the Toronto Central LHIN launched Partnerships for Service Improvement (PSI) with four demonstration projects spanning human resources and legal, information management/ information technology, infection prevention and control, and pharmacy.

In June 2009, hospital CEOs worked with the LHIN to undertake six HAPS Value and Affordability task forces as part of the Hospital Annual Planning Submission (HAPS) process. This resulted in a focused set of shared collaboration priorities which hospital CEOs are driving to achieve greater value and affordability in areas such as laboratory services, clinical efficiency, and intensive case management for key populations with complex needs.

Critical Enablers of Transformation

Health Equity

Health inequities are costly for both the system and the individual. Access barriers among different groups have been linked to prolonged lengths of stay, avoidable hospitalizations and readmissions. Overall, health inequities in our system contribute to poorer quality, less efficiency and less patient satisfaction.

In 2009, the Toronto Central LHIN required hospitals to begin reporting on equity in a standardized way through the Hospital Health Equity Plans created through a collaborative effort involving all 18 hospitals.

In addition, the Toronto Central LHIN partnered with the Ministry of Health and Long-Term Care's Health Equity Branch and the Wellesley Institute to develop a Health Equity Impact Assessment Tool to be used by the LHIN and health service providers to ensure that equity is considered in planning, program design and decision making.

Short-listed applicants for Year 3 Aging at Home were required to complete and submit a Health Equity Impact Assessment as part of the selection process. The use of the tool is also being promoted through the extended Hospital Service Accountability Agreements and all hospitals are required to use the tool in the next round of Hospital Health Equity Plans in 2010/11.

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eHealth

Over the past year, Toronto Central LHIN and its partners have made excellent progress towards the implementation of electronic tools to integrate clinical information across the continuum of care.

HIGHLIGHTS

Resource Matching and Referral

Resource Matching and Referral (RM&R) is an electronic information and referral system that matches patients/clients to the earliest available and most appropriate care/support setting, ensuring more people receive the right level of service at the right time.

At the end of last year, 53 Health Service Providers in the LHIN were using RM&R to facilitate their referral processes which has significantly shortened referral times. Patients are getting from hospital to the next level of care faster and freeing up hospital beds for acutely ill patients who require hospital care.

ConnectingGTA

ConnectingGTA is a joint initiative of the five GTA LHINs (Toronto Central, Central, Central East, Central West, Mississauga-Halton). It will allow GTA health care providers to view all relevant health care information related to their patients at the point of care. The project made significant progress in 2009/10 and lab information is anticipated to be incorporated into the system in summer 2010.

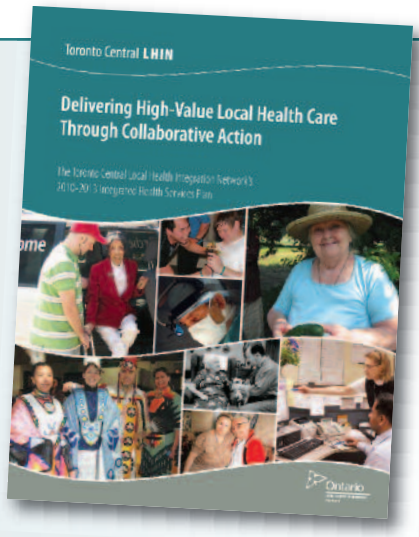
Client Access to Integrated Services and Information (CAISI)

CAISI, an initiative funded by the Toronto Central LHIN, is an electronic medical record that features case and bed management tools and medical record capabilities tailored to meet the needs of shelters, drop-in centers, outreach teams, health clinics and hospitals working with homeless and at-risk populations. In 2009/10, 42 agencies and 650 providers used CAISI for case management and over 11,000 homeless clients were registered.

The road ahead

Over the past year, the Toronto Central LHIN developed its second Integrated Health Service Plan (IHSP-2) through careful examination of latest evidence and data; consultation with health service providers, health professionals and experts; and extensive community input. Over the next three years, the LHIN and its partners will build on the successes we have achieved so far and focus on accelerating the process of transformation outlined in the IHSP-2.

Visit our website at **www.torontocentrallhin.on.ca** to download a copy of our IHSP-2.



CEO update

By Bonnie Ewart, CEO, Toronto Central LHIN

Since becoming the interim CEO of the Toronto Central LHIN in late March 2010, what has been most striking – besides the sheer scope and volume of work undertaken by Toronto Central LHIN staff and partners – is the incredible teamwork within the local health care system.

This teamwork and shared commitment to doing what is best for the people who depend on local health care services is in my mind the single most important factor driving progress in the Toronto Central LHIN.

The cover story on 2009/10 year in review provides both hard numbers and, just as importantly, personal insights and stories of people from the community. Significant progress has been made in all of the Toronto Central LHIN priority areas. These improvements are translating into meaningful differences in the health, independence and wellbeing of individuals and communities. Over the past year, there were continual and substantial improvements in ER wait times – a signature initiative of the province and the LHINs. Aging at Home initiatives are showing a measurable impact on transferring ALC patients from hospital beds to a better place of care.

Collaboration occurred through large-scale initiatives such as Resource Matching and Referral which involved 53 health service providers using one system to match patients with the care they need. Collaboration also occurred within sectors and related to specific services and issues such as health equity and supportive housing.

Most recently, health care stakeholders from across the Toronto Central and GTA LHINs collaborated on an extraordinary level to plan for and respond to the G20 Summit. The G20 was an unprecedented event because of the security presence and the large number of protesters in the downtown core where most Toronto hospitals and other key agencies are located. Fortunately, there were no serious injuries as a result of G20 incidents. The careful planning and collaboration among health care organizations across Toronto helped to ensure that residents and visitors had access to health care services, and that patients and staff were protected throughout the weekend. The LHIN brought together health service providers to plan ahead of the Summit, as well as to share real-time information and coordinate efforts during the event. Under the leadership of Dr. Laurie Mazurik, Emergency Medicine Physician at Sunnybrook Health Sciences Centre and the Toronto Central LHIN's G20 Lead, the LHIN's plan involved several elements:

- Creating a G20 health system planning team involving hospitals, the Toronto Central Community Care Access Centre (CCAC), community health centres, primary care, Ministry of Health and Long-Term Care's Emergency Management Branch and clinical leaders from emergency departments, trauma, paediatrics, critical care, public health, and Emergency Medical Services. The team linked with the GTA LHINs, City of Toronto and Toronto Police Service.
- Creating plans for various scenarios including blocked access to downtown hospitals, tear gas exposure and events causing minor and major trauma. A system-wide simulation was conducted to test these plans.

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- Working with hospitals and the Toronto Central CCAC to create additional capacity to respond to emergency situations. This included fast tracking and safely discharging patients who are ready to leave hospital to the most appropriate level of care including home care, long-term care and rehabilitation.
- Creating a web site for health care providers to share plans and information in the months leading up to the Summit and an innovative online dashboard that provides stakeholders with credible real-time information about unfolding situations including each hospital's capacity to accept patients, blood inventory levels, and critical incidents.
- Keeping the public informed about health care system impacts through media alerts and interviews.

The Toronto Central LHIN is conducting a comprehensive debrief this summer to identify lessons learned and effective practices that can be incorporated into day-to-day health care relationships and operations.

I am optimistic that the spirit of teamwork and shared commitment to patient/client-driven care will not only enable us to weather the challenges ahead, but also to transform health care for the better.

Recruiting for the Toronto Central LHIN's Health Professionals Advisory Committee

The Health Professionals Advisory Committee brings the critical perspective of health professionals to the LHIN's strategy and implementation efforts. Local decision-making is strengthened by the input of these professionals who are close to the ground and have a current understanding of the needs of the patients and clients in their care.

The Toronto Central LHIN is currently seeking to fill five positions on our Health Professionals Advisory Committee (HPAC). We are recruiting a Physician, Registered Practical Nurse, Allied Health Professional, Personal Support Worker and Mental Health and Addictions Outreach Worker to join our LHIN's HPAC.

If you would like to apply to become a member of the Toronto Central LHIN's HPAC, please visit **www.torontocentrallhin.on.ca** to download an Expression of Interest form. Completed forms, together with a brief CV, should be forwarded to the attention of Krissa Fay at **Krissa.Fay@lhins.on.ca**

Home First –
Getting Patients to the Right Place of Care

Home First is transforming the patient experience for alternate level of care (ALC) patients in acute care hospitals across the Toronto Central LHIN who are waiting to be transferred to a more appropriate care setting, such as in their own homes or long-term care. A partnership between Toronto Central Community Care Access Centre (CCAC), and hospitals and community agencies, this Aging at Home program is resulting in ALC patients getting home faster and safely and, in many cases, remaining home instead of going to long-term care.

Home First is designed to identify and support seniors who can wait at home rather than in the hospital to make this important decision about their future care. Before Home First, many patients designated ALC waited in hospital for long periods for an alternative setting better suited to their needs, and many ended up in long-term care prematurely.

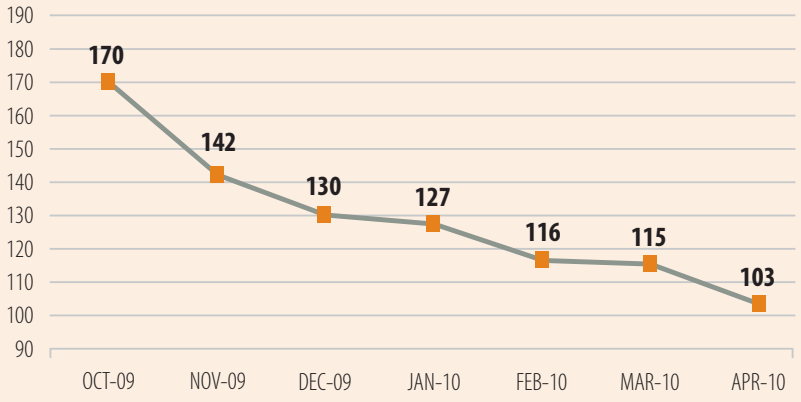
"Moving to long-term care is a major life changing decision and one which is better made at home and not in hospital. Home First allows patients the time to get back on their feet in the comfort of their own homes before they make these life-changing decisions," said Stacey Daub, Toronto Central CCAC Senior Director, Client Services.

Getting patients home also reduces their risk of getting hospital acquired infections and increases the availability of beds in acute care hospitals for patients coming from the emergency department who really need this level of care.

The program employs a specialized team led by a community care coordinator whose role is to support and assess the care needs of the patient and family within one to two days of discharge from hospital. The care coordinator supports the patient with seniors-focused intensive case management and has access to a specialized team of care professionals comprised of a pharmacist, occupational therapist and nurse practitioner.

Fewer Clients Waiting in Acute Hospital for Long-Term Care

The metric: Number of patients now receiving care in the community instead of waiting for long-term care in hospital



Results:

70 fewer seniors waiting for long-term care from hospital every month

Better for clients:

– Support to return home instead of remaining in hospital
– Enhanced support for caregivers
– Improved transitions home

Better for the system:

– 70 acute beds freed up every month
– Better hospital patient access and flow

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The remarkable feedback from clients is a testament to the impact the Home First strategy is having on the patient experience and quality of life.

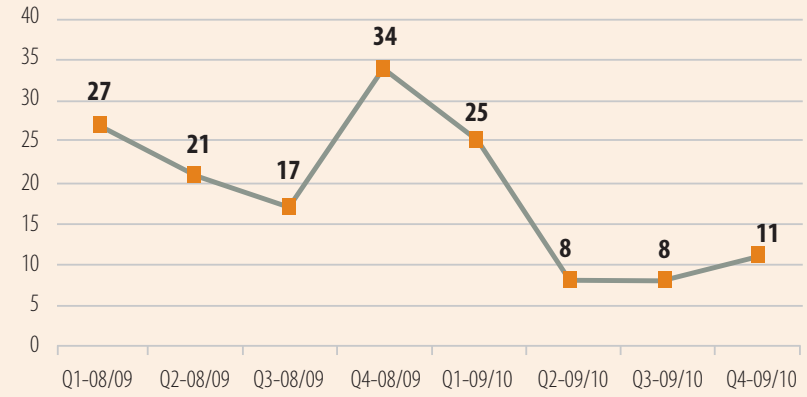
Home First, a Toronto Central LHIN funded project implemented in July 2009, is already showing some remarkable health system benefits:

- 70 fewer seniors waiting in hospital for long-term care every month, making more beds available for acute care
- 30% reduction in applications from hospital to long-term care
- Significant reduction in crisis placements from hospital with six to 25 seniors avoiding crisis placements every quarter
- Significant increase in the number of high-risk frail seniors remaining in the community

The Home First Strategy in the Toronto Central LHIN initially began in seven acute care hospitals and has now been expanded to include rehab, convalescent and other facilities – giving patients more options for their care after their hospital care and increasing the availability of acute care beds for people who really need this level of care.

Fewer Seniors Crisis Placed into a Long-Term Care Home from a Hospital Emergency Department

The metric: Crisis placement is a measure of the system's ability to support seniors in the community and system crisis response. Crisis placement is a very upsetting experience for clients and their caregivers and is not the optimum way to transition to long-term care



Results:

Significant reduction in crisis placement from hospital over last year

6-25 seniors avoid crisis placement every quarter

Better for clients:

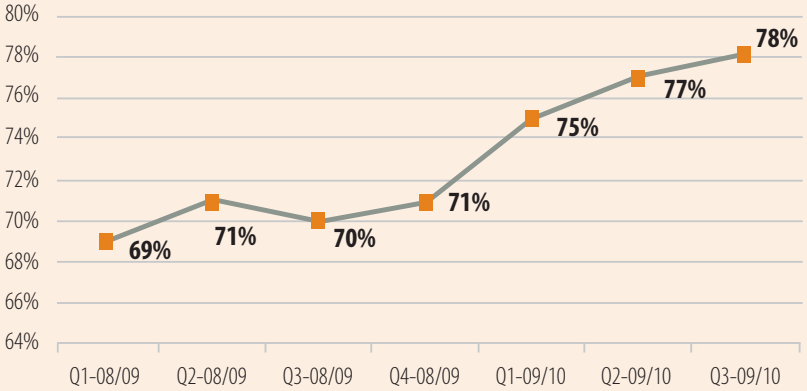
– More seniors avoid experience of crisis; able to go home to a better environment to make life changing decisions
– Delay in need to go to long-term care
– Improved transitions to long-term care

Better for the system:

– Delay admission to higher cost long-term care resources
– Long-term care bed resources accessed in a planned and systematic way (vs crisis management)

More high-risk clients are remaining in the community

The metric: Per cent of long-term care placements with high or very high MAPLe Score indicates the ability of the system to support seniors to age in their preferred place of care*



Results:

7% increase in the number of high-risk seniors with moderate to high needs supported in the community instead of long-term care

30 clients/quarter who have moderate to high needs remain at home longer

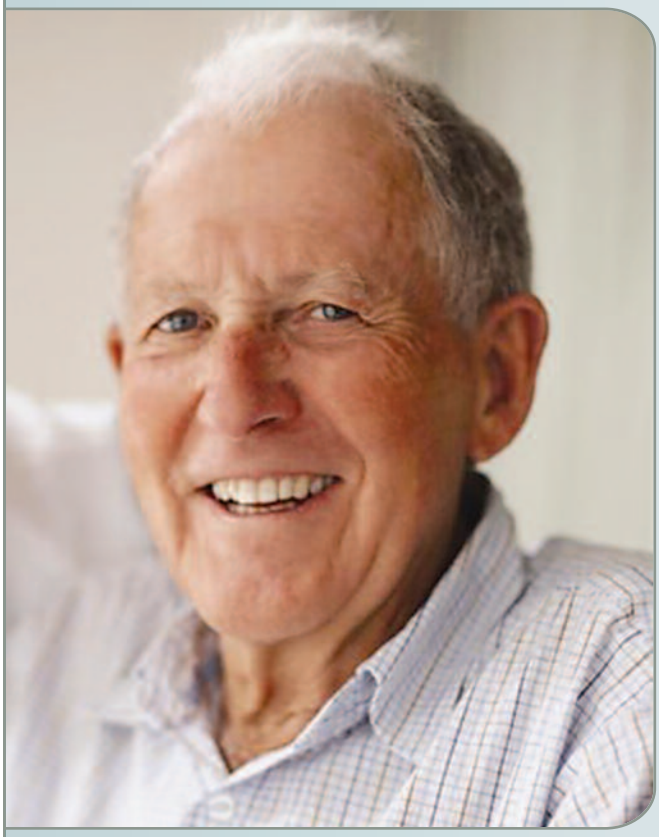
Better for clients:

– More choice regarding place of care
– Enhanced support to remain at home
– Improved support for caregivers

Better for the system:

– Increased capacity for higher level of support in the community – a lower cost and more desirable environment

* Method of Assigning Priority Levels – a tool used to determine the client's relative need for care and risk of adverse outcomes



Doug's Story:

Doug, an 87-year-old veteran of World War II, recently suffered a serious fall and broke several vertebrae at the base of his spine. As a result, he spent several weeks in an acute care hospital with his mobility severely limited. He lives alone, although he is in close contact with his children who live in the same city. As he began to regain his mobility, Doug and his family made it clear he wanted to continue his recuperation in the comfort of his own home.

A Toronto Central CCAC care coordinator visited Doug in hospital to assess his needs and decide whether he could benefit from the Home First Program. Since Doug's needs were a good match for Home First, the care coordinator developed a detailed care plan and arranged for the required services to be provided in his home. The care team included a nurse and an occupational therapist when he first returned home, along with the ongoing support of a personal support worker who helps him shower and dress in the morning and undress in the evening. As his recovery continued, a physiotherapist began working with him.

Veterans' Affairs arranged for some of the equipment and accessories he needed such as a walker and hand rails in the bathroom. The CCAC connected him with additional services including Meals on Wheels and Lifeline, a personal medical alert emergency response service.

Since returning home Doug has made steady progress in regaining his mobility. He has a positive outlook and is very happy with the care he's received in his home.

Ten days after discharge he remarked:

"I'm managing quite well in my home with the assistance I'm getting. In fact, I now only require one little pain killer to get me through the entire day. The people providing my care – nursing, occupational therapy, physiotherapy, and personal support – as well as my CCAC care coordinator, are all friendly, professional and wonderful to work with. I feel safe and confident with the support I'm getting and am very happy with the pace of my recovery."

Engaging Our Community

Community engagement helps ensure that health system decisions are informed by the expert advice, lived experience and diverse perspectives of those who provide and receive care in the Toronto Central LHIN. The Toronto Central LHIN has a diverse population and effective engagement requires a creative approach that not only promotes equity and reflects diversity, but also builds on the strengths of the leaders within the health care and broader community. The Toronto Central LHIN is continually seeking more effective ways to deepen its connection to local communities, including Aboriginal, Francophone, ethno-cultural neighbourhoods, and marginalized groups.

Strengthening the Circle: Building knowledge on Aboriginal health in an urban environment

The health needs and priorities of Aboriginal peoples and communities are important concerns for the LHINs. Over the past two years, the five Greater Toronto Area (GTA) LHINs – Central, Central East, Central West, Mississauga Halton and Toronto Central – have worked together to facilitate better coordination and access to services for Aboriginal people across the GTA.

On March 17, 2010, the GTA LHINs jointly hosted a one-day forum on urban Aboriginal research/ data collection, planning and service delivery at the Native Canadian Centre of Toronto. The forum facilitated communication and network building across diverse organizations, planning agencies and academic institutions. Its ultimate goal was to better guide health planning while fostering relationship building among GTA Aboriginal communities, service providers and the GTA LHINs.

A number of community leaders and researchers of Aboriginal health presented at the forum, including Dr. Janet Smylie, Aboriginal Research Scientist for the Centre for Research on Inner City Health (CRICH) at St. Michael's, who spoke about working in partnership with Aboriginal stakeholders to develop and apply population-based urban Aboriginal health datasets. In addition, an expert panel of researchers, including Mario

Dr. Janet Smylie speaking about working in partnership with Aboriginal stakeholders to develop and apply population-based urban Aboriginal health datasets

Gravelle of the Métis Nation of Ontario, Dr. Heather Howard-Bobiwash of Michigan State University, and Bela McPherson of CRICH, presented their research and participated in a discussion on respectful Aboriginal research methodologies. The day also featured a cultural display of traditional dancers accompanied by drumming as well as an explanation on the cultural significance and background provided by the Native Canadian Centre's Visiting Schools Program Coordinator.

Attendees enjoy a cultural display of traditional dancers accompanied by drumming

Forum participants appreciated the opportunity to network among diverse Aboriginal and non-Aboriginal service providers and to participate in meaningful discussion and provide input on future directions in health planning. All the participants who filled in their evaluations felt that the event was effectively organized and 92% of the participants felt that the session provided them an opportunity to express their views.

As a result of the event, the GTA LHINs will be disseminating a forum summary as well as video of the day's proceedings to all participants. The information will also be posted publicly to foster knowledge sharing. Additional discussions will also be held at the next meeting of the Roundtable on Urban Aboriginal Health.

Healthy Connections 2010 – Self Managing Care

Building on the success of the June 2008 health equity conference, Healthy Connections, the Toronto Central LHIN was pleased to support Healthy Connections 2010 – Self-Managing Care: From Ideas to Solutions on February 17, 2010. The conference brought together front-line workers, administrators, policy-makers, consumers and families to discuss self-managing care. The Toronto Central LHIN has a strong commitment to health equity and we believe that self-managing care is an important component of health equity as it has been shown to contribute to improved health outcomes. A growing body of evidence shows that disadvantaged and marginalized people have the greatest health care needs and the worst health outcomes, and are most at-risk for hospitalizations.

Many participants commented that the conference enhanced their opportunity to network, exchange knowledge, and learn from others in the field. The conference opened with a keynote address from author Wayson Choy on his experiences with ill health and his resulting insight on the importance of human relationships to our survival, followed by a panel session with experts on self-managing care. Delegates felt that the conference's morning keynote and panel session provided "a wonderful foundation for the day" and set a "constructive tone and emotional atmosphere" for the rest of the conference sessions.

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Engaging Our Community, continued from page 13

The conference also offered skill-building workshops, including a workshop on the Health Equity Impact Assessment (HEIA) Tool which was sponsored by the Toronto Central LHIN and facilitated by Dr. Bob Gardner of the Wellesley Institute and Anthony Mohamed of St. Michael's. The workshop received an excellent rating and was noted by many as being the most valuable session of the afternoon. The tool is designed to be used by LHINs and health service providers to assess the impact of decisions and investments on diverse populations and was developed by the Ministry of Health and Long-Term Care's Health Equity Branch in partnership with the Toronto Central LHIN and the Wellesley Institute. The tool also comes with a companion Health Equity Impact Assessment Workbook, which provides step-by-step instructions and examples to illustrate on how the HEIA Tool should be used. Both the tool and the workbook can be downloaded from the Health Equity section of our website **www.torontocentrallhin.on.ca**.

PERSPECTIVES – A Profile of Health Care Leaders

Brian Smith, President and CEO, WoodGreen Community Services

Please describe your current role, training and relevant background.

I have served as President and CEO of WoodGreen Community Services since 1978. I hold an MBA from the University of Western Ontario, an Honours Certificate in Voluntary Sector Management from York University, a Bachelor Degree in Sacred Theology from Trinity College in Toronto and a Bachelor of Arts from Bishop's University.

During my tenure at WoodGreen, I have focused on growing and diversifying programs to meet the needs of the community, including developing a 'wrap around' service model that puts the client's needs at the centre. I have also advocated policy changes that allow social service agencies to better serve vulnerable populations.

In addition, I have been heavily involved with various community organizations including the International Federation of Settlements and Neighbourhood Centres; the Voluntary Sector Management Program at York University's Schulich School of Business; the Toronto East Rotary; and the Danforth Mosaic Business Improvement Area.

Tell us about WoodGreen Community Services. What type of organization are you, what is your mission and what types of services do you provide?

WoodGreen Community Services has served Toronto for over 70 years and is one of the largest and most innovative social service agencies in the city. Our mission is to enhance self sufficiency, promote wellbeing and reduce poverty in our community through innovative solutions to critical social needs. Our vision is to create a Toronto where everyone has the opportunity to thrive.

As a United Way founding agency, we focus on poverty and homelessness, chronic underemployment, childcare, support for seniors, new

PERSPECTIVES – A Profile of Health Care Leaders

immigrant settlement, support for individuals living with mental health and developmental challenges, and affordable housing. WoodGreen operates more than 75 programs in 23 locations across Toronto's east end and serves more than 37,000 people each year.

What are the main priorities for WoodGreen Community Services and for your community?

WoodGreen is committed to creating opportunities for people, including opportunities for seniors to age in their communities and homes; newcomers to settle into Canada; parents to access childcare; families and individuals to access affordable housing; people to find jobs; and so much more. We address social issues through holistic, wrap around supports and programming.

Ensuring that patients get the care they need in the most appropriate health care setting is a priority for the Toronto Central LHIN. How is WoodGreen Community Services addressing this challenge?

The community support sector has a broad range of programs and services that help seniors remain at home, reduce premature admissions to long-term care and ensure the appropriate use of health and social service resources. These services reduce demands on other parts of the health care system.

One example is our commitment to supportive housing. WoodGreen operates five supportive housing sites, giving residents access to 24-hour personal support and homemaking services. We deliver an additional 8,760 hours of supportive housing services to people living in other facilities within the community.

As well, this past year, WoodGreen opened the First Step to Home program which combines safe and affordable housing with on-site health services and wrap-around support to transform the lives of seniors who have endured life on Toronto's streets. The First Step to Home program provides affordable, clean, bright and furnished housing to 28 homeless seniors with mental health and substance use issues, as well as on-site counselling, mental health supports, social recreational activities, homemaking, community volunteer programs, food programs, and 24-hour staffing.

In partnership with the Centre for Addiction and Mental Health's Shared Care Team and Community Outreach Programs in Addictions, seniors have access to primary health, nursing support, mental health services, and drug and alcohol harm reduction and treatment services. Homeless seniors with mental health and/or substance use issues receive services in their homes, avoiding unnecessary trips and long waits in hospital emergency departments.

In your opinion, what are the main challenges and opportunities to improving care for seniors within the Toronto Central LHIN?

Better coordination of services for seniors is a key piece of improving care for seniors in Toronto. There must be easy access to important seniors' services through a system that is clear and easy to navigate. This is why WoodGreen has been committed to addressing improved access and coordination of services.

As the lead agency, WoodGreen, together with 34 participating agencies in the Community Navigation and Access Project (CNAP) network, is working toward simplifying the navigation of systems that can often be frustrating for seniors.

The goals of the CNAP project are to standardize the intake process and to improve coordination and referral among service providers to enhance the client's experience.

To this end, the CNAP project is beginning to organize agencies into 'hubs' by organizing

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PERSPECTIVES – A Profile of Health Care Leaders

Brian Smith, President and CEO, WoodGreen Community Services, continued from page 15

community support agencies in the Toronto Central LHIN into geographic groupings in order to facilitate referrals and enhance access to a broad range of services. This model will benefit seniors and their caregivers by providing them with facilitated access to services within a system that is easier to navigate.

As an organization that is a leader in programs that empower the community, can you describe how WoodGreen uses grassroots groups to help vulnerable populations within its community?

Through our Outreach to Vulnerable and Diverse Seniors program, WoodGreen has partnered with 10 different grassroots organizations this year to address gaps in the community that are necessary for vulnerable seniors to thrive within their home. The seniors served through the project can be described as having significant challenges accessing supports that would enable them to age within their homes and communities.

WoodGreen enables grassroots groups to address the pressing needs in their community by creating a low barrier access to funding and managing the progress and evaluation of these projects. Our work has created the opportunity for groups to provide appropriate levels of care for vulnerable seniors to prevent aging issues from resulting in a crisis leading to hospital admissions and re-admissions.

Since the launch of this project, 3,102 vulnerable seniors (1,350 in 2008/09 and 1,752 in 2009/10) have been served through the various grassroots groups. The success of this project is evidence of the value in creating opportunities for grassroots groups to draw upon their informal resources and networks to provide care and support that is both culturally and linguistically appropriate and cost effective for the health system as a whole.

As an organization that serves a diverse community, how does WoodGreen reach out to marginalized or socially isolated populations?

An example of how we reach out to marginalized populations is our Crisis Outreach Service for Seniors. In June of 2009, WoodGreen began providing an on-call, seven-day-a-week mobile crisis intervention and outreach service for seniors who have mental illness and/or addictions in the south east area of the Toronto Central LHIN. The service provides support to frail, marginalized and at-risk seniors, many of whom are homeless or underhoused, living in poverty, and/or are new immigrants.

The Crisis Outreach Service for Seniors provides a continuum of supports including crisis intervention and counselling; short-term intensive case management; harm reduction and concurrent disorder services; limited primary care and immediate nursing; and mental health and addictions assessment, counselling and referrals.

The multi-disciplinary team has staff from each partner agency including Community Outreach Programs in Addictions, the Good Neighbours' Club, the South Riverdale Community Health Centre, and Street Health.

The Crisis Outreach Service for Seniors' impacts on the acute care and long-term care systems by making available the intensive support and supervision necessary for clients to be discharged earlier from hospitals, and by providing specialized care in the community and diverting people from hospital emergency departments.