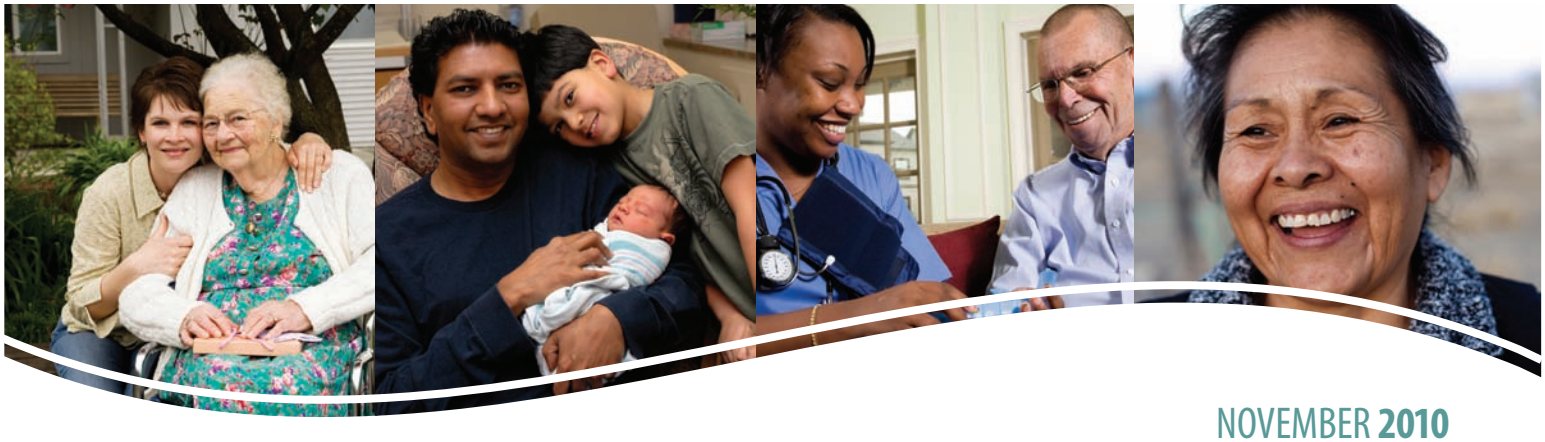

NOVEMBER **2010**

Toronto Central **LHIN** **LHIN REPORT**

In this Issue

A Systems Approach to Reducing Wait Times

The amount of time patients wait in the emergency room (ER) is a top concern for the public.

ER overcrowding and delays are like the proverbial canary in the coalmine: they signal significant problems and breakdowns in different areas of the health care system.

The LHINs play a key role in implementing local strategies to address ER wait times. Consistent with the provincial ER wait time strategy that is being implemented across all LHINs, Toronto Central (TC) LHIN health service providers and stakeholders are tackling ER wait times on three fronts: 1) preventing the need for ER visits; 2) improving the capacity and performance within emergency departments; and 3) supporting people to access alternate care options outside of hospitals.

The TC LHIN's two main programs to address ER wait times are ER Pay for Results, which funds hospitals based on their ER wait time performance, and Aging at Home, which increases seniors' access to care options at home and in the community. Aging at Home contributes to reducing alternate level of care (ALC) days, a key reason for ER backlogs. ALC patients are those in hospital who would be

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Over the past two years, ER wait times improved by 43% – the greatest improvement in Ontario

Ontario
Local Health Integration Network

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better cared for in – and who often prefer to be transferred to – an alternate care setting such as home, supportive housing, rehabilitation and long-term care.

TC LHIN initiatives in other priority areas such as mental health and addictions and diabetes management all contribute to reducing ER wait times and ALC.

During the first quarter of this year, there was a positive trend in all three ER wait time targets (patients with minor conditions; patients with serious conditions; and patients with serious conditions who require admission to hospital). Overall, TC LHIN hospitals were within 10% of the targets. These improvements were achieved in the face of an ever rising number of patients visiting ERs. Based on current trends, the LHIN is on track to reach its ER targets this fiscal year.

In Ontario, ER wait times are measured from the time people see a triage nurse to the time they leave the ER. In the ER, after they are seen by a physician, many patients continue to have periods of waiting while they receive care, such as waiting for tests to be done, waiting for an examination by a specialist and waiting for a hospital bed to become available. While some of these waits cannot be avoided, the goal of the ER strategy is to compress the waiting time to a safe and clinically appropriate target.

Quick Facts

As of June 2010, patients with minor conditions are treated within 5.2 hours in Toronto Central LHIN – a 25% or 1.7 hour reduction since April 2008; patients with complex conditions are treated within 11.9 hours – a 47% or 10.5 hour reduction since April 2008.

This year, TC LHN is investing $6.5 million in eight TC LHIN hospitals.

For more information about ER wait times at Toronto hospitals go to Ontario.ca/waittimes or visit TC LHIN's web site for updates – www.torontocentrallhin.on.ca

ER Pay for Results

This year, TC LHIN is investing $6.5 million in the ER Pay for Results program at eight Toronto hospitals, including The Hospital for Sick Children which joins the program for the first time.

ER Pay for Results hospitals are using staff differently and working in teams, using technology, and making ERs more efficient to help patients move more quickly through the ER and on to the next level of care. All of these improvements translate into shorter wait times, better outcomes and a better experience for patients.

TC LHIN hospitals are all reducing the time it takes for patients to see a physician for a first assessment (PIA or Physician Initial Assessment).

The TC LHIN's ER Pay for Results program also encourages hospitals to look beyond their own walls and pursue collaborative solutions across hospitals, community agencies and other sectors. Hospitals and other health service providers are taking what is called in health care jargon a 'systems approach' to ER wait times.

Aging at Home

Similarly a 'systems approach' is essential to reducing ALC days. Over the spring and summer of 2010, TC LHIN health service providers have been able to incrementally reduce the number of ALC patients in hospital – particularly those waiting for long-term care. However, reducing ALC is proving to be a persistent challenge, particularly as the number of patients requiring hospitalization continues to rise. This year, Aging at Home investments together with other ALC strategies are expected to bring ALC numbers down even

more. Also, over 40% of ALC patients discharged from TC LHIN hospitals reside in other LHINs. TC LHIN is working with the other GTA LHINs to pursue joint strategies to transition ALC patients back to their home LHIN, where they can be closer to their families and communities.

By increasing care options in the community and supporting patients to recover more quickly and transition to the next level of care, Aging at Home is contributing to better outcomes for seniors, and shorter ER wait times.

TC LHIN's Aging at Home program was designed based on significant input from seniors, service providers and health professionals about what they feel seniors need to live healthy and independent lives.

Community groups in high needs neighbourhoods hosted sessions where seniors congregate – including community centres and places of worship. Sessions were held in French, Mandarin, Somali, Spanish, Italian, Portuguese, Tamil, Korean, Farsi, and Bengali. The LHIN heard from some 650 people in 33 community sessions, spanning 18 neighbourhoods.

Across all languages, incomes, cultures and neighbourhoods the LHIN heard similar ideas.

Seniors want their home and community services to be better coordinated. They want more options to prevent declining health and keep them active and involved with their families and communities. And once their hospital treatment is complete, they want assistance to safely return back home or to another level of care that meets their needs.

Now in its third year, the TC LHIN's strategy has a special focus on supporting seniors with the highest and most complex needs, many of whom are vulnerable and marginalized. Through Aging at Home, community agencies, the Toronto Central CCAC, long-term care homes and hospitals are working together to safely transition seniors to a level of care that best meets their needs and assisting seniors to live at home.

Other ER/ALC Highlights

Alongside ER Pay for Results and Aging at Home are a number of other initiatives designed to get people to the right place of care.

Resource Matching and Referral

Resource Matching and Referral is an electronic information system that matches patient and clients with the first available and most appropriate care setting, so that people receive the right level of services at the right time.

Currently, 20,000 individuals at 52 organizations use RM&R for patient referrals, including six acute care organizations, eight rehab/complex continuing care organizations (including one from Central LHIN), 37 long-term care homes, as well as the TC CCAC.

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Did you know?

Approximately 16,000 Toronto seniors will benefit from 26 Aging at Home programs in 2010/11.

Over 11,000 seniors benefited from Aging at Home program in previous years.

TC LHIN is investing $24.2 million in Aging at Home this year.

TC LHIN's strategy has a special focus on supporting seniors with the highest and most complex needs.

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As a result of RM&R, the average time from the submission of a referral to the receiving organization responding to the referral dropped from 3 days in August 2009 to 1.9 days in March 2010 – a 37 per cent drop. The next steps this year are to implement RM&R in the 34 community support agencies that make up the Community Navigation and Access Program (CNAP) to better match seniors with support services in their communities. 'Bed level matching' for long-term care beds is slated to be implemented across the LHIN in January 2011. This will more precisely match seniors with the long-term care services that meet their individual needs.

Senior Friendly Hospital Initiative

There is considerable evidence that seniors' health declines the longer they stay in hospitals as a result of adverse events, safety issues such as falls and hospital acquired infections. All TC LHIN adult hospitals were asked to conduct a *Senior Friendly Hospital* Audit and develop an improvement plan to enhance the care of seniors in hospital. A report highlighting the current state of Senior Friendly Care in TC LHIN hospitals, leading practices, and opportunities for further improvement will be released in the coming months. The TC LHIN Aging at Home Steering Committee, the Seniors Advisory Panel and the Health Professionals Advisory Committee provided important early advice and insights into the development of this initiative in the TC LHIN.

The 14 LHINs are working together to share their successes and look for strategies that should be pursued provide-wide. RM&R and the *Senior Friendly Hospital* initiative are two ideas that began in the TC LHIN that are likely to spread across the province.

Long-Stay ALC Patients

Approximately 300 patients in TC LHIN hospitals are considered 'long-stay ALC patients' which means they have been waiting over 40 days to transition from hospital to a more appropriate level of care. In August and September, the LHIN's *Long-Stay ALC Task Group* developed strategies to help facilitate the transition of this patient population.

To find out more about Aging at Home, ER Pay for Results and other efforts to tackle ER and ALC visit our website at www.torontocentrallhin.on.ca. ■

Keith's Story

Helping Seniors

Stay Healthy and Independent at Home

Keith Cooper with his personal support worker

Keith Cooper is 79 and spent most of his career working as a paramedic in cities across Canada. He has lots of extended family in Toronto, but no wife or kids. He retired in 1989 after suffering a stroke. He now has diabetes and uses a motorized wheelchair to get around.

For the past three and a half years, Keith had been living in a long-term care home but, he felt that he didn't need 24-hour nursing care and that he much preferred living independently. With the support of the Home First program funded through the Aging at Home strategy, Keith transitioned out of long-term care and into his own bachelor apartment in March 2010.

Home First is an innovative program that identifies and supports seniors in hospitals or long-term care who are able to return home and connect them to the necessary supports so that they can safely do so.

"I would like to do it all on my own but I realize that there are some things that I now cannot do," said Keith.

Through the Toronto Central LHIN's Home First program, Keith got the supports he needed to enable him to live at home, where he wanted to be.

> "I am getting excellent care. I can't think of anything that would improve it," said Keith.

Some of the Home First services Keith has received include assistance with the activities of daily living (e.g., preparing meals, showering, dressing, etc.) from a personal support worker; help navigating the health care system from a nurse practitioner; falls prevention education; and consultations with a nutritionist to help control and managing his diabetes.

Changing Lives
Through Social Supports

By Johanna Rico,
Assistant to the Manager of
Public Relations and Development,

St. Clair West Services for Seniors

It is not unusual to become socially isolated as one ages. Disabilities and/or poor health, living alone, the loss of a spouse, limited social networks, transportation restrictions and poverty are all factors that lead to social isolation[1].


The Shovel and Spoon gardening and cooking group

A person's well being is not determined solely by the state of his/her functional, cognitive or mental health. Being part of a personal network or community, as well as interacting and sharing experiences and knowledge with others through various leisure activities, are important factors to a person's self-esteem and lifestyle. This is why the supportive housing services provided by St. Clair West Services for Seniors (SCWSS) go beyond addressing the basic needs of seniors by integrating social participation.

In 2008, SCWSS in association with St. Christopher House received funding from Toronto Central (TC) LHIN through the Aging at Home strategy to create supportive housing programs in three former City of York Toronto Community Housing buildings (Doug Saunders Apartments, Louise Towers and Outlook Manor). Through this program, frail, at-risk and marginalized seniors receive traditional supportive housing services and intensive case management.


Louise Towers' participants at The STOP's Green Barn

SCWSS' front-line supportive housing team includes case workers, home support workers (mainly personal support workers) and a health and wellness coordinator. Services include help with the activities of daily living, wellness programming, health promotion, and mental health and chronic diseases management services.

Providing opportunities for seniors to engage in social activities and expand their social network is central to SCWSS' services and contributes to community cohesion at supportive housing sites. SCWSS takes a holistic and flexible approach to improving the overall health and social well-being of clients. Staff facilitate the participation of clients in many wellness and recreational activities based on their individual needs and interests.

Working with clients to collaboratively plan their care, staff at SCWSS address each client's individual issues, which for many clients includes the lack of informal supports (e.g., friends, families, neighbours). Lack of informal supports is one of the top three triggers assessed by case workers in all three sites and the top trigger at Louise Towers.

Through collaborative care planning:

- Clients are changing those behaviours and perceptions of life which trigger isolation;
- Techniques are being identified to conserve clients' physical energy at home, so clients can invest time in attending community programs; and

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> A personal network is an important factor in a person's wellbeing and overall quality of life.

1 "Social Isolation Among Seniors: An Emerging Issue". Children's, Women's and Seniors Health Branch, British Columbia Ministry of Health. March 2004. p.3

2 Professor dr. Anja Machielse. "Social Isolation and the Elderly: Causes and Consequences". Paper presented at the '2006 Shanghai International Symposium on Caring for the Elderly', workshop 'Community & Care for the elderly'. June 2006. p. 2-3.

- Clients are being encouraged to build their own 'surrogate' family from the relationships they create with their fellow tenants, and even with staff members.

A personal network is an important factor in a person's wellbeing and overall quality of life. A personal network is also important in terms of social support. If a person is socially engaged and knows that people around him/her care for his/her well-being, they are better able to request practical (e.g., shelter, money, food, information) and/or emotional (e.g., advice on personal problems) support when needed, without feeling intimidated, scared or ashamed.[2]

Social participation has many documented benefits for older adults. Persons who are socially active report better health, reduced levels of depression, higher levels of psychological well-being, delayed cognitive decline, and better resilience and coping. Social participation also builds social networks, another determinant with a recognized positive effect on health.

Currently SCWSS' community programs provide older adults with the opportunity to engage with others in exercise, the arts, gardening, cooking, health workshops and much more. These activities are designed to bring older adults around a common interest and foster a personal network of support and friendship. The programs are open to all building tenants and to community members, with a special focus on the inclusion of clients that lack supports and who are vulnerable to social isolation, as well as clients who would benefit from programs that address chronic diseases (e.g., exercise program or a disease management workshop).

Programs such as the Community Kitchens, funded by Toronto Community Housing's Social Investment Fund, have generated cross-cultural group interaction, positive and caring environments, and even entrepreneurial initiatives that are working due to the strong bonds of collaboration and respect formed between its participants.

Supportive housing provides clients and tenants with opportunities and resources that allow neighbours to break barriers and prejudices, create relationships, encourage each others' participation in social, recreational and health and wellness activities, and live independently with dignity. Tenants are experiencing a comfort zone in their buildings where they can feel a sense of belonging, security and trust; neighbours are more socially responsible towards others, and now they acknowledge and look after each other. Stronger social networks are contributing to the health and wellness of both the client and the community. ■

Mrs. W's Story

Helping Seniors get the Social Supports and Care they Need

Mrs. W is a proud woman. Initially she refused supportive housing services despite struggling with the symptoms of several chronic diseases, mobility issues and a very complicated medication regiment. However, when SWCSS staff asked about participating in summer trips she leapt at the chance. Through SWCSS' programs Mrs. W visited the zoo, went strawberry picking, went on a mansion tour and attended Afrofest.

On her last trip Mrs. W was sitting with the SCWSS health and wellness coordinator when she said "you know I have so much fun with St. Clair West, they take such good care of me."

The health and wellness coordinator once again broached the subject of supportive housing assistance and this time Mrs. W accepted. Shortly after, Mrs. W was able to meet with a case worker who arranged services including home support as well as consultations with allied health professionals.

Ms. C's Story

From Housing to 'Home'

On one of Tatiana's first days on the job as a home support worker she visited a client whose name she recognized to be from her home country – Ukraine. When she arrived at her client's apartment she found Ms. C, a strong, intelligent and determined woman whose opportunities for social and physical stimulation were limited due to the effects of a stroke. Ms. C. spoke of her loneliness and isolation.

That afternoon Tatiana was scheduled to assist with the Community Kitchen program and she immediately invited Ms. C to participate. Ms. C. has since joined the Community Kitchen and she is also participating in exercises and making friends. Ms. C recently told Tatiana, "it feels like home."

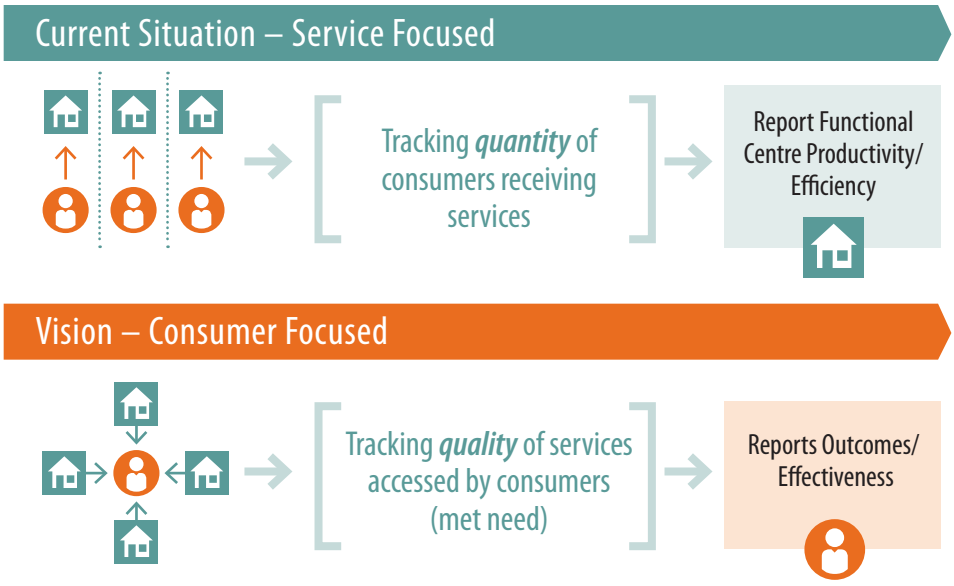
Consumer-focused Care for Better Outcomes

The community mental health sector identified a need to make the assessment process more effective for both consumers and service providers.

After years of community-led tool selection and provincial piloting, the province's Community Care Information Management Group (CCIM) in partnership with LHINs, health service providers (HSPs) and the Ministry of Health and Long-Term Care led the implementation of the Ontario Common Assessment of Need (OCAN), a tool that offers consumers an effective way to voice their needs and preferences and a more inclusive approach to care. This is the first time community mental health agencies are implementing a common assessment tool. Last year, community mental health programs in the Toronto Central (TC) LHIN began implementing the tool.

Quick Fact

In a recent survey[1], 91% of consumers were either satisfied or very satisfied with OCAN.



Currently, each HSP organization collects certain information about the people it serves in order to track the quantity of consumers who are receiving service, at a minimum. The vision is to use OCAN to put the consumer at the centre. By reporting met and unmet needs over time, OCAN can be used to demonstrate the effectiveness of the mix of services that the consumer is receiving. This is accomplished by completing a needs assessment (OCAN) every six months and tracking the various services that a person receives.[2]

OCAN is based on an existing assessment tool which was modified to reflect the needs of local HSPs. Consultations were held in each of the 14 LHINs to gather feedback on the design and implementation of a common assessment tool. Nearly 500 individuals – consumers and staff – provided comments and submitted questions that were reviewed by working groups and by the provincial steering committee.

OCAN is a standardized, consumer-focused tool that allows information to be electronically gathered. It asks questions about topics such as physical health, housing, daily living skills, friends and family connections, and income, while allowing consumers to share insights into their hopes and future goals. This allows consumers to tell their personal stories, and empowers them by allowing them to prioritize their needs and treatments. It supports a conversation between the health provider and the consumer that creates a deeper relationship.

Continued on page 8 ▶

1 Pautler, Kate. Evaluation of the Ontario Common Assessment of Need (OCAN) North East LHIN Consumer/Survivor Programs Consumer and Staff Perspectives. Toronto: CCIM, 2010.

2 OCAN User Guide V2.0. Toronto: CCIM, 2010.

▶ Continued from page 7 Customer-focused Care for Better Outcomes

Increased engagement with consumers helps to identify unmet needs, leading to improvements in matching consumers with existing services, which ultimately reduces crises and avoidable ER visits and hospital admissions. So far, 28 agencies in TC LHIN have implemented OCAN and 50% of mental health community agencies in TC LHIN will be using the tool by the end of 2010/11.

"OCAN allows consumers to start exploring areas of their lives before they become a crisis."[2]

– Direct service worker using OCAN

"At first I thought there were a lot of questions but when the assessment was finished I felt differently. I now see that the agency wanted to make sure they did not miss any areas that could affect my mental health."[2]

– Consumer, after using OCAN

OCAN will eventually facilitate communication between agencies and reduce the need for clients to repeat information at every health care encounter.

Standardized tools such as OCAN will eventually facilitate communication between agencies and reduce the need for clients to repeat information at every health care encounter. The data provide invaluable insights into the impact of services on clients over time, supporting decision making needed to achieve client-centred recovery.

A recent CCIM study[1] examining the use of OCAN found that there is strong support for the tool. Overall, consumers believed OCAN identified and clarified their needs, helped them to focus on their goals and improved care planning related to their identified needs. Based on the highly successful LHIN-led pilots, OCAN has now expanded across the province.

Benefits of the Ontario Common Assessment of Need Tool

For the Consumer	For the Health Professional	For the LHIN
Links individuals to the most appropriate treatment	Creates best-practice and supports clinical standards	Promotes equitable access to services
Reduces the need to repeat information	Links organizations providing treatment	Ensures the collection of quality information that aids benchmarking, policy development and sector planning
Respects the consumer as a whole person	Opens a meaningful conversation between the caregiver and the consumer	Reduces crisis, ER visits and admissions

For more information on OCAN, visit https://www.ccim.on.ca/CMHA/OCAN/default.aspx. ■

One Central Number
to Connect with Community Support Services

By Jane Piccolotto

Director of Community Care and Wellness for Seniors, WoodGreen Community Services (lead agency for CNAP), and Chair of the CNAP Network

The Community Navigation and Access Program (CNAP) is a network of over 30 not-for-profit community support service (CSS) agencies serving seniors across the Toronto Central (TC) LHIN.

Supported with funding from the TC LHIN, CNAP is leading the development of infrastructure, tools and processes to implement a seamless system to access community support services for seniors, including the creation of a new toll-free number that provides a single access point to CSS agencies serving seniors.

> CNAP aims to help seniors maintain their independence and live at home with the supports they need.

The overall goal of CNAP is to provide seniors living in the community and professionals within the healthcare system with a simple way to access community support services and move between providers and sectors of care. CNAP aims to help seniors maintain their independence and live at home with the supports they need. More broadly, by building capacity and coordination among CSS agencies, CNAP aims to impact the system as a whole by helping to reduce hospital ER visits and alternate level of care days.

Since its inception, CNAP has engaged its member agencies and other community partners in developing standardized intake and referral tools, common reporting tools and service definitions. CNAP is also collaborating with providers of specialized services (such as CNIB, Toronto Palliative Care Network, Alzheimer Society, and Hospice Toronto, among others) to identify triggers which would indicate a need for referral to these specialized services. For the first time, CNAP infrastructure and processes have enabled the collection of standardized sector–wide client and intake data for CSS agencies serving seniors. CNAP agencies now have a growing awareness of each others' services, and overall communication across the CSS sector has improved immensely, for the benefit of clients accessing multiple services.

This past year, in collaboration with the Toronto Central CCAC, the CNAP network piloted a hub model which successfully demonstrated a process for directing calls from a single access point to a local CSS agency. CNAP is now implementing a single toll-free phone number across the TC LHIN.

Stakeholders can still call their local agencies directly, while the toll-free number (1-877-540-6565) offers another simple, friendly point of access for anyone unsure of where to turn for community support services.

▶ Continued from page 9 One Central Number to Connect with Community Support Services

This will be a significant change for people in our communities but also for providers such as family physicians who are often faced with senior patients that could benefit from a service (such as meals on wheels) but have no idea which agency to call or how to make a referral.

CNAP envisions its future to include ongoing interactions with other service hubs and nodes of care across the various care settings in the TC LHIN, with a level of collaboration that ensures the delivery of appropriate care. ■

MHA Peer Led Focus Groups

1. The Family Council, Centre for Addictions and Mental Health (CAMH)
2. Family Outreach & Response (FOR) Program, Toronto East General Hospital
3. Schizophrenia Society of Ontario
4. Hong Fook
5. Sistering
6. A-Way Courier Services
7. Sound Time Support Services
8. Rainbow Health Network – LGBT community
9. Ontario Council of Alternative Businesses (OCAB)
10. Houselink

Consumer Community Engagement: Mental Health and Addictions

Community engagement is central to the Toronto Central (TC) LHIN's work. Effective and meaningful engagement requires a creative approach that promotes equity and reflects Toronto's diversity, while building on the strengths of leaders within Toronto communities and health service provider organizations.

The TC LHIN is constantly seeking better ways to reach into the diverse communities that make up central Toronto.

Consumer and family groups play a critical role. They provide the LHIN with insight into the needs of specific populations who are directly affected by TC LHIN programs and the changes underway in the health care system. The Mental Health and Addictions (MHA) Consumer Survivors Advisory Panel and the MHA Family Advisory Panel help ensure that the 'lived experiences' of consumer survivors and their family members inform program planning, decisions and actions.

The Lived Experience

Over the past year and a half, the TC LHIN, together with the MHA Consumer Survivor and Family Advisory Panels, have developed an approach to community engagement that provides opportunities for people with lived experiences to contribute their knowledge about how to improve MHA services.

The peer-led process includes mechanisms to enhance engagement with diverse communities of individuals using MHA services and their families. Both panels strongly agreed that many of the consultation processes they had experienced in the past were not inclusive of the diverse communities and

experience and were largely 'one-way' processes that did not allow community members to articulate their self-defined needs and concerns.

The consumer and family panels formed a working group to employ a community-based approach that uses peer facilitated focus groups to gather meaningful feedback. This approach builds skills and experience with focus group facilitation within the consumer/survivor and family communities.

A peer-led model was developed and piloted through focus groups in 10 community-based MHA organizations. The pilots looked at how personal experiences and community realities can inform MHA strategy development, initiatives and funding at the systems level.


Mark Shapiro

Mark Shapiro, a member of the TC LHIN MHA Family Advisory Panel, has many years of experience as a family member who provides support to a sibling with mental health issues, and as an active participant in many community-based organizations and advisory boards. Shapiro remarked that by having peer-to-peer engagement, "there is a level of honesty, frankness and a true representation of peoples' experiences that find an expression," often giving a voice to a group of people who have never been asked to share their experiences before.

He added: "The approach taken really helps to empower participants through this expression of openness in order to foster understanding of people who have mental health and/or addictions."

According to Shapiro, including this input in the health care system is critical to fostering integration. MHA affects people from every background and at every age. To not engage and understand their shared experience, strength and hope is to add to the stigma of MHA by perpetuating the "not in my backyard" perception of citizens living and working in the TC LHIN.

Continued on page 14 ▶

For over 15 years, Mark Shapiro has been involved as a family member of someone who relies on the support of MHA services in Toronto. Mark has been heavily involved in research, education and outreach in the areas of supportive and affordable housing for people with MHA.

The Mental Health and Addictions Panels help ensure that the 'lived experiences' of consumer survivors and their family members inform program planning, decisions and actions.

"The approach taken really helps to empower participants through this expression of openness in order to foster understanding of people who have mental health and/or addictions."

Providing a Safe Environment

An environment that is perceived to be unsafe causes focus group participants to share fewer ideas and to carefully filter the ideas they do share. Therefore, the location and format of the focus groups are carefully selected to provide safe and supportive environments.

- Only those who self-identify as MHA Consumer/Survivors, people with lived experiences and/or people with addictions or family members of people involved in the MHA system, participated.
- Facilitators were volunteers and/or peer support workers from the participating community organizations.
- Training was provided in order to build their capacity to facilitate in the future.

By offering a safe environment for sharing and by having peer facilitators, participants are able to speak openly and honestly about their intensely personal experiences with the MHA system in a way that, according to Shapiro, "brings more passion and reality."

Results in Action

This past summer, the TC LHIN responded to gaps identified from input provided through various engagement activities, including the Homelessness Think Tank, by issuing two calls for proposals:

Community Outreach Worker Peer Program

The chosen project will employ trained community outreach peers to support better health outcomes for homeless individuals experiencing MHA issues.

Concurrent Disorders and Problematic Substance Use Crisis Response Services

The chosen project will address a current gap in crisis response services for people with substance use issues or concurrent disorders. The goal is to increase MHA community crisis response capacity to reduce avoidable visits to the emergency department.

The full report on the TC LHIN Peer-led Community Engagement Approach will be released in fall 2010. Information about the panels and the report are available at www.torontocentrallhin.on.ca. ■

Barbara Liu

Executive Director, Regional Geriatric Program of Toronto

Dr. Barbara Liu, Executive Director, Regional Geriatric Program of Toronto

1. Please describe your current role and your background.

I am a physician with specialty training in internal and geriatric medicine and clinical pharmacology. I have a clinical practice at Sunnybrook Health Sciences Centre with an interest in falls and medication use. In 2004, I became the Executive Director of the Regional Geriatric Program of Toronto. I am an Associate Professor of Medicine and recently became the program director for the postgraduate geriatric medicine training program at the University of Toronto.

2. Tell us about the Regional Geriatric Program (RGP). What type of organization is it, what is its mission and what types of services does it provide?

Our vision is **better health outcomes for frail seniors**. RGP supports health care professionals in Toronto and surrounding regions in the provision of interprofessional, senior-friendly, and evidence-based care that optimizes the function and independence of seniors and their ability to age in place.

This is achieved through various specialized geriatric services delivered to frail seniors by the 28 organizations that make up the RGP network. The RGP central office supports our network members through added-value services including collaborative service planning, program evaluation and development, information and communication technology, knowledge translation, and advocacy.

Our vision is better health outcomes for frail seniors.

3. Ensuring that patients get the care they need in the most appropriate health care setting is a priority for the Toronto Central (TC) LHIN. How is the Regional Geriatric Program addressing this challenge?

Much of the disease, disability and dependency in old age is preventable, treatable, or manageable. Seniors with complex health problems present challenges for accurate diagnosis and assessment, which is why it is extremely important that health care providers are able to provide a comprehensive geriatric assessment, recognize geriatric syndromes, and provide the appropriate treatment to seniors.

Specialized geriatric services affiliated with the RGP of Toronto provide services to frail seniors across the health care continuum. These services

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include geriatric outreach teams that provide services to frail seniors in their homes; emergency mobile nursing services (EMNS) teams that provide clients at TC LHIN long-term care homes with medical care and avoid unnecessary emergency room (ER) visits; geriatric emergency management (GEM) nurses that deliver geriatric assessment and facilitate care coordination for seniors in the ER; day hospitals and ambulatory care clinics that provide care on an outpatient basis; and acute care of the elderly units and consultation teams within hospitals.

"Much of the disease, disability and dependency in old age is preventable, treatable, or manageable."

4. In your opinion, what are the main challenges and opportunities to improving care for seniors within the TC LHIN?

There are many challenges. Here are some that I feel are most pressing.

Ageist attitudes are widespread in our society. Many people, including health care providers, fail to recognize this as a form of discrimination, yet it affects their language, attitude and behaviours towards older people.

We have a province-wide shortage of health professionals with advanced skills and expertise in geriatric care. In addition to encouraging students to pursue studies in geriatrics, gerontology or care of the elderly, health professional faculties need to enhance their curriculum in geriatrics and increase the level of competency of all graduates in the care of older people.

"Ageist attitudes are widespread in our society."

Coordination and collaboration is another challenge. Frail seniors have complex needs and require solutions that involve multiple providers. Interprofessional teamwork and interorganizational collaboration need active support to develop successfully.

Choosing the appropriate indicators to monitor and drive system change is also a challenge. Functional ability and quality of care in the context of multiple complex health issues are challenging to measure and collect. Most frail seniors receive services from multiple providers, across multiple sectors, so monitoring senior care at a system and population level should be our goal.

5. As you know, reducing emergency room wait times is one of the TC LHIN's top priorities. How does the Regional Geriatric Program ensure that seniors get the care they need in the community and avoid unnecessary trips to the ER and hospital readmissions?

Comprehensive geriatric assessment has been shown to reduce unnecessary ER visits and reduce functional decline. In every TC LHIN emergency department (ED), Geriatric Emergency Management (GEM) Nurses are available to identify seniors at risk, provide targeted assessment and optimize linkage to other services or assessment, as appropriate. In 2009-10 2,684

patients were assessed by GEM nurses in TC LHIN and more than 60% were discharged home with an appropriate plan of care. The goal is to get patients to the most appropriate care setting. This may mean creating a management plan to support safe discharge to the community or it may mean advocating to have a patient admitted to hospital.

Another example is the Emergency Mobile Nursing Service (EMNS). Through the EMNS, residents of long-term care (LTC) homes who might otherwise go to an ER are assessed and treated in their LTC homes by hospital nurses. Every nursing home in TC LHIN is now linked with an EMNS team at either Toronto Western Hospital or Toronto East General Hospital. The teams teach, coach and participate in regular rounds to help build the capacity of LTC staff to handle medical issues. In addition, when a resident needs emergency care, LTC staff can call their EMNS nurse who then either goes to the LTC home to help manage the emergency or coaches the LTC staff to manage the emergency themselves. The resident-focused approach of the EMNS staff ensures that care is given at the right time and in the right place. The nurses and long-term care staff estimate that more than 75 per cent of the emergencies they attend are resolved without a visit to the hospital, helping to reduce unnecessary visits to the ER.

> "The goal is to get patients to the most appropriate care setting."

6. A growing body of evidence shows that frail seniors often lose independent function while hospitalized. How is the Regional Geriatric Program working with the TC LHIN to reduce the complications of hospitalization for seniors?

During a hospital stay, one-third of frail seniors lose independent function, half of whom are unable to recover the function they lost. By enhancing the care we provide to seniors while in hospital, we can help seniors maintain their functional independence and improve the likelihood of their return to living in their own home. This in turn will help reduce alternate level of care days and ER wait times.

Changing care practices in hospitals to better meet the needs of frail seniors, requires a systematic approach. To support this effort, the RGPs of Ontario have developed a framework for Senior Friendly Hospitals designed to improve outcomes, reduce inappropriate resource use, and improve client and family satisfaction.

Along with Jocelyn Bennett, Senior Director of Acute and Chronic Medicine and Nursing at Mount Sinai Hospital, I co-chair the TC LHIN Senior Friendly Hospital Task Force. The Task Force has been working to identify indicators that hospitals may find helpful in monitoring their progress in becoming senior friendly organizations. The Task Force has also provided recommendations to the LHIN for senior friendly specific Hospital Service Accountability Agreement obligations. ■

> "By enhancing the care we provide to seniors while in hospital, we can help seniors maintain their functional independence and improve the likelihood of their return to living in their own home."

Thank You & Welcome

Thank you Bonnie!

On behalf of the Board of the Toronto Central (TC) LHIN I'd like to recognize Bonnie Ewart for her tremendous leadership and contribution to the Toronto Central LHIN. Bonnie has been a key force in the LHIN since joining the Board of Directors in 2006. When her term on the Board came to an end and the TC LHIN needed an interim CEO this past spring, Bonnie put her well earned retirement plans on hold and agreed, without hesitation, to lead the LHIN through an important transition.

Bonnie's main objective as interim CEO was to keep the TC LHIN moving and to continue to deliver results in priority areas. Under Bonnie's leadership, the LHIN accomplished this and much more.

During her leadership as interim CEO, the TC LHIN played a central role in coordinating the health care system in Toronto and beyond for the G20 Summit. Also during this time, the LHIN made substantial improvements in ER wait times and saw ALC rates start to drop. While Aging at Home, ER Pay for Results and other signature LHIN programs were skillfully implemented, the TC LHIN launched new initiatives that will help address ER overcrowding including the Senior Friendly Hospital audit.

Bonnie further strengthened partnerships with health service providers, community members, MPPs, and colleagues at the other 13 LHINs.

Bonnie's dedication to and belief in public service, exemplified throughout her career as a senior official in the provincial and municipal governments, was obvious in everything she did at the LHIN.

.....And Welcome Camille!

On November 1, we are delighted that the LHIN's new CEO Camille Orridge will join us to take the LHIN into the future.

Camille is a health system leader who is singularly driven to improve the health of people and their communities. A social justice visionary, Camille has been a constant advocate for improving the circumstances and health status of disadvantaged people, including through better housing and better education. Among her many accomplishments, Camille co-founded Pathways to Education, the Canadian Home Care Association, and the Black Coalition for AIDS Prevention.

During her tenure as CEO of the Toronto Central CCAC, Ms. Orridge has served on various provincial and TC LHIN advisory groups including the provincial ER/ALC Expert Panel and as Co-Chair of the Toronto Central LHIN Aging at Home Steering Committee.

We are looking forward to benefitting more directly from Camille's trademark passion, energy and focus on results.

Dr. Dennis Magill, PhD
Interim Chair, Toronto Central LHIN

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