Virtual State of the Health Care System address
October 16, 2017
SPEAKING NOTES - CHECK AGAINST DELIVERY

SLIDE 1

- Good morning everyone. Bonjour, my name is Lori Brady and on behalf of the board and staff of the Central East LHIN I would like to welcome everyone to the launch of the Central East LHIN sub-region planning tables. Welcome to the new members of each of the seven sub-region planning tables, as well as the steering committee.
- I would like to extend a special welcome to those viewing our virtual "State of the Health System Update" from your boardroom, your office, or your kitchen table. We appreciate you taking the time to spend the next 90 minutes with the Senior Team of the Central East LHIN.
- And thank you to those that submitted questions and comments on the registration form – we trust that we will be able to provide more insight to all of you by the end of the session.
- This webcast will be archived on our website for future viewing for anyone who was not able to join us this morning.
- As we come together as peers in person and virtually, we acknowledge the traditional owners of the land on which we are meeting. We pay respects to their Elders past and present, and the Elders from other communities who may be here today.
- And now I would now like to invite Deborah Hammons, the Central East LHIN Chief Executive Officer, to begin today's session.
- Good morning everyone and welcome to the Central East LHIN's State of the Health Care System update.
- As Lori said, my name is Deborah Hammons and I am the CEO of the Central East LHIN.

- Through the wonders of technology we are live streaming this part of today's kickoff event to partners from all seven of our sub-regions and from a variety of sectors including hospitals, long term care homes, community support services agencies, community health centres, community mental health and addiction agencies, public health, municipalities, new immigrant centres, our First Nation and Metis communities, our francophone communities and of course patients and caregivers.
- So to everyone out there watching on their computers – welcome.
- Here at the Ajax Convention Centre we are joined by the members of our seven sub-region planning tables who have come together today for the formal launch of the Central East LHIN Sub-region Planning Tables.
- Our Primary Care physician leads have been out in the sub-regions for many, many months, meeting with their primary care and other colleagues to gain a better understanding of the care needs in our local communities.
- Later this morning our newly established Sub-region planning tables, co-chaired by our Primary Care physician leads, will hold their inaugural meetings as we launch the renewed LHIN's approach to sub-region planning.
- This is a very exciting day and marks an important milestone in the evolution of the LHIN and the ongoing transformation of the local health care system.
- With the recent passing of the *Patients First Act*, the receipt of a Ministry mandate letter by all the LHINs and the transition of the CCACs and the accountability for the delivery of Home and Community Care into the LHINs, we are now collectively presented with the opportunity to transform the health care system into one that is better coordinated, better integrated and even more patient-centered.
- As our transformation journey now sees us even **more** focused on the goal of supporting local residents to live healthier at home, we felt it was very important to come together to reflect on where the Central East LHIN started its journey in 2006 and what lies ahead.

SLIDE 2

- So our objective this morning is to provide you with:
  - an overview of the Renewed Central East LHIN – where we have come from and where we are going;
  - an overview of Central East LHIN's approach to Sub-region Planning including *Health Links* next steps;
  - we'd like to highlight for you the updated Sub-region Profiles and Data tools that will support us going forward;
  - And we would like to introduce you to the members of the seven Sub-region Planning Tables.
- So if you will indulge me we will take a little trip down memory lane, so back to the beginning.

SLIDE 3

- As you know, the Central East Local Health Integration Network, like all LHINs, is accountable to the Minister of Health and Long-Term Care, and works with its health service providers and with people who live in the LHIN to manage the local health care system.
- Our LHIN is one of the fastest growing geographic regions in the Province and home to over 1.4 million people.
- The region is a mix of urban and rural populations and is the sixth-largest LHIN in land mass in Ontario.
- In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park!
- The neighbourhoods in our sub-regions boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

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- LHINs have responsibility for approximately half of the Ontario health care budget.
- In the Central East LHIN this means providing over $2.3 billion on an annual basis to:
    - 8 hospitals operating on15 sites
    - 68 Long-Term Care Homes
    - 41 Community Support Services
    - 3 Acquired Brain Injury Services
    - 16 Assisted Living Services in Supportive Housing
    - 6 Community Health Centres
    - 21 Community Mental Health Programs
    - 6 Addictions Programs

      and
    - 11 Diabetes Education Programs

      And now, because of the recent integration between the LHIN and the legacy CCAC, we are accountable for just over $320 million in annual funding for Home and Community Care service delivery with a staff just under one thousand.
- On December 17, 2015, the ministry released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, a discussion paper that outlined proposed changes for the health system.
- The structural changes proposed in that paper suggested that Local Health Integration Networks should assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning so that together LHINs and other partners could improve the accessibility, integration, and consistency of patient care.

- In gathering feedback on the proposal, the Ministry and the LHINs highlighted the many achievements of the Ontario Health System over the preceding ten years:

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- LHINs have **demonstrated success** in integrating local health care systems
- 95% of Ontarians now have a **regular family health care provider**
- 92% of home and community care clients say their care **experience has been good, very good or excellent**
- The 36 public health units in Ontario are delivering programs and services using a **population health approach**.
- All of these achievements are the result of the sustained commitment, collaboration and ongoing adapting to change by many, many partners including Community Mental Health organizations, care providers, physicians and nurse practitioners, community services, long term care, hospitals, LHINs, Public Health and of course patients and their caregivers.
- But despite the progress we have made over the past ten years, we still need to do more to ensure that the health care system is meeting the needs of Ontarians.

SLIDE 6

- In evaluating the system the Ministry found that:
    - Some Ontarians **are not always well-served** by the health care system
    - Many Ontarians have **difficulty seeing their primary care provider** when they need to, especially during evenings or weekends
    - Some families find home and community care services **inconsistent and hard to navigate**; family caregivers can experience **high levels of stress**
    - Public health services are **disconnected** from parts of the health care system; population health is not a consistent part of system planning

    - Health services are **fragmented** in the way they are planned and delivered; fragmentation can affect the patient experience and can result in poorer health outcomes
- And so the government introduced and ultimately passed the *Patients First Act* with the view of improving the patient experience and providing better access to care for Ontarians no matter where they live, including:
    - **Improving communication and connections between primary health care, hospitals and home and community care for a smooth patient experience**.
    - **Making it easier for patients to find a family doctor or nurse practitioner** when they need one, see that person quickly when they are sick, and find the care they need, closer to home.
    - Making it easier for doctors, nurses and other primary care providers to connect their patients to the health care they need.
    - Ensuring there is **local planning** so health care providers are available to patients where and when they are needed.
    - **Strengthening Indigenous involvement** in the planning, design and delivery of health programs and services provided to Indigenous communities.

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- What does the passing of the Patients First Act mean:
- Under the legislation the LHINs role now includes home and community care, health promotion and equity; LHINs are required to establish sub-regions; an entity has been created to support LHINs with their shared services and each LHIN is required to have one or more Patient and Family Advisory Committees;
- The legislation adds primary care models (not physicians) as health service providers funded by the LHIN and allows LHINs (for planning purposes) to

collect information about practice and service capacity from primary care providers

- The act provided for the transfer of CCAC staff and functions to the LHINs – which took place on June 21st here in the Central East LHIN
- It establishes a formal relationship between LHINs and local boards of health
- It gives LHIN some new and stronger accountability mechanisms for health service providers and long-term care homes and also gives the Minister accountability mechanisms for the LHINs and the ability to set standards
- Through a number of complementary legislative changes its allows for integrated clinical care councils to be established to advise on clinical standards, it gives the Patient Ombudsman oversight of complaints for the health services provided and or arranged by LHINs
- And allows for the establishment of a provincial Patient and Family Advisory Council.

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- It is clear that the Ontario Health Care system is being **transformed** with goals of :
    - **more effective** service integration and greater equity
    - **timely access** to primary care, and seamless links between primary care and other services
    - **more consistent and accessible** home and community care, and
    - **stronger links** between population and public health and other health services

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- On May 1, 2017, the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care issued a mandate letter to the LHINs.
- The mandate letter focuses on key ministry initiatives and outlines the broad service and performance expectations for LHIN in 2017/18.
- The letter reinforces the *Patients First* goals and collective key priorities of improving the patient experience; addressing the root causes of health inequities by strengthening the social determinants of health and investing in health promotion; improving access to primary care and reducing wait times for specialist care, mental health & addictions services, home and community care and acute care; and breaking down the silos between our health care sectors and providers to ensure seamless transitions for patients, and to ensure that they work together to provide patient-centred care.
- It's interesting to see how the ***Patients First*** **legislation** and the **mandate letter** builds on the foundation that we have collectively been constructing since 2006.

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- The LHIN has a strong history of stakeholder engagement.
- From the beginning, the LHIN's goal has been **not just to listen** to people's concerns and ideas, **but also to empower them** in creating solutions that lead to better health and a better health care system.
- The development of the LHIN first Integrated Health Service Plan laid out a familiar engagement path and if you are interested, have a look at the LHIN website to watch the nine minute video we created back in 2006 entitled "We're Listening – Community Engagement in the Central East LHIN."
- The first step we took back in 2006 was to meet with **more than 4,000 citizens** through a series of informal and formal community consultations to discuss their ideas for the future of their health care system. Some of these sessions were large public forums and day-long workshops.

- The LHIN also conducted **dozens of engagement opportunities**, small and large, with members of our health care community: from physicians to front-line workers, from youth to seniors, from members of our Francophone community to Tamil mothers and from members of our First Nations communities to new immigrants.
- During the public meetings, the LHIN found consensus among the communities across the region on common challenges, common values and common hopes for their public health care system. There was also strong agreement on system priorities and opportunities to achieve real, lasting change.
- The next step was to establish **nine** local planning and engagement collaboratives, **three** LHIN-wide Priority Networks and **numerous** focused Task Groups.
- The collaboratives were **local advisory teams** made up of doctors, pharmacists, nurses and other health professionals as well as representatives from hospitals, community health centres, community support agencies and mental health and addiction services. They also included consumers of health care services and members of the community with an interest in improving the health care system.
- The **networks and task groups** were composed of local experts, including citizens, and advised the LHIN directly on its priority initiatives and activities.
- And finally, just before we turned IHSP 1 from DRAFT to FINAL, we hit the malls, arenas and grocery stores to ask over 2,000 local residents whether we were on the right track as we got ready to move from planning to implementation.

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- In the first IHSP we focused on four priorities for change:
    - Mental Health and Addiction Services

    - Seamless Care for Seniors
    - Chronic Disease Prevention and Management
    - And Wait Times and Critical Care
- We also focused on a set of enablers that were common to all four priorities
    - e-Health
    - Shared Non-Clinical Services
    - Moving People through the System
    - Safe Environments of Quality Care
    - Health and Human Resources
- Attention was paid to System Outcomes so that we could demonstrate how actions stemming from our identified priorities for change and enablers were making a direct contribution to the performance dimensions of a high-performing health care system.
- Always we focused on our priority populations – both the Francophone and Indigenous communities.

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- In IHSP 1, IHSP 2, IHSP 3 and now IHSP 4 we have stayed true to this best practice of **listening and working directly** with patients and caregivers, doctors, nurses, other clinicians, health care leaders, boards/governors, elected officials, social service partners, public health, EMS, the police and other stakeholders as **we continued to focus on the mission of ensuring that an integrated and sustainable health care system is available to deliver better health, better care and better value**.

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- Because of those collaborative partnerships, we have made a difference. For instance:
    - In 2006 **Cheryl McCarthy** of Courtice told us that the health care system was "broken" after her experiences in attempting to get help for her daughter who had anorexia.

- When her daughter first became ill at the age of 12, she said, “we could not find anywhere to go for help”.
- When we asked her about her experiences she told us that “There is no connection between agencies, no flow of information, and that has to change.”
- She told us that while the Hospital for Sick Children had an excellent program for children with eating disorders, it took a crisis situation before her daughter was assessed and treated.
- She told us that there were long waits to get into such programs and that her daughter had been in an inpatient hospital program five or six times but still had to go through a reassessment to get into each outpatient program.
- “The whole system is choked down with paperwork and duplication and it doesn’t work,” she said.
- She said “There is also a need for more community services for people with addictive behaviours, from eating disorders to alcohol, drug and gambling addictions.”
- Finally she said “There should be a transitional place, a safe environment where people can spend a couple of months getting interim care, learning job skills and how to cope in the community.”

- Cheryl and many others like her who have shared their stories have helped us to understand that mental health and/or substance abuse issues can be very disruptive to patients and their family’s lives.
- Because of their stories and the initiatives we have worked on together, we have seen that when interventions are less disruptive and focused on connecting individuals with the right care, outcomes are improved.
- With approximately 20% of Canadians experiencing a mental illness during their lifetime, and the remaining 80% affected by an illness in family members, friends or colleagues, a continuing focus on designing and

delivering quality based and flexible recovery-based mental and addictions health care is paramount.

- That's why with advice from the Mental Health and Addiction physician leads, Co-ordinating Councils, Work Groups, providers and people with lived experience the LHIN has, since 2006, funded and the system has implemented:
    - An Adolescent Care Unit at Ontario Shores for youth with eating disorders and another eating disorder service at Peterborough Regional Health Centre
    - Assertive Community Treatment Teams
    - Community Crisis Beds
    - Housing and Homelessness Strategies
    - Hospital to Home Teams
    - Strengthened and sustainable Consumer Survivor initiatives and Mental Health delivery via OTN and the Big White Wall, just to name a few.

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- In 2006 Judy Nemis told us about being part of the growing "sandwich generation," squeezed between providing care for her 95-year-old father so that he could stay in his home and helping her 22-year-old son to establish himself in his own home while she continued working as a registered nurse.
    - She said "It helps to have a good sense of humour," when we asked her about how she coped with juggling the demands of caregiver, parent, grandparent, wife and nurse.
    - Caregiver burnout is a problem for those looking after an ageing family member, Nemis who lives in the Durham Region admitted back in 2006 and we know that this has only continued to increase since then.
    - "We have our frustrating days and we would all love to have respite," she said. "Support groups for caregivers are important because you

learn that you are not alone, you can throw ideas around and there is the opportunity of introducing your senior to others to establish relationships."

- In her case, she said, it helped to have a supportive husband and supportive group of friends.
- She was visiting her father at least once a day to help out around the house, go grocery shopping and run errands such as picking up prescriptions. And he was receiving Meals on Wheels service three times a week and regular Community Care phone calls.

- Judy reminded us that people of her father's generation grew up at a time when there were no supports and people were taught not to ask for help.
  - She told us how important it was to educate people as they approached their senior years about what help is available.
  - "If they will accept help, they can have a better quality of life."
  - She was concerned that too many seniors who don't have family support fall through the cracks because they didn't qualify for home care.
  - She said "I worry about seniors without family support. With children now moving far away from home, more seniors find themselves alone as they age."
- So where do we start to remind ourselves of the improvements we collectively made since then in the delivery of care for Seniors and support for their families and caregivers.
- Initially spearheaded by the Seamless Care for Seniors Network and supported with Aging at Home funding, the LHIN's approach to caring for seniors continued to evolve and led to the Regional Specialized Geriatrics Program Development initiative which was a health services integration exercise that in May 2011 provided recommendations for the establishment of a Central East LHIN Regional Specialized Geriatric Program.

- The project was aimed at determining how best to coordinate current and future Specialized Geriatric Services, Senior Friendly Hospital initiatives and overall coordination with psychogeriatric services in the region and ultimately led to the development of the Seniors Care Network.
- Again with the support of clinical, administrative and front line leaders, partnering with frail seniors and their caregivers, the LHIN has funded and the system has implemented:
    - Geriatric Assessment and Intervention Network (GAIN) – hospital and community teams
    - Increased Adult Day Programming and Assisted Living for High Risk Seniors
    - Assess and Restore initiatives
    - Behavioural Supports Ontario initiatives in all the Long-Term Care Home
    - NPSTAT – which sees Nurse Practitioners working with their long term care home colleagues to avert transfers to hospital emergency departments and/or support discharges back home
    - Exercise and Falls Prevention Classes
    - Geriatric Emergency Management Nurses
    - *Health Links* Coordinated Care Plans
    - Memory Clinics
    - More funding for respite and caregiver support
    - And more funding for Home and Community Care services to respond to increasing volumes and higher patient needs

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- In 2006, Reginald Lyon told us that simple things like tying shoelaces were a struggle for people like him when they have Chronic Obstructive Pulmonary Disease.

    - He was having difficulty shaving because he had to wear a nasal cannula that provided oxygen 24 hours a day and he couldn't leave home without calculating whether he had enough oxygen in his tank to get him home again.
    - "When you have trouble breathing, you need to be pushed to exercise," he explained.
    - That was why the respiratory rehabilitation program in Courtice was so important to him.
- He said he "lucked" into finding the program in a clinic operated by Lakeridge Health. He was looking for a rehabilitation program and discovered many of the doctors he spoke to were not aware of any programs.
    - "Doctors should have more information about these clinics," he said. "Finally, a doctor told me he had a colleague who knew a colleague, a respirologist in Oshawa who recommended the respiratory rehabilitation program in Courtice."
    - As a result of that referral, Reg was going to the maintenance exercise program in Courtice twice a week and described the effects as "absolutely wonderful. I can get out and am able to do things."
- Reg told us that there should have been more information on what was available and more facilities like the clinic in Courtice for people with chronic diseases.
    - He said that the clinic had had another important benefit since it allowed him to meet and mix with others in the same condition.
    - "It's good to relax around people who have something in common with you," he said. "It's like a support group, its good therapy and it adds so much to quality of life."
- So let's take stock of the initiatives the LHIN has funded and the system has implemented since then.
- Again initially established as a Chronic Disease and Prevention Management Network and later as the Vascular Coalition, the LHIN, together with the

Coalition and associated Task Forces and Work Groups, health services providers, specialty clinicians and patients and caregivers have implemented:

- Designated Stroke Units
- Improved Diabetes Education Programs
- Complex Diabetes Care Centres
- Centralized Diabetes Intake and Referral
- The Ontario Telemedicine Network (OTN) teleopthalmology program
- Telehomecare for COPD and CHF patients
- The Central East Self-Management program
- Free exercise and falls classes in numerous locations across the LHIN
- The Regional Cardiovascular Rehabilitation and Secondary Prevention Program which is now available in 13 community and hospital-based sites in Scarborough, Pickering, Ajax, Whitby, Oshawa, Bowmanville, Cobourg, Port Perry, Lindsay, Peterborough and Campbellford.

- In **IHSP 2**, we introduced the concept of **Strategic Aims** as together we focused on **Saving 1,000,000 Hours of Time that Patients were spending in local Emergency Departments** and **reducing the Impact of Vascular Disease.**

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- And in **IHSP 3** our strategic aims expanded to include **Palliative Care** as we focused on the theme of ***Community First*** and helping Central East LHIN residents spend more time in their homes and in their communities.
- Meeting with our stakeholders during the development of that IHSP 3 allowed us to hear **the story of Anne and her daughter Mary**.
    - Anne told us it started when her daughter fainted at work and bumped her head.
    - At the hospital they said it was just a concussion and had told Mary to eat more but Anne, in her late seventies, was worried when two days

later her 40 year old daughter Mary could only drink liquids. The bad news came after a visit to the local clinic.

- Mary had inoperable pancreatic cancer that quickly metastasized in her liver and spread throughout her body.
- Anne said "We did what she wanted and what I knew was right and brought her home to spend the remaining time surrounded by family and friends."
- It wasn't easy Anne told us.
- It can be exhausting – physically, mentally and emotionally - taking care of a family member when they are coming to the end of their life. A lot of people told Anne that she and her husband should take Mary back to the hospital. But that wasn't what Mary wanted.
- "People travelled from across the country to sit by her bed, have a visit and say goodbye. It was so much easier for them to spend time with her in her own environment rather than a busy hospital with all the noise and busy staff dealing with so many other patients."
- At the end however, when Mary collapsed one last time, the ambulance was called.
- "The nurses and doctors in the Emergency Department bent over backwards to manage her pain while they worked to get her a bed in the cancer ward. It took a while to sort it all out but when we finally got her there she drew her last breath and passed."
- A year and a half later, as would be expected, Anne was still dealing with the grief. But she was also sharing her experiences and asking questions.
- "Why was there a delay in sending her medical information from the hospital to the home care agency when we brought her home? I had to advocate on Mary's behalf to speed things up so that the proper medications and supplies could be ordered from the drug store."

- "One of the personal support workers who helped me care for Mary was amazing, tender and compassionate. But many of them didn't seem to know how to take care of someone who was dying and just added to her discomfort. That made me very upset."
- "What were we supposed to do when her medications needed to be renewed? My daughter didn't have a family doctor so we were challenged when her pain pills ran out. We need more palliative care doctors and nurse practitioners who can take care of people in their homes and help with the medical care."
- "A lot of my friends are facing the same situation as they age and they want to have the choice to die at home too. I'm not that confident that they'll be able to access the right care, in the right time, at the right place. We need information on what's out there, where are the people who can help us care for our family members. Make sure we gain the confidence by knowing what to do."

- Again, because of the leadership of so many here in this room or watching this live stream, including the members of the Central East Regional Palliative Care Steering Committee, the LHIN has funded and the system has delivered on:
  - A Central East Regional Palliative Care Strategy
  - Six Palliative Care Community Teams, interdisciplinary team-based models providing clinical and non-clinical community-based care to palliative and end-of-life patients and their caregivers in all of our sub-regions
  - Interdisciplinary Palliative Education
  - And a Residential Hospice Strategy that will ultimately lead to more than 50 residential hospice beds for people across our LHIN

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- And since 2006, as part of the LHIN's regular business cycle, we have also been collectively focused on our shared stewardship of the monies we receive from the government by **equitably allocating funding** based on patient need; ensuring the **timely delivery of services** through volume acquisition and allocation; taking steps to make sure that organizations have **balanced budgets**; supporting **innovative service delivery models** and the capital construction that supports their implementation; **building stronger relationships** with other parts of the health system such as Public Health; our municipal partners in local government, education, policing and emergency services; our primary and specialty care providers; our priority populations – Francophone community and Indigenous communities; patients and caregivers; **sharing and integrating** best practices with other LHINs and **supporting, reviewing and facilitating integrations**.

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- In the Central East LHIN, Integration is defined as "improving the health care experience by creating a seamless system of care."
- In the *Local Health System Integration Act*, section 2, sub section 1, the definition of "integration" includes
    - to co-ordinate services and interactions between different persons and entities;
    - to partner with another person or entity in providing services or in operating them;
    - to transfer, merge or amalgamate services, operations, persons or entities;
    - to start or cease providing services;
    - to cease to operate or to dissolve or wind up the operations of a person or entity.

- Integrations can result from changes in funding, as a voluntary initiative, a facilitated or negotiated decision or as a required integration.
- Integrations take courage.
- Sometimes they are the result of an **immediate sustainability challenge** like we saw with the delivery of community-based hospice services in Northumberland, Lindsay and Toronto; with community-based mental health services in the North East cluster or with consumer survivor initiatives in the North East cluster and again in Durham.
- Sometimes they result when two or more organizations **voluntarily recognize** the benefits of an integration that will lead to higher quality or a better patient experience like we saw with the lab integrations between Ross Memorial Hospital and PRHC and then Campbellford Memorial Hospital and PRHC;
- Sometimes the voluntary integrations are the result of a **facilitation integration planning process** like the ones that took place with 10 community-based agencies in the Durham Cluster and six agencies in Peterborough City and County; or with the hospital and community-based providers in the Haliburton/City of Kawartha Lakes sub-region; and in the Northumberland sub-region.
- And for the first time in the province's history, they can also be the result of a **Minister's Order** like the recent hospital integrations between The Scarborough Hospital and Rouge Valley Centenary and Lakeridge Health and Rouge Valley Ajax Pickering.
- In every instance since 2006, and continuing to today, the LHIN Board has followed through on its **Service and System Integration Strategic Direction** of working with all partners to **integrate** the health care delivery system to better meet the current and future needs of patients, caregivers and communities.
- The LHIN organization and the LHIN Board look forward to receiving more integrations in the weeks, months and years to come.

- And ironically now the LHIN has just gone through its own integration.

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- On June 21st as a result of a transition process, the accountabilities and assets of the Central East Community Care Access Centre were transferred to the Central East LHIN and the CCAC ceased to exist.
- The process was seamless for patients and home care clients, with no disruption to care or patient experience and no need for them to change health care providers.
- As a result:
    - We began to **expand our board** from 9 members to 12 to take on increased governance responsibilities
    - We created an **integrated management structure** comprised of six divisions with clear lines of accountability
    - We began working on a common **patient-focused culture** from a system and organizational perspective
    - The Ministry established **HSSO or Health Shared Services Ontario** from the previous Ontario Association of Community Care Access Centres (OACCAC) and the LHIN Shared Services Organization (LSSO) to provide back office services for all the LHINs
    - And through efficiencies we managed to **decrease management and administration costs by 8%** so that those savings could be redirected back into front line care.
- These transitional efforts and the system journey we have travelled so far have put us in a good place for transformation because together we are a LHIN **that has not wavered** from the core mission, vision, values, priorities and strategic aims and strategic directions first laid out in 2006.

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- This is a LHIN where:
    - People are **proactively managing** their own health and wellness.
    - People are **involved in designing** their health care system.
    - People are **participating in planning** the coordinated delivery of their care.
- And this is a LHIN where we will continually be measuring that:
    - People have **timely and equitable access to care**.
    - Health care providers and their partners **work together** to improve the health and well-being of their communities.
    - And the **health of the population has improved**.
- Now with the support of some other members of the LHIN Senior Team, I'd like to continue this update by inviting Dr. Barry Guppy from the LHIN's Clinical Division to the podium. Barry…..

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- Thank you Debby and good morning everyone.
- As Debby said I am Dr. Barry Guppy and I joined the LHIN in June of this year as the Vice President of the Clinical Division.
- I came to the LHIN from Lakeridge Health where I previously served as Vice-President for Medical and Academic Affairs and before that as the Interim Regional Vice-President for the Central East Regional Cancer Program.
- In my time at Lakeridge , in my work with the Ministry, in my academic dealings and as a practicing neurologist I have seen time and time again the achievements that can be realized when the clinical perspective – that of physicians, nurses and other front line health care providers – is integrated in the planning and delivery of local health care services.
- This LHIN has a long, strong history of reaching out for those perspectives and actively inviting clinical leaders to champion innovative initiatives.

- I think about my Lakeridge Health colleague Dr. George Buldo and the leadership role he played in the development of the LHIN's first Clinical Services Plan; Dr. John Peto from Rouge who in the early days at the Seamless Care for Seniors Network table kept reminding us all about the pending silver tsunami; Dr. Andrew Steele and his work with the Vascular Health Strategic Aim Coalition; Dr. Joe Ricci and his cardiac rehab leadership; Linda Dacres who served as the first Central East LHIN Nurse Practitioner Clinical Director; Dr. Peter Pendergast, Dr. Howard Clasky, Dr. David Broderick and other Chiefs of Staff who served as members of the LHIN's Medical Leadership Group; Dr. Rob Drury, Dr. Christopher Jyu, the LHIN's first Primary Care coleads; Dr. Ian Dawe the LHIN's first Mental Health and Addictions Lead; the clinicians who served on the LHIN's Health Professionals Advisory Committee; Dr. Larry Erlick who participated in LHIN planning activities and now is bringing his vast experience and expertise to our sub-region table in Scarborough South and most recently Dr. Paul Caulford, who stepped down from the role of Primary Care Physician Lead at the end of September and who, through his personal presence, regular communications, numerous speaking engagements and his warm, collegial, and receptive approach, developed strong relationships with the local and provincial primary care community that will continue to benefit patients, caregivers, primary care providers and other health system stakeholders for many years to come.
- Dr. Buldo, Dr. Caulford and so many that I have forgotten to name are those clinical champions who recognized early the difference they could make in their patients' lives by actively participating in the work of the LHIN.
- Now, in the renewed LHIN, the Clinical Division and the numerous clinical champions who continue to work with the LHIN, are accountable for improving clinical integration and the achievement of sub-region strategic objectives, performance metrics and quality goals.

SLIDE 22

- That's why I am so pleased that so many clinical leaders are continuing to provide input into the implementation of the LHIN's Integrated Health Service Plan and the obligations set out in its Ministry-LHIN Accountability Agreement.
- And why we are fortunate to have the system-level Specialty physician leads and sub-region Primary Care Physician Leads who are actively working with their local physician colleagues and other health service providers to improve the design, delivery and access to health services in their local communities.

SLIDE 23

- In the renewed LHIN, the organization, with the support of the sub-region primary care physician leads and other partners, will have an increasing role in Primary Care:
    - LHINs, in partnership with local clinical leaders, will take responsibility for linking patients with primary care services, health workforce planning, and improving access to inter-professional teams.
    - This includes funding **Primary Care models** with **interprofessional teams**
    - This includes ensuring stronger ties between Primary Care and the **Care Connectors** who are now LHIN employees and who help to match individuals with a primary care provider
    - And this includes a stronger voice at the Ministry table in recommending the designation of high needs areas so that equitable access to primary care, **regardless of where you live in the LHIN**, is achieved.

SLIDE 24

- In addition the LHIN's specialty physician leads are supporting the:
  - Ongoing recruitment of Geriatricians and Geriatric Specialists
  - Continuing to build Palliative and End-of-Life Capacity
  - Working with local leaders on the stability of Emergency Department staffing
  - Supporting timely repatriation of Critical Care patients inside and outside of the LHIN
  - Providing clinical leadership in the development of the Central East LHIN Regional Mental Health and Addictions Plan
  - Working with provincial and local champions on clinical quality pathways and best practices

SLIDE 25

- Improving access to high quality care for Musculoskeletal conditions is a key priority for the MOHLTC and the Central East LHIN.
- In the renewed LHIN, we will be quickly moving forward to ensure that all patients in the Central East LHIN have equitable access to high quality, integrated, hip and knee care.
- We will be implementing a Central Intake model for hip and knee replacement so that when a patient is seen by their Primary Care provider they can be referred to one place – a central intake centre - for the Central East LHIN.
- The referral will be triaged and then sent to Advance practice clinicians who will conduct the initial assessment and then the patient will have the choice of the first available or their preferred surgeon. This will help to streamline wait times and have patients seen faster.
- ISAEC – or the Inter-professional Spine Assessment and Education Clinic - is a model of care for patients who experience low back pain. Did you

know that the majority of patients who have low back pain don't need to see a surgeon?

- That is why we will be implementing Spine Assessment and Education clinics where patients will be seen by Advance practice Clinicians – Physiotherapists, Nurses, Chiropractors - who will conduct an assessment and prescribe non-surgical interventions to improve function.
- If the non-surgical intervention aren't successful, then patients will see a Practice Leader who can provide injections, order extra diagnostic testing and then those patients who need to see a spine surgeon, will be seeing one in a more timely fashion.
- Planning is underway on both these initiatives with the goal of implementing in 2018
    - Reference to development of Stroke Strategy
    - Reference to work of Quality Committee
- It's important to remember though that no part of the Patients First Act changes the control that patients have over their own health care. The Patients First Act, the creation of sub-regions, the planning being done in partnership between primary care providers, the LHIN, patients and caregivers and other health and social service partners **are not** boundaries to care.
- There are no borders between LHINs or LHIN sub-regions.
- Patients, providers, local residents can and will continue to move across the region and across the province to access the care they need, when they need it.

- What will this time of clinical leadership bring to the renewed LHIN as we focus on sub-regions, care communities, improving the patient experience.
- As Debby said earlier, the journey we have travelled so far has put us in a good place for transformation because together, with our clinical champions by our side, we are a LHIN **that has not wavered** from the LHIN Board-approved Strategic Direction related to Quality and Safety.

SLIDE 26

- This is a LHIN where the Board defines health care as being **patient-centred, safe and of high quality**.
- This is a LHIN where Health Service providers **will meet defined standards and targets for safety and quality of services**.
- This is a LHIN where health service providers **will deliver high quality and safe care informed by patient experience.**
- This is a LHIN where health service providers **will demonstrate ongoing improvement in the quality and safety of services and care.**
- This is a LHIN where providers **are held accountable; quality, safety and patient experience are used to evaluate and make decisions** on actions that impact the health care system.
- And, I know, this is a LHIN where clinicians are and **will continue to be** actively informed, engaged, involved and empowered to contribute to those achievements.
- And now I'll turn the podium over to my colleague Lisa Burden.

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- Thank you Barry and hello to everyone here in the room and out there on the internet.
- My name is Lisa Burden and in May of this year, just before the June 21st Transition Day, I became the Central East LHIN Vice President of Home and Community Care services, a division which is accountable for the development, implementation and evaluation of home and community care programs and services.
- Many of you will know me from my previous CCAC roles – as Senior Director Patient Services or Program Director for Chronic Disease Management in Patient Services.
- I have had the privilege to work in many parts of our health care system over the course of my career including the hospital sector, Long-term Care, the

Ministry of Health and Long-Term Care and now for many years in the Home and Community Care sector.

- Like Dr. Guppy, my background is clinical and as a nurse I too have seen the power that comes when the voices of people with lived and professional experience is acknowledged and embedded into policy and planning. I have also seen the power that comes from listening to and working with patients and caregivers.
- That's why I'm so excited about the transformation opportunities in front of us now that the delivery of Home and Community Care is integrated into the LHIN organization.

SLIDE 28

- What has been the immediate impact?
- Well we now have eight branch offices instead of seven and patients and caregivers in the Ajax community can now access our care coordinators for assessment and referrals by visiting the LHIN office at Harwood and Bayly.
- We are weeks away from opening a new Home and Community Care Nursing Clinic in the Town of Ajax where ambulatory patients requiring Home and Community Care nursing services will be able to come for booked appointments for services such as wound care and IV maintenance.
- This will mean that we now have seven nursing clinics providing timely access to community-based nursing services across the Central East LHIN.
- And across our branches and hospital locations everyone has been focused on ensuring that the relationships between our patients and front line care coordinators has been uninterrupted so that seamless Home and Community Care has continued to be delivered despite the major transitional activities behind the scenes.

SLIDE 29

- For those of you not as familiar with the services delivered by the Home and Community Care division, here are some of the facts and stats that we like to share to show the difference we are collectively making in patients' lives:
    - Debby already highlighted the Home and Community Care budget – 93% of which is targeted to the delivery of front line care
    - Between April and August of this year we provided care for close to 65,000 individuals and on any one day just over 43,000 care episodes were happening
    - Just over 1,900 palliative patients were supported with in-home end of life care
    - Close to 15,000 long-term care home applications were completed and, with the support of our colleagues in the long-term care home sector, over 1,400 individuals were placed or admitted into a long-term care bed
    - Close to 28,000 visits were made to those nursing clinics I referenced earlier
    - And nearly 3,000 unattached patients were connected to a Primary Care provider

SLIDE 30

- The opportunity in front of us now as the renewed LHIN is to deliver on the Home and Community Care **improvements** that we know our patients and other partners want and need.
- Based on the report developed a team led by Dr. Gail Donner, the Ministry, in its *Patients First: A Roadmap to Strengthen Home and Community Care*, laid out a ten point plan:
    - 1. Develop a Statement of Home and Community Care Values - to guide the transformation of home and community care, with the needs of patients and their caregivers at the centre

- 2. Create a Levels of Care Framework - to ensure services and assessments are consistent across the province.
- 3. Increase Funding for Home and Community Care - by five per cent each year, investing an additional $750 million across the province over the next three years
- 4. Move Forward with Bundled Care - in which a group of providers will be given a single payment to cover all the care needs of an individual patient.
- 5. Offer Self-Directed Care – in which patients and their caregivers are given funds to hire their own provider or purchase services from a provider of their choice.
- 6. Expand Caregiver Supports – to ensure caregivers have better resources to care for their loved ones and also to take care of themselves.
- 7. Enhanced Support for Personal Support Workers - to improve the stability of the PSW workforce.
- 8. More Nursing Services - to increase the maximum number of nursing visits a patient can receive and allow us to exceed nursing service maximums in certain cases, subject to necessary regulation changes.
- 9. Provide Greater Choice for Palliative and End-Of-Life Care – through improved access, oversight, accountability, supports and education
- 10. Develop a Capacity Plan - that includes targets for local communities as well as standards for access to home and community care and for the quality of the patient experience across the province.

SLIDE 31

- As part of the renewed LHIN:

- The Home and Community Care division will work with Dr. Guppy and the primary care leads to better embed care coordination and the role it plays in supporting our patients to navigate the primary health care system to ensure a better patient experience;
- We are working with our pan LHIN and Ministry partners on the Levels of Care framework to ensure that no matter where a person lives in Ontario they will receive a consistent "basket of services" from Home and Community Care providers
- We have also worked with the Ministry around our Caregiver support hours and in the last year have provided 1800 patients with caregiver support hours in which they have been able to participate and decide when those hours would best meet and suit their needs.
- And we will be enhancing the current Self Directed Care program)so that patients and caregivers with complex and long term care needs will have a better choice over their care plans and an improved patient experience.

- As the legacy CCAC, we enjoyed a collaborative relationship with so many other partners in the health care continuum. We sat at the tables, identifying and assessing patients after an acute episode in the hospital, taking care referrals from the community or supporting placements in long term care homes.
- Together with you and now our LHIN colleagues, we have made a difference with initiatives such as our ED Division project, the Centralized Intake for Complex Diabetes Care, Self Management, BSO, our NPSTAT team, Telehome care, Telewoundcare, Palliative Care Nursing Teams and, with the latest initiative, Total Contact Casting for diabetic foot ulcers which has been shown to cost costs, improve care and lead to an even better patient experience.
- And, as the renewed LHIN, the Home and Community Care division will continue to support our Hospital partners with the Home First philosophy

and help to co-ordinate a regional focus on our Alternate Level of Care patient challenges.

- As Debby said earlier, the journey we have travelled so far has put us in a good place for transformation.
- I came from the CCAC, where the vision was to deliver outstanding care to every person, every day. That vision guided everything we did and it meant that everyone - patients, caregivers, our staff, service providers and community partners - deserved the best from us.
- It was a vision that we were determined to live up to and I know that it is one that is just as true in the renewed LHIN because:
    - This is a LHIN that is committed to true collaboration with all of its health system partners.
    - And this is a LHIN where together, all of us, and the organizations and people we represent, are focused, passionate and committed to improving the health of the population that we are privileged to serve.
- Thank you and now I'll turn the podium over to my colleague Stewart Sutley.

SLIDE 32

- Good morning everyone. I appreciate that many of you in the room or viewing the live stream know who I am. I've been with the Central East LHIN for a number of years now, most recently as the Senior Director of System Finance and Performance Management.
- The transition of the CCAC into the LHIN has resulted in the creation of a new division, the Health System Strategy, Integration, Planning and Performance division. I am its Vice President, and I now lead a team that is accountable for providing strategic leadership, direction and oversight of the development, implementation and evaluation of:
    - Firstly, health system strategies and plans;
    - Secondly, integration, performance, accountability and quality improvement frameworks;

    - Thirdly, strategies, initiatives, metrics, monitoring and reporting; and
    - Fourthly, sub-region alignment.
- Working in partnership with my colleagues from the Clinical Division and the Home and Community Care division, we three are now what you might call the "sharp end" that is pointing the way forward for the system and our patients
- And that, together with other health and social service partners, patients and caregivers, clinicians and community leaders, will have the biggest impact on where we go from here.
- Where we go from here includes sub-region planning, which is my area to speak to in this morning's update.
- The Patients First Act, the Ministry mandate letter and the June 21st transition of the CCAC into the LHIN have put us on a solid footing for our transformation journey.
- With the formalization of our long standing geographic planning zones or *Health Links* communities into the seven sub-regions, we are ready to move forward with activities that will lead to greater planning, funding and integration of services from a sub-region or local population health perspective.

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- As previously mentioned, there are seven Sub-region Planning Tables in the Central East Local Health Integration Network (LHIN): two in Scarborough, two in the Region of Durham, and three in the North East (Northumberland County, Peterborough City and County, and Haliburton and the City of Kawartha Lakes)

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- As you can see from these data, there are vast differences in population and population density across the seven sub-regions, reflecting both the rural and

urban features of the Central East LHIN. These data clearly illustrate the need for local planning to address our LHIN-wide diversity.

SLIDE 35

- As geographic foundations for the development of local integrated systems of care, LHIN Sub-Regions will…
    - Bring together health system and community partners, as well as clinical leadership, at the local level in health system planning and improvement
    - Enable more focus on assessing population health need and service capacity
    - Use health system data and information for the population of the sub-region
- LHIN Sub-Regions won't…
    - Result in more bureaucracy. Sub-regions will use existing LHIN staff in more effective ways - no new organizations are being formed
    - Impede the Ministry's or the LHIN's obligations to engage with provincial and regional partners and patients. These engagements will continue
    - Infringe on traditions or established jurisdictions in the planning, delivery or improvement of health services

SLIDE 36

- Based on the expression of interest process that was launched in August, over 70 people with lived and professional experience have now stepped forward to represent a variety of perspectives at the Central East LHIN's seven Sub-region planning tables. There are, in total, 15 perspectives represented here, ranging from patients and caregivers – our starting points – through specialized populations to the well-known sectors comprising the local health system:
    - Patients

- Caregivers
- Representatives from the Indigenous communities
- Representative from the Francophone community
- New Immigrant representatives
- Primary Care
- Specialists
- Hospital sector
- Public Health Units – based on confirmation from the Medical Officers of Health
- Municipal Services
- Community Health Centres/Family Health Teams
- Community Support Services sector
- Long-Term Care Home sector
- Mental Health sector
- Addictions sector

- The appointment criteria used to select Planning Table members were specific and categorized into clear themes:
  - Health System Experience
  - System Planning Experience
  - Sub-region Community Linkages
- These criteria allowed the LHIN to recruit and select members with diverse sector perspectives and skill sets.
- It's important to remember that members are not representing the organizations they come from. Instead they are being asked and directed to represent their sector or communities and to work as a team to help improve the health of the population within their sub-region geography

SLIDE 37

- It is for these reasons that the mandate of the Planning Tables is to:

    - Foster joint accountability for innovative, integrated system redesign
    - Address health and service gaps
    - Advance quality
    - Improve patient experience and outcomes
- The Sub-region Planning Tables will actively seek out input and perspectives of their members – which will include local patients, caregivers, physicians, community representatives, and service provider representatives – in order to improve the health of the population within a sub-region geography.

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- Based on our learnings since 2006, and through our ongoing engagement with our Public Health colleagues, it is imperative that the tables apply a population health approach to their sub-region planning activities:
    - Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.
    - In order to reach these objectives, a population health approach looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.
    - This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health.
    - The best articulation of this concept of health in our view is "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish et al., 1996).

SLIDE 39

- That's why the LHIN will be supporting the sub-region planning tables:
    - To focus on the health of the local populations in each of the seven sub-regions

- To address, in partnership with other engagement structures and organizations, the determinants of health and their interactions
- To base recommendations and decisions on evidence
- To work with the LHIN and the Ministry to see how we can increase upstream investments
- To consider the application of multiple interventions and strategies
- To collaborate across sectors and levels
- To continually engage with people who are impacted by or involved in the health care system by employing mechanisms for public involvement
- And to ensure that we demonstrate ongoing shared accountability for health outcomes

- In RSVPing to today's update, many of you asked about the governance model for the sub-region planning tables and how recommendations would move forward to decision makers at the LHIN and the province.

SLIDE 40

- The governance model to support sub-region planning at the Central East LHIN will consist of:
  - A **Steering Committee** - whose role will be to provide strategic direction and oversight and offer recommendations for local sub-region investment and reallocation of savings/surplus;
  - **Seven (7) sub-region planning tables**;
  - **Work groups**, which will support the implementation of the change ideas identified by the Planning Tables.
- **The strength and effectiveness of the Sub-region Planning Tables will be the result of the contributions of their members, including physician leads, and all members acting and communicating as a single, united team.**

- The Sub-region Planning Tables will be expected to adopt action and outcome oriented agendas and to make quality the framework for their work and recommendations.
- The Sub-region Planning Tables are responsible to consider the health and social care system and what is best for patients and populations, and will be expected to have strong and effective relationships with other Central East LHIN structures and affiliated processes.

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- The **Sub-region Steering Committee** will serve as an advisory body to the Central East LHIN and will comprise representatives from each Sub-region Planning Table, as well as senior leaders of the Central East LHIN.
- The **Sub-region Planning Tables** will be expected to make recommendations to the Sub-region Steering Committee for innovative and integrated strategies to address local health gaps, following the established funding cycles of the LHIN. The Sub-region Steering Committee will then report to the **Central East LHIN Senior Team,** which will then proceed to the **LHIN Board** for any final decision making.

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- Within the scope of the Planning Tables will be the ability to:
  - Assess local health needs
  - Plan to improve patient experience
  - Implement innovative, integrated strategies
  - Evaluate local health system performance
  - Address system-level concerns, issues, and risks
- What lies outside of the scope of the Planning Tables includes:
  - Governance of the sub-region health care system

- Decision-making regarding service delivery operations and funding of individual providers/entities within the sub-region
- Advancing collective action on sub-region priorities without the endorsement of the Central East LHIN
- Advocacy on behalf of organizational interests or political interests
- Addressing specific patient's concerns.

- Members of the Sub-region Planning Tables will provide regular updates to their respective sector/governing bodies/communities of practice, as appropriate. We recognize that timely, transparent and accessible communication and engagement processes are needed to ensure that all stakeholders are aware of the work of the Sub-region Planning Tables and the Sub-region Steering Committee.
- Throughout this update we have been speaking to the LHIN's commitment to Community Engagement. Since 2006, the LHIN staff and board have benefitted from the active participation and sharing of lived and professional experiences of patients and caregivers, clinicians, front line staff, health care organizations and administrators, Public Health and municipal partners and many others.
- Most recently we had been working with *Health Links* Networks, which were comprised of health service providers in local geographies, who, with patients and caregivers, were actively involved in the development and implementation of **Coordinated Care Plans** for patients with complex health care needs.
- To date, this has led to the initiation of 4,816 **Coordinated Care Plans** for patients with complex care needs.
- But, as we prepared for the launch of the seven sub-region planning tables, we recognized that it was important to consider the system's capacity to participate in so many engagement, planning and service delivery initiatives.
- That's why we took the necessary step of "retiring" the Health Links Steering Committee, Design Teams and Quality Improvement Teams.

- However, the development of Health Links Coordinated Care Plans will continue, through five Working Groups, which will be in alignment with the seven sub-region planning tables. The membership for those tables is currently being confirmed.
- At present, all of the LHIN's engagement structures are being reviewed as we embark upon this transformation journey.
- We have a lot of work ahead of us as we turn our collective efforts towards improving the health of the local population at the sub-region level. **With your support and participation, we will achieve this goal.**

SLIDE 43

- This is a LHIN that works with all partners to integrate the health care delivery system to better meet the current and future needs of patients, caregivers and communities:
    - It does so by supporting the creation and implementation of provincial and LHIN strategic plans to guide local decision making.
    - It does so by engaging stakeholders to identify opportunities to enhance the health care experience and improve the system of care
- This is also a LHIN that:
    - Prioritizes high quality and high performance when allocating funding.
    - Invests in initiatives that lead to patient-centred care across the care continuum, greater coordination of care, and quality outcomes.
    - And promotes a population needs-based approach to system resource planning and management.
- One of the tools that will continue to assist us all in assessing the needs of our populations are our Sub-region profiles. Just before Debby comes back to the podium to wrap up this morning's update, I would like to invite Marilee Suter, the LHIN's Director of Decision Support to share some exciting news about the profiles. Marilee…..
- Thank you Stewart and good morning everyone.

- Later on this morning I will be working with the sub-region tables to give them an in-depth overview of the Sub-region profiles which have been available on the LHIN website as pdf documents for a number of months.

SLIDE 44

- To support enhanced collaboration amongst health service providers and other stakeholders and local decision making, the LHIN developed pdf documents which serve as an environmental scan of demographics, population health, social determinants of health and health system information at the LHIN sub-region level.
- In addition each document shows the location of LHIN-funded and some non-LHIN funded health care services, including Primary Care locations.
- With the support of our Public Health colleagues and other sources, we have been able to capture this information not only at the sub-region level, but that also through geographical spatial analysis, to link population health and health equity data with health system information (including utilization and financial data) in the 97 neighbourhoods that make up the Central East LHIN so that we can better determine gaps and opportunities in the delivery of care.

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- As you go through the documents, you will be able to see how we have taken the different maps and layered them, in this example showing the number of falls related emergency department visits per 1000 people aged 75 or older with the location of Exercise and Falls prevention clinics and physiotherapy clinics.
- There are eight chapters to the pdf'd environmental scan, one for the Central East LHIN and one for each sub-region and each document is hundreds and hundreds of pages of valuable information.

- Already I know that many of you here in the room and watching on line have been accessing the documents and the Decision Support team here at the LHIN has been happy to answer your questions.
- But I want to share some exciting news with you.

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- The pdf'd Profiles have now migrated to a web-enabled tool.
- Now you can head to the LHIN website and surf through all the different chapters, zooming in and out of sub-regions and neighbourhoods to get an even more detailed perspective on our local health care system.
- And thanks to Patients and Caregivers who have shared their stories, the web-enabled tool also includes videos and other documents that help to demonstrate that by taking action on lived experiences, new programs have been established, improvements have been made to existing services and, when warranted, accountability for services has been re-designed or re-assigned.
- I hope you will go and take a look at the information posted on the LHIN website and we look forward to continually updating this tool as new data becomes available.
- Thank you Marilee. A lot of work has gone into creating first the pdf'd profiles and now the web-enabled profiles. We haven't seen anything like this anywhere else in the province and I know that the benefits of having this kind of data at our fingertips will be immeasurable.
- Okay, so Barry, Lisa, Stewart and I have spent the last hour or so providing you with an update on where we've come from and where we're going - from 2006 to now – from the LHIN to the renewed LHIN - from Transition to Transformation.
- I would also like to recognize Randy Filinski and Anne-Marie Yaraskavitch, the co-chairs of the Central East LHIN's Patient and Family Advisory Committee and members of the Sub-Region Steering Committee for their

ongoing support and leadership in making sure that the LHIN is actively bringing patients and caregivers into everything that it does.

- It has been an interesting journey, not without its challenges, not without its problems – but I know that as a system of patients and caregivers, organizations and individuals, clinicians and administrators, community leaders – we can deliver on the Patients First goals and the Minister's mandate and we will.
- Much has been accomplished, much more is to be accomplished.
- As we strive to meet our collective performance targets, we need to be innovative, we need to be integrated, we need to think outside the box, we need to embrace new technologies and new ways of doing things, we need to plan from a sub-region and a system perspective, we need to always be patient centred.
- The individuals who have committed to being part of our sub-region tables are here in the room and their names are there on the screen.

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- As we end this update and get ready to hold the inaugural meetings of the seven sub-region planning tables, I would like to invite everyone to stay informed and involved, stay committed and engaged.
- Please continue to follow along through our communication vehicles, through the LHIN website, by attending LHIN Board meetings and being active participants in current and future engagement structures.
- The LHIN's Community Engagement page provides a link for you to become part of the Central East LHIN Stakeholder and Engagement database and provides information on current engagement structures, including an opportunity for patients and caregivers to join the LHIN's Patient and Family Advisory Committee.

- The Board meeting page contains links to all archived and current Board meeting materials.
- The Sub-regions page contains the profiles and an Expression of Interest form for some vacancies still to be filled at the seven tables.
- The Priorities page contains information on the LHIN's Mental Health and Addictions, Seniors, Vascular and Palliative Care Priorities.
- The Home and Community Care page provides valuable information to Connect patients with Care.
- And the Contact Us page gives you the addresses, phone numbers and email addresses to all of our branch locations.
- We are always available to answer your questions. Please do not hesitate to contact us if you require more information or have suggestions on how we can continue to communicate with you and other stakeholders.

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- Thank you for joining us for this morning's update and we look forward to meeting with you again in the future.