Rideau Tay Health Link

Report

Board-to-Board Meeting January 27, 2015

10 a.m. – 1:00 pm Lancaster Room, Royal Canadian Legion, Smiths Falls, ON

Summary:

This is a report of the third meeting of representatives of the boards of directors of the agencies working within the Rideau Tay Health Link (RTHL). At the meeting, the 34 participants heard a presentation from Dr. Jonathan Kerr regarding the Provincial Health Links, and Health Care Tomorrow, an update on the South East Health Link from Cheryl Chapman, and a presentation from the Rideau Tay Health Link team. Participants then shared their goals re-confirming the Nine Board Roles in Supporting the Success of RTHL and the Common Metrics.

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1. Introduction

a. Goal of the Meeting, Outcomes for the day

This is the third gathering of the members for the boards of directors of the agencies that make up the Rideau Tay Health Link (RTHL).

The purpose of this meeting was:

- To update and inform the boards about Health Links at a local, LHIN, and provincial level.
- To receive an update on changes that has occurred at board level at various boards.
- To re-confirm that the 9 roles still hold true and the commitment from boards to continue.

The meeting agenda is presented in Appendix A

2. Presentations

Zip file with presentations attached

3. Questions and Answers

Q. What are RTHL Goals and Objectives?

A. These have been articulated in the RTHL Business Plan. Discussion occurred as to how this could be made more available to Boards. It would be beneficial for each Board to review the goals and objectives for ones that are common to their organization's goals and objectives.

Q. Why is the Emergency Department usage high?

A. In some cases it is due to lack of access to Family Physicians. In some Health Links when the Coordinated Care Plan is reviewed with the patient, discussion occurs as to what the root cause of an emergency visit is and solutions are investigated.

Q. Will Health Links be part of the discharge process?

A. Yes, from two perspectives Health Links in involved in this process. If the individual is a Health Link patient then the HL Care Coordinator will be involved in the discharge. At a system level Health Links has identified the discharge process as a "transition" area to focus on with the Transitions Working Group.

Notes based on general questions:

Jonathan: approximately 50 Health Links are being developed; eventually there will be about 95 Health Links around the province. All 7 in the SE LHIN are primary care led – the only LHIN where this is the case.

RTHL is leading in the LHIN in the Board-to-Board governance area.

All 7 Health Links are doing coordinated care planning, but are testing different ways of carrying out the planning. Rideau-Tay is testing the involvement of a care coordinator who is seconded from the CCAC.

The coordinated care plan is not yet available as an electronic record, but a provincial system is being tested (in two waves). In the meantime, there is a system in use by the SE LHIN.

IN response to a question about privacy and the sharing of health information, a one-page document is being used that clients can sign to allow their information to be exchanged among providers (with exceptions that clients can specify).

4.

Small Group Discussion: Re-confirming the Nine Board Roles

Question #1: Do the nine roles still hold true? What, if anything needs to be added, removed, changed?

Role	Does the role still hold true? What, if anything needs to be added, removed or changed?
Role 1. Embrace the idea that health link success require us all to change	• Understand the challenges of shifts in service levels – hospitals getting smaller i.e. resources move to community • Importance of painting picture of success • What does success look like, what is our next step • It is an ongoing evolution – not starting at ground zero, now need to be operational
Role 2. Ensure our organization's mission, vision and key strategies align with the RTHL shared purpose and goals.	• Change in mindset of doctors • Hospitals access medical records electronically • Quality strategies that align with Federal/Provincial and Local priorities • Make sure it is collaborative i.e. – mission, vision and strategies are in alignment – some boards embed in strategic planning
Role 3. Use RTHL goals to inform ED/CEO selection and support.	
Role 4. Work with our ED/CEO to set metrics, and ensure we have operational goals and processes that contribute to RTHL success	• Adopt a shared quality improvement strategy approach • Local metrics and Regional metrics • Dashboard report – same metrics reporting on big metrics (shared communication)
Role 5. Ensure our organization is responsive to community needs	• Communication and patient engagement is key • Formally incorporate how community linkages relate to each organization • Bring in non-Ministry of Health funded organizations and system level metrics
Role 6. Include Health Link advocacy in our community, funders and other stakeholders	• Very Important • Establish Websites • Establish goals & objectives • Ministry of Health linkages • Important that we build support to continue -avoid being swept away by next need
Role 7. Review all aspects of our governance (board recruitment, orientation, learning, evaluation etc.) in relation to achieving RTHL goals	• Not in so far as RTHL goals are the priority filter of governance (i.e. duplication if Role 2 done)
Role 8. Continue to explore	• Could be seen as redundant

how best to support RTHL success	
Role 9. Take action in collaboration with other boards of directors within RTHL	• Sharing vulnerabilities, admitting that you don't know

Large Group Discussion: Re-confirming the Nine Board Roles

Question #1: Do the nine roles still hold true? What, if anything needs to be added, removed, changed?

Role	**Does the role still hold true? What, if anything needs to be added, removed or changed?**
Role 1. Embrace the idea that health link success require us all to change	• Roles 1,2,4 have shared similarities • Shared goals and objectives
Role 2. Ensure our organization's mission, vision and key strategies align with the RTHL shared purpose and goals.	• What does success look like? (vision → strategy)
Role 3. Use RTHL goals to inform ED/CEO selection and support.	• Roles 3 & 7 have the possibility of being grouped together
Role 4. Work with our ED/CEO to set metrics, and ensure we have operational goals and processes that contribute to RTHL success	• Shared Quality Improvement Strategy – Alignment (provincial, regional and local) • As Health Link grows – concentrate on 4,5,6
Role 5. Ensure our organization is responsive to community needs	• Roles 5,6 have the possibility of being grouped together • Roles 5,6,7 to work on now
Role 6. Include Health Link advocacy in our community, funders and other stakeholders	• Communication with communities – Share the stories
Role 7. Review all aspects of our governance (board recruitment, orientation, learning, evaluation etc.) in relation to achieving RTHL goals	
Role 8. Continue to explore how best to support RTHL success	
Role 9. Take action in collaboration with other boards of directors within RTHL	

5. Small Group Discussion: Common Metrics

How can Boards align the work of their organizations to deliver on the 11 Health Link metrics?

Operational Metrics (getting us started)	
1. All high risk (complex) patients have coordinated care plans 2. Increase number of high risk (complex) patients with regular and timely access to primary care provider	• CEO to engage/educate all staff in value/purpose and goals of Health Link • Use RTHL staff for this delivery • For the CCAC consider and review regularly the indicators (part of MSSA) • Also review through the Quality Committee the explanation behind the data • Not yet reviewing across organizations • Required detail data from RTHL to each CHC

Results-based Metrics ("moving the dot")	
3. Reduction of time for referrals from PC to specialist 4. Reduction of 30 day readmission rates 5. Reduction of avoidable emergency department visits 6. Reduction of time form referral to home visits 7. Reduction of unnecessary admissions to hospitals 8. PC follow up 7 days post discharge from hospital	• These are system level metrics • Some metrics are tracked at LHIN level • Does changing the conversation help focus on these metrics? • Focus on readmission for example can contribute to a broader approach to a problem. • Develop Walk in clinics • Difficult to call PC physician – automatic referral to emergency • Extended physicians' office hours • Close co-operation with hospital and CHC

Evaluation-based Metrics ("outcomes")	
9. Alternate level of care rate is 9% or less 10. Improved system experience for high risk (complex) patients. 11. Reduction of average cost of care for high risk (complex) patients.	

Large Group Discussion: Common Metrics

How can Boards align the work of their organizations to deliver on the 11 Health Link metrics?

Operational Metrics (getting us started)	
1. All high risk (complex) patients have coordinated care plans 2. Increase number of high risk (complex) patients with regular and timely access to primary care provider	• Each organization has its own metric and definitions • Who identifies complex patient? • CCP for high risk patients • Unattached patients access to primary care provider

Results-based Metrics ("moving the dot")	
3. Reduction of time for referrals from PC to specialist 4. Reduction of 30 day readmission rates 5. Reduction of avoidable emergency department visits 6. Reduction of time form referral to home visits 7. Reduction of unnecessary admissions to hospitals 8. PC follow up 7 days post discharge from hospital	• Data required • Segmented data by Group, Provider • Reduction of avoidable emergency department visits is key

Evaluation-based Metrics ("outcomes")	
9. Alternate level of care rate is 9% or less 10. Improved system experience for high risk (complex) patients. 11. Reduction of average cost of care for high risk (complex) patients.	• Perhaps individuals do not need to be here- possibly waiting for long-term care

Appendix A: Agenda January 27, 2015

AGENDA
Jan 27th Rideau Tay Health Link
Board-to-Board meeting

Smiths Falls Legion
7 Main Street East,
Smiths Falls

10am – 1pm

A. Introductions (*Graeme Bonham-Carter and Richard Schooley)*	*10:00am-10:10am*
B. Inform	
o Provincial Health Link perspective *(Dr. Jonathan Kerr)*	*10:10am-10:15am*
o South East Health Link update *(Cheryl Chapman)*	*10:15am-10:25am*
o Health Care Tomorrow *(Dr. Jonathan Kerr)*	*10:25am-10:30am*
o Rideau Tay Health Link *(RT Health Link Team)*	*10:30am-10:45am*
C. Board Updates *(Graeme Bonham-Carter)*	*10:50am-11:05am*
o Large group discussion	*11:05am-11:15am*
D. Re-Confirm 9 Board Roles in Supporting the Success of RTHL	*11:15am-11:25am*
o Large group discussion	*11:25am-11:40am*
*** Quick BREAK ***	***11:40am-12:00pm***
E. Common Metrics	
o Small group discussion	*12:00pm-12:20pm*
o Large group debrief	*12:20pm-12:40pm*
F. Wrap-up	*12:40pm-1:00pm*

The meeting will be facilitated by Dr. Jonathan Kerr and Cheryl Chapman

Appendix B: Participant List January 27, 2015

1. **Alzheimer Society of Lanark County (ASLC)**
   Don McDiarmid, Board Chair; Louise Noble, Executive Director

2. **Belleville & Quinte West Community Health Centre**
   Marsha Stephen, Executive Director; Michael Piercy, Director/Officer Past President

3. **Champlain LHIN**
   Chantale LeClerc, CEO; David Somppi, Acting Vice-Chair

4. **Community Home Support Lanark County (CHSLC)**
   Doug Burt, Board Member; Colin Sangster, Dignity House Board Member

5. **Country Roads Community Health Centre**
   Marty Crapper, Executive Director; Brian Preston, Board Member

6. **Lanark County Mental Health**
   Sherry Baltzer, Chair, Community Advisory Committee

7. **Lanark Renfrew Health & Community Services**
   John Jordan, Executive Director; Noreene Adam, Co-Champion, Board Member; Jean Dunning, Co-Champion, Community Member; Ann Monroe, LRHCS Past Chair

8. **Leeds, Grenville, Lanark District Health Unit**
   Rebecca Kavanagh, Manager Healthy Living & Development

9. **Perth and Smiths Falls District Hospital**
   Beverley McFarlane, President and CEO, Richard Schooley, Vice-chair; Donna Howard, Tom Belton, Board Members

10. **Rideau Community Health Services**
    Graeme Bonham-Carter, Board Member; Tom Rankin, Chair; Jan Hopkins, Secretary; Don Dutton, Treasurer; Wynn Turner, Vice-Chair; Terry Lee, Board Member; Wendy Quarry, Board Member; Peter McKenna, Executive Director

11. **Rideau Tay Health Link Team**
    Maureen McIntyre, Project Manager, Jennifer Spencer, Health Link Coordinator; Kelly Barry, Patient and Provider Engagement Lead; Sandra Marchant, Administrative Assistant

12. **South East Community Care Access Centre**
    Carol Ravnaas, Senior Director, Strategic Partnerships; Wendy Cuthbert, Board Member;

13. **South East Local Health Integration Network**
    Janet Cosier, Board Member.

Appendix C:

Updates on the 9 Roles. Responses from Boards (as of Jan 25, 2015)

SE-CCAC (Southeast CCAC), ASLC (Alzheimer Society of Lanark County), RCHS (Rideau Community Health Services), CHSLC (Community Home Support Lanark County) and LRHCS (Lanark Renfrew Health and Community Services) have responded so far.

Role 1. Embrace the idea that health link success will require us all to change

SE CCAC --Board and organization are committed to Health Links, regional sustainability and provision (with partners) of integrated care.

RCHS-- The Board confirms that they have fully embraced the Rideau Tay Health Link. Graeme Bonham-Carter was confirmed as our HL Champion. Health Links are now a standing item on our monthly Board Agenda.

CHSLC-- The nine points of the roles of the Boards of Directors have been discussed at the last three board meetings. This was preceded by a comprehensive presentation and discussion in September. The CHSLC Board fully embraces the concept.

LRHCS—An October Board retreat and in-service on HL (attended by 30 people, including Board members, community members serving on Board Committees, staff from all parts of LRHCS, staff from 3 HL's, and a Board and staff member from the Champlain LHIN). We identified 4 HL champions and created a working group of same to follow-up on retreat discussions, considerations and recommendations and as a way to move forward on HL governance commitments. Our support will continue to evolve in response to our work with HL (currently 3 HLs). We will identify and implement actions that are in the best interests of client care. Commitment to use existing LRHCS Board, Committee and Management structure for moving forward with HL initiatives, and to establish new systems/structures that are sustainable – when required. LRHCS is allocating resources through the establishment of a HL Champions working group (comprised of the ED, 2 Board members and 2 community members who serve on Board Committees, and a staff resource) to follow-up on retreat discussions, considerations, actions in a thoughtful and deliberate manner.

Role 2. Ensure our organization's mission, vision and key strategies align with the RTHL shared purpose and goals.

ASLC-- I find it difficult to respond any more than previously without knowing RTHL's purpose and goals. In any event, renewal of our strategic plan awaits completion of our amalgamation with the Alzheimer Society of Leeds Grenville.

RCHS-- has added a 6th strategic direction specific to RTHL and system thinking. The operational plan will reflect RTHL goals and be approved by the Board.

CHSLC-- The CHSLC mission statement " We strive to provide programs and services that help our clients continue to reside in their homes and remain a part of the community" supports the RTHL Shared Purpose. The "coordinated care across transitions" will be dependent upon the coordination methodologies developed for the critical care plans (CCPs) of our complex and other clients. There will be a training phase required. It is likely that the coordination methodologies will have to be developed before a "vision and strategy to carry out our parts of the Health Link (HL) process" can be thoroughly developed. The CHSLC Strategic Plan will be reviewed to specifically

support the RTHL. The concept of the strategic objectives regarding improved transitions, etc., is supported. All the CHSLC services provided to clients with various conditions, including complex, contribute to the achievement of RTHL priorities for the next two years. The missing pieces are the identification of complex patients (i.e., having a CCP) and the RTHL coordination methodologies.

LRHCS-- As follow-up to the our Board Retreat, this item has been referred to our Planning and Review Committee of the Board for review (An initial review by the HL working group felt that our current beliefs, vision and mission are fully aligned with /complementary to the work of HL).

Role 3. Use RTHL goals to inform ED/CEO selection and support

ASLC--Our revised ED job description encompasses this role in a general sense. We need to have a statement of RTHL goals to go any further.

RCHS-- The Board intends to revisit the ED job description to ensure it aligns with system thinking and balances RCHS and RTHL priorities.

CHSLC-- This item and sub-elements are clearly supported by the Board. The ED's/CHSLC performance objectives as set by SELHIN state a requirement to support the Health Link.

LRHCS-- Board supports ED's participation on the RTHL Steering Committee (LRHCS), and staff involvement and participation on North and South Renfrew HL....and an evolving relationship with LH #7 (a Champlain LHIN health link). Board supports ED and staff involvement in the Hospice Palliative Care Working Group (LRHCS). As work with HLs evolves, Board will continue to support ED in carrying out health link-related priorities. Board recognizes the complexities of being involved with 4 HLs and the challenges this poses for clients, front line staff, management and governance involvement.

Role 4. Work with our ED/CEO to set metrics, and ensure we have operational goals and processes that contribute to RTHL success

SE CCAC-- Jennifer Spencer, a SE CCAC Care Coordinator is seconded to SE LHIN full time effective January 2015 to June 2015. Nurse Practitioners for Palliative Care and Rapid Response Nurses are also attached to Health Links in the SE area. SE CCAC is an active member of the Palliative Care Working Group. As a Board we have had dedicated education and updates related to Health Links.

ASLC--The Alzheimer societies in Ontario are beginning to explore a certification process which, among other things, will require the development of performance metrics. For us specifically this will have to await completion of our amalgamation with the Alzheimer Society of Leeds Grenville (ASLG). One of the main conclusions of our board's discussion of this topic is that it is best not to extend the number of metrics beyond those central items or factors which are central to effective operation and that metric formulae should be as simple as possible consistent with meaningful assessment of the intended function. If there are too many metrics or the formulae are too complicated, the exercise is apt to become mechanical with concomitant loss of a clear understanding of the point of the exercise. Also the cost of ongoing assessment can easily get to where it rises faster than benefits.

RCHS-- Our Board actively endeavours to make sure our strategies, and operational plans are aligned with Provincial, LHIN, HL and Health Care Tomorrow goals.

CHSLC-- The focus on the development of metrics, etc., at the 27 January meeting is welcomed. The Board thinks this needs to take place at the RTHL/LHIN levels and perhaps could be developed based on data submitted by agencies to the LHIN.

LRHCS-- The identification of suitable metrics was discussed by both the LRHCS HL Champions Working Group and at the Board Affairs Committee. ED includes a report on HL activities in the monthly ED report to the Board. Metrics would be included here and at the annual LRHCS Management presentation to the Planning and Review Committee of the Board. HL Champions Working Group, through the Board Affairs Committee, and LRHCS Management will be assessing which metrics are useful, feasible and sustainable to collect and report on. Need to know partners and what we collectively need to accomplish (LGMH). Staff will be engaged through presentations at full staff and team meetings in operationalizing goals in support of HL.

Role 5. Ensure our organization is responsive to community needs

SE-CCAC-- Currently our organization is trying several tests of change depending on community needs and Health Link priorities.

ASLC-- In addition to the commitment already made, we are in the process of developing memory clinics with ASLG (Alzheimer Society of Leeds Grenville). Memory clinics are a partnering of Alzheimer societies with the medical community to assess memory loss and to provide information and services to the families when memory loss impacts them.

RCHS-- We are open to and wish to promote a collaborative approach to community engagement and communication. We would like to encourage a meeting of community engagement/communication champions from provider boards in order to communicate to and involve the public in a more coherent, coordinated manner.

CHSLC-- The CHSLC plans to update/create a formal process of client/family satisfaction/separation process. As the RTHL/CCP processes are established CHSLC will ensure that in-house processes/policies/training are developed to guide program staff and volunteers in client assessment procedures to reduce the development of complex conditions as long as possible.

LRHCS-- our first strategic direction is to "Maintain and further build excellence in meeting health and community needs". All Parts of LRHCS and all our programs and services are guided by community needs. Planning, resource allocation, evaluation systems and structures are guided and informed first and foremost by community needs. Involvement with/ through HLs may help us better target/re-align limited resources to places where we can make the most impact.

Role 6. Include health link advocacy in our communication with community, funders and other stakeholders

CHSLC-- The CHSLC and CHSLC Foundation Boards will advocate for RTHL in all community interactions and at AGMs. Our web site will include information on the concepts and goals of the RTHL.

LRHCS-- The Board Retreat was structured to encourage and support cross-HL information exchange and discussion. At the retreat, cross-LHIN and cross-HL communications and collaboration were identified as key issues/items/priorities for LRHCS. Communications have been initiated between LRHCS ED/Board Chair and SE and Champlain LHINs re: cross-boundary concerns/ opportunity related to mental health re-design. The LRHCS HL Champions working group will initiate further discussions and exploration of how to raise and address cross-boundary (cross HL and cross-LHIN) issues that affect client service and/or organizational capacity to provide effective client service cross-boundary. LRHCS is committed to

engaging in productive discussions and in seeking collaborative resolution to cross-boundary issues. LRHCS and RCHS ED's and RTHL Program Manager attended meeting with Champlain LHIN HL meeting. More/similar involvement to come.

Role 7. Review all aspects of our governance (board recruitment, orientation, learning, evaluation etc.) in relation to achieving RTHL goals

SE CCAC-- Some board members attended the Fall session(s) of the SE LHIN Collaborative Governance.

RCHS—Our Nominating Committee will seek new board candidates that can bring experience from RTHL partners for mutual benefit.

CHSLC-- These points (7,8 and 9) form part of the evolution of the RTHL and the role/contribution of CHSLC. There will be a dedicated time at each board meeting for both the ED and RTHL Board Champion to comment upon and provide updates on the RTHL.

LRCHS—Our day-long LRHCS Board retreat provided venue for in-depth information exchange and discussion re: HL in general and the 4 HLs in which LRHCS provides service, in particular. A workplan to follow-up on actions considered and/or recommended during the retreat has been developed by the HL Champions Working Group. The HL Champions Working Group reports to the Board through the Board Affairs Committee. HL has been added to board orientation process. The HL Champions Working Group will identify and move forward (to the appropriate Board Committee) recommendations for action or for further consideration/discussion.

Role 8. Continue to explore how best to support RTHL success

ASLC-- Our earlier commitment is now action taken.

RCHS-- An active role in advocacy may also be better discussed within the HL goals and geographic boundaries. Perhaps our watch phrase should be: system success will mean more successful pursuit of our individual organizational goals.

CHSLC—see Role 7

LRHCS-- We are arranging for a detailed briefing to identify how we can best contribute (ASLC). Seek ways to bring boards of agencies funded by the Ministry of Community and Social Services (MCSS) into this circle (RCHS). Advocate to the Association of Ontario Health Centres and the SE LHIN re bringing in other government departments into health links (RCHS).

Role 9. Take action in collaboration with other boards of directors within RTHL

RCHS—We would like to see a collaborative approach to community engagement (see note under role 5), perhaps with an across-board committee to develop this idea (the full Board-to-Board meetings too large).

CHSLC—See Role 7

LRHCS-- Strong board presence at Board-to-Board meetings. Creation of LRHCS HL Champions Working Group will help support our involvement/understanding/responsiveness to the 4 HLs within which LRHCS provides service. LRHCS HL Champions Working Group is still under development. The roles and responsibilities of Champions will evolve as we move forward.

Appendix D

Follow-up Email to Board Chairs – Action Item re: Community Engagement

February 2, 2015

To: Dear Board Chairs of Organizations in Rideau Tay Health Link

From: Graeme Bonham-Carter and Richard Schooley

At the Rideau Tay Health Link Board-to-Board (RTHLB2B) meeting in Smiths Falls on Jan 27th, the idea of forming a community engagement discussion group from across the participating boards was put forward.

We believe this would be an excellent idea for a variety of reasons.

1. Community engagement is an important activity that is recognized by all the boards in RTHL—and many boards already have a committee (maybe under a variety of names besides 'community engagement').
2. We share the same geographic space—i.e. Lanark, Leeds and Grenville in the main—so our community population is also shared. Coordination between boards (and staff) on this issue makes total sense.
3. The Health Link B2B group provides an ideal framework for collaboration.

The full B2B group is probably too large for effective discussion. A smaller group would allow focus.

This letter is to ask you, as Board chair, to put forward the name and contact details of one of your board members who could act as the RTHL Community Engagement Champion (or whatever it will be called).

Once we have enough people to form an effective group (perhaps 5 or 6?), we will organize an initial meeting—probably in early March.

Appendix E: Invitation List

Alzheimer Society of Lanark County		
Louise Noble	Alzheimer Society of Lanark County	Executive Director
Don McDiarmid	Alzheimer Society of Lanark County	Board Chair
Scott Chamberlain	Alzheimer Society of Lanark County	Board Member
Bruce Sells	Alzheimer Society of Lanark County	Board Member
Belleville & Quinte West Community Health Centre		
Marsha Stephen	Belleville & Quinte West Community Health Centre	Executive Director
Michael Piercy	Belleville & Quinte West Community Health Centre	
Brockville General Hospital		
Sheri Hudson	Brockville General Hospital	Board Member
Canadian Cancer Society		
Leanne Waddell	Canadian Cancer Society	Unit manager of the Community Office for Lanark, Leeds and Grenville
Champlain LHIN		
Chantale LeClerc	Champlain LHIN	CEO
David Somppi	Champlain LHIN	Acting Vice-Chair
County of Lanark		
Kurt Greaves	County of Lanark	Chief Administrative Officer
Lanark County Paramedic Service		
Ed McPherson	Lanark County Paramedic Services	Chief
Sean Teed	Lanark County Paramedic Services	Deputy Chief
Community/Primary Health Care Lanark, Leeds & Grenville		
James E. Garrah	Community/Primary Health Care Lanark, Leeds & Grenville	Board Secretary
Tina Montgomery	Community/Primary Health Care Lanark, Leeds & Grenville	Community Support Services Manager
Kristen Argue-Hobbs	Community/Primary Health Care Lanark, Leeds & Grenville	Interim Board Chair
Ruth Kitson	Community/Primary Health Care Lanark, Leeds & Grenville	Executive Director
Jenny Lane	Manager	
Country Roads Community Health Centre		

Marty Crapper	Country Roads Community Health Centre	Executive Director
John MacTavish	Country Roads Community Health Centre	Board Chair
Robin Jones	Country Roads Community Health Centre	Board member
Community Home Support- Lanark County		
Mary Anne Nicholson	Community Home Support--Lanark County	Executive Director
Doug Burt	Community Home Support--Lanark County	Board Member
Colin Sangster	Dignity House Hospice	Board member
Lanark County Mental Health		
Sherry Baltzer	Lanark County Mental Health	Chair Community Advisory Committee
Wayne Johnson	Perth & Smiths Falls District Hospital	Board Member
Diana MacDonnell	Lanark County Mental Health	Board Chair
Lanark Renfrew Health & Community Services		
Stephen Bird	Lanark Renfrew Health & Community Services	Board Chair
Nic Maennling	Lanark Renfrew Health & Community Services	Board Vice-chair
John Jordan	Lanark Renfrew Health and Community Services	Executive Director
Noreene Adam	Lanark Renfrew Health & Community Services	Co-Champion, Board Member
Jean Dunning	Lanark Renfrew Health & Community Services	Co-Champion, Community Member
Annette Hewitt	Lanark Renfrew Health & Community Services	Co-Champion, Community Member
Kara Symbolic	Lanark Renfrew Health & Community Services	LRHCS Staff Member
Ann Munroe	Lanark Renfrew Health & Community Services	LRHCS Past Chair
Pamela Salvarakis	Lanark Renfrew Health & Community Services	Co-Champion, Board Member
Leeds, Grenville, Lanark District Health Unit		
Jack Butt	Leeds, Grenville, Lanark District Health Unit	Board Chair
Ken Graham	Leeds, Grenville and Lanark District Health Unit	Smiths Falls Council Representative
Leeds Grenville Mental Health		
Claire Laing	Leeds-Grenville Mental Health	Board Member

Laurie Dube	Leeds-Grenville Mental Health	CEO
Judy Fielding	Leeds-Grenville Mental Health	Board Chair
Perth and Smiths Falls District Hospital		
Beverley McFarlane	Perth & Smiths Falls District Hospital	President & CEO
Richard Schooley	Perth & Smiths Falls District Hospital	Board Chair
Wayne Johnson	Perth & Smiths Falls District Hospital	Board Member
Warren Hollis	Perth & Smiths Falls District Hospital	Board Member
Donna Howard	Perth & Smiths Falls District Hospital	Board Member
Dennis Staples	Perth & Smiths Falls District Hospital	Board Member
Tom Belton	Perth & Smiths Falls District Hospital	Board Member
Bruce Rigby	Perth & Smiths Falls District Hospital	Board Member
John Hewitt	Perth & Smiths Falls District Hospital	Board Member
Gardner Church	Perth & Smiths Falls District Hospital	Board Member
Dr. Peter Cunniffe	Perth & Smiths Falls District Hospital	Co-Chair Health Link Steering Committee
Rideau Community Health Services		
Graeme Bonham-Carter	Rideau Community Health Services	Board Member
Tom Rankin	Rideau Community Health Services	Board Chair
Jan Hopkins	Rideau Community Health Services	Board Secretary
Don Dutton	Rideau Community Health Services	Board Treasurer
Wendy Quarry	Rideau Community Health Services	Board member
Wynn Turner	Rideau Community Health Services	Board Vice-Chair
Peter McKenna	Rideau Community Health Services	Executive Director
Christina Dolgowicz	Rideau Community Health Services	Board Member
Maureen McIntyre	Rideau Community Health Services - Health Link	Project Manager
Kelly Barry	Rideau Community Health Services - Health Link	Patient & Provider Engagement Lead
Smiths Falls Nurse Practitioner Led Clinic		
Ruth Kitson	Smiths Falls Nurse Practitioner Led Clinic	Board Chair
Nancy Unsworth	Smiths Falls Nurse Practitioner Led Clinic	Executive Director
Lee Ann Brennan	Smiths Falls Nurse Practitioner Led Clinic	Nurse
South East Community Care Access Centre		
Carol Ravnaas	South East Community Care Access Centre	Senior Director, Strategic Partnerships
Wendy Cuthbert	South East Community Care Access Centre	Board Member
David Vigar	South East Community Care Access C	Board Chair

Jackie Redmond	South East Community Care Access Centre	CEO
Jennifer Spencer	South East Community Care Access Centre	Care Coordinator CCAC
Tri-County Addiction Services		
Helen Clarke-Hanna	Tri-County Addiction Services	Board Chair
Caitlin Carter	Tri-County Addiction Services	Board Secretary-Treasurer
South East Local Health Integration Network		
Janet Cosier	SE LHIN	Board Member
Donna Segal	SE LHIN	Board Chair