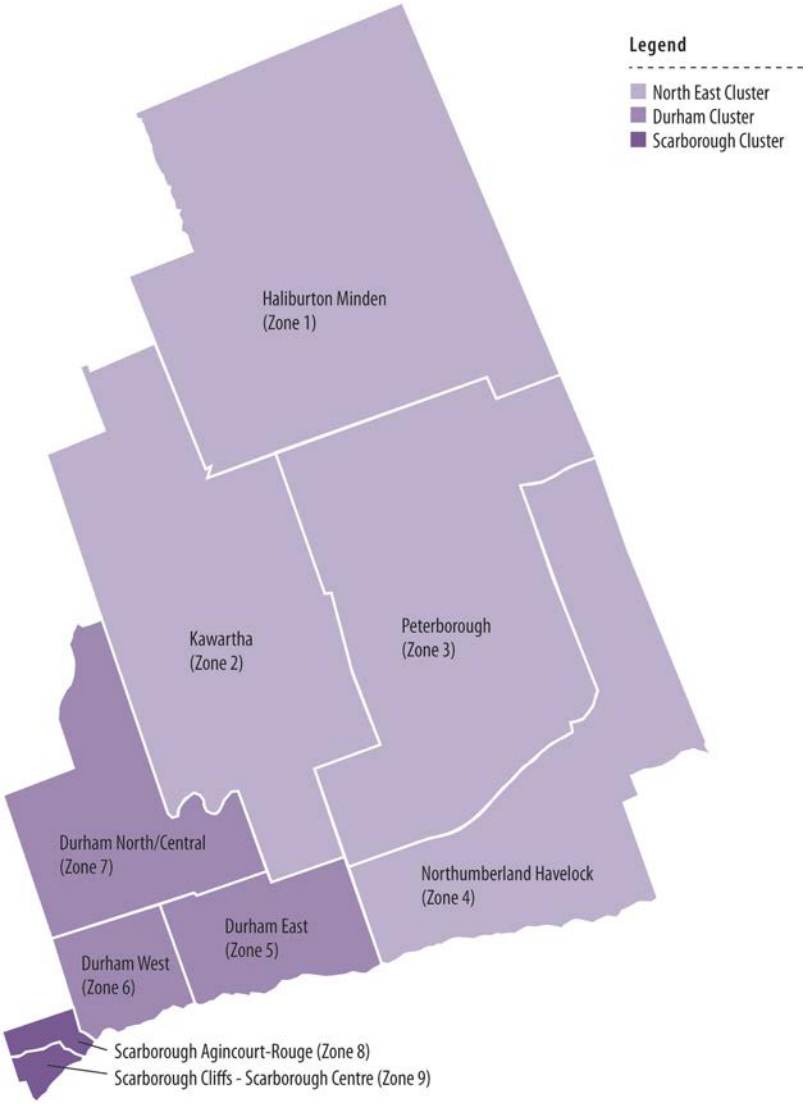
Central East **LHIN**

A Year in Review

Engaged Communities. Healthy Communities.
Central East LHIN 2012-13 Annual Report

Ontario
Local Health Integration Network

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)



The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the seventh Annual Report for the LHINs with their full authorities.

For more information about LHINs, including frequently asked questions, visit the Central East LHIN web site at www.centraleastlhin.on.ca.

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MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report – "A Year in Review" – takes its title from a report presented to the Central East LHIN Board at the end of 2012/13 in which a month by month snapshot of initiatives and programs highlighted the progress made by the system in providing an integrated sustainable healthcare system to the residents of the Central East region that ensures better health, better care, better value for money.

Being a critical part of the evolution of health care in Ontario, LHINs are continuing to work with their communities to develop a quality system that is patient-focused, results-driven, integrated and sustainable.

In 2012/13, the Central East LHIN did not hold its annual Symposium, to update the system on progress against its two strategic aims contained in the 2010/2013 Integrated Health Service Plan (IHSP), in recognition of the difficult financial situation facing the Ontario government. Instead the Board of the Central East LHIN passed a motion to defer the event and directed staff to continue to utilize the most cost-effective and accessible methods of engaging with stakeholders and communities as the LHIN and these groups worked together on delivering high quality care for local residents.

This year's annual report once again demonstrates how LHINs are facilitating effective and efficient integration of health care services, thus making it easier for people to get the best care in the most appropriate setting, when they need it. The Central East LHIN has continued to realize this mandate through community engagement, local health system planning, funding and allocation, and accountability and performance management.

During this last year of the LHIN's 2010-2013 Integrated Health Service Plan (IHSP), the system goals which were articulated by the government – improve access to emergency department care by reducing the amount of time that patients spend waiting in the emergency department, improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds and improve access to integrated diabetes care – continued to guide the work of the local healthcare system.

These system goals had been translated into the LHIN's two Strategic Aims - *Save 1,000,000 hours spent by patients in hospital Emergency Departments by 2013 and Reduce the impact of Vascular Disease by 10% by 2013* – and this Annual Report documents how these aims were achieved.

As always we would like to thank the hundreds of health service providers – doctors, nurses, allied health, support staff, administrators and volunteers – who dedicate themselves to their patients, clients, consumers and their families.

With their support we were able to implement many of the innovative programs detailed in this report. We look forward to sharing updates, via our communication and engagement activities, on our collective progress in the coming months and years.

Original Signed By

Wayne Gladstone,
Chair

Original Signed By

Deborah Hammons,
Chief Executive Officer

MEMBERS OF THE BOARD

Front Row

Margaret Risk, Member
Term of Office:
May 17, 2011 – May 16, 2014

Wayne Gladstone, Chair
Term of Office:
June 2, 2010 – June 1, 2011 (Member)
June 2, 2011 - June 14, 2013 (Chair)

Second Row

Valmay Barkey, Member
Term of Office:
June 2, 2011 – June 1, 2014

David Sudbury, Member
Term of Office:
June 17, 2010 – June 16, 2013

Third Row

Chuck Powers, Member
Term of Office:
June 2, 2011 – June 1, 2014

Samantha Singh, Member
Term of Office:
June 17, 2010 – June 16, 2013

Fourth Row

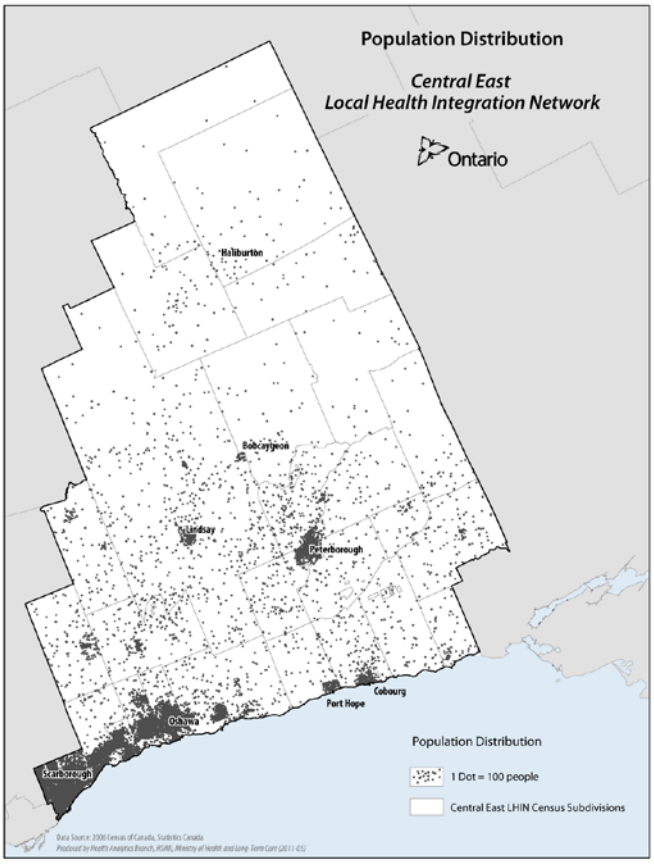
Joanne Hough, Member
Term of Office:
May 4, 2011 – May 3, 2014

David Nichols, Member
Term of Office:
February 17, 2010 – February 16, 2013
Resigned:
December 1, 2012

The governance structure for the LHINs is set out in the Local Health System Integration Act, 2006. LHINs operate as not-for-profit organizations governed by a board of directors appointed by the province. Each LHIN has a maximum of nine board members appointed by the Lieutenant Governor in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and at least one Vice-Chair from among the members. The board of directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The board may pass by-laws and resolutions and may establish committees. Certain by-laws may require the Minister's approval. Details on the Central East Board of Directors can be found on the Central East LHIN web site at: http://www.centraleastlhin.on.ca

INTRODUCTION

Population Map



The Central East LHIN is one of 14 Local Health Integration Networks that have been established by the Government of Ontario as community-based organizations to plan, co-ordinate, integrate and fund health care services at the local level including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres.

In 2011, the Central East LHIN had the second highest population within the Province accounting for 11.8% of the population of Ontario. Between 2006 and 2011, Central East LHIN's population has increased by 5.5% which is similar to the provincial growth rate. Between 2011 and 2016, the population is expected to increase by 8.2% and by 2021 the population will have increase by 17.0%. Ontario's population projection is expected to increase by 13.0% for the same time period. In 2011, over 14% of Central East LHIN's population were seniors aged 65 years and over. By 2016, seniors will account for 16% of the LHIN's population and by 2021, it will be 18%. Population projections from 2008/2013 (five year projection) indicate that there will be a six percent growth with year-to-year incremental increases of 1% to 1.3%.

The LHIN includes the eastern section of the city of Toronto (i.e., Scarborough). This area accounts for approximately 42% of the LHIN's population. Oshawa, Whitby, Pickering, and Ajax together account for an additional 30% of LHIN residents. In 2006 just over 70% of the LHIN's population reported English as their mother tongue, and only 1.4% of the population included French as their mother tongue. In 2006, a third of the population in the LHIN were immigrants – 5.6% were recent immigrants, having arrived in Canada between 2001 and 2006.

Socio-Demographic Characteristics, Central East LHIN			
	Central East LHIN	Ontario	Comments
Population, 2011 (MinFin)*	1,572,453	13,372,996	2nd largest*
Senior Population, age 65+	14.4%	14.2%	13.7% in the Scarborough Cluster to 20.3% in the North East Cluster
Population with English mother tongue	72.1%	69.8%	
Population with French mother tongue	1.4%	4.4%	
Population who are immigrants	33.3%	28.3%	
Population who are recent immigrants (2001-2006)	5.6%	4.8%	
Population who are visible minorities	34.5%	22.8%	
Population of Aboriginal identity	1.2%	2.0%	
Labour force participation (15+)	65.6%	67.1%	
Unemployment rate, 2011 (age 15+)	10.0%	7.8%	2nd highest LHIN
Population in low income	16.1%	14.7%	3rd highest LHIN
Without certificate/degree/diploma (aged 25-64)	13.6%	13.5%	
Completed post-secondary education (aged 25-64)	59.2%	61.4%	

**** (MinFin) Ministry of Finance estimates and projections*** ***Source: IHSP 2013-2016 – Common Environmental Scan***

MINISTRY/LHIN PERFORMANCE AGREEMENT (MLPA)

What is an MLPA?

The Central East Local Health Integration Network (Central East LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed a performance agreement which defines the obligations and responsibilities of both the LHIN and the Ministry over a defined period of time. The Ministry/LHIN Performance Agreement (MLPA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and Reporting. The MLPA is mirrored in the Accountability Agreements that LHINs have now negotiated with all health service providers.

MLPA Performance Indicators

The *Ministry-LHIN Performance Agreement* sets out the mutual understandings between the Ministry of Health and Long-Term Care and the Central East LHIN of their respective performance obligations in the period covering the 2012/13 fiscal year. The following table outlines Central East LHIN's performance against targets for 2012/13.

Central East LHIN MLPA Performance Indicators 2012/13

Performance Indicator	LHIN Starting Point 12/13	LHIN Performance Target – 12/13	Most Recent Quarter 2012/13 LHIN Performance	FY 2012/13 LHIN Annual Result
Emergency Room/Alternate Level of Care				
1. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	**17.35%**	15.20%	15.00%	**13.48%**
2. 90th Percentile ER Length of Stay for Admitted Patients	**44.53**	36.00	34.45	**33.72**
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	**6.83**	7.00	6.13	**6.45**
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	**4.33**	4.00	4.10	**4.13**
Surgical Wait Times				
5. 90th Percentile Wait Times for Cancer Surgery	**47**	49	42	**48**
6. 90th Percentile Wait Times for Cardiac By-Pass Procedures	**NA**	NA	NA	**NA**
7. 90th Percentile Wait Times for Cataract Surgery	**114**	135	109	**101**
8. 90th Percentile Wait Times for Hip Replacement	**163**	179	141	**130**
9. 90th Percentile Wait Times for Knee Replacement	**166**	179	154	**145**
Diagnostic Wait Times				
10. 90th Percentile Wait Times for Diagnostic MRI Scan	**83**	83	52	**70**
11. 90th Percentile Wait Times for Diagnostic CT Scan	**23**	28	15	**20**
Excellent Care for All/Quality				
12. Readmission within 30 Days for Selected CMGs**	**15.74%**	14.90%	16.56%	**16.02%**
Mental Health and Substance Abuse				
13. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	**18.66%**	17.00%	20.11%	**18.59%**
14. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	**21.87%**	19.60%	22.66%	**23.87%**
Access to Community Care				
15. 90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)*	**56**	46	28	**29**

Note:
***FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 - Q3 2012/13) due to availability**
****FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 - Q2 2012/13) due to availability**

At the end of 2012/13, the Central East LHIN was able to **achieve thirteen of the fourteen performance targets** identified in its MLPA. A description of these thirteen targets and an explanation for the achievements follows:

Performance Indicator #1 – TARGET MET
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:
This improvement was for the most part due to the ongoing implementation of the Home First philosophy across all Central East LHIN hospitals. Home First is designed to reduce the overall volume of ALC designated patients at every hospital, and this reduction in cases has resulted in a reduction in %ALC. This reduction has also been supported by investments in post-acute capacity such as home care, rehabilitation services and assisted daily living programs.

Performance Indicator #2 – TARGET MET
90th Percentile ER Length of Stay for Admitted Patients
The limiting factor for the flow of admitted patients through the hospital is inpatient capacity. But as the business processes involved in Home First were embedded and sustained at each Central East LHIN hospital, the overall volume of ALC patients was reduced, thus increasing the capacity available to inpatients waiting in the ED. Central East LHIN continued to focus on system-wide flow as described in the Central East Home First business processes (admission avoidance, patient activation, early engagement of CCAC and CSS, and prompt discharge of patients back into the community) to meet this target.

Performance Indicator #3 – TARGET MET
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients
Nine of the 13 hospitals operating Emergency Departments in the Central East LHIN are designated P4R (Pay for Results) hospitals. Enhanced staffing and process improvements provided through this funding stream have led to maintained Emergency Department times for high acuity patients that meet the reduced provincial target of 7 hours.

Performance Indicator #4 – TARGET MET
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients
Combined with the initiatives referenced above, the LHIN continued to monitor performance and to work collaboratively with the hospitals by providing specific recommendations regarding opportunities to improve performance on this indicator.

Performance Indicator #5 – TARGET MET
90th Percentile Wait Times for Cancer Surgery
Sustained and continuing efforts to engage with hospitals and their leadership in 2012/13 on Data Quality Improvement Initiatives meant that the Central East LHIN met this performance indicator and exceeded the target. This engagement included ongoing meetings with the LHIN sponsored Wait Times Strategy Working Group in order to discuss, identify and resolve pressures/risks, identify volumes for reallocation, as well as to share best practices. The Central East LHIN fully implemented SUBMIT in June 2012 to assist with the management of wait times and incorporating this Wait Time Performance Indicator into each hospital's Accountability Agreement, with specific negotiated targets, ensured that efforts were undertaken to improve performance.

Performance Indicator #6 – TARGET N/A
90th Percentile Wait Times for Cardiac By-Pass Procedures
Not Applicable

Performance Indicator #7 – TARGET MET
90th Percentile Wait Times for Cataract Surgery
As noted above, significant engagement, the implementation of SUBMIT and incorporating this Wait Time Performance Indicator into each hospital's Accountability Agreement has led to the Central East LHIN meeting and exceeding this target in 2012/13. Funding for an additional 865 cases also supported the system in achieving this result.

Performance Indicator #8 – TARGET MET
90th Percentile Wait Times for Hip Replacement
Similar to Cancer Surgery – see text above.

Performance Indicator #9 – TARGET MET
90th Percentile Wait Times for Knee Replacement
Similar to Cancer Surgery– see text above.

Performance Indicator #10 – TARGET MET
90th Percentile Wait Times for Diagnostic MRI Scan
As noted above, the Central East LHIN implemented a Wait Times Strategy Working Group WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices. A second Diagnostic Imaging (DI) Working Group looks at systemic issues that affect wait times, such as the education of primary care physicians, radiologists, referral patterns and protocolling best practicess. Together the hospitals and Central East LHIN implemented ongoing data quality improvement initiatives and wait time performance indicators were incorporated into the H-SAAs with hospital-specific negotiated targets. Volumes are allocated among hospitals to optimize wait time performance and unmet volumes are reallocated to hospitals that have additional capacity on an ongoing basis. In January 2013, the LHIN provided $1,037,920 to purchase an additional 3,992 MRI hours to assist with wait time reduction and in mid-March, an additional 2,500 incremental MRI hours were allocated through the Wait Time Strategy for the remaining two weeks of 2012/13. Together these strategies and initiatives supported the LHIN in meeting this performance target.

Performance Indicator #11 – TARGET MET
90th Percentile Wait Times for Diagnostic CT Scan
Similar to Diagnostic MRI Scan – see text above.

Performance Indicator #12 – TARGET MET
Readmission within 30 Days for Selected CMGs
The Central East LHIN facilitated the collaboration of vascular health leads across the region to draft priorities to address reducing avoidable hospital readmission for selected vascular related CMGs. As part of these priorities, an implementation plan was established to create short-term and long-term stretch goals that align with the Central East LHINs Vascular Strategic Aim of saving 10,000 days by 2013. Incorporating education programs into the vascular priorities of the Central East LHIN for both professionals and patients in smoking cessation, diabetes management and rehabilitation for both stroke and cardiac and heart failure, alongside self-management and self-management support, identified the need for better communication initiatives between primary and tertiary HSPs. The Diabetes Regional Coordination Centre alongside the Central East LHIN facilitated a Value Stream mapping event in April 2012, and the outcomes were evaluated to include centralized intake as a core quality process improvement in diabetes health services. All but two Health Service Providers surpassed their Chronic Obstructive Pulmonary Disorder (COPD) and Congestive Heart Failure (CHF) targets after one hospital conducted a substantial "refresh" to external Health Care Providers who also refer to the comparative hospital in the same Cluster that provides a Heart Failure Clinic. With specific indicators in place to measure Quality Improvement Plans for hospitals in the region, this measurement was closely investigated as integral to several other intermediate outcomes in improvements including: the quality of care, communication back to Primary Care Providers and coordination both within individual HSPs and inter-HSP collaboration regarding transitions in care for vascular CMGs.

Performance Indicator #13 – TARGET MET
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
Implementation of the Hospital to Home (H2H) program in 2012/13 along with a focus on quality improvement supported efforts in this domain, showing the benefit of the additional investments made in late 2011/12 in expanding and coordinating crisis support services provided by the community and hospital partners. The Schedule 1 Bed Registry, implemented in 2012-13, helped to reduce time spent in the ED by providing those who require a Schedule 1 Bed with more timely access.

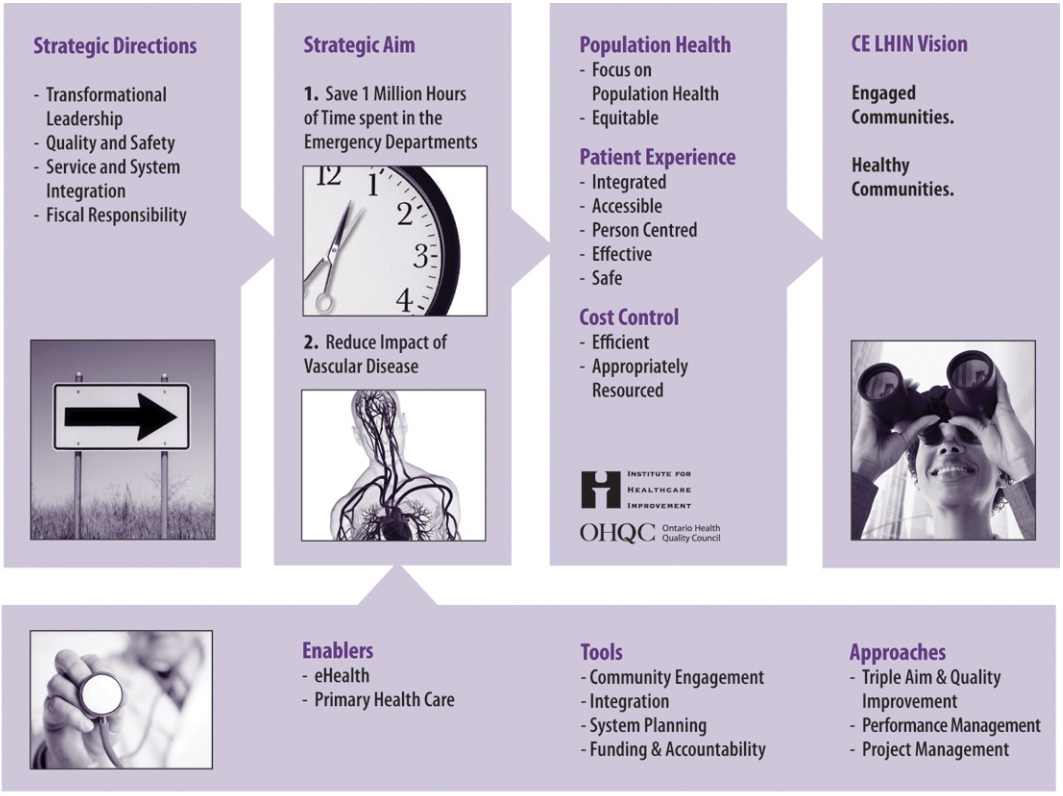
Performance Indicator #15 – TARGET MET
90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)
The Central East CCAC continued to support the LHIN and health system focus on the reduction of hospital utilization and to that end, continued to experience high hospital referrals with many clients referred from the hospital, both inpatient and emergency departments, having high needs and therefore having a shorter wait time between referral and first service. The CCAC worked with its Community Support Services partners to transfer clients from existing CCAC Personal Support services to six Assisted Living for High Risk Seniors Programs

At the end of 2012/13, the Central East LHIN was **unable to achieve one of the fourteen performance targets** identified in its MLPA. A description of this one target and an explanation for the variance follows:

Performance Indicator #14 – TARGET UNMET
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions
With only two quarters reported, we do not have a full picture of Repeat Unscheduled Emergency Department visits for Substance Abuse in 2012-13. But based on the data available, the Central East LHIN performed on average with the Greater Toronto Area LHINs. The implementation of the Hospital to Home (H2H) program, referenced above, was expected to reduce the unscheduled return visits for Addictions but it will be the Opiate Strategy, which came online in Q4 of 2012/13, which will have the greater impact. The Opiate Strategy will pay particular attention to vulnerable populations such as aboriginals and in those areas of the LHIN where the numbers of methadone registration is high.

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN (IHSP)

The Central East LHIN Strategy Map, which was included in the IHSP, highlights how the LHIN's strategic directions of Transformational Leadership, Quality and Safety, Health Service and System Integration and Fiscal Responsibility provide the basis for decision making that leads to a high performing system that achieve the vision of *Engaged Communities, Healthy Communities* and the LHIN's two Strategic Aims - *Save 1,000,000 hours spent by patients in hospital Emergency Departments by 2013* and *Reduce the impact of Vascular Disease by 10% by 2013.*



Implementation of the IHSP

Below are just a few of the exciting initiatives and accomplishments that happened in 2012/13 during the implementation of the third year of the 2010-2013 IHSP.

As of March 31, 2013 the system had collectively saved 512,274 hours of time that people would have spent waiting in local Emergency departments and 44,063 inpatient days for vascular conditions far surpassing the goal of 10,000 days. These achievements and successes are a credit to the thousands of physicians, nurses, front line staff, administrators, volunteers, community leaders, patients/clients/consumers/residents, caregivers and local community residents who continue to share their stories and their expertise to create an integrated sustainable healthcare system that ensures better health, better care, better value for money.

April 2012

- On April 1, 2012, the VON Toronto-York Region and Scarborough Centre for Healthy Communities (SCHC) officially declared the successful and complete transfer of ***hospice visiting services***. This culminated in transitioning 15 clients and their respective volunteers to the newly formed SCHC program. Congratulations to both partners for all their efforts in this transition process and for their commitment to quality care!
- An ***electronic Schedule 1 Bed Registry and implementation of Common Assessment Tool*** was in place by April 1, 2012. This allows health service providers to see, at a glance, where ***inpatient mental health beds are available and to share information that supports a collaborative model of care.***
- The Durham Cluster Community Health Services Integration Planning Team (IPT) held their first facilitated integration meeting and began the process of designing ***a cluster-based service delivery model for Community Support Services and Community Health Centres***. At the same time, the governors from CMHA-Peterborough and CMHA-Kawartha Lakes struck a Management Integration Team as they began the transition work for their ***new community mental health service model in the North East Cluster.***
- Front line staff from "early adopter" long term care homes began fanning out to other long term care homes in the Durham cluster to provide training for their colleagues on how to deal with residents with challenging behaviours. This was just one part of the ***Behavioural Supports Ontario (BSO)*** project in the Central East LHIN.

May 2012

- The May 3rd Strategic Planning Day with the ***Ontario Renal Network*** highlighted the amazing work underway across the LHIN for the delivery of home hemodialysis, peer support, chronic kidney disease planning and multidisciplinary teams providing care.
- Numerous presentations both locally and across Canada highlighted the new SUBMIT tool. The ***Surgical Utilization Booking Management Integration Tool (SUBMIT)*** is a web-based project geared to improve patient Wait List management and Wait Times reporting for surgeons and hospitals in the Central East LHIN when booking surgical procedures for their patients and scheduling OR time. By moving from a paper based system to an electronic system, ***costs were reduced by over 40%.***
- The Central East Mental Health and Addictions Network was asked to work on an aim for Mental Health and Addictions as ***engagement began on the development of specific aims to be included in the LHIN's 2013-2016 Integrated Health Service Plan*** (IHSP). Similar outreach to the LHIN's Regional Specialized Geriatrics Service entity, the Central East Hospice and Palliative Care Network and the Vascular Health Coalition has ensured that aims were developed for these four priority populations.

- A ***Haliburton County Integration Planning Team*** held its first meeting in May. Similar to the Durham process that started in April, the Haliburton County IPT were asked to develop a new service model for the delivery of community based health services but this time with input from the local hospital, family health team and the Community Care Access Centre.
- On May 24, 2012 the Ministry of Health and Long-Term Care announced the development of its ***Seniors Care Strategy*** which is focused on helping seniors to stay healthy and live at home longer. Dr. Samir Sinha was appointed as the expert lead for the strategy. Dr. Sinha is the Director of Geriatrics at Mount Sinai and the University Health Network and is Chair of the Health Professionals Advisory Committee with the Toronto Central LHIN. A list of recommendations will be provided to the Ministry of Health in the fall of 2012 addressing how to help more seniors live independently at home and in their community.

June 2012

- On June 1, staff from the Central East LHIN met with the office of the Minister of Francophone Affairs, the French Language Commissioner's office, the Entity and other LHINs to discuss the Minister of Francophone Affair's role, mission and mandate and to discuss their responsibility and the ***role of the LHINs and the Entity in providing French Language Services***.
- The Timely Discharge Information System (TDIS) was developed to ensure family doctors and other community physicians receive the information concerning a patient's hospital stay within 72 hours of transcription from the hospital. By June, ***over 150 physicians were receiving discharge summaries and other reports into their clinical management systems*** (CMS) via TDIS and more than 10,000 reports were being accessed on a monthly basis. Early feedback supported the fact that clinicians were better able to make timely and informed decisions for patient care.
- LHIN staff were continuing to work with all Central East LHIN hospitals as the deadline got closer for signing the annual ***Hospital Service Accountability Agreements*** by July 1st. Accountability agreements detail what types of volumes of services hospital are contracted to deliver and how performance will be measured in return for annual funding from the LHIN/Ministry of Health and Long-Term Care and aligned with the LHIN's IHSP and Strategic Aims. In the coming year the new ***Health System Funding Reform (HSFR),*** which includes Patient Based Funding, will have a significant impact on how the system is organized and volumes allocated for specific clinical procedures and in June the hospitals were looking at the allocation of current and future cataract volumes.
- The ***Assisted Living for High Risk Seniors program*** offered by Community Care Durham (CCD) in Oshawa and Whitby and the VON in Scarborough, north Durham, Peterborough and Lakefield was continuing to make positive impacts in the health status of the clients being served. Clients with limited informal/family supports rely on the regular services and care provided by the PSWs and allows the Community Care Access Centre to focus their resources on providing enhanced services for patients being discharged from the hospitals.
- The new CMHA in the North East cluster chose its new name: ***CMHA: HKPR*** Serving the Counties of Peterborough, Haliburton, Northumberland and the City of Kawartha Lakes and Brock Township. The organization also determined its new staffing and service delivery structure as it headed towards its official launch in April 2013.

July 2012

- On July 30th the first of five OTN-supported ***"Doc Talks"*** was held as the Central East LHIN's Primary Care Physician Leads Dr. Robert Drury and Dr. Christopher Jyu talked to doctors and other primary care providers about Mental Health and Addictions. Four other sessions, to be held by the end of October, focused on other priority populations as development continued on the LHIN's 2013-16 IHSP.
- The Regional Diabetes Coordinating Centre received approval from the MOHLTC Diabetes team to proceed with planning and implementation of ***centralized intake for diabetes education programs*** across the LHIN.
- The 2013-17 ***Long-Term Care Service Accountability Agreement (L-SAA) process*** officially launched and a Steering Committee was established with representation from the Ontario Long Term Care Association (OLTCA), Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), Ontario Hospital Association (OHA), Association of Ontario Municipalities (AMO), as well as representatives from three LHINs and one from the MOHLTC. Chaired by the Central East LHIN CEO Deborah Hammons, together the group began developing performance targets to be included in the next funding and accountability agreement for all long-term care homes in the province.
- By July, the free ***"Living a Healthy Life" self-management workshop*** had been delivered to local residents and caregivers over 25 times with the focus on chronic pain and diabetes. These workshops reflected the strong demand for self-management workshops in these areas. Staff of this CE CCAC program had partnered with the Ontario Pharmacists Association to provide the course to pharmacists, with the Town of Ajax and the local Welcome Centre to hold sessions and was starting to talk to the YMCA in Scarborough and Northumberland about holding sessions in those communities too.
- ***Over $2 million*** was allocated to local hospitals and community agencies to fund programs that focus on supporting seniors to be safely discharged from hospital to home. This included Ross Memorial Hospital's ***Assess and Restore Expansion***, Campbellford Memorial Hospital's ***Transitional Care/Assess and Restore Model***, VON Durham's and the Canadian Red Cross – Peterborough's ***Assisted Living for High Risk Seniors*** programs and ***Home First Service Enhancements*** co-ordinated by Community Care Durham.

August 2012

- The new Regional Manager for the LHIN's ***Geriatric Assessment and Intervention Network Clinics (GAIN)*** was hard at work supporting the GAIN Nurse Practitioners (NPs) in developing an orientation package for new GAIN NPs, streamlining administrative tasks and documenting the process that local physicians and emergency room staff use to refer seniors to the GAIN clinics in The Scarborough Hospital – General site, Rouge Valley Centre, Lakeridge Health Oshawa and Peterborough Regional Health Centre.
- Local residents in the Durham cluster ***were asked to provide their feedback*** on the current community based health services as the Durham Cluster Community Health Services Integration Planning Team continued their work. A check in meeting with the 10 organizations' governors in late August ensured that they were kept up to date on the work and next steps.
- In mid-August, LHINs received a formal briefing note from the MOHLTC confirming the allocation of ***Nurse Practitioner (NP) palliative care positions*** to enhance palliative care, facilitate care connection across sectors and promote continuity of care for complex high risk individuals. This funding helped support the Community Palliative NP program expansion across the Central East LHIN as initially set out in the Central East Hospice Palliative Care Network Steering Committee project plan and associated project status reports.

- A new system, introduced in August, ensured that each time the Central East LHIN launches a web alert to the website subscribers, ***an active offer of French*** goes along with the message to direct all interested recipients to the French Language Services Coordinator for information en Français.
- Carefirst Seniors was selected to develop and implement an '***Ontario Needs Assessment' for Chinese Ontarians living with Heart Disease***. Five focus groups with patients/caregivers who speak Mandarin and Chinese and additional health care provider focus groups, surveys and phone interviews supported this work.

September 2012

- The proposed "Community First" aim for the LHIN's 2013-2016 Integrated Health Service Plan (IHSP) was shared with stakeholders – ***Help Central East LHIN residents spend more time in their homes and their communities.*** By improving service provision in the community, the Central East LHIN's IHSP aims to reduce: demand for long-term care for seniors; the impact of vascular disease; the need for hospital-based care for mental health and addictions; and the number of patients that receive palliative care in the hospital when they would prefer to spend their time at home.
- Engagement on the IHSP aims also included meetings with the ***Central East LHIN First Nations Health Advisory Circle and Central East LHIN Métis, Non-Status Circle***, two very important planning partners teams first formally established in the Central East LHIN in 2010.
- Staff from Lakeridge Health's Pinewood Addiction program continued to work with their colleagues at The Scarborough Hospital and other Scarborough-based agencies to expand the level of local addictions services to include a ***community-based substance abuse withdrawal program, integrated opioid treatment response and programs for pregnant and parenting women with addictions.***
- ***Nine new specialized Mental Health Nurses in schools*** were hired by the CECCAC to support local students who are returning from hospitalization to school.
- Funding was provided to Haliburton Highland Health Services to support ***a dedicated palliation bed at the HHHS Haliburton site*** to provide best practice care for individuals and their families at end-of-life who are not able to stay at home.
- At the September Board meeting, staff provided an update on ***health system performance trends*** from fiscal 2009/10 to July 2012. The highlight of the report was that the system - hospitals, the community care access centre, community support service agencies, community health centres, community mental health and addiction agencies, long term care homes - had ***met 12 out of 13 performance targets***, a testament to the thousands of dedicated health care providers, volunteers, board members, patients, caregivers and the general public who understand the value of working together as a system.

October 2012

- An investment of over $1.4 million by the LHIN supported the recruitment of ***20 new telemedicine nurses in hospital and community settings***. Using the Ontario Telemedicine Network (OTN) these nurses will be able to provide clinical care in close to home settings, using the OTN equipment to link patients and clients with specialists and other providers from across the LHIN and the province.
- The Central East LHIN was excited to be identified as an ***early adopter LHIN for implementation of the Ontario Integrated Vascular Health Blueprint***. The Blueprint's vision is directly aligned with the Central East LHIN's 2013-2016 IHSP aim of continuing to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
- The ***Health Care Connects (HCC) program*** was launched in February 2009 to support the placement or 'connection' of individuals without a primary care provider with a comprehensive primary care practice.

By October 31st, over 19,000 residents had been referred to a primary care provider with 73% of them living within 10 km of the provider they were referred to.

November 2012

- The Minister of Health and Long-Term Care – the Honorable Deb Matthews - visited The Scarborough Hospital on November 8th to announce and highlight the full operations of the ***Central East LHIN Centre for Complex Diabetes Care (CCDC)*** at The Scarborough Hospital General site, Peterborough Regional Health Centre and Lakeridge Health - Whitby. The CCDC program, which is co-ordinated by the Central East Community Care Access Centre, provides ***a patient-centered approach to care for individuals with diabetes and complex health requirements***. The CCDC team works collaboratively with primary care providers to support effective coordination and delivery of diabetes services.
- Community Engagement continued to be the foundation of all activity at the Central East LHIN. Being more responsive to local needs and opportunities requires ongoing dialogue and planning with those who use and deliver health services. Engagement with a wide range of stakeholders conducted at various levels includes informing and educating; gathering input; consulting; involving and empowering. In November, this included ***a significant number of presentations to local municipal councils*** on the LHIN's 2013-2016 IHSP and the system's "Community First" aim.
- The LHIN launched a ***regional orthopaedic and rehabilitation planning process*** with hospital and medical leaders and the CECCAC. The goal was to develop a plan that focused on access, quality and value for money and is implementation ready in fiscal year 2013-14.
- Given changes to the Central East LHIN's ***Community Health Services Integration Strategy*** approved by the Board at its November meeting, efforts focused on leveraging the significant work completed by the Haliburton County CHS facilitated integration planning team with a retooled process that adds the health service providers in Kawartha Lakes. On November 30, 2012, a teleconference was held with staff and some governance liaison members of all participating agencies in the Haliburton County integration planning process to fully inform them of the changes and field questions and concerns they had.

December 2012

- Following a comprehensive ramping up process, ***Home First was launched at Ontario Shores on December 3, 2012***. A Community Partners meeting was held on December 5 to consider two examples of some of the very complex people who are awaiting discharge from Ontario Shores. This community participation and buy in is crucial, since these are the services that will provide the discharge destinations for Ontario Shores clients. The meeting was an important step in developing and enhancing the relationships between Ontario Shores and the community.
- During the month of December the LHIN asked for Expressions of Interest for membership for the establishment of the ***Central East LHIN Maternal Child Youth Advisory Committee***. This committee functions in an advisory capacity, providing leadership to all relevant health service providers, partners, key stakeholders, including the Provincial Council Maternal Newborn Health (PCMCH) and the Central East LHIN to support the adoption of evidence-based practice with the goal of improving the health of mothers and newborns. The overall role of the Advisory Committee is to promote standardization, implementation of evidence and best practices within women's and children's programs.

January 2013

- The Central East LHIN, in collaboration with Drs Howard Burke, Larry Erlick and Scott Allan organized a ***Learning Essential Approaches to Palliative Care (LEAP) for physicians, medical student residents, Nurse Practitioners (including hospital and community) and Palliative Pain and Symptom Management Consultants***. The eleven-module course offered learning on Palliative Pain Management, Grief and Bereavement, Working as a Team and much more.
- ***A DRAFT Service Delivery Model for Community Health Services in the Durham Cluster*** was shared with local stakeholders for feedback. Stakeholders were advised of their opportunity to review the DRAFT Service Delivery Model and complete a survey through each organization and the Central East LHIN website (news release, blast email, web-posting and web-alerting). Feedback was accepted through hard-copy submission or via completion of a web-enabled survey on the Central East LHIN website. The survey was also distributed by IPT members to their own internal and external stakeholders (i.e. staff, clients/caregivers, agency partners, third party funders).
- An ***Assisted Transportation Model – Scarborough Ride*** to support clients displaced by changes in the TTC Wheel Trans eligibility got underway in January 7 with approximately 15 drivers from the Scarborough Ride partners meeting the staff at The Scarborough Hospital's Regional Dialysis Program and satellites to start an orientation process.
- Preliminary negotiations of each hospital's ***Service Accountability Agreement*** were completed in January and despite operating in an environment of uncertainty based on unknowns stemming from the Health System Funding Reform, Quality Based Procedures and Health Links, the hospitals tackled the task of projecting a balanced budget with minimal service adjustments for 2013/14.
- The Rehabilitation Services Task Group held their kick-off meeting on January 8th as the group began examining how to ***best improve the delivery of rehab care for musculoskeletal patients*** in the Central East LHIN.
- The first meeting of the Central East LHIN Local Partnership (LP) was held in January to help support the successful implementation of ***Health System Funding Reform (HSFR)***. With membership from the hospitals, the CECCAC and long-term care – including clinical and program leadership, financial leadership, clinical health informatics and decision support and quality and performance improvement staff – the LP will help coordinate a supportive change management environment locally and across Ontario.

February 2013

- Discussions continued amongst the orthopaedic surgeons and administrative leads who sit on the LHIN's Orthopaedic Surgical Task Group on the principles of ***how and where orthopaedic care will be provided in the future for all orthopaedic procedures***. Decision Support and System Finance and Performance Measurement staff have played an important role in providing information on past reallocation methodology, future need projections and analysis of current patterns of orthopaedic procedures. Development on the future state model continued to be included in the final recommendations to be presented to the LHIN Board in March.
- The ***Peterborough Health Links*** initiative began focusing their efforts on two priorized patient cohorts as they continued to work on greater collaboration and co-ordination to improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers.

- The Durham Community Health Services Integration Planning Team shared the ***Final Integration Plan*** with their respective boards and the general public on February 12th. The plan moved through each HSP Board for local decision making before heading to the Central East LHIN Board in March 2013.
- To support the transfer of accountability for Diabetes Education Programs to LHINs and as a result of the province-wide closure of the Diabetes Regional Coordinating Centres, the Central East LHIN was pleased to welcome the ***new Diabetes/Vascular staff team*** who joined the LHIN organization during February and March 2013.

March 2013

- The integration of the Canadian Mental Health Association, Peterborough and Kawartha Lakes Branches was now complete. Central East LHIN staff attended a celebration and team building event at the Peterborough Navy Club on March 25, 2013. The full incorporation process was completed on April 1, 2013. Congratulations to the Board and staff at the ***newly constituted Canadian Mental Health Association Haliburton Kawartha Pine Ridge (HKPR)*** on their accomplishment in successfully completing this integration project. A new M-SAA for 2013/14 has been executed for this agency.
- A report on the sustainability of the Central East LHIN's Behavioural Supports Ontario (BSO) project was posted on the LHIN website detailing how health service providers from across the LHIN will continue to build capacity in caring for people with challenging behaviours. Over 180 front line staff received BSO training in March bringing ***the total number of staff from long-term care homes, hospitals and community agencies who received training to respond to residents and clients with behavioural issues to well over 1400 in fiscal 2012/13***.
- ***Residential Hospice Planning*** in the Central East LHIN is moving along in the following three provincial designated areas/organizations: ***Hospice Peterborough*** has purchased a property for the purpose of establishing a free standing hospice and is in the middle of their capital campaign; the recently approved Durham Community Health Services Integration Plan has the ***Durham Hospice*** voluntarily merging with the ***VON*** which is seen as the best option to support the development of a residential program given their expertise elsewhere and ***Scarborough's Yee Hong Centre for Geriatric Care*** has initiated a community development approach with stakeholders. Next steps include identification, prioritization and addressing system and process issues for integrating Hospice Palliative Care in Scarborough and development of a systems based business case.

Community Engagement Activities

Community Engagement is the foundation of all activity at the Central East LHIN. Being more responsive to local needs and opportunities requires on-going dialogue and planning with those who use and deliver health services. Since 2005, board members and LHIN staff have actively engaged with local community residents, health care service providers, provincial associations, local government leaders and many other organizations and individuals on how to improve and enhance the public health system.

In February 2011, the Ministry of Health and Long-Term Care approved community engagement guidelines and a toolkit to be used by all LHINs in an effort to promote consistency across the province. By developing provincial guidelines, all 14 LHINs have a consistent approach to community engagement planning and are better able to show how feedback gathered through community engagement activities is considered as part of each LHIN's decision making process. http://www.centraleastlhin.on.ca/Page.aspx?id=130

In the guidelines, it is recognized that stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by the

project, or anyone that may exert influence over the project or its results is considered a project stakeholder. For the purpose of stakeholder identification in the Central East LHIN, "communities" can be interpreted to mean geographic locations (i.e. Scarborough, Durham Region, North East), communities of interest or communities of practice.

- *Community of interest (COI)* - an informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.
- *Community of practice (CoP)* - an informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).
- *Political Entity* - For the purpose of stakeholder identification, "political entity" is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.
- *Planning Partners* – for the Central East LHIN, a Planning Partner stakeholder is defined as a group that has been formally constituted and/or is supported by the LHIN in order to facilitate engagement related to LHIN MLPA deliverables.

Community engagement also refers to the methods by which LHINs interact, share and gather information from and with their stakeholders. The purpose of community engagement is to inform, educate, gather feedback, consult, involve and empower stakeholders in both health care or health service planning and decision-making processes to improve the health care system.

- *Inform and Educate* - To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities to community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.
- *Gather Inpu*t - To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for a community or communities to voice their opinions, express their concerns and identify modifications. There may be potential to influence the final outcome.
- *Consult* - To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between the community and the LHIN. Consultation may re*sult in* changes to the final outcome.
- *Involve* – To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. At this level, community stakeholders may provide direct advice as this is a two-way communication process. This level will influence the final outcome and encourage participants to take responsibility for solutions.
- *Empower* – to allow final decision making.
  (Please note that the Empower Level of Engagement rests with the government and the Board of the Central East LHIN.)

Once again, in 2012-13, refreshed and new engagement structures, introduced with the launch of the 2010-2013 Integrated Health Service Plan, ongoing engagement with our francophone and aboriginal stakeholders and the continued use of the website, open board meetings, public communication and face to face meetings supported the LHIN as it worked with local community stakeholders on enhancing the public health care system.

Francophone Initiatives

In 2010, the provincial government created a regulation under the Local Health System Integration Act (LHSIA), 2006 related to Francophone community engagement. The Central East LHIN began working with its LHIN partners – Central and North Simcoe Muskoka - on developing a partnership with the provincially-named French language health planning Entité 4 for Central South West Ontario. This has included the development of an accountability agreement between Entité 4 and the LHINs, the development of a Joint Action Plan and the creation of a liaison committee.

In the 2012/13 Joint Action Plan the LHINs and the Entité set out five key specific objectives for the Francophone community:

- Improve access for patients/individuals to the appropriate care, in the appropriate place, at the appropriate time in the community in order to reduce the number of Alternate Level of Care days in hospitals;
- Enhance quality of life for Francophones living with chronic illness and reduce complications resulting from such illnesses;
- Improve mental health and reduce drug addiction in francophone youth in elementary and secondary schools;
- Collect data on usage of health care services by the francophone community; and,
- Identify 2013-2016 objectives to improve access to French-language health care services in each LHIN.

To support these objectives, Entité 4 made a series of recommendations to the Central East LHIN which resulted in the the following key actions:

Resource Matching and Referral (RM&R): Entité 4 recommended that the Central East LHIN ensure that that the RM&R electronic solution include the capability to address linguistic and cultural needs so that these needs are considered during the process of matching resources to the needs of francophone users and that the Entité be involved in the committees and working groups involved in the development of this electronic solution. In response, the Central East LHIN confirmed that provincial standards for a common referral form was a collaborative process involving all 14 LHINs and language and cultural preferences are included as minimum data standards.

Behavioural Support Ontario Program (BSO): The Entité provided seven recommendations to the Central East LHIN about the BSO program. This resulted in ensuring that the BSO program contains information on the impact of the language of communication on behaviours and the need to work in a language mastered by the patient. Entité 4 was pleased that the Central East LHIN indicated an openness to further discussions to explore opportunities for improving services delivered to Francophones as part of the BSO project.

Long-Term Care Homes: The Central East LHIN supported the Entité in establishing a Steering Committee to develop a forum for exchange and collaboration between the key stakeholders in long-term care in order to optimize bed occupancy by francophone at Pavillon Omer Deslauriers and to work on the establishment of a Memory Centre within the Bendale Acres long-term care facility. The Steering Committee oversees two subcommittees: Bed Occupancy Subcommittee and Memory Center Subcommittee. At present, french-speaking seniors, who are eligible for long-term care and apply to Bendale Acres, have priority access to beds at Pavilion Omers Deslauriers in Scarborough, as a result of the Steering Committee efforts supported by the Central East LHIN.

Mental Health and Addictions: The French Language Health Planning Entity, the Central East LHIN, and other partnering LHINs have committed to measuring program results where specialized mental health and addictions nurses are working with students in the French-language school boards and ensuring Francophone representation on committees formed for local implementation of the "Open Minds, Healthy Minds" strategy to ensure that this program is accessible to francophone children.

Developing the 2013-2016 IHSP: The Central East LHIN and the Entité jointly engaged the francophone community in the development of the LHIN's next Integrated Health Service Plan. This included a series of community engagement sessions and focus groups of francophone residents and organizations along with an online survey which was available in French and was actively promoted by the Central East LHIN and Entité 4. As a result the Central East LHIN's 2013-2016 Integrated Health Service Plan was highlighted by the French Language Services Commissioner of Ontario, as an Honourable Mention in his own Annual Report 2012-2013 commending the Central East LHIN for its planning initiatives directed to French language needs in the Central East Region. Honourable Mentions in the FLS Commissioner report recognize the leadership shown by government ministries and agencies that have made efforts to expand the delivery of high-quality French Language services.

Aboriginal Initiatives

In 2010/11, the Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Métis Nation of Ontario, Mississaugas of Scugog Island First Nation and the Central East LHIN established a significant partnership to benefit the health, communities and the future of First Nations, Metis, Inuit and Non-Status people.

Through two advisory groups - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN has received advice on a variety of topics related to provincial and Central East LHIN priorities and how they pertain to the First Nations people represented.

In 2012/13 both advisory groups continued to meet bi-monthly, with a joint meeting of both the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee in October 2012.

Additional Engagement Structures

Board to Board Engagement
The Central East LHIN Board of Directors continued to meet with its three Governance Advisory Councils in the Scarborough, Durham and Northeast clusters. Membership has been open to governors from each health service provider across all sectors. Quarterly meetings are held to discuss best practices, challenges and successes encountered at each organization along with LHIN initiative updates. These meetings have advanced the dialogue and forged stronger relationships between our health service providers to establish clear messaging aand identify integration opportunities. In an effort to meet the need for good governance, the Central East LHIN continued to support the United Way's "Good Governance Boot camps" by encouraging all of our health service provider boards to participate in these workshops.

Central East Executive Council (CEEC)
Senior Administrators from the Central East LHIN, all Central East LHIN hospitals and the Central East Community Care Access Centre meet on a monthly basis to review shared projects and initiatives that support the system's goal of reducing ED wait time and reducing the impact of vascular disease. Guided by a memorandum of understanding, the council also considers programs, service, and back office alignment that would decrease cost, increase quality or improve patient access for service, and collectively develop human resource capacity and the opportunity to share experience.

Medical Leadership Group
Strong partnerships with hospitals' Chiefs of Staff and Chief Nursing Executives, formed during the development of the first "Clinical Services Plan", continued in 2012/13 and the LHIN continued to meet with this group and other physician groups to discuss system wide deliverables and the development of regional programs and initiatives.

Vice President and Chief Nursing Executive Steering Committee (VP/CNE)
The VP/CNE Steering Committee facilitates the provision of safe, quality, seamless, consistent and efficient patient care within the Central East LHIN. Through collaboration and open and joint decision making, the Steering Committee seeks out opportunities to enhance the patient experience and makes recommendations around practice directions, with the aim of optimizing patient care. The Steering Committee also seeks out opportunities for ongoing development of health care professionals within the Central East LHIN, including, but not limited to, standardization of policies, processes and protocols with the Central East LHIN boundaries.

Hospital/CCAC Financial Leadership Group (HCFLG)
The HCFLG provides expert content-knowledge, directional leadership and expertise in financial management within a collaborative forum in accordance with Central East LHIN priorities and strategies (e.g. IHSP). At their monthly meetings, members identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

E-health Steering Committee
The Central East Local Health Integration Network's eHealth Steering Committee, which meets on a quarterly basis, has continued to provide active leadership in developing and implementing the Central East LHIN eHealth Strategy and Tactical Plan to enable LHIN health care providers to leverage the potential of Information and Communications Technology (ICT).

Wait Time Strategy Working Group
The Wait Time Strategy Working Group provides directional leadership, content-knowledge and expertise in planning and implementing specific initiatives within a collaborative forum in accordance with Central East Local Health Integration Network priorities and strategies (e.g. IHSP) as well as with the current Wait Time Strategy. The aim is to improve priority area wait times across the Central East LHIN, while easing patient flow and maintaining quality along the broader continuum of care. Also, in parallel, members utilize their role to identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

Diagnostic Imaging Working Group
Throughout 2012/13, the DI Working Group met monthly to support the Wait Time Strategy Working Group and the Central East LHIN in managing wait times related to diagnostic imaging (MRI and CT). In doing so, the group discussed and promoted best practices in quality and methods of improving efficiency (e.g. MRI PIP) across the LHIN.

Health Professionals Advisory Committee (HPAC)
Like all LHINs, the Central East LHIN has established a Health Professionals Advisory Committee. This committee is responsible for assisting the LHIN in carrying out its responsibilities by providing advice on how to achieve patient-centered health care.

Partnership with Public Health
In the Central East LHIN, quarterly meetings are held with the Medical Officers of Health (MOH) from the four Public Health Units in the region. Chaired by the LHIN CEO, the group discusses many topics of mutual concern, in particular the review of best practices related to infection control, outbreak and system surge management, falls prevention and smoking cessation.

Primary Care Working Group (PCWG)
The Primary Care Working Group's vision is "The Best Primary Care Everywhere." The Primary Care Working Group meets monthly and includes 18 members comprised of primary care physicians from across the LHIN, Nurse Practitioners, pharmacy and public health representatives. The Working Group is co-chaired by a physician and a non-physician lead and provides expert advice to the Central East LHIN on current and emerging trends and issues in primary health care and population health. At its monthly meetings and through the ongoing leadership of its co-chairs, the PCWG continues to work with all stakeholders and the Central East LHIN to support and promote best practices to create an efficient patient centered health care system that will better navigate our patients safely through their journey of care.

Strategic Aim Coalitions - Vascular Health Strategic Aim Coalition
First established in May 2010, coalitions were formed to provide leadership to the achievement of the LHIN's Strategic Aims. The *Vascular Health Strategic Aim Coalition* is comprised of fifteen individuals from primary care, acute, community and long-term care home sectors. During 2012/13 the coalition continued to develop and implement a Vascular Health Strategy for Central East LHIN to achieve the Strategic Aim of saving 10,000 in patient days related to Vascular (including diabetes) conditions.

Regional Specialized Geriatric Services (RSGS) entity Governance Authority
The goal of ensuring that frail seniors living in the Central East have access to a regional, integrated system of care continued to move forward in 2012/13 as the Central East LHIN Regional Specialized Geriatric Services (RSGS) entity Governance Authority began developing a Strategic Plan for regional specialized geriatric services to be included in the LHIN's 2013-16 Integrated Health Service Plan.

Central East Hospice Palliative Care Network
Members of the hospice palliative care sector within Central East integrated three predecessor End-of-life Care Networks operating in Central East: Durham Region End-of-Life Care Network; Haliburton, Kawartha and Pine Ridge End-of-Life Care Network; and Toronto Palliative Care Network-East Region into the Central East Hospice Palliative Care Network under the direction of the Central East Community Care Access Centre. The Network advises both the CECCAC and the LHIN on palliative care planning and co-ordination to support the LHIN's strategic aims.

Central East BSO (Behavioural Supports Ontario) Design Team
As an Early Adopter LHIN, the Central East LHIN brought together a BSO Design Team comprised of representatives from hospital, community and long term care providers. The BSO Design Team worked with the LHIN to develop a local BSO Action Plan that led to a significant investment in the enhancement of services to improve care for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions. The Action Plan included the rollout of BSO training to over 800 front line staff, that is continuing to improve the quality of life for long-term care residents with challenging behaviours. This team continued to support their peers in 2012/13 as the BSO model was expanded across the LHIN and into community settings.

Central East LHIN Self-Management Program Advisory Council
The Program Advisory Council was established in April 2010 to provide strategic advice on the implementation of the Self Management program, recommend partnerships with other stakeholders and review program outcomes, case studies and best practices. Meetings are held four times a year.

Central East Diabetes Network (CEDN)
Comprised of diabetes health care providers from across the Central East LHIN, members of the CEDN work together to improve access to diabetes care for local residents. The Network is also closely aligned with the Central East Diabetes Regional Co-ordination Centre (DRCC) and advises the LHIN on investments to improve care. The DRCC identified two Diabetes and Primary Care Lead physicians, Dr. Tom Bell and Dr. Christopher Jyu to support their activities. The DRCC also engaged endocrinologists in the Central East LHIN to provide specialist consultation to under serviced communities. Under the leadership of the DRCC and the Central East CCAC, planning and implementation for the creation of Complex Diabetes Care Centres with centralized intake and triage for clients with all types of diabetes was initiated in 2011/2012 and resulted in the opening of a new Centres in November 2012.

System Surge Management Committee
The Central East LHIN System Surge Management Committee is a group of individuals comprised of hospital senior administration, LTCH senior management, ethicists, Central East CCAC senior management, the Central East LHIN Primary Care Lead, Central East LHIN Critical Care Lead, and Central East LHIN Staff (Senior Director of SDI, Communications Lead, Implementation Consultant, Health Planner). The Central East LHIN System Surge Management Committee meets bi-monthly when there is no existing surge or pending surge activity. Overall the System Surge Management Committee continued over the past year to provide an effective and efficient forum for managing and coordinating system level response to moderate surge and major surge events impacting the local health care system (surge is any health care situation where demand exceeds capacity). Furthermore, the Committee has provided an opportunity for communication and sharing of best practices between health care providers, local public health officials and others, e.g. EMS in the event of a regional/sub-regional moderate or major surge event. The Central East LHIN System Surge Management Committee is currently working on the development of a Ventilation Best Practices Protocol to ensure timely, effective and consistent use of ventilators throughout the Central East LHIN in times of surge activity.

Engagement Activities

Open Board meetings
Board meetings and board committee meetings (Audit and Finance, Nominations and Governance) are held on a regular basis so that information can be reviewed and discussed by the Board to assist the decision making process as it supports the work of the staff of the Central East LHIN. Materials from all the meetings continue to be posted to the Central East LHIN website and stakeholders were alerted to this posting through a web-enabled MY PAGE system.

Sector Based Providers
Targeted engagement with sector based providers in the Central East LHIN supported the sharing of information as LHINs worked with hospitals, community based agencies and long-term care homes on completing annual service accountability agreements. Information shared at these sessions was posted on the Central East LHIN website so that stakeholders from across the LHIN could see the work being done by these providers to ensure accessible, efficient and quality health care services.

Physician Engagement
The Central East LHIN continued to engage with its physicians in 2012/13. An example of this was ongoing participation in annual CME events. In partnership with the LHIN's Primary Care Leads, Dr. Robert Drury and Dr. Christopher Jyu, the Central East LHIN hosted "Doc Talks", a series of physician-led OTN-supported

webinars in July, August, September and October of 2012. These CME accredited "Doc Talks" provided primary care providers with an opportunity to share their expertise by discussing key issues, challenges and opportunities from the perspective of primary care practitioners in five key areas that were later incorporated into the LHIN's 2013-2016 IHSP including mental health and addictions, creating a system of care for frail seniors, diabetes and vascular health, palliative and end of life care and LHINs and Primary Care.

Regional, County and Municipal Councils
The Central East LHIN continued to visit regional, county and municipal councils in 2012/13 to provide updates to local elected officials on the work being done to improve the local delivery of health care services to their residents and constituents.

MPP Engagement
Regular meetings between LHIN leadership and the Members of Provincial Parliament from all Central East ridings helped to ensure that these provincial leaders were aware of LHIN initiatives that would be benefitting their local constituents.

Speakers' Bureau
LHIN staff and board members attended a number of third-party events in 2012/13 as part of the "Speakers' Bureau." This included health service providers' Annual General Meetings, public announcements and open houses. This provides the LHIN with an opportunity to hear from local stakeholders on local issues and opportunities for improvement, but also an opportunity for the LHIN to inform the public and stakeholders.

Integration

One of the main goals of each LHIN is the integration of health care services to create a more efficient health care system while at the same time improving the health care experience by creating a seamless system of care. In order to execute integrations, the Local Health Services Integration Act, 2006 (LHSIA), provides several tools that the LHIN, the Minister of Health and Long-Term Care and health services providers (HSPs) can use to integrate.

These include:
- Integrations through Funding where the LHIN uses its funding authority to promote integration of services;
- Facilitated and Negotiated Integrations where the LHIN and/or HSPs explore appropriate integration strategies and the LHIN facilitates or negotiates integration with the HSPs;
- Required Integrations where the LHIN orders HSPs to integrate services;
- Voluntary Integrations where a HSP, at their own initiative, plans to integrate services funded by the LHIN;
- Minister's Order where the Minister orders a HSP to integrate i.e. cease to operate, dissolve, windup its operations, amalgamate or transfer operations.with/between health service providers.

In 2012/13, the Central East LHIN continued to support integration activities through the following:

Organizational Health – Self Assessment Tool
The Central East LHIN self assessment tool supports community support services and community mental health and addictions agencies to quickly assess their organizational health status. Developed by the Central East LHIN and shared with all stakeholders, the tool is an important resource for a health service provider to consider as they assess whether they are effectively and efficiently providing client/patient services in an accountable manner. Completing the assessment allows agency boards and senior executive leaders to assess

the health status of their organizations which may then suggest action, including integration opportunities, to mitigate the issues identified.
http://www.centraleastlhin.on.ca/Page.aspx?id=96

Voluntary, Facilitated and Negotiated Integration Process and Requirements Guides
The Central East LHIN's "Voluntary Integration Process and Requirements Guide" and its "Facilitated and Negotiated Integration Process and Requirements Guide" supports Central East LHIN funded health service providers through the process of planning and implementing either a voluntary, facilitated or negotiated integration. We continue to share these resources with all stakeholders, including our sister LHINs as it is posted on the Central East LHIN website.
http://www.centraleastlhin.on.ca/Page.aspx?id=96

Significant integrations that were initiated or completed in 2012/13 include:

Spruce Corners - Facilitated Integration – see http://www.centraleastlhin.on.ca/Page.aspx?id=21002
Since 1993, the Board of Apsley and District Satellite Homes for Seniors (ADSHS) had provided a supportive housing service at its Spruce Corners location, 30 Simeon Crescent, Apsley. Over the years numerous people have lived in the agency's 8-unit building, supported by staff and contracted personal support workers. By providing this service, the ADSHS Board has ensured that its residents have had the ability to remain as independent as their interests allow, have received prompt effective service to meet their varying needs and have been provided with leisure time options and opportunities. A number of challenges had prompted the ADSHS Board to seek out a new health service organization that would be able to take over the building at 30 Simeon Crescent and continue operating the 8-unit supportive housing service. The Central East LHIN offered their support to resolve this situation. This process has now been completed and a news release, issued on May 16, 2012, describes how a facilitiated integration between the ADSHS Board, the Canadian Red Cross Society and Peterborough Housing Corporation has led to a successful outcome.

Canadian Mental Health Association – North East Cluster – Facilitated Integration – see http://www.centraleastlhin.on.ca/Page.aspx?id=19612
The Canadian Mental Health Association, Haliburton, Kawartha, Pine Ridge (CMHA HKPR) Branch launched April 1, 2013, with the amalgamation of its Peterborough and Kawartha Lakes Branches. The new organization now services the counties of Peterborough, Northumberland, Haliburton, City of Kawartha Lakes and the Township of Brock, and covers an area equal to the size of Prince Edward Island - that's 12,000 km2 - making it one of the largest branches in Canada, geographically. The amalgamation process started back in April 2011, through an integration process facilitated by the Central East Local Health Integration Network (Central East LHIN). An integration plan, developed by representatives from the two CMHAs over a 12 month period, provided the information necessary for the two Boards to make an informed decision on the integration of mental health services previously provided by both organizations into one larger organization.

Community Health Services Integration Strategy – see http://www.centraleastlhin.on.ca/Page.aspx?id=96
On February 22, 2012, the Board of the Central East LHIN passed a motion supporting a Community Health Services Integration Strategy, the LHIN's facilitated integration strategy for Community Support Services (CSS) agencies and Community Health Centres (CHCs), to commence in April 2012 and be completed by 2015.

Community Health Services Integration – Durham Cluster, Group 1 Integration Plan - see http://www.centraleastlhin.on.ca/report_display.aspx?id=21752
In late February and early March 2013, after ten months of planning meetings, community engagement and due diligence, the Boards of the 10 organizations that formed the Durham Cluster CHS Integration Planning Team reviewed and decided whether they approved integrations affecting their organizations that were contained in the "Community Health Services Integration – Durham Cluster, Group 1 Integration Plan". The 187-page Plan included information on how the facilitated integration process began, a profile of the Durham

Cluster, the current state of community health services, an outline of how integration opportunities were identified, a high level analysis of the options, the proposed DRAFT Integrated Service Delivery Model and information on proposed transition planning and implementation. At the LHIN's March 27, 2013 Board meeting a series of motions were passed, incorporating the decisions made by each of the 10 organizations at their board meetings.

Community Health Services Integration Strategy – North East Cluster – see http://www.centraleastlhin.on.ca/report_display.aspx?id=26082
At their Open Board Meeting on November 28, 2012, the Board of the Central East LHIN passed a series of motions that resulted in changes to the timing, sequencing and scope of the current Community Health Services Integration Strategy. Based on the motions passed by the Board, hospitals are now included in the North East Cluster phase of the Community Health Services Integration Strategy and the North East process, which started in January 2013, is now be a three-area plan involving Haliburton County/City of Kawartha Lakes, Northumberland County and Peterborough City and County. The North East process started in January 2013 with a select group of health service providers forming a Haliburton County/City of Kawartha Lakes Integration Planning Team (IPT) and a Northumberland County Integration Planning Team (IPT).

Peterborough Health Link – see http://www.centraleastlhin.on.ca/report_display.aspx?id=24968
Ontario is improving co-ordination of care for high-needs patients such as seniors and people with complex conditions through the creation of the Peterborough Health Link in Peterborough which was announced in December 2012. One of 19 across the province to be initially rolled out, this new Health Link will encourage greater collaboration and co-ordination between a patient's different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers.

Scarborough Cluster Hospitals - Facilitated Integration – see http://www.centraleastlhin.on.ca/report_display.aspx?id=26676
On March 27, 2013, the Board of the Central East LHIN passed a motion directing The Scarborough Hospital (TSH) to partner with Rouge Valley Health System (RVHS) in a facilitated integration planning process to design and implement a Scarborough Cluster hospital services delivery model. With the goal of having a proposed Integration Plan developed by early September 2013, the Leadership Committee, with direction from the Boards of the two hospitals and the support of the LHIN, will lay out a work plan that will include receiving reports from the panel reviewing the Maternal Newborn and Women's Health and Surgical Models first proposed for The Scarborough Hospital (TSH) during TSH's recent Strategic Plan Refresh and a team developing a future state model for an integrated Maternal-Child-Youth model for the whole Scarborough Cluster.

ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE

In 2012/13 the Central East LHIN received a total operating budget of $5.8 million which included operations at $4.5 million and additional funding of $1.3 million as noted in the financial statements (note 8). The Central East LHIN exercised prudent fiscal management to balance its internal operations budget and met the objective target of less than 1% in surplus. The additional funding for special projects allowed the Central East LHIN to pursue initiatives such as Aboriginal health planning; evaluating and monitoring emergency care performance; e-Health projects and continued support for the provision of a Central East LHIN Emergency Department Physician LHIN Lead, and to the French Language Services and Aboriginal initiatives. The LHIN received continued funding for the Primary Care position and the Diabetes Vascular Health funding was received as a new responsibility for the LHINs this fiscal year.

The Primary Care funding was for a Physician LHIN Lead that can advance primary care services to support timely, accessible and effective primary care and prevent unnecessary emergency department visits. The Diabetes Vascular Health responsibilities include the objectives and deliverables for the regional coordination of diabetes services and the delivery of our Vascular Health Aim.

The organizational structure of the Central East LHIN is a collaborative model which has supported the achievement of the Central East LHIN's strategic aims by improving our internal work flow processes. The assignment of co-leads acting as "points of contact" for each sector reporting to the Central East LHIN – hospitals, the CCAC, community support services and community health centres, mental health and addiction providers and long term care homes - has improved the support for issues and matters related to the sectors.

The Central East LHIN's Performance Management Program continues to ensure that all staff positions support the organization's objectives through the achievement of their specific goals and objectives and identification of development opportunities. The Central East LHIN organization is comprised of three distinct units – Corporate (Governance, Communications, Business Support); System Design and Implementation (Integration, Quality Improvement, System Planning) and System Finance and Performance Management (Finance, Performance). With additional support from Health Force Ontario and Health Quality Ontario, the staff complement of 33 FTEs effectively managed a $2 billion health service system on behalf of the residents of the Central East LHIN.

The Central East LHIN Code of Conduct, which was developed by LHIN staff throughout 2010 and adopted by the LHIN's Board of Directors in November 2010, is intended to be a central guide and reference for all employees and the Board in support of day-to-day interactions and decision making, and to help employees and the Board work more effectively together. In 2011/12, the structure to support the successful implementation of the Code included ongoing promotion with staff, development of a compliance procedure, ongoing policy development and education initiatives.

http://www.centraleastlhin.on.ca/Page.aspx?id=18896&ekmensel=e2f22c9a_72_184_18896_2

INDEPENDENT AUDITOR'S REPORT

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To the Members of the Board of Directors of the Central East Local Health Integration Network

We have audited the accompanying financial statements of the Central East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2013, and the results of its financial activities, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants May 22, 2013

Central East Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**692,314**	537,963
Due from Ministry of Health and Long Term Care ("MOHLTC")	**4,507,430**	3,093,800
Accounts receivable	**85,947**	273,858
	5,285,691	3,905,621
Liabilities		
Accounts payable and accrued liabilities	**541,153**	338,210
Due to Health Service Providers ("HSP")	**4,507,430**	3,093,800
Due to MOHLTC and eHealth Ontario (Note 3b, 3c)	**268,988**	509,300
Deferred capital contributions (Note 5)	**212,202**	237,523
	5,529,773	4,178,833
Net debt	**(244,082)**	(273,212)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**31,880**	35,689
Tangible capital assets (Note 7)	**212,202**	237,523
	244,082	273,212
Accumulated surplus	**-**	-

Approved by the Board

Original Signed By

_____David Sudbury, Vice Chair (Co-Chair Audit/Finance Committee)

Original Signed By

_____Wayne Gladstone, Board Chair (Co-Chair Audit/Finance Committee)

Central East Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 8)	2013 Actual	2012 Actual
	$	$	$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	**2,088,200,455**	**2,163,791,335**	2,129,743,201
Operations of LHIN	**4,534,130**	**4,388,751**	4,693,700
Emergency Department ("ED") Lead (Note 10a)		**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") (Note 10b)	**-**	**100,000**	100,000
Aboriginal Planning (Note 10c)	**-**	**20,000**	20,000
eHealth (Note 10d)	**-**	**580,000**	600,000
Critical Care (Note 10e)	**-**	**75,000**	75,000
French Language Services (Note 10f)	**-**	**106,000**	106,000
Diabetes & Vascular Health (Note 10g)	**-**	**127,717**	-
Diabetes & Vascular Health OT (Note 10g)	**-**	**122,100**	-
Behavioural Supports Ontario Pilot (Note 10h)	**-**	**-**	750,000
Primary Care (Note 10i)	**-**	**75,000**	43,750
Amortization of deferred capital contributions (Note 5)	**-**	**170,700**	156,794
	2,092,734,585	**2,169,631,603**	2,136,363,445
Funding repayable to the MOHLTC (Note 3a)		**(268,988)**	(509,300)
	2,092,734,585	**2,169,362,615**	2,135,854,145
Expenses			
Transfer payments to HSPs (Note 9)	**2,088,200,455**	**2,163,791,335**	2,129,743,201
General and administrative (Note 11)	**4,534,130**	**4,540,884**	4,821,126
ED Lead (Note 10a)	**-**	**72,000**	72,161
ER/ALC (Note 10b)	**-**	**75,955**	100,000
Aboriginal Planning (Note 10c)	**-**	**1,525**	3,882
eHealth (Note 10d)	**-**	**460,669**	422,449
Critical Care (Note 10e)	**-**	**72,000**	72,000
French Language Services (Note 10f)	**-**	**106,000**	49,290
Diabetes & Vascular Health (Note 10g)	**-**	**78,357**	-
Diabetes & Vascular Health OT (Note 10g)	**-**	**88,890**	-
Behavioural Supports Ontario Pilot (Note 10h)	**-**	**-**	551,905
Primary Care (Note 10i)	**-**	**75,000**	18,131
	2,092,734,585	**2,169,362,615**	2,135,854,145
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

Central East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	Budget	2013 Actual	2012 Actual
	$	$	$
Annual surplus			
Acquisition of tangible capital assets	-	**(145,379)**	(79,030)
Amortization of tangible capital assets	-	**170,700**	156,794
Change in other non-financial assets	-	**3,809**	(9,381)
Decrease in net debt	-	**29,130**	68,383
Net debt, beginning of year	-	**(273,212)**	(341,595)
Net debt, end of year	-	**(244,082)**	(273,212)

Central East Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	170,700	156,794
Amortization of deferred capital contributions (Note 5)	(170,700)	(156,794)
	-	-
Changes in non-cash operating items		
(Decrease) increase in due from MOHLTC	(1,413,630)	10,817,383
Increase (decrease) in accounts receivable	187,911	(236,018)
Increase (decrease) in accounts payable and accrued liabilities	202,943	(193,272)
Increase (decrease) increase in due to HSPs	1,413,630	(10,817,383)
Decrease in due to the MOHLTC	(240,312)	(31,995)
Increase (decrease) in prepaid expenses	3,809	(9,381)
	154,351	(470,666)
Capital transactions		
Acquisition of tangible capital assets	(145,379)	(79,030)
Financing transactions		
Capital contributions received (Note 5)	145,379	79,030
Net increase (decrease) in cash	154,351	(470,666)
Cash, beginning of year	537,963	1,008,629
Cash, end of year	692,314	537,963

Notes to the Financial Statements

1. Description of business

The Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN ("CE LHIN") is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). 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 planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics. The LHIN has also entered into an accountability agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC. The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN's financial statements do not include any MOHLTC managed programs.

The Central East LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The Central East LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

2. Significant accounting policies (continued)

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable, expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Funding payments to Health Service Providers in the LHIN geographic area flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2013.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation*", Section PS 2601 *"Foreign Currency Translation"*, PS 3410 "*Government Transfers*" and Section PS 3450, *"Financial Instruments".* There was no impact of the adoption of these new standards on the financial statements.

3. Funding repayable to the MOHLTC

In accordance with the TPA, the Central East LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC or to eHealth Ontario, respectively.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

			2013	2012
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**2,163,791,335**	**2,163,791,335**	**-**	-
LHIN operations	**4,559,451**	**4,540,884**	**18,567**	29,367
ER/ALC	**100,000**	**75,955**	**24,045**	-
ED/Lead	**75,000**	**72,000**	**3,000**	2,839
Critical Care	**75,000**	**72,000**	**3,000**	3,000
E-Health	**580,000**	**460,669**	**119,331**	177,551
Aboriginal Planning	**20,000**	**1,525**	**18,475**	16,118
French Language Services	**106,000**	**106,000**	**-**	56,710
Diabetes & Vascular Health	**127,717**	**78,357**	**49,360**	-
Diabetes & Vascular Health OT	**122,100**	**88,890**	**33,210**	-
Behavioural Supports	**-**	**-**	**-**	-
Ontario	**-**	**-**	**-**	198,095
Primary Care Lead	**75,000**	**75,000**	**-**	25,619
	2,169,631,603	**2,169,362,615**	**268,988**	509,300

3. Funding repayable to the MOHLTC (continued)

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2013	2012
	$	$
Due to MOHLTC, beginning of year	**331,749**	541,295
Recovery by MOHLTC during the year	**(331,749)**	(541,295)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**268,988**	331,749
Due to MOHLTC, end of year	**268,988**	331,749

c) The amount due to the eHealth Ontario at March 31 is made up as follows:

	2013	2012
	$	$
Due to eHealth Ontario, beginning of year	**177,551**	-
Paid to eHealth Ontario during year	**(177,551)**	-
Funding repayable to the eHealth Ontario related to current year activities (Note 3a)	**-**	177,551
Due to eHealth Ontario, end of year	**-**	177,551

In the previous fiscal year (2011-12) the LHIN was funded by MOHLTC through the MLPA and eHealth Ontario directly in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect the one time funding arrangement for comparative purposes. In the current fiscal year (2012-13) the funding for eHealth Initiatives with respect to Enabling Technologies for Integration are incorporated as part of the budget arrangements of the MLPA.

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	**237,523**	315,287
Capital contributions received during the year	**145,379**	79,030
Amortization for the year	**(170,700)**	(156,794)
Balance, end of year	**212,202**	237,523

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due to 2017 are as follows:

	$
2014	232,949
2015	228,331
2016	133,193
2017	-
	594,473

The LHIN also has funding commitments to HSPs associated with accountability agreements. The Transfer Payment Planning Targets to HSPs based on the current accountability agreements are as follows:

	$
2014	2,084,259,282
2015	2,084,247,582

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

			2013	2012
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office furniture and fixtures	**643,616**	**493,234**	**150,382**	101,281
Computer equipment	**291,738**	**280,631**	**11,107**	24,355
Web development	**36,100**	**28,507**	**7,593**	7,593
Leasehold improvements	**668,025**	**624,905**	**43,120**	104,294
	1,639,479	**1,427,277**	**212,202**	237,523

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $2,163,791,335 is made up of the following:

	$
Initial HSP funding budget	**2,088,200,455**
Adjustment due to announcements made during the year	**75,590,880**
Total HSP funding budget	**2,163,791,335**

8. Budget figures (continued)

The total revised operating budget of $5,814,947 is made up of the following:

	$
Initial budget as represented on the statement of financial activities	**4,534,130**
Additional funding received for one time initiatives	
ER/ALC	**100,000**
ED/Lead	**75,000**
Critical Care	**75,000**
E-Health	**580,000**
Aboriginal Planning	**20,000**
French Language Services	**106,000**
Diabetes & Vascular Health	**249,817**
Primary Care	**75,000**
Total budget	**5,814,947**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $2,163,791,335 (2012 - $2,129,743,201) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2013 as follows:

	2013	2012
	$	$
Health Infrastructure Renewal Fund	**-**	-
Operation of hospitals	**1,263,345,821**	1,252,096,815
Grants to compensate for municipal taxation - public hospitals	**281,250**	283,200
Long term care homes	**414,237,631**	410,848,439
Community care access centres	**241,514,062**	227,764,449
Community support services	**34,631,413**	32,615,566
Assisted living services in supportive housing	**13,880,255**	13,809,205
Community health centres	**22,142,397**	20,843,048
Community mental health addictions program	**59,747,858**	57,930,372
Specialty psychiatric hospitals	**112,515,437**	112,077,447
Acquired brain injury	**1,469,786**	1,450,060
Grants to compensate for municipal taxation - psychiatric hospitals	**25,425**	24,600
	2,163,791,335	2,129,743,201

10. Separate funding amounts were received by the Central East LHIN from the MOHLTC and eHealth Ontario for specific initiatives

a) ED Lead

The LHIN received funding of $75,000 (2012 - $75,000) related to the ED Lead project. ED Lead expenses incurred during the year are as follows:

	2013	2012
	$	$
Consulting services	**72,000**	72,000
Other	**-**	161
	72,000	72,161

b) ER/ALC

The LHIN received funding of $100,000 (2012 - $100,000) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of $75,133 (2012 - $93,570) of salaries & benefits and $822 (2012 - $6,430) of other expenses.

c) Aboriginal Planning

The LHIN received funding of $20,000 (2012 - $20,000) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of $1,525 (2012 - $3,882) of other expenses.

d) E-Health

The LHIN received funding of $580,000 (2012 - $600,000) related to the E-Health project. E-Health project expenses incurred during the year are as follows:

	2013	2012
	$	$
Consulting services	**-**	20,006
Salaries and benefits	**315,773**	290,314
Meetings	**5,410**	18,468
Supplies and other	**139,486**	93,661
	460,669	422,449

e) Critical Care

The LHIN received funding of $75,000 (2012 - $75,000) related to the Critical Care project. Critical Care project expenses incurred during the year consist of $72,000 of consultant expenses (2012 - $72,000).

f) French Language Services

The LHIN received funding of $106,000 (2012 - $106,000) related to the French Language project. French Language project expenses incurred during the year consist of $100,478 of salaries and benefits (2012 - $49,290) and $5,523 of other expenses (2012 - $Nil).

10. Separate funding amounts were received by the Central East LHIN from the MOHLTC and eHealth Ontario for specific initiatives (continued)

g) Diabetes & Vascular Health

The LHIN received funding of $249,817(2012 - $Nil) related to the Diabetes & Vascular Health project. Diabetes and Vascular Health project expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and Benefits	**57,051**	-
Operations	**21,306**	-
One-Time Funding	**88,890**	-
	167,247	-

h) Behavioral Supports Ontario Pilot Project

The LHIN received funding of $Nil (2012 - $750,000) related to the Behavioural Supports Ontario Pilot Project. Behavioural Supports Ontario Pilot Funding Project expenses incurred during the year consist of $Nil of consulting expenses (2012 - $150,296), $Nil (2012 - $223,720) of salaries & benefits, $Nil (2012 - $74,326) of meeting expenses and $Nil (2012 - $103,563) of other expenses.

i) Primary Care

The LHIN received funding of $75,000 (2012 - $43,750) related to the Primary Care project. Primary Care project expenses incurred during the year consist of $75,000 (2012 - $18,000) of consulting fees and $Nil (2012 - $131) of meeting expenses.

11. General and administrative expenses

The Statement of financial activities presents the expenses by function, the following classifies these same expenses by object:

	2013	2012
	$	$
Salaries and benefits	**3,338,338**	3,441,389
Occupancy	**175,397**	282,431
Amortization	**170,700**	156,794
Shared services	**429,020**	501,995
Community engagement	**15,352**	88,617
Consulting services	**74,029**	57,418
Supplies	**95,930**	98,524
Board member expenses	**90,979**	103,146
Mail, courier and telecommunications	**2,262**	2,211
Other	**148,877**	88,601
	4,540,884	4,821,126

11. General and administrative expenses (continued)

Included in general and administrative expenses are board per diems and expenses as follows:

	2013 Budget	**2013**	2012
	$	**$**	$
Board chair per diem expense	**50,000**	**28,110**	50,957
Other board members per diem expense	**74,000**	**46,067**	25,419
Governance costs and travel	**50,000**	**16,802**	26,770
Total expenses	**174,000**	**90,979**	103,146

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 33 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $276,327 (2012 - $270,985) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation of the plan was completed for the plan at of December 31, 2012. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act.*

STAFF MEMBERS

Back Row

Chantelle Vernon, Romina Vincente, Laura Wise, Marco Aguila, Kate Reed, Lauren Chitra, Christine Laity, Jennifer Persaud, Callum Anderson, Ritva Gallant, Sheila Rogoski

Middle Row

Sheila Stirling, Indra Narula, Trixie Williams, Jeanne Thomas, James Meloche, Deborah Hammons, Janet Boland, Brian Laundry, Charli Law, Marilee Suter, Karol Eskedjian, Katie Cronin-Wood

Front Row

Linda Henry, Karen O'Brien, Lisa Kitchen, Jai Mills, Dieufert Bellot, Chad Gyorfi, Sherry Harvey, Usha Cithiravel, Jina Mintsinikas

Absent

Alex Ruppert, Paul Barker, Karen Poon, Dana Lian, Joanne Lau, Tapas Kar, Emily Van de Klippe, Suzette Stines-Walford, Amanda English

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