

Community First

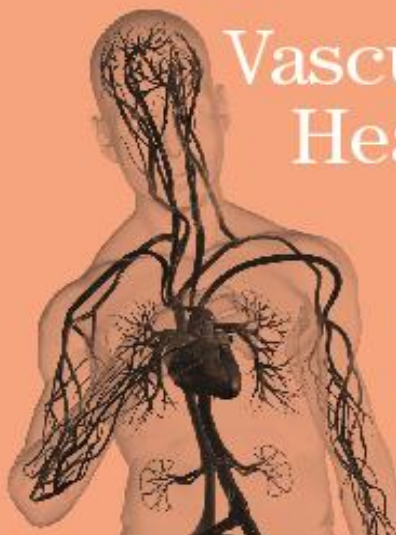
Engaged Communities. Healthy Communities.

Central East LHIN 2013-14 Annual Report

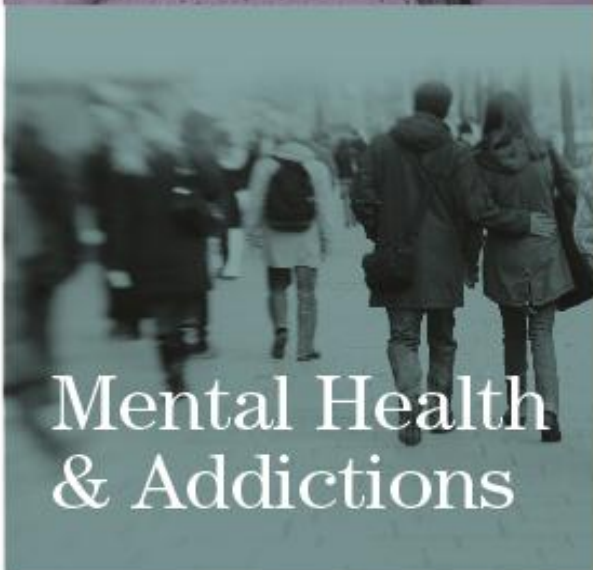
Seniors



Vascular
Health



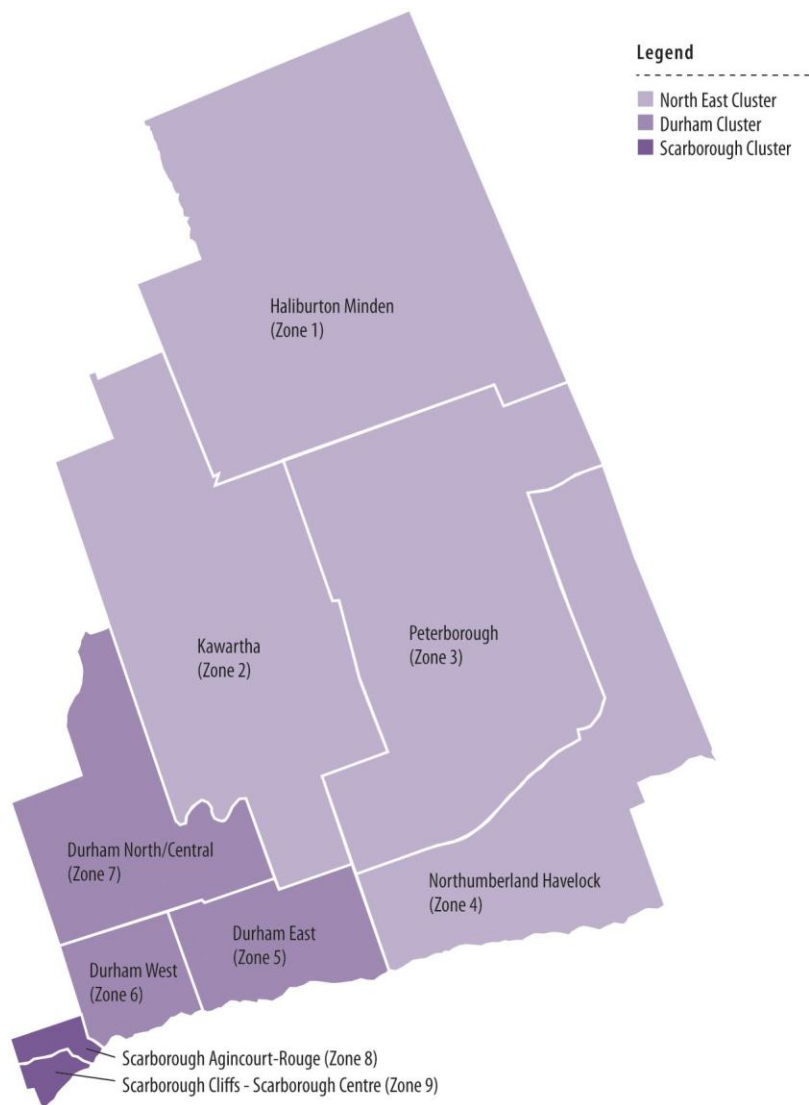
Mental Health
& Addictions



Palliative Care



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 eighth 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 – “Community First” – takes its title from the Central East LHIN's 2013-2016 Integrated Health Service Plan (IHSP). The Central East LHIN's third IHSP once again sets out a shared goal for the local health care system and outlines the LHIN's overall theme of “*Community First – Help Central East LHIN residents spend more time in their homes and their communities*”.

Guided by our 2013-2016 IHSP that is outcome focused, clear and measurable, and sets out a bold, but realistic, road map for health care improvement for our region, the Central East LHIN has continued to work with our communities to develop a quality system that is patient-focused, results-driven, integrated and sustainable.

This year's annual report once again demonstrates how LHINs are facilitating the 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.

We recognize that a Community First approach requires focused and disciplined actions to create an integrated community-based health system that is able to pro-actively respond to emerging health care trends in our communities. With dramatic changes underway in health care finance, clinical practice, demographic shifts, and technology – these changes are too large and too important to leave to chance.

The Central East LHIN's Community First focus is rooted in four Strategic Aims. This Annual Report outlines the progress that has been made in 2013-2014 on these four aims:

- Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.
- Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
- Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016.
- Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

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 and are working with us to deliver on the vision of *Engaged Communities, Healthy Communities*.

With their support we were able to continue to be bold in our ambitions and clear in our aims as we 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

Samantha Singh, Member

Term of Office:

June 17, 2010 – June 16, 2016

Wayne Gladstone, Chair

Term of Office:

June 2, 2010 – June 14, 2016

**Amorell Saunders N'Daw
Member**

Term of Office:

April 2, 2014 – April 1, 2017

Chuck Powers, Member

Term of Office:

June 2, 2011 – June 1, 2014

Second Row

Valmay Barkey, Member

Term of Office:

June 2, 2011 – June 1, 2015

David Sudbury, Vice-Chair

Term of Office:

June 17, 2010 – June 16, 2016

Margaret Risk, Member

Term of Office:

May 17, 2011 – May 16, 2017

Joanne Hough, Member

Term of Office:

May 4, 2011 – May 3, 2017

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 LHIN Board of Directors can be found on the Central East LHIN web site at: <http://www.centrealesthin.on.ca>

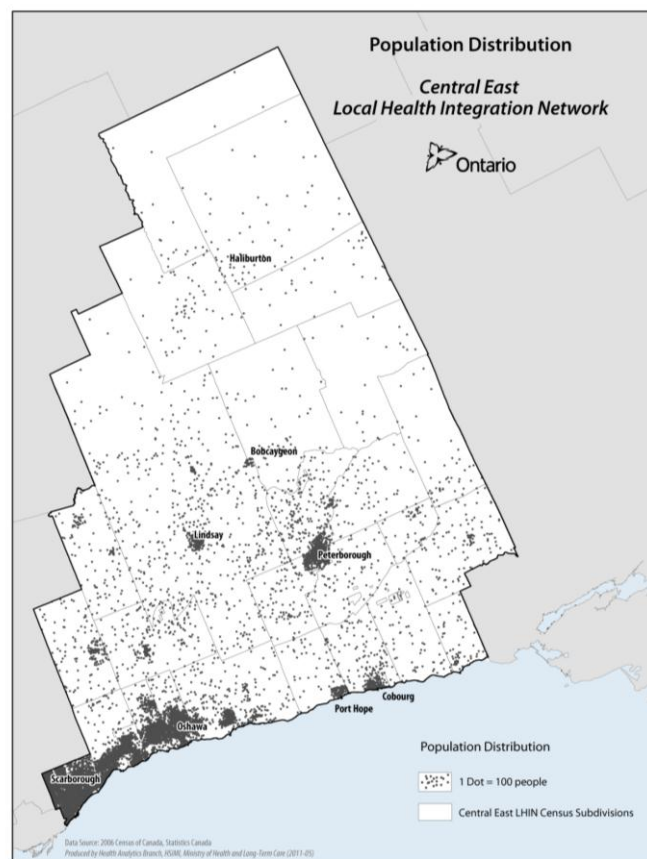
INTRODUCTION

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, coordinate, 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.

Population Map



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; and, Local Health System Performance and Reporting. The MLPA is mirrored in the Accountability Agreements that LHINs negotiate 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 2013/14 fiscal year. The following table outlines Central East LHIN's performance against targets for 2013/14.

Central East LHIN MLPA Performance Indicators 2013/14

Performance Indicator	LHIN Starting Point 13/14	LHIN Performance Target 13/14	Most Recent Quarter 2013/14 LHIN Performance	FY 2013/14 LHIN Annual Result
1. Access to healthcare services				
1. 90th percentile ER length of stay for admitted patients	33.72	30.00	36.75	30.28
2. 90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.45	6.45	6.12	6.02
3. 90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.13	4.00	3.97	3.88
4. Percent of priority IV cases completed within access target (84 days) for cancer surgery	96.00%	90.00%	96.65%	98.10%
5. Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	NA	NA	NA	NA
6. Percent of priority IV cases completed within access target (182 days) for cataract surgery	99.00%	90.00%	99.02%	97.98%
7. Percent of priority IV cases completed within access target (182 days) for hip replacement	96.00%	90.00%	96.35%	92.06%
8. Percent of priority IV cases completed within access target (182 days) for knee replacement	96.00%	90.00%	95.24%	91.08%
9. Percent of priority IV cases completed within access target (28 days) for MRI scans	47.00%	50.00%	85.10%	64.38%
10. Percent of priority IV cases completed within access target (28 days) for CT scans	91.00%	90.00%	91.60%	92.97%
2. Integration and coordination of care				
11. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	13.48%	12.80%	14.18%	15.85%
12. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	29.00	29.00	40.00	38.00

3. Quality and improved health outcomes				
13. Readmission within 30 Days for Selected CMGs**	16.02%	14.80%	17.12%	16.26%
14. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	18.60%	17.00%	18.68%	18.47%
15. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	24.30%	22.50%	24.38%	24.84%

Note:

*FY 2013/14 is based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability

**FY 2013/14 is based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability

At the end of 2013/14, the Central East LHIN was able to **achieve eight of the fourteen performance targets** identified in its MLPA. A description of these eight targets and an explanation for the achievements follows:

Performance Indicator #2 – TARGET MET

90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients

The Central East LHIN has been below the median on this performance indicator since November 2012. The Central East LHIN saw an upward trend between September and January 2014. The Central East LHIN has met the 2013/14 MLPA target of 6.45 hours during the entire fiscal year.

Performance Indicator #3 – TARGET MET

90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients

The Central East LHIN met the MLPA target of 4.0 hours in 11 of 12 months in fiscal year 2013/14. In March 2014, the Central East LHIN saw a slight increase to 4.1 hours for this indicator.

Performance Indicator #4 – TARGET MET

Percent of priority IV cases completed within access target (84 days) for cancer surgery

The 98.10% annual result in this performance indicator is well above the 2013/14 negotiated target of 90% and reflects that all Central East LHIN hospitals performed above the LHIN target, with Lakeridge Health (LH), Ross Memorial Hospital (RMH) and Rouge Valley Health System (RVHS) achieving 100%. This builds on the work completed previously when the Central East LHIN implemented a Wait Time Strategy Working Group (WTSWG) at the beginning of 2009/10 with participation from all hospitals delivering Wait Times (WT) services in order to discuss, identify and resolve pressures/risks, as well as to share best practices. The Central East LHIN fully implemented the Surgical Utilization Booking Management Integration Tool (SUBMIT) in June 2012 to assist with the management of WT. The hospitals and the Central East LHIN have ongoing data quality improvement initiatives. The new WT indicators, measuring Percent of Priority IV Cases Completed Within Access Target, were incorporated into the 2013/14 Hospital Service Accountability Agreements (H-SAAs).

Performance Indicator #5 – TARGET N/A

Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery

Not Applicable

Performance Indicator #6 – TARGET MET

Percent of priority IV cases completed within access target (182 days) 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 2013/14 as hospitals met or exceeded this target. The Central East LHIN, in collaboration with the clinical and financial leadership of hospitals and Community Care Access Centre (CCAC), completed a regional planning process in 2012/13 and determined that the optimal model of service delivery for cataracts was volume optimization. Volumes were allocated among hospitals to optimize Wait Time performance and the new WT indicators, measuring Percent of Priority IV Cases Completed Within Access Target, were incorporated into the 2013/14 H-SAAs.

Performance Indicator #7 – TARGET MET**Percent of priority IV cases completed within access target (182 days) for hip replacement**

Similar to Performance Indicators #4 and #6, the ongoing work of the WTSWG and the implementation of SUBMIT have had a significant impact on the positive achievement of this indicator. In addition, volumes are allocated among hospitals to optimize WT performance and the new WT indicators, measuring Percent of Priority IV Cases Completed Within Access Target, were incorporated into the 2013/14 H-SAAs. Individual hospitals introduced mitigation strategies to improve their performance including opening up extra operating rooms and ongoing engagement with surgeons' offices. Throughout 2013/14, the Central East LHIN, in collaboration with the clinical and financial leadership of hospitals and CCAC, underwent a regional orthopaedic planning process to determine and implement the optimal model of service delivery for all orthopaedic Quality Based Procedures (QBP). This work will continue in 2014/15.

Performance Indicator #8 – TARGET MET**Percent of priority IV cases completed within access target (182 days) for knee replacement**

Similar to Hip Replacement – see text above. In addition, to address the increasing demand for knee replacements over hip replacements, hospitals were able to move volumes from hips to knees during the 2013/14 reallocation process, subject to LHIN and Ministry approval.

Performance Indicator #9 – TARGET MET**Percent of priority IV cases completed within access target (28 days) for MRI scans**

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 practices. Together the hospitals and the Central East LHIN implemented ongoing data quality improvement initiatives and wait time performance indicators that 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. However, the Central East LHIN continued to experience significant challenges in meeting the provincial wait time target in 2013/14 as hospital facilities had long wait lists and the allocated MRI hours could not address demand. All facilities have undergone Performance Improvement Plans (PIP) analysis and, where appropriate, have implemented mitigation strategies, to improve performance overall. Where funding permitted, the LHIN also reallocated additional MRI operating hours in order to improve on this performance indicator in 2014/15.

Performance Indicator #10 – TARGET MET**Percent of priority IV cases completed within access target (28 days) for CT scans**

As noted previously, 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 practices. 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. Nearly all of the Central East LHIN hospitals performed at or above the Central East LHIN target with only one hospital performing slightly under. The Central East LHIN will continue to closely monitor hospital performance and is exploring the expansion of SUBMIT to Diagnostic Imaging to assist with the management of Wait Times.

At the end of 2013/14, the Central East LHIN was **unable to achieve six of the fourteen performance targets** identified in its MLPA. A description of these targets and an explanation for the variance follows:

Performance Indicator #1 – TARGET UNMET

90th Percentile ER Length of Stay for Admitted Patients

The Central East LHIN has trended below the median (36.6 hours) for ED admitted patients in fiscal year 2013/14. We are seeing a trend (increase) which is signaling a slow change. Historically, January has had the highest ED Length of Stay (LOS) for Admitted Patients. There has been significant growth in ED visits and admit volumes have exceeded existing capacity and any additional capacity that was created. As an example, Rouge Valley Ajax Pickering is experiencing tremendous growth in patients admitted through the ED - a 16.3% increase since 2009. To improve ED capacity and performance, the Central East LHIN has focused on identifying best practices to reduce ED demand and improve quality thereby reducing health care utilization and costs and promoting patient centric care. Initiatives designed to decrease ED Length of Stay and improve patient satisfaction have been targeted by hospitals participating in the Pay-for-Results Program. These projects are yielding positive results due to improved processes within Emergency Departments as well as in general patient flow. Process improvement methodologies, (e.g. LEAN) are being utilized to optimize patient flow in the ED and throughout the hospital. The Central East LHIN is concentrating on activities both in and outside the hospital setting to help with patient flow. The Central East LHIN remains focused on the sustainability of Home First across all hospitals in the Central East LHIN and constantly reviews access to post-acute related programs/services including long-term care, complex continuing care, inpatient rehabilitation and assisted living. Health Links, Resource Matching and Referral (RM&R) are being implemented with an aim to reduce ED wait times and improve flow.

Performance Indicator #11 – TARGET UNMET

Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:

As a reminder, the challenge with this indicator is that it is measured only when a patient is discharged from the hospital. The numbers will rise during periods when there has been success in discharging a large number of patients designated ALC, or patients who have been in that designation for a long period of time.

To improve hospital bed utilization, the Central East LHIN has focused on moving patients through the hospital to the most appropriate setting which includes the community. Ongoing management and sustainability of Home First remains within the purview of the Central East CCAC. A LHIN-wide Home First steering committee is chaired by the CCAC, with representation from the LHIN, each hospital, each Community Support Services (CSS) agency, and the CCAC itself. The Home First processes are being continuously monitored and reviewed. ALC cases are reviewed regularly and early discharge support meetings are held in a timely manner. At risk for discharge patients are identified at regular bullet rounds in every hospital. The CCAC frequently identifies the need for Home First refreshes and undertakes this work accordingly.

The Central East LHIN continuously engages hospital leadership and community partners in identifying issues/concerns and possible solutions to the ALC issues. Attention is being placed on Post-Acute care specifically system challenges in access to LTC and Assisted Living for Mental Health.

The Central East LHIN has invested over \$27M towards enhancing care and supports in the community including additional adult day programs, assisted living services and geriatric assessment and intervention teams. The investment also includes funding to the CECCAC for home care and the maximum five day wait time target for personal support services for clients with complex needs. As these programs become operational they will assist seniors and others with complex needs to either avert an admission or return home, in a timely and supported fashion, contributing to fewer potential ALC designations.

Further investments have been made in the Assess and Restore (A&R) approach in the Central East LHIN, which will improve screening, assessment, placement, A&R intervention, and finally transition home.

Performance Indicator #12 – TARGET UNMET**90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)**

In 2013, the Ministry of Health and Long-Term Care completed its physiotherapy (PT) reform which included an expansion of in-home physiotherapy for 60,000 more seniors and people with mobility issues. As part of this initiative, CCACs were asked to clear current PT waitlists in order to manage the substantial influx of new clients post-August 1, 2013. Only when a patient is removed from a waitlist to active service, do their days waiting get reported within this performance indicator. As a result of these changes and the technical aspects of this indicator, the 90th percentile wait time for first PT service increased by 54% (37 days to 57 days) and new PT clients increased 302% (3,130 to 12,584) provincially from Q1 2013/14 to Q2 2013/14. In sum, while the reported Wait Time increased, access to care was dramatically increased during this time period. All LHINs reported an increase in PT clients and 11 LHINs reported increased PT wait times.

Performance Indicator #13 – TARGET UNMET**Readmission within 30 Days for Selected CMGs**

During 2013/14 there was a saturation of both the Congestive Heart Failure (CHF) clinics and Centralized Cardiac rehabilitation for the Central East LHIN, thus the LHIN supported hospital integrations for the Centralized Cardiac Rehabilitation Regional Intake program. During 2013/14 the LHIN embarked on a process improvement plan through the creation of a Centralized Diabetes Intake process to streamline people with diabetes and diabetes complications to improve access to Diabetes Education Programs and the Centre for Complex Diabetes Care sites. Through this, the expectation is that improvements will be seen in readmission rates for selected CMGs in 2014/15. Designated Diabetes Education Programs became accountable to the Central East LHIN in April 2013 and as such the goal is that there will be improved accesses to coordinated care.

Performance Indicator #14 – TARGET UNMET**Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**

The Central East LHIN is currently evaluating the existing initiatives that were implemented in order to support the achievement of this MLPA indicator. These initiatives [the Hospital to Home (H2H) Program and the Opiate Strategy] will be evaluated using the original funding criteria, which included the MLPA Indicators for both Mental Health and Addictions. The Central East LHIN is also implementing the Mental Health and Addictions Strategy that is designed to achieve both the IHSP Mental Health and Addictions Strategic Aim and the MLPA targets. This strategy includes QI strategies related to ACTT and Hospital Based Child and Adolescent Services that are currently in their implementation phase, as well as the Community Crisis Review Project that will develop recommendations designed to improve that system across the LHIN. The Community Crisis Review will include a review of the Mobile Crisis Intervention Teams (MCIT).

Performance Indicator #15 – TARGET UNMET**Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**

The Central East LHIN is currently evaluating the existing initiatives that were implemented in order to support the achievement of the IHSP Strategic Aim and the MLPA Targets. These are the "Hospital to Home (H2H)" Strategy, the Opiate Strategy and Scarborough Addictions Service Expansion. The results of these evaluations will provide information that will advise the improvements that are required in order to achieve both the IHSP Aim and the MLPA Targets. In addition, the Central East LHIN is embarking upon a project that will evaluate the Community Crisis System, including the MCIT. This will provide information regarding the current and future potential for this system to support the achievement of the IHSP Aim and the MLPA Targets.

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN 2013-2016

During 2010-2013, the Central East LHIN, through its second Integrated Health Service Plan, focused the system on the achievement of 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*.

To support the achievement of these two strategic aims, the IHSP identified target populations for whom the LHIN prioritized its efforts:

- At risk seniors;
- People with a mental illness and/or addictions;
- People with chronic disease; and
- Francophone, First Nations, and Aboriginal communities and residents.

By April 2014, the system had saved 866,721 hours spent by patients in hospital Emergency Departments in the Central East LHIN.

- While not the original goal of 1,000,000 hours, the local health system - which includes hospitals, community support services organizations, community mental health and addiction agencies, community health centres and the Central East Community Care Access Centre - was challenged by a 20.3% volume increase in the number of patients requiring care at a CTAS I-III level and an 8.8% increase in the number of patients who were admitted to the hospitals through the Emergency Departments.
- Recognizing that many of the initiatives introduced during the 2010-2013 IHSP would have a lag effect on the health care system, the final analysis of the system's achievements for the ED Aim included fiscal year 2013-14.

By April 2013, the system had saved 37,870 days spent by patients admitted to hospitals for vascular conditions.

- With saving 10,000 inpatient days being used as the proxy measure for a 10% reduction in the impact of vascular disease, the system far surpassed the goal set out by this strategic aim. This was despite a 25% increase in the number of patients being treated for renal issues, a 19% increase in the number of patients being treated for Type 1 Diabetes and a 8% increase in the number of patients being treated for Ischemic Heart Disease. At the same time there were 382 fewer cases of Pulmonary Heart Disease in the Central East LHIN.
- The system responded to this increase in volume by providing safe and accessible primary care and community-based alternatives to vascular care which resulted in a 14% decrease in the overall Average Length of Stay in acute hospital settings and a 15% decrease in overall days. In fact, the amount of days spent in hospital for Diabetes decreased by 73%, for Vascular Dementia by 61% and for Heart Disease by 43%.

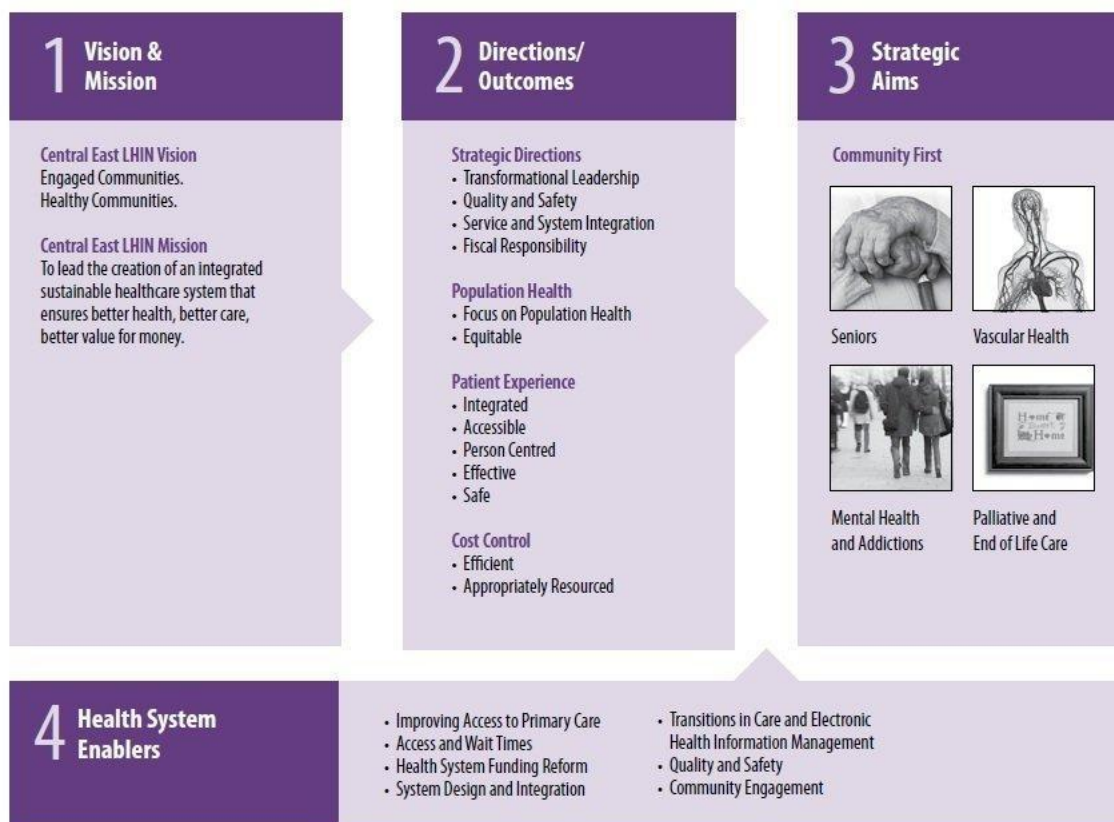
By focusing health service providers on these strategic aims and populations, the health system began to see:

- Engaged, pro-active and prepared patients and their formal and informal care providers;
- A reduction in unnecessary ED demand and hospital readmissions;
- An improvement of wait times within the ED;

- More appropriate levels of care provided in the community for patients who no longer require acute care services within the hospital;
- Improved hospital utilization and efficiency;
- A reduction in the impact of vascular disease on individuals and the health care system;
- A reduction in the number of hospital days associated with vascular diseases;
- A decrease in the prevalence of co-morbidity for those patients with an existing primary chronic condition;
- Improved wait times for diagnostic and surgical procedures; and,
- Better access to home care services.

These achievements provided a strong foundation for Year 1 of the Central East LHIN's 2013-2016 Integrated Health Service Plan. This third Integrated Health Service Plan (IHSP), once again set out a shared goal for the local health care system.

The Central East LHIN IHSP Strategy Map 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 overall theme of ***“Community First – Help Central East LHIN residents spend more time in their homes and their communities”***.



This is further broken down into four aims which are guiding the system over the next three years:

- Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.
- Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
- Strengthen the system of supports for people with Mental Health and Addictions issues so they spend 15,000 more days at home in their communities by 2016.
- Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

Implementation of the IHSP

Below are just a few of the exciting initiatives and accomplishments that happened in 2013/14 during the implementation of the first year of the 2013-2016 IHSP.

Integrated Health Service Plan Strategic Aim #1: Reduce the Demand for Long-Term Care so that Seniors Spend 320,000 More Days At Home in Their Communities by 2016

Improving health care for seniors continued to be a top priority of the Central East LHIN. The population of seniors is growing, and this group often has complex health care needs. As a result, there is increased pressure on caregivers, communities and our health care system. In 2013/14, the ongoing focus on seniors helped to foster improvements in the health care experience of patients and their caregivers, as well as in the overall quality and sustainability of the health care system in the Central East LHIN.

- The **Central East Regional Specialized Geriatric Services Entity**, continued to implement ***a regional model for the organization, coordination and governance of specialized geriatric services*** by bringing the following programs and initiatives under its mandate:
 - Geriatric Assessment and Intervention Network (GAIN)
 - Geriatric Emergency Management Nurses (GEM)
 - Behavioural Supports Ontario initiative (BSO)
 - Nurse Practitioner Outreach to Long-Term Care (LTC) Program [also known as Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)]
- In addition the Entity completed a ***needs assessment and capacity analysis*** of Specialized Geriatric Services (SGS); identified ***performance standards*** for SGS providers; developed an RSGS ***multi-year strategic plan*** and began the development and implementation of a ***shared communications, community engagement and branding strategy/plan***.
- Access to the Geriatric Assessment and Intervention Network (GAIN) clinics was significantly increased in 2013/14 after the LHIN announced that the program would be expanded to include the creation of ***six new community-based GAIN Teams***. Paired with the four existing hospital-based GAIN clinics, work began to ***launch inter-professional teams in Scarborough, Durham Region, Lindsay, Peterborough and Northumberland*** in order to continue to support patients at home, in the community. Using gerontological best practices, standardized assessments and protocols, the teams began to ***create individualized integrated care plans for high risk seniors***. ***Health Career Case Managers***, working in partnership with each patient's primary care provider, also began to work with seniors and their caregivers to help them better navigate the system including access to community programs.

- A new **fellowship program** was instituted for January 2013 – March 2013 as a “test of change” **to build specialized geriatric capacity in the Central East LHIN** and four individuals participated in this inaugural endeavor.
- There’s no place like home to recover from illness, regain strength and make important lifestyle decisions. That’s the philosophy and purpose behind **Home First**, an initiative, first rolled out in 2010/11, that continues to drive patient discharge practices across the Central East LHIN and helps patients in hospital return to the community in a timely manner with the appropriate supports to remain at home. Since the initiative was first introduced there have been **482 fewer ALC (Alternate Level of Care) patients in Central East LHIN hospitals and 573 more patients have been discharged home.**
- Aligned with the expansion of the GAIN Model to include community-based teams, the Central East LHIN made **significant investments in a variety of services** across the region to ensure that seniors and their caregivers had access to multiple community based services that would assist them to reside in an environment that is least restrictive and most suitable to their needs. This included **increasing the number of clients who receive services from the Central East Community Care Access Centre**; providing **more assisted living services for high-risk seniors**, especially from the Chinese and South Asian communities in Scarborough and also for high-risk seniors in Havelock and the surrounding geographic area including Norwood, Lindsay, Campbellford and Cobourg; **increasing the number of frail, elderly clients in existing adult day programs**, including a **new program for Francophone seniors in Oshawa** and for **seniors at Curve Lake First Nation**; and implementing a mental health and addictions strategy and **increasing the number of specialized teams supporting mental health clients** receiving care in their homes.
- On April 18, 2013 the Ministry of Health and Long-Term Care announced that more than 200,000 additional seniors and patients across the province will benefit from **improved access to high-quality physiotherapy, exercise and fall prevention classes.** The Central East LHIN worked with the Ministry and local health service providers to ensure that people had access to these vital services. This included **maintaining and introducing new and expanded sites for Exercise and Falls Prevention Classes, supporting the call for physiotherapy in primary care settings, working with the Central East Community Care Access Centre as they became the single point of access for all publically funded one-on-one in home physiotherapy services, providing funding for existing and new community-based physiotherapy clinics and physiotherapy and exercise activities in the LHIN’s long term care homes.**
- The Central East LHIN’s Behavioural Support Ontario (BSO) program moved into its sustainability phase in 2013/14 as the LHIN

There’s no place like home to recover from illness, regain strength and make important lifestyle decisions.

That’s the philosophy and purpose behind Home First, an initiative that has been rolled out across the Central East Local Health Integration Network (Central East LHIN) that helps patients in hospital return to the community sooner with the appropriate supports for success.

According to the Home First philosophy, every patient admitted to the hospital should expect to be discharged home at the end of the acute period of care.

“People now have an option to go home and make longer-term decisions in the comfort of their own home,” says Jean Kish, Central East Community Care Access Centre (CCAC) program director.

“Home First is a philosophy, it’s about supporting people to return to the community. It helps patient flow in the hospital and gets patients back where they should be -- in their home.”

Even if the ultimate destination is not the patient’s current home, it will be the first stop from hospital.

“We’re affording them the opportunity to stay at home longer,” Kish says.

continued to provide strategic oversight and system planning. Supported by the Central East Community Care Access Centre and with front line and administrative leadership from hospitals, long-term care homes and community support services organizations participating on the Design Team, Implementation Tables and Education Committee, the program saw ***another 2,000 front line staff trained in how to deal with responsive behaviours such as dementia, over 600 attendees at cluster-based community of practice forums and informal coaching provided to their health care partners by the Early Adopter BSO long-term care homes and the BSO Integrated Care Team.*** With over 46% of new admissions to long-term care homes having responsive behaviours, over 2,000 long-term care residents were assessed using a Behavioural Assessment Tool (BAT) which assisted in the planning of their care and visual communication systems, which support memory retention and communication with aging residents, were implemented in 82% of the Central East LHIN's long-term care home facilities. A qualitative analysis of the results to date continue to show ***a reduction in responsive behaviours amongst long-term care population, improved resident quality of life, increased family engagement and increased staff confidence.***

Integrated Health Service Plan Strategic Aim #2: Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.

Vascular diseases are major causes of illness, disability, hospitalization and death in the Central East LHIN and across Canada. Despite reductions in the number of people who die each year from vascular diseases, it remains the number one threat to the health of Canadians. Recognizing that achieving the vascular health aim would require inter-sectoral action between hospital, primary & specialty care, the CCAC and community agencies and stronger partnerships with patients and their families, the Central East LHIN continued to lead the system in 2013/14 to deliver on the regional coordination of vascular services, cardiac rehabilitation, stroke care and stroke rehabilitation.

- On April 1, 2013, the operational mandate, functions and funding for the delivery of **goals set out in the Ontario Diabetes Strategy were transferred to the LHINs.** This transfer of accountability was welcomed by the Central East LHIN's existing Vascular Health Strategic Aim Coalition and its members as they continued to be responsible for monitoring the implementation of the ***Vascular Health Strategic Aim strategy*** and initiating projects in partnership with their health care colleagues.
- **The three complex Diabetes Care Centres (CCDC),** first opened in the Central East LHIN in November 2012, are located within The Scarborough Hospital, Lakeridge Health and Peterborough Health Centre. In 2013/14 the LHIN continued to monitor the performance of these centres to ensure that patients were provided with the ***specialized diabetes education, management and treatment including access to specialists*** they required.
- The Central East LHIN and Central East CCAC led the development and implementation of a **centralized diabetes intake and referral process** to establish a more streamlined and integrated system for the intake and referral of patients with diabetes. This has allowed local residents, providers and/or caregivers to contact one telephone number resulting in ***increased access and navigation*** through available services.
- New investments in infrastructure and human resources by the Central East LHIN provided the support required for the use of **Ontario Telemedicine Network for vascular clinical and education opportunities.** A pilot site for the teleophthalmology program was identified and planning began ***to improve access to eye screening for people with diabetes.***
- The Central East CCAC continued to manage the "Central East Self Management Training Program". The six-week self-management **Living a Healthy Life with Chronic Conditions** workshop continued to empower people to develop new tools and skills to break the cycle of symptoms that can result from chronic conditions was identified as ***a major priority of the Vascular Aim coalition.***
- An integration between Rouge Valley Health System Centenary site as the hub and Ross Memorial Hospital as a spoke in the Centralized Cardiac Rehabilitation Intake Service Delivery Model was

successful and, during 2013/14, this regional service model increased access to services and improved patient outcomes.

Integrated Health Service Plan Strategic Aim #3: Strengthen the system of supports for people with Mental Health and Addictions issues so they spend 15,000 more days at home in their communities by 2016.

Mental health and/or substance abuse issues can be very disruptive to individual and family lives. When interventions are less disruptive and focused on connecting individuals with the right care, outcomes are improved. Ensuring that those with mental health and addictions issues are provided with proper supports, positively impacts individuals and families as well as the health system at large. In 2013/14, the Central East LHIN continued to lead the system to deliver programs and initiatives through ongoing investment and implementation of more “upstream” solutions that were tracked through the performance targets of reducing unscheduled ED visits within 30 days and reducing In-Patient Psychiatric Bed Days.

- An integrated **Hospital to Home Team (H2H)**, embedded in the emergency department at Lakeridge Health Oshawa, links the hospital with its community partners and includes Intensive Case Management, Community Crisis Supports and Beds, Community Treatment Order Case Management, Substance Abuse Withdrawal Management, Addictions Treatment and Case Management, Concurrent Disorder Treatment Services and Consultation and links to Primary Care. In 2013/14 *a second team was embedded into the emergency department at the Peterborough Regional Health Centre*, specifically focused on an accessibility strategy for Aboriginal Peoples.
- In 2013/14 stronger linkages were built between the **Mental Health Support Unit (MHSU)**, the **Police/Mental Health Team** and the Hospital to Home Team at Lakeridge Health. In addition, the **“Elliot House” Community Crisis Bed Program**, located in Ajax and linked with the Rouge Valley Health System, continued to support the H2H team.
- The use of the **Ontario Telemedicine Network (OTN) and Telepsychiatry**, including the installation of three new OTN machines in the North East cluster, made direct treatment and consultation services *more available to residents of this largely rural area*. OTN also provided improved access to specialized Addiction and Concurrent Disorder treatment and consultation services across the LHIN through stronger links to the Pinewood Centre in Oshawa.
- The implementation of the **Opiate Strategy** led to Methadone Clinics being located in each of the LHIN’s three clusters. By expanding existing Methadone Case Management in the Durham cluster, establishing Methadone Case Management in the North East Cluster and expanding Pre and Perinatal services throughout the LHIN, the strategy targeted areas of greatest need.
- The **Scarborough Cluster Integrated Addictions System Project** was led and implemented by the Pinewood Centre in January of 2013. This project continues to be refined through the quality

A new addictions and mental health specialist working at the Centenary site of the Rouge Valley Health System (RVHS) is opening up many eyes and minds to change.

Patients who had previously hesitated to seek the type of treatment they need are becoming much more open about it after talking with the specialist, says RVHS’s mental health manager, Julie Kish.

“Just from the volumes and numbers of people that the specialist has started seeing, you know she’s going to be touching a lot of lives and improving a lot of lives,” Kish says.

Then there are hospital staff members whose beliefs are shifting as they work and train with the specialist, and begin considering new ways of treating concurrent disorders.

“It’s interesting to see how some people who have some very ingrained ideas are definitely open to change when the right person presents the information to them,” Kish says.

improvement processes built into the implementation plan. This initiative is ensuring local access to Scarborough residents to Withdrawal Management and Addictions Treatment services.

Integrated Health Service Plan Strategic Aim #4: Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their community by 2016.

Palliative and end of life care is an approach to caring for people who are living with a life-threatening illness. It focuses on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones. Palliative and end of life care is holistic in nature and aims to address peoples' physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears; prepare people for and to manage self-determined life closure and the dying process; and, help them cope with loss and grief during the illness and bereavement.

With the stated aim of increasing the number of palliative patients who die at home by choice and spend 12,000 more days in their community by 2016, the Central East LHIN continued to work with its health service providers and specifically its Central East Hospice Palliative Care Network (CEHPCN) in 2013/14 to make investments and implement initiatives that would support the achievement of the aim.

- The **Palliative Pain and Symptom Management Consultation (PPSMC) service** and the **Community Palliative Care Nurse Practitioner Program (CPCNP)** were expanded and now provides *equal access across community organizations in the Durham, Scarborough and North East clusters* of the LHIN.
- **Community hospice services** were strengthened through investments in innovative hospital-community partnerships in an effort *to improve access to end of life care in all settings*.
- **Interdisciplinary Palliative Education** continued to be an area of focus in 2013/14 with numerous physicians, nurse practitioners and registered nurses taking the *“Learning Essential Approaches to Palliative and End of Life Care (LEAP)”* course.
- A **social worker with a passion for supporting the Aboriginal path to health and healing** joined the Central East Regional Cancer Program at Lakeridge Health in fall 2013 and began working with First Nations Inuit Metis (FNIM) communities to improve system access to cancer care. This also led to enhanced communication focusing on *improving linkages and partnerships regarding cultural competencies and awareness, especially related to palliative and end-of-life care*.
- The Central East Hospice Palliative Care Network (CEHPCN) finalized their **Central East Regional Palliative Plan**. Priority areas for investment and implementation were identified including *the creation of Dedicated Palliative Care Outreach Teams; promoting Hospice Palliative Care Education & Training; establishing Integrated Hospice Palliative Care Hospital Programs in all Central East LHIN hospitals and Long Term Care Homes, and; Promoting Community Hospices as Central Hubs for access to information, 24/7 patient, family and caregiver volunteer support in partnership with hospitals, long term care homes and other community agencies*.

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 Input* - 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 result 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, refreshed and new engagement structures, introduced with the launch of the 2013/16 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. In 2013/14, the Central East LHIN continued to work with Entité 4, the local French Language Health Planning Entity, through a Joint Action Plan, on a shared goal of building engaged and healthy communities together.

This was achieved through a results-oriented relationship between the Central East LHIN and the Entité.

In the 2013/14 Entité 4 made five recommendations to the Central East LHIN which resulted in four of them being implemented.

Adapting Existing Services: By engaging with Francophone stakeholders, the Entité identified a need for **increased access to long-term care beds at a designated long term care home in the Scarborough Cluster**. Working together, the Entité, the LHIN and Bendale Acres collaborated to identify needed improvements which resulted in the prioritization of Francophones for access to beds at Pavillon Omer Deslauriers in Bendale Acres. A similar evaluation of the **Chronic Disease Self-Management Peer Leadership Training (Train the Trainer) for Francophones** led to the delivery of a **Chronic Disease Self-Management Workshop in Scarborough** that has had a significant impact on the quality of life for Francophone residents in the Scarborough cluster.

Developing New Services: Using a similar engagement approach, the Entité identified that a need for an Adult Day Program for francophone seniors in the LHIN's Durham cluster. By working directly with an appropriate health service provider, the Entité supported the development of a business proposal that was reviewed and accepted by the Central East LHIN. On March 25, 2014, Centres d'Accueil Héritage officially launched its **Adult Day Program for Francophone seniors living in the Oshawa area**. The new program, open two days per week, is offered in French to frail seniors from Durham region who experience physical and (or) cognitive difficulties. Seniors participate in social and recreational activities, as well as physical exercises, overseen by professional staff in a warm and secure environment. Nutritious lunches are also available.

In 2013/14, the Central East LHIN and Entité 4 entered into a partnership with the TAIBU Community Health Centre (TAIBU CHC), a health service provider (HSP) who provides primary health care and community development programs and services for the African and Caribbean community in Scarborough, to support the implementation of the **Coalition for Healthy Francophone Communities in Scarborough (CHFCS)**. The primary focus of the CHFCS is on health promotion and secondary prevention to slow or stop the progression of chronic disease and, where possible, prevent adverse events or disability. The Coalition meets on a regular basis and has hired a Health Promoter as they continue to focus on meeting the needs of Francophone stakeholders.

A number of lessons were learned in 2013/14 as the Central East LHIN and Entité 4 continued to collaborate and partner to meet Francophone needs:

- Recognize the work of our providers as the key to implementing and sustaining change
- Build and maintain strong relationships between Entité staff and LHIN FLS coordinators and planners
- Ensure LHIN senior leaders are at Entité/LHIN Liaison Committee table
- Ensure Francophone Community Engagement through Entité/ LHIN Strategic Planning

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.

Since that time, 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 continued to 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 2013/14 both advisory groups continued to meet bi-monthly and their work centred on **three major themes**:

- Relationships with the Central East CCAC
- Development of Cultural Competency Indicators
- Mental Health and Addictions issues facing the First Nations Communities located within the LHIN

In May of 2013, the Central East LHIN Board of Directors approved **a motion requiring all Health Service Providers receiving Central East LHIN funding to demonstrate their competence in providing service to First Nations, Métis, Non-Status and Inuit Peoples in a culturally safe manner.**



In June 2013, the Board and staff of the Central East LHIN participated in an **Aboriginal Awareness training session** at Alderville First Nation Community Centre. Led by Kelly Brownbill, the day-long session taught the group about the history of Aboriginal people in Canada, the impact of the residential school system and treaty policies on their self-identity and the steps being taken by Aboriginal leaders to empower their communities to reclaim their culture and make positive changes in their health journeys.

The annual joint meeting of the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee was held in October in Peterborough on October 11, 2013. The purpose of this Annual meeting was to discuss joint concerns and determine joint priorities for the next year. It was agreed that both the **Cultural Safety Indicator and Mental Health and Addictions issues** as they relate to members of the communities represented by both Circles were priorities.

In November, the Alderville First Nation held a Ceremony to finalize their **Memorandum of Understanding with the Central East Community Care Access Centre**. This Agreement outlines the relationship between the Alderville First Nation and the Central East Community Care Access Centre, and sets a process in place for their continued dialogue with each other.

With the support of the LHIN, meetings were held at the Curve Lake and Hiawatha First Nations with LHIN-funded Mental Health and Addictions Service Providers ***to establish positive working relationships between these providers and the Aboriginal communities they serve.*** Additional meetings are planned in FY 14/15.

Base funding was provided to the Victorian Order of Nurses to provide an ***Adult Day Program in partnership with the Curve Lake First Nation.***

One-time funding was provided to FOURCAST, who worked in partnership with the Niijkiwendidaa Anishnaabekwewag Services Circle to ***provide training in Concurrent Disorders within a Culturally Safe context to Health Service Providers in the North East Cluster.*** This work was enhanced by a one-time grant from the Ministry of Health and Long Term Care, which provided for additional training. A service manual and instructions were also developed as a result of this project.

In February, the Central East LHIN Aboriginal Lead was honoured as the only LHIN representative to be invited to attend the ***8th Annual Chiefs of Ontario Health Forum.*** This annual forum is a venue to inform Ontario First Nations on new and emerging strategies, the progress of health activities by the COO Health Unit, and to bring together First Nations, the province and the federal government to discuss and share information toward common goals.

A comprehensive Cultural Safety Training was held at the Curve Lake First Nation in March of 2014, which included the staff of the Peterborough Regional Health Centre, and a variety of other Health Service Providers.

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. Regular 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 and 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 where a number of organizations have arranged for the session to be delivered to their full Boards this past year. Members of the Board engaged with Governor Liaisons as part of the Community Health Services Integration Strategy at their regular check-in meetings in Durham, Northumberland County, Haliburton County/City of Kawartha Lakes, Scarborough and Peterborough.

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 "Community First" aim outlined in the 2013-16 IHSP as well as the Ministry of Health priorities. 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 2013/14 with adhoc meetings between the LHIN and this group and other physician groups.

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 during monthly meetings, 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 within Central East LHIN boundaries.

Health Professionals Advisory Committee (HPAC)

Each LHIN has established a Health Professionals Advisory Committee. These committees are responsible for assisting the Network in carrying out its responsibilities by providing advice on how to achieve patient-centered health care. In 2013/14, the Central East LHIN HPAC continued to meet on a quarterly basis, providing input into the Community First strategic aims and discussing the ongoing recruitment of health human resources. The membership continued to expand and includes professionals with backgrounds in nursing, physiotherapy, chiropractic, dietary, pharmacy, social work, midwifery, community medicine, speciality medicine and family medicine.

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 strategies and Hospital Service Accountability Agreement (H-SAA) accountability requirements). During the past fiscal, the HCFLG has met monthly, identifying and examining current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the mitigation of potential risks and the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

Health System Funding Reform Local Partnership (HSFR LP)

The new Patient-Based Funding (PBF) approach was introduced effective April 1, 2012 and has two components: the Health-Based Allocation Model (HBAM) and Quality-Based Procedures (QBP). Both components utilize demographic, clinical and financial information to estimate expected volumes and costs at a facility level, which influences improved value for money, outcomes and reduced variation across providers. The mandate of this group is to develop local volume management strategies which align with operational change, support education and knowledge transfer, improve data quality, and ultimately improve access to services and outcomes. Over the past fiscal year, the HSFR LP has met bi-monthly, determining strategies to support funding reform, wait times, and innovative service delivery models which emphasize evidence based best practice and enhanced cost efficiencies.

E-health Steering Committee

The Central East LHIN's eHealth Steering Committee, provides Enabling Technology and Information (ETI) Strategy and Tactical Planning to enable LHIN health care providers to leverage existing and emerging technologies and leverage provincial assets. The group will continue to meet bi-annually as a planning and advisory body.

Wait Time Strategy Working Group (WTSWG)

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 LHIN priorities and strategies (e.g. IHSP) particularly with respect to 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. In 2013/14 the WTSWG met monthly, evaluating current wait time performance and assessing innovative opportunities to address access to

service challenges. Development and implementation of innovative solutions addressed improved access to care through integration/coordination and performance improvement strategies resulting in a more streamlined and efficient health care service delivery model.

Diagnostic Imaging Working Group (DIWG)

The objectives of the Diagnostic Imaging Working Group include a comprehensive, ongoing review of Diagnostic Imaging services across the Central East LHIN. In a collaborative forum, members share best practice and innovation to enhance access, improve utilization and wait times, as well as investigate cost reduction strategies related to diagnostic service modalities. Throughout 2013/14, 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 Performance Improvement Plans) across the LHIN. They are currently reviewing software opportunities which would support diagnostic imaging intake, protocol standardization, radiology reporting, and the provincially mandated wait time reporting expansion – tracking the patient from decision to treat through to exam completion.

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 Health Care Advisory Group (PHCAG)

Since inception, the Central East LHIN has recognized engagement of primary care providers as a critical success factor in fulfilling its mandate of integrated care. In 2013 the former Primary Care Working Group (2007) mandate and membership was reviewed and reconstituted. The creation of this advisory group builds on past and current efforts to involve physicians, nurse practitioners and other health care professionals in the LHIN change agenda. A membership of 12-15 provides a balance of perspectives of different primary care settings and pressures across the LHIN. The Primary Health Care Advisory Group vision is “The Best Primary Care Everywhere.” The mission is to provide expert advice to the Central East LHIN on primary health care and population health. The Primary Health Care Advisory Group meets 6 times per year and is Chaired by the Central East LHIN Primary Care Physician Lead. Members serve 1-3 year terms and represent a variety of primary care perspectives including hospital and community based physicians, Nurse Practitioners, Executive Administration from Community Health Centres and other Patient Enrolment Models.

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 has expanded its membership to over 20 members which include representation from primary care, acute care, community services, supporting programs (i.e. Ontario Telemedicine Network, Self-Management Program) as well as a patient perspective. To meet the needs of the region, the coalition continues to develop and implement a Vascular Health Strategy for the Central East LHIN, including stroke and diabetes care, to achieve the Strategic Aim of continuing to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.

Regional Specialized Geriatric Services (RSGS) entity Governance Authority

The goal of ensuring that frail seniors living in the Central East LHIN have access to a regional, integrated system of care continued to move forward in 2013/14 as the Central East LHIN Regional Specialized Geriatric Services (RSGS) Entity Governance Authority adopted three new action orientated strategic aims. The directions “Fostering excellence”, “Improving care” and “Increasing awareness of seniors age-related

needs” are the driving force behind a number of seniors related initiatives including the expansion of the Geriatric Assessment and Intervention Network and Senior Friendly Hospital initiatives.

Central East Hospice Palliative Care Network (CEHPCN)

The CEHPCN has a mandate to provide direction, coordination and leadership for the development of a coordinated and integrated system of hospice palliative care within and across the Central East LHIN Region. Current membership includes senior level leadership and representation from local hospitals and community settings with a focus on hospice palliative and end of life care. 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

BSO continues to be spread to all long-term care homes across the Central East LHIN as well as into the community and hospitals. The BSO Design Team provides leadership, advice, guidance and support to long-term care homes, community service providers, hospitals and Integrated Care Team stakeholders in the development, implementation and sustainability of BSO in long-term care homes. Recently expanded through an Expression of Interest, the team now includes long-term care home representatives from Early Adopter and Phase 2 homes as well as members from multiple sectors representing the three Central East LHIN geographic clusters. Working collaboratively with health service providers to focus, learn, spread and sustain BSO, key focus areas for 2013/2014 included spreading the program to all 56 Phase 2 long-term care homes, development of the BSO Community model, continued emphasis on capacity building and metrics analysis and refinement.

Central East LHIN Diabetes Education Programs and Networks

Effective April 2013, the accountability of twelve adult and two paediatric Diabetes Education Programs (DEPs) was transferred to the Central East LHIN. Oversight of the DEPs within the Central East LHIN is to coordinate the regional services, identify regional and local services needed to support long term planning of diabetes care in alignment with the LHIN and provincial priorities and engagement of stakeholders across the region to facilitate the adoption, integration of consistent, evidence-based standards and best practices in diabetes management. These goals are reviewed and work to align diabetes work is established through the three Diabetes Network tables within the region - North East, Durham and Scarborough.

Stroke Working Group

The Central East LHIN Stroke Working Group was formed to support the implementation of a stroke Quality Based Procedures (QPBs) across the LHIN. The work of this group will review the needs of the Central East LHIN stroke care. This will allow us to build on the successes of best practices and evidence based care within our region.

System Surge Management Committee

The Central East LHIN System Surge Management Committee is a group of individuals comprised of hospital senior administration, Long-Term Care Homes senior management, ethicists, Central East CCAC senior management, the Central East LHIN Critical Care Lead, and Central East LHIN Staff (Senior Director of System Design and Implementation, 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. Over the past year, the System Surge Management Committee continued 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). 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 and preparation of the 2015 Toronto Pan-Parapan AM Games planning. The Committee will continue to provide a forum for communication and sharing of best practices between health care providers, local public health officials, in the event of a

regional/sub-regional moderate surge or major surge event. The Committee will also continue to provide linkages with other LHIN structures and activities, for example the Primary Health Care Advisory Group.

Central East LHIN Maternal, Newborn and Paediatric Advisory Committee

In 2013 The Central East LHIN established the Central East LHIN Maternal, Newborn and Paediatric Advisory Committee (MNPAC). The Committee functions in an advisory capacity, providing leadership to all relevant health service providers, partners, key stakeholders, including the Provincial Council for 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 will be to promote standardization, implementation of evidence and best practices within women's and children's programs.

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 has recognized engagement of physicians as a critical success factor in fulfilling its mandate of integrated care. Ensuring strong physician engagement provides the Central East LHIN with the opportunity to continue to build on current efforts to involve physicians, nurse practitioners and other health care professionals. In 2013/2014 Health Links was a major area of focus for physician engagement in the Central East LHIN. Through initiating Health Links, engagement activities such as office visits were conducted to further build relationships with primary care providers and administrators, introduce them to Central East LHIN projects, and gain feedback into how they prefer to participate in Health Links planning and implementation. A Health Links information session for physicians was also jointly held between the Ontario Medical Association and the Central East LHIN on October 24, 2013 to further Health Links awareness. Several primary care providers are now members of Health Link improvement teams, identifying complex patients, testing processes, and suggesting refinements before implementation. Through strong physician engagement the Central East LHIN will continue to form partnerships and collaborations with all members of the circle of care, ultimately leading to enhanced patient care at all levels of the health care system.

Regional, County and Municipal Councils

The Central East LHIN continued to visit regional, county and municipal councils in 2013/14 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. Updates on LHIN initiatives were shared with local councillors on a regular basis, including news releases and LHINfo Minutes.

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. Updates on LHIN initiatives were shared with local MPPs on a regular basis, including news releases and LHInfo Minutes. Constituency staff continued to regularly contact LHIN staff to support any health care related inquiries that were received in their offices.

Speakers' Bureau

LHIN staff and board members attended a number of third-party events in 2013/14 as part of the "Speakers' Bureau." This included health service providers' Annual General Meetings, public announcements and speaking engagement such as Seniors events hosted by local MPPs. 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 service 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.

Significant integrations that were initiated or completed in 2013/14 include:

Health Links

In November 2012, the Minister of Health and Long-Term Care announced the creation of **Health Links** to improve the co-ordination and quality of care for high-needs patients such as seniors and people with complex conditions.

• Peterborough Health Link

In Peterborough, this introduction to a new model of care has led to the development of a Peterborough Health Link (PHL). Working in consultation with patients, caregivers, physicians, and front-line staff, the PHL identified two key patient groups that would benefit from this emerging model – (1) Seniors with exacerbated congestive heart failure (CHF) and at least one other co-morbidity, with the possibility of other complicating factors (such as inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues) and (2) Patients with serious mental health and/or addictions (MHA) disorders and at least one other co-morbidity with the possibility of other complicating factors (factors like inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues). Determined to make real change that meets the needs of these priority patient groups, Peterborough Health Links agencies listened to the unvarnished perspective of patients who bravely agreed to tell their

stories to help provoke and bring about patient-centered improvement. Their stories helped identify known and previously hidden gaps in delivery systems that are contributing to patient and caregiver challenges, and adding unnecessary steps and waste. Using the stories and data, the Peterborough Health Link improvement teams began to develop and test change ideas that are now being implemented. This includes Integrated Individualized Care Plans (IICP); improved flow for Mental Health and Addictions (MH&A) clients in the Emergency Department (ED) to the Community Improvement Team and improved Transitions between the hospital, primary care providers and community-based agencies.

- **Durham North East Health Link**

At their June 24, 2013 meeting, the Board of the Central East LHIN passed a motion outlining the geographic boundaries of future Health Link areas and an implementation schedule starting in the Durham Cluster. Primary care providers and health care organizations in the Durham Cluster were invited to signal their interest in participating in one of the two Durham Health Links (Durham West or Durham North East) by completing and returning an Expression of Interest (EOI) form. Based on the responses, a Durham North East Health Link was established. The members of the Durham North East Health Link completed a standard Health Link Readiness Assessment which was submitted to the Ministry of Health and Long-Term Care. The Readiness Assessment outlines the degree of alignment to the key features of the Health Link model and the characteristics of provider groupings that are proposing to work together as a Health Link.

Community Health Services (CHS) Integration Strategy

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. With a strategic aim of designing and implementing a cluster-based service delivery model for Community Support Services (CSS) organizations and Community Health Centres (CHC) agencies by 2015, the Central East LHIN, in 2013/14, continued to support local health service providers to identify and implement front-line services, back office functions, leadership and/or governance integration opportunities in order to improve client access to high-quality services, create readiness for future health system transformation and, make the best use of the public's investment.

- **Durham Cluster - Durham North Zone Collaborative**

The Durham North Zone Collaborative which is comprised of representatives of Community Care Durham; Victorian Order of Nurses for Canada, Ontario Branch; the Regional Municipality of Durham (Adult Day Programs); and Brock Community Health Centre (Brock CHC) was established in March 2013. Brock CHC was designated the lead organization. A Durham North Zone Partnership Agreement was completed in May 2013 and signed by the Executive Directors/Designated Administrative Persons and governing bodies of the four organizations in June 2013. In July 2013, the Durham North Zone partners completed the "Strategic and Operational Plan", a forward-looking blueprint for the next three years. With a focus on a key target population of those at highest risk and a commitment to supporting local residents in a coordinated, cost effective manner, the Collaborative worked together to develop and deliver expanded exercise and falls prevention classes in the local communities, work with the CCAC on service needs in north Durham Region, began planning for a mobile diagnostic imaging service at a local long-term care home, developed shared accountability protocols and a collaborative intake and assessment process. The Durham North Zone also co-sponsored the very successful conference entitled "Healthy Rural Communities: Join the Dialogue on Mental Health and Addictions" held on October 4th, 2013 in Cannington.

- **Durham Cluster - Sunrise Seniors and Community Care Durham**

The Board of Sunrise Seniors worked with Community Care Durham to develop a transition plan as the accountability for delivering congregate dining and supportive housing transferred from Sunrise to

Community Care Durham effective August 31, 2013. Together the two organizations developed a plan that saw the services transferred without any disruption to the residents of the Sunrise Seniors buildings including the ongoing availability of the Lifeline support system. Community Care Durham has reported that many clients and their families now take advantage of the other services offered by their organization. These include Friendly Visiting and Transportation Services. Personal Support Workers have also supported Sunrise residents with greater access to other community services such as the Oshawa Senior Citizen's Centre, which is across the street from the Sunrise Seniors (Durham) Building.

- **Durham Cluster - Durham Hospice and VON for Canada (Ontario Branch, Durham Region Site)**

The Boards of both Durham Hospice and VON approved the Community Health Services Integration Plan which proposed the integration of hospice services between Durham Hospice and VON for Canada. An Integration Implementation Plan was prepared by the two organizations' Integration Implementation Team and presented to their respective boards. The LHIN continued to monitor their progress as this integration headed towards implementation in 2014/15.

- **Durham Cluster - Community Care Durham and Faith Place Support Services**

The Community Health Services Integration Plan for the Durham Cluster proposed the integration of congregate dining services and supportive housing between Community Care Durham and Faith Place Support Services. The two organizations prepared an Integration Implementation Plan which was reviewed by their respective Boards and the accountability for delivering the services was transferred to Community Care Durham. The integration was implemented as of March 31, 2014 and has been met by positive feedback from the affected staff and clients.

- **Durham Cluster - Community Care Durham and VON for Canada (Ontario Branch, Durham Region Site)**

The Boards of both CCD and VON approved the Integration Plan which recommended the integration of volunteer visiting services between Community Care Durham and VON for Canada (Ontario Branch, Durham Region Site). The two organizations met with their volunteers and clients in December and January and prepared an Integration Implementation Plan which was reviewed by their respective Boards. The Integration Implementation Plan was presented to the LHIN Board in March 2013 and the integration was implemented as of March 31, 2014.

- **Durham Cluster – The Youth Centre and Oshawa Community Health Centre**

Based on a demonstrated willingness by both organizations to continue working together, the Boards of the Oshawa Community Health Centre and The Youth Centre partnered in the development of a directional plan confirming how they would move forward with the integration opportunities outlined in the Durham CHS Final Integration Plan. On July 24, 2013, the Board of the Central East LHIN endorsed a Directional Plan after it was approved by the Boards of The Youth Centre and the Oshawa Community Health Centre. The Directional Plan showed that the organizations agreed, in principle, to come together to form a single Community Health Centre. This led to the development of an Integration Implementation Plan which in December 2013 was approved by the OCHC Board and rejected by The Youth Centre Board. LHIN staff did some further analysis of the Integration Implementation Plan which was then presented to the LHIN Board at its Open Meeting on February 26, 2014, specifically around meeting the health needs of youth and seniors in West Durham. Afterwards the LHIN engaged both Boards to discuss the Integration Plan, its process and began to explore strategic opportunities for service expansion of both Youth and Adult services more broadly in South Durham. This work will continue in 2014/15.

- **Durham Cluster – Oshawa Senior Citizens Centre and Community Care Durham**

Based on the effective footcare service delivery model already in place across Durham Region, the accountability for the delivery of footcare services in the City of Oshawa remained with the Oshawa Senior Citizens Centre as Community Care Durham continued to offer services in the remainder of the

Region. Oshawa Senior Citizens Centre and Community Care Durham worked together to enhance the coordination of referrals and delivery of Foot Care Services between the two organizations.

- **North East Cluster – Community Care City of Kawartha Lakes and CHC/Community Care Haliburton County/Haliburton Highlands Health Services/Ross Memorial Hospital/Supportive Initiatives for Residents in the County of Haliburton (SIRCH Community Services)/Victorian Order of Nurses – Ontario Branch, Peterborough, Victoria and Haliburton**

Starting in January 2013, a group of Health Service Providers (HSPs) from Haliburton County and the City of Kawartha Lakes met as part of the CHS facilitated integration process. After months of due diligence and stakeholder engagement, the Integration Planning Team (IPT), which was comprised of senior administrative representatives from **six local agencies**, developed an “Integrated Governance and Service Delivery Model” which was included in a “Final Integration Plan - Hospital and Community Health Services Integration – Haliburton County and City of Kawartha Lakes.” The Final Integration Plan recommended how hospitals and community-based health services could be delivered in the future to improve client access to high-quality services, create readiness for future health system transformation and make the best use of the public’s investment. The Plan was presented to the Health Service Provider Boards in November 2013 and early December and LHIN Board on December 18, 2013 for final decisions and was approved by all parties. The organizations moved forward with developing transition plans to support the implementation of the integrations contained in the Final Integration Plan.

- **North East Cluster – Campbellford Memorial Hospital/Campbellford Multicare Lodge/Community Care Northumberland/Branch 133 Legion Village/Northumberland Hills Hospital/Port Hope Community Health Centre/Victoria Order of Nurses – Ontario Branch, Hastings, Northumberland and Prince Edward County**

Similarly a group of Health Service Providers (HSPs) from Northumberland County participated in the CHS facilitated integration process. After months of due diligence and stakeholder engagement, the Integration Planning Team, which was comprised of senior administrative representatives from **seven local agencies**, developed an “Integrated Governance and Service Delivery Model” which was included a “Final Integration Plan - Hospital and Community Health Services Integration – Northumberland County” that was approved by the IPT and LHIN Boards in February 2014. The organizations moved forward with developing transition plans to support the implementation of the integrations contained in the Final Integration Plan.

- **North East Cluster - Community Care Peterborough/Community Counselling & Resource Centre/Hospice Peterborough/Lovesick Lake Native Women's Association/St. John's Retirement Homes Inc./Victorian Order of Nurses for Canada, Ontario Branch**

The Peterborough City and County CHS Integration Strategy process began in August 2013 with a select group of community-based providers forming a Peterborough Integration Planning Team (IPT). As of March 2014, the IPT, with the support of their respective Boards, had developed a Directional Statement that provided the necessary guidance to develop a Draft Integrated Service Delivery Model. The IPT was getting ready to share the Draft Model with their stakeholders for input and conducting additional due diligence before developing a Final Integration Plan to be presented to the respective Boards in 2014/15.

- **Scarborough Cluster - TAIBU Community Health Centre/Scarborough Centre for Healthy Communities/St. Paul's L'Amoreaux Centre/TransCare Community Support Services/Centre for Immigrant and Community Services**

The Scarborough CHS Integration Strategy process began in August 2013 with a select group of providers forming a Scarborough Integration Planning Team (IPT). On December 18th, 2013, after being presented to each of the IPT boards, a Directional Plan was presented to the Central East LHIN Board of Directors. In acknowledging receipt of the Plan, which was endorsed by 4 of 5 of the participating health

service providers, the LHIN Board directed the IPT to do further analysis to support the development of a Draft Integrated Service Delivery Model. It was expected that a Final Integration Plan would be presented to the respective Boards in 2014/15.

Voluntary Integration of Sexual Assault and Domestic Assault Aftercare Services between The Scarborough Hospital and The Scarborough Centre for Healthy Communities

The Scarborough Hospital (TSH) and Scarborough Centre for Healthy Communities (SCHC) submitted a Voluntary Integration Proposal to the Central East LHIN in July of 2013 that proposed the integration of TSH's Sexual Assault and Domestic Assault Aftercare Services (SA/DVTC) with existing services at SCHC. Acute care services offered within the SA/DVTC at TSH were not in scope for this Voluntary integration. The voluntary integration proceeded in October 2013. By developing a comprehensive referral and intake process that ensured a smooth transition, clients now have increased access to sexual assault and domestic violence counselling, more community-based services such as access to primary care or additional support services now being "wrapped around" the client.

Ontario Shores/Northumberland Hills/Campbellford Memorial Hospital Community Mental Health Integration

The voluntary integration of Community Mental Health Programs at Northumberland Hills Hospital (NHH) and the Ontario Shores Centre for Mental Health Sciences (OSCMHS) occurred in 2010. NHH developed a partnership with OSCMHS in order to strengthen their commitment and improve access to mental health care. Building on the success of this partnership, Campbellford Memorial Hospital (CMH) submitted a Voluntary Integration Proposal to the Central East LHIN on August 23, 2013 to join with NHH and OSCMHS. This partnership, which was "not stopped" by the LHIN Board and therefore proceeded sought to:

- Build local capacity to offer quality-driven Mental Health Services and Supports
- Coordinate those services and supports more effectively
- Reduce time spent in hospital and wait times for specialty services
- Ensure that people were able to access the services and supports they require closer to home

Since moving forward, the three organizations have developed joint supervision and training for frontline staff, have synchronized all electronic clinical documentation, jointly recruited psychiatrists in order to reduce local wait times and made effective use of the Ontario Telemedicine Network to support access to speciality services.

The Scarborough Hospital – Rouge Valley Facilitated Integration

In the spring of 2013 the Board of the Central East LHIN directed 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 preferred integration plan developed by early September 2013 and submitted to the respective hospital boards later in September and the Central East LHIN Board in October 2013, an Integration Leadership Committee was formed and committed to engaging and hearing from community residents, patients and caregivers, volunteers, front line staff, physicians, local government stakeholders and other health care partners, on how the hospitals could build a new, stronger integrated model for delivering health care services in Scarborough.

In January 2014, the two hospitals submitted a joint *Notice of Intent to Merge* to the Central East LHIN after developing a preferred integration plan in partnership with their physicians, staff, and community members. After submitting the notice the two hospitals continued to work together to complete additional documentation and confirm the level of financial support they would require to merge the organizations, specifically related to capital planning and operational funding.

In March 2014, the Rouge Valley Health System Board passed a motion agreeing to proceed with the merger and The Scarborough Hospital Board passed a motion to not proceed with the merger. The hospitals then rescinded their *Notice of Intent to Merge*.

The LHIN staff continue to work with both hospitals, their administrative and physician leaders and their staff to integrate appropriate back office services and clinical programs that will improve access and quality and support the ongoing transformation of the health care system. Work is expected to continue in 2014/15 on identified clinical and back office integrations that will improve quality, safety, accessibility and fiscal responsibility.

ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE

In 2013/14 the Central East LHIN received a total operating budget of \$6.6 million which included operations at \$4.5 million and additional funding of \$2.1 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; Enabling Technologies 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 Diabetes & Vascular Health funding was received for the full 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 Central East LHIN continued to complete a detailed agency risk assessment tool report that introduces a risk-based reporting mechanism to assess the agency risks, identify mitigating options and provide context for a risk management plan. This report was submitted annually to the Ministry and the LHIN continued to identify and mitigate risk by ensuring compliance with directives, business processes, governance practices and applying appropriate issues management strategies.

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 continued to ensure that all staff positions supported 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 the additional Diabetes & Vascular health funding the staff complement of 42 FTEs effectively managed a \$2.2 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 2013/14, the structure to support the successful implementation of the Code included ongoing promotion with staff, implementation of a compliance procedure, ongoing policy development and education initiatives.

http://www.centraleastlhin.on.ca/Page.aspx?id=18896&ekmense1=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, 2014, and the statements of operations, 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, 2014, and the results of its operations, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in black ink that reads "Deloitte LLP".

Chartered Professional Accountants,
Chartered Accountants
Licensed Public Accountants
May 28, 2014

Statement of Financial Position

Central East Local Health Integration Network

Statement of financial position as at March 31, 2014

	2014	2013
	\$	\$
Financial assets		
Cash	672,385	692,314
Due from Ministry of Health and Long Term Care ("MOHLTC")	14,644,300	4,507,430
Accounts receivable	46,133	45,680
Due from LHIN Shared Services Office ("LSSO")	7,266	40,267
	15,370,084	5,285,691
Liabilities		
Accounts payable and accrued liabilities	533,612	541,153
Due to LSSO	1,464	-
Due to Health Service Providers ("HSP")	14,644,300	4,507,430
Due to MOHLTC (Note 3b)	44,335	268,988
Due to Central West LHIN (Note 3c)	172,238	-
Deferred capital contributions (Note 5)	211,679	212,202
	15,607,628	5,529,773
Net debt	(237,544)	(244,082)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	25,865	31,880
Tangible capital assets (Note 7)	211,679	212,202
	237,544	244,082
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)

Statement of Financial Activities

Central East Local Health Integration Network

Statement of financial operations
year ended March 31, 2014

	Budget (Note 8)	2014 Actual	2013 Actual
	\$	\$	\$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	2,084,259,282	2,207,469,168	2,163,791,335
Operations of LHIN	4,534,130	4,472,532	4,388,751
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)		802,027	580,000
Critical Care (Note 10e)		75,000	75,000
French Language Services (Note 10f)		106,000	106,000
Diabetes & Vascular Health (Note 10g)		779,061	127,717
Diabetes & Vascular Health OT (Note 10g)		30,000	122,100
Physio Funding (Note 10h)		27,344	-
Primary Care (Note 10i)		75,000	75,000
Amortization of deferred capital contributions (Note 5)		124,356	170,700
	2,088,793,412	2,214,155,488	2,169,631,603
Funding repayable to the MOHLTC (Note 3a)		(216,573)	(268,988)
	2,088,793,412	2,213,938,915	2,169,362,615
Expenses			
Transfer payments to HSPs (Note 9)	2,084,259,282	2,207,469,168	2,163,791,335
General and administrative (Note 11)	4,534,130	4,586,844	4,540,884
ED Lead (Note 10a)		72,000	72,000
ER/ALC (Note 10b)		91,753	75,955
Aboriginal Planning (Note 10c)		11,489	1,525
eHealth (Note 10d)		629,789	460,669
Critical Care (Note 10e)		72,000	72,000
French Language Services (Note 10f)		106,000	106,000
Diabetes & Vascular Health (Note 10g)		767,528	78,357
Diabetes & Vascular Health OT (Note 10g)		30,000	88,890
Physio Funding (Note 10h)		27,344	-
Primary Care (Note 10i)		75,000	75,000
	2,088,793,412	2,213,938,915	2,169,362,615
Annual surplus and accumulated surplus, end of year	-	-	-

Statement of Changes in Net Debt

Central East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2014

	Budget	2014 Actual	2013 Actual
	\$	\$	\$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(123,833)	(145,379)
Amortization of tangible capital assets	-	124,356	170,700
Change in other non-financial assets	-	6,015	3,809
Decrease in net debt	-	6,538	29,130
Net debt, beginning of year	-	(244,082)	(273,212)
Net debt, end of year	-	(237,544)	(244,082)

Statement of Cash Flows

Central East Local Health Integration Network

Statement of cash flows

year ended March 31, 2014

	2014	2013
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	124,356	170,700
Amortization of deferred capital contributions (Note 5)	(124,356)	(170,700)
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	(10,136,870)	(1,413,630)
(Increase) decrease in accounts receivable	(453)	187,911
Decrease in due from LHIN Shared Services Office ("LSSO")	33,001	-
(Decrease) increase in accounts payable and accrued liabilities	(7,541)	202,943
Increase in due to LSSO	1,464	-
Increase in due to HSPs	10,136,870	1,413,630
Decrease in due to the MOHLTC	(224,653)	(240,312)
Increase in due to Central West LHIN	172,238	-
Decrease in prepaid expenses	6,015	3,809
	(19,929)	154,351
Capital transaction		
Acquisition of tangible capital assets	(123,833)	(145,379)
Financing transaction		
Capital contributions received (Note 5)	123,833	145,379
Net (decrease) increase in cash	(19,929)	154,351
Cash, beginning of year	692,314	537,963
Cash, end of year	672,385	692,314

Variance of \$ 3,354.66

Total cash balance per 2013 Statement of cash flows is \$ 692,314 and total per general ledger is \$ 695,668.72.

Variance due to a chq# 005466 CompuCom Cheque dated March 28,2013 was voided on May 10, 2013 and reissued. (chq# 005568)

Notes to the Financial Statements

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 km²). 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, 2014.

The LHIN enters into service accountability agreements with service providers.

1. 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, 2014.

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 Operations, 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 Operations 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. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

2. 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:

			2014	2013
	Funding received	Eligible expenses	Excess funding	Excess funding
	\$	\$	\$	\$
Transfer payments to HSPs	2,207,469,168	2,207,469,168	-	-
LHIN operations	4,596,888	4,586,844	10,044	18,567
ER/ALC	100,000	91,753	8,247	24,045
ED/Lead	75,000	72,000	3,000	3,000
Critical Care	75,000	72,000	3,000	3,000
Enabling technologies	-	-	-	119,331
Aboriginal Planning	20,000	11,489	8,511	18,475
French Language Services	106,000	106,000	-	-
Diabetes & Vascular Health	779,061	767,528	11,533	49,360
Diabetes & Vascular Health OT	30,000	30,000	-	33,210
Behavioural Supports	27,344	27,344	-	-
Primary Care Lead	75,000	75,000	-	-
Repayable directly to MOHLTC	2,213,353,461	2,213,309,126	44,335	268,988
Enabling technologies repayable to MOHLTC through Central West LHIN	802,027	629,789	172,238	-
	2,214,155,488	2,213,938,915	216,573	268,988

3. Funding repayable to the MOHLTC (continued)

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

	2014	2013
	\$	\$
Due to MOHLTC, beginning of year	268,988	331,749
Recovery by MOHLTC during the year	(268,988)	(331,749)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	44,335	268,988
Due to MOHLTC, end of year	44,335	268,988

c) Effective February 1, 2012, the LHIN entered into an agreement with Central, Central West, Central East, Toronto Central, Mississauga Halton and North Simcoe Muskoka (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses.

The following provides condensed financial information:

	2014	2013
	\$	\$
Revenue	802,027	-
Expenses	629,789	-
Accumulated surplus due to the LHIN	172,238	-

3. 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.

4. Deferred capital contributions

	2014	2013
	\$	\$
Balance, beginning of year	212,202	237,523
Capital contributions received during the year	123,833	145,379
Amortization for the year	(124,356)	(170,700)
Balance, end of year	211,679	212,202

5. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due to October 31, 2020 are as follows:

	\$
2015	250,361
2016	251,511
2017	254,721
2018	257,948
2019 and beyond	677,433
	<u>1,691,974</u>

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:

	\$
2015	2,152,849,191
2016	<u>2,152,434,291</u>

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

6. Tangible capital assets

			2014	2013
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	741,340	556,600	184,740	150,382
Computer equipment	317,847	300,325	17,522	11,107
Web development	36,100	28,507	7,593	7,593
Leasehold improvements	668,028	666,204	1,824	43,120
	<u>1,763,315</u>	<u>1,551,636</u>	<u>211,679</u>	<u>212,202</u>

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Operations reflect the initial budget at April 1, 2013. 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 \$2,207,469,168 is made up of the following:

	\$
Initial HSP funding budget	2,084,259,282
Additional funding due to announcements made during the year	123,209,886
Total HSP funding budget	<u>2,207,469,168</u>

8. Budget figures (continued)

The total revised operating budget of \$6,685,802 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
Enabling Technologies	802,027
Aboriginal Planning	20,000
French Language Services	106,000
Diabetes & Vascular Health	871,301
Primary Care	75,000
Physio Funding	27,344
Total budget	6,685,802

8. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of \$2,207,469,168 (2013 - \$2,163,791,335) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2014 as follows:

	2014	2013
	\$	\$
Health Infrastructure Renewal Fund		-
Operation of hospitals	1,260,843,365	1,263,345,821
Grants to compensate for municipal taxation - public hospitals	279,675	281,250
Long term care homes	428,323,700	414,237,631
Community care access centres	252,697,822	241,514,062
Community support services	41,483,398	34,631,413
Assisted living services in supportive housing	14,634,683	13,880,255
Community health centres	29,231,688	22,142,397
Community mental health addictions program	64,683,560	59,747,858
Specialty psychiatric hospitals	113,654,937	112,515,437
Acquired brain injury	1,610,915	1,469,786
Grants to compensate for municipal taxation - psychiatric hospitals	25,425	25,425
	2,207,469,168	2,163,791,335

9. Separate funding amounts 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 (2013 - \$75,000) related to the ED Lead project. ED Lead expenses incurred during the year consist of \$72,000 (2013 - \$72,000) of consulting services.

b) ER/ALC

The LHIN received funding of \$100,000 (2013 - \$100,000) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of \$90,000 (2013 - \$75,133) of salaries and benefits and \$1,753 (2013 - \$822) of other expenses.

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

c) Aboriginal Planning

The LHIN received funding of \$20,000 (2013 - \$20,000) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of \$11,489 (2013 - \$1,525) of other expenses.

d) Enabling Technologies for Integration Project Management Office

The LHIN received funding of \$802,027 (Note 3(c)) (2013 - \$580,000) related to the Enabling technologies project. Enabling technologies project expenses incurred during the year are as follows:

	2014	2013
	\$	\$
Consulting services	3,359	-
Salaries and benefits	308,260	315,773
Meetings	1,297	5,410
Supplies and other	316,874	139,486
	629,790	460,669

e) Critical Care

The LHIN received funding of \$75,000 (2013 - \$75,000) related to the Critical Care project. Critical Care project expenses incurred during the year consist of \$72,000 of consultant expenses (2013 - \$72,000).

f) French Language Services

The LHIN received funding of \$106,000 (2013 - \$106,000) related to the French Language project. French Language project expenses incurred during the year consist of \$95,188 of salaries and benefits (2013 - \$100,478) and \$10,812 of other expenses (2013 - \$5,523).

g) Diabetes & Vascular Health

The LHIN received funding of \$841,301 (2013 - \$249,817) in base funding and \$30,000 in one time funding, of which \$809,061 is included in the Statement of operations and \$62,240 is included in Deferred capital contributions on the Statement of financial position. Expenses incurred of \$797,528 are made up as follows:

	2014	2013
	\$	\$
Salaries and benefits	539,126	57,051
Operating expense	228,402	21,306
One time expense	30,000	88,890
	797,528	167,247

In addition, capital asset purchases of \$62,240 are included in tangible capital assets on the Statement of financial position.

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

h) Physiotherapy

During fiscal 2014, the LHIN received funding of \$27,344 (2013 - \$Nil) towards resources to support the Physiotherapy Initiative. Project expenses incurred during the year consist of \$27,344 (2013 - \$Nil) of consulting expenses.

i) Primary Care

The LHIN received funding of \$75,000 (2013 - \$75,000) related to the Primary Care project. Primary Care project expenses incurred during the year consist of \$74,851 (2013 - \$75,000) of consulting fees and \$149 (2013 - \$Nil) of meeting expenses.

10. General and administrative expenses

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

	2014	2013
	\$	\$
Salaries and benefits	3,431,592	3,338,338
Occupancy	254,138	175,397
Amortization	124,356	170,700
Shared services	406,019	429,020
Community engagement	12,048	15,352
Consulting services	29,702	74,029
Supplies	131,616	95,930
Board member expenses	90,405	90,979
Mail, courier and telecommunications	1,922	2,262
Other	105,046	148,877
	4,586,844	4,540,884

Included in board member expenses are board per diems and expenses as follows:

	2014	2014	2013
	Budget	\$	\$
Board chair per diem expense	74,000	30,100	28,110
Other board members per diem expense	50,000	36,525	46,067
Governance costs and travel	20,000	23,780	16,802
Total expenses	144,000	90,405	90,979

11. 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 2014 was \$329,175 (2013 - \$276,327) for current service costs and is included as an expense in the Statement of Operations. The last actuarial valuation of the plan was completed for the plan as of December 31, 2013. At that time, the plan was fully funded.

12. 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*.

13. Comparative figures

Certain comparative numbers have been reclassified to conform to the current year presentation.

STAFF MEMBERS



Front Row

Marco Aguila, Paul Barker, Kelly Sanders, Karen Poon, Kate Lowndes, Chantelle Vernon, Jennifer Persaud, Janice Kelly, Usha Cithiravel, Emily Van de Klippe

Second Row

Alex Ruppert, Sheila Rogoski, Christine Laity, Linda Henry, Ritva Gallant, Deborah Hammons, Trixie Williams, Romina Vicente, Lisa Kitchen, Callum Anderson, Jai Mills, Katie Cronin-Wood

Third Row

Natasha Yussuf, Vanitha Navarathinam, Sherry Harvey, Kasia Luebke, Karol Eskedjian, Karen O'Brien

Back Row

Adam Erwood, Suzette Stines-Walford, Sheila Stirling, Janet Boland, Dieufert Bellot, Brian Laundry, Lauren Chitra, Pauline Rahaman, Jeanne Thomas, James Meloche

Absent

Melissa Chard, James Draper, Tapas Kar, Jina Mintsinikas, Indra Narula, Marilee Suter, Sue Wojdylo, Jennifer Kerswill

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