Central East **LHIN**

Leading Transformation

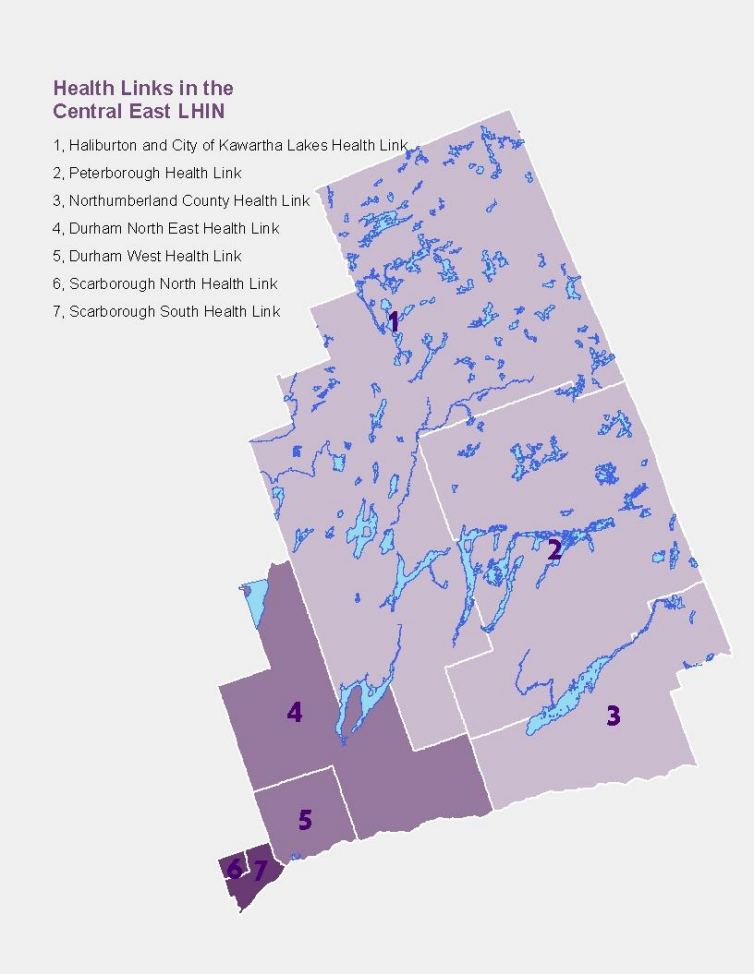
Engaged Communities. Healthy Communities.

Central East LHIN 2014-15 Annual Report

Ontario

Réseau local d'intégration des services de santé

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.

TABLE OF CONTENTS

MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report is titled *"Leading Transformation"* and is reflective of the transformative journey the Central East LHIN continued to lead in 2014/15 as it worked with its stakeholders - patients and caregivers, health care providers and other local organizations, community leaders, local residents and the Ministry of Health and Long-Term Care - to create an integrated sustainable health care system that ensures better health, better care and better value for money.

With dramatic changes underway in health care finance, clinical practice, demographic shifts, and technology, the LHIN provided strategic oversight and system leadership to a diverse health care system that encompasses Scarborough, the Region of Durham, Northumberland County, Peterborough City and County, the City of Kawartha Lakes and Haliburton County.

Accountable to the Ministry of Health and Long-Term Care to flow more than *$42 million a week* to local health service providers, the Central East LHIN continued to monitor the performance of its hospitals, the Community Care Access Centre, long-term care homes, community health centres, community support services and community-based mental health and addiction agencies, taking the necessary steps to confirm that they were meeting the obligations and responsibilities laid out in their annual Service Accountability Agreements that were then reflected in the year end report of the Ministry-LHIN Performance Agreement.

In 2014/15, the Central East LHIN was in year two of its 2013-2016 "Community First" Integrated Health Service Plan, rooted in four Strategic 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 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.

Once again, this Annual Report outlines the progress that has been made in 2014/15 on these four aims with projects and initiatives, informed by local and provincial engagement, continuing to be implemented and evolving.

Further informed by the Premier's Mandate Letter to the Minister of Health and Long-Term Care and the *Patients First:Action Plan for Health Care*, the LHIN also focussed its attention on four key Ministry objectives including providing faster access to the right care; delivering better coordinated and integrated care in the community, closer to home; providing people with the education, information and transparency they need to make the right decisions about their health; and, making evidence based decisions on value and quality, to sustain the system for generations to come.

As always we would like to thank the hundreds of health care 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 the ongoing support of its partners, the Central East LHIN continued to demonstrate strong progress in meeting its objectives and remained committed to ongoing improvement to create a sustainable local health care system.

Original Signed By

Wayne Gladstone,
Chair

Original Signed By

Deborah Hammons,
Chief Executive Officer

MEMBERS OF THE BOARD

Standing *Sitting*

Margaret Risk, Member
Term of Office:
May 17, 2011 – May 16, 2017

Joanne Hough, Member
Term of Office:
May 4, 2011 – May 3, 2017

David Sudbury, Vice-Chair
Term of Office:
June 17, 2011 – June 16, 2016

Valmay Barkey, Member
Term of Office:
June 2, 2011 – June 1, 2015

Amorell Saunders N'Daw
Term of Office:
April 2, 2014 – April 2, 2017

Wayne Gladstone, Chair
Term of Office:
June 2, 2011 – June 14, 2016

Samantha Singh, Member
Term of Office:
June 17, 2011 – June 16, 2016

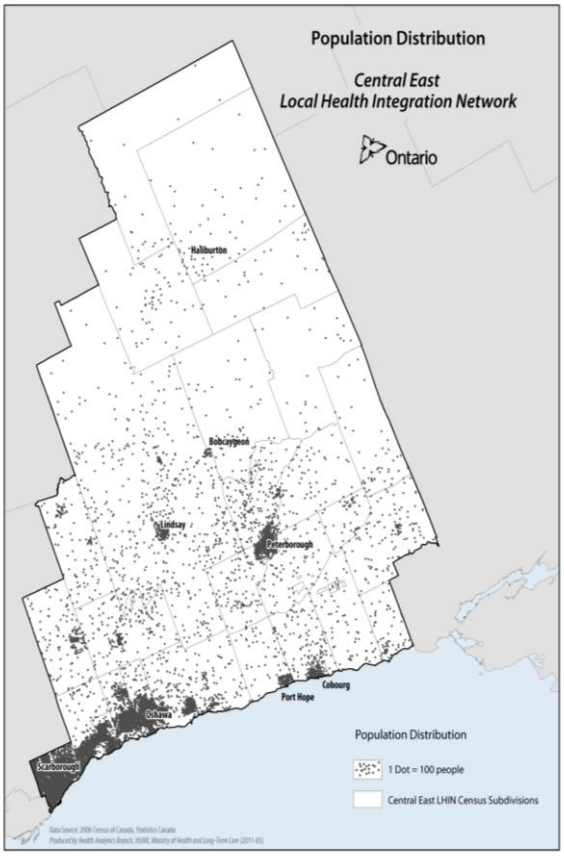
S. Gopikirishna, Member *(Absent)*
Term of Office:
October 22, 2014 – October 21, 2017

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.centraleastlhin.on.ca

INTRODUCTION

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

Population Map



As per the latest census, in 2011, the Central East LHIN had the second highest population within the Province accounting for 11.8% of the population of Ontario. Since 2006, Central East LHIN's population has experienced a slight increase 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 increased 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%, which is expected to be mirrored in the overall provincial growth rate of seniors across the province.

The Central East LHIN includes the eastern section of the city of Toronto, 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 2011 just over 70% of the LHIN's population reported English as their mother tongue, and 1.4% of the population included French as their mother tongue. Additionally 1.2% of the Central East LHIN population identified as Aborginal. In 2011, a third of the population in the LHIN were immigrants – 5.6% were recent immigrants, having arrived in Canada since 2001.

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%	

Source: IHSP 2013-2016 – Common Environmental Scan

MINISTRY/LHIN PERFORMANCE AGREEMENT (MLPA)

What is an MLPA?

The Central East LHIN and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed a performance agreement which outlines 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 Service Accountability Agreements that LHINs negotiate with all health service providers.

MLPA Performance Indicators

The *Ministry-LHIN Performance Agreement* set out the mutual understandings between the Ministry of Health and Long-Term Care and the Central East LHIN regarding their respective performance obligations for the period covering the 2014/15 fiscal year. The following table outlines the Central East LHIN's performance against targets for 2014/15.

Central East LHIN MLPA Performance Indicators 2014/15

Performance Indicator	LHIN Starting Point 14/15	LHIN Performance Target 14/15	Most Recent Quarter 14/15 LHIN Performance	FY 14/15 LHIN Annual Result
1. Access to healthcare services				
1. 90th percentile ER length of stay for admitted patients	33.72	30.00	37.25	31.30
2. 90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.45	6.45	6.12	6.08
3. 90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.13	4.00	4.03	4.02
4. Percent of priority IV cases completed within access target (84 days) for cancer surgery	96.00%	90.00%	97.94%	97.22%
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) cataract surgery	99.00%	90.00%	97.59%	98.13%
7. Percent of priority IV cases completed within access target (182 days) for hip replacement	96.00%	90.00%	93.97%	96.57%
8. Percent of priority IV cases completed within access target (182 days) for knee replacement	96.00%	90.00%	94.16%	95.28%
9. Percent of priority IV cases completed within access target (28 days) for MRI scans	47.00%	50.00%	63.24%	55.00%
10. Percent of priority IV cases completed within access target (28 days) for CT scans	91.00%	90.00%	87.38%	91.54%

Performance Indicator	LHIN Starting Point 14/15	LHIN Performance Target 14/15	Most Recent Quarter 14/15 LHIN Performance	FY 14/15 LHIN Annual Result
2. Integration and coordination of care				
11. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	13.48%	12.80%	16.53%	15.75%
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	22.00	23.00
3. Quality and improved health outcomes				
13. Readmission within 30 Days for Selected CMGs**	16.02%	14.80%	16.06%	16.22%
14. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	18.60%	17.00%	19.02%	19.78%
15. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	24.30%	22.50%	23.05%	23.97%

Note:
*** due to availability FY 2014/15 is based on most recent four quarters of data (Q4 2012/13 - Q3 2014/15)**
**** due to availability FY 2014/15 is based on most recent four quarters of data (Q3 2012/13 - Q2 2014/15)**

At the end of 2014/15, the Central East LHIN achieved **nine of the fifteen performance targets** identified in its MLPA. A description of these nine 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. Despite an upward trend between September 2014 and January 2015, the Central East LHIN met the 2014/15 MLPA target of 6.45 hours during the entire fiscal year. Achievement of this performance target continued to be supported by hospitals participating in the Pay-for-Results program. With funding provided by the LHIN for shared projects that benefitted the LHIN system as a whole, hospitals were focused on establishing or continuing Emergency Room (ER) initiatives that improved patient flow, quality and human resources practices and coverage.

Performance Indicator #4 – TARGET MET
Percent of priority IV cases completed within access target (84 days) for cancer surgery
The 97.0% annual result in this performance indicator was well above the 2014/15 negotiated target of 90% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. Lakeridge Health (LH) and Ross Memorial Hospital (RMH) provided cancer surgery to 100% of the priority IV cases within 84 days. This result was due in large part to the work completed by the Wait Time Strategy Working Group (WTSWG), which was initiated in 2009/10 with participation from all hospitals delivering Wait Times (WT) services. This Working Group provides an opportunity to its members to discuss issues and operations, identify and resolve pressures/risks, as well as to share best practices. The improved software functionality provided through the LHIN's and HSPs' investment in the Surgical Utilization Booking Management Integration Tool (SUBMIT) funded by the Central East LHIN continued to assist with the management of Wait Times.

Performance Indicator #6 – TARGET MET

Percent of priority IV cases completed within access target (182 days) for cataract surgery

The 98.0% annual result in this performance indicator was well above the 2014/15 negotiated target of 90% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. As noted above, significant engagement with hospitals, the implementation of SUBMIT, and the incorporation of this Wait Time Performance Indicator into each hospital's Service Accountability Agreement led to the Central East LHIN meeting and exceeding this target in 2014/15. The Central East LHIN, in collaboration with the clinical and financial leadership of hospitals and the Community Care Access Centre (CCAC), initiated a Vision Care Strategy Working Group in 2014/15. This Working Group met at regular intervals with the objective of both creating and advancing local and province-wide improved vision care services. In 2015/16, the Working Group will focus on improved health outcomes at the LHIN level for individuals experiencing vision care challenges.

Performance Indicator #7 – TARGET MET

Percent of priority IV cases completed within access target (182 days) for hip replacement

The 97.0% annual result in this performance indicator was well above the 2014/15 negotiated target of 90% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. Similar to Performance Indicators #4 and #6, the ongoing work of the WTSWG and the implementation of SUBMIT had a significant, positive impact on the Central East LHIN's ability to perform relative to this indicator. In addition, volumes were allocated among hospitals to optimize WT performance. Throughout 2014/15, the Central East LHIN, in collaboration with the clinical and financial leadership of hospitals and the CCAC, underwent a regional orthopaedic planning process to determine and implement the optimal model of service delivery for all orthopaedic Quality Based Procedures (QBPs). This work will continue in 2015/16.

Performance Indicator #8 – TARGET MET

Percent of priority IV cases completed within access target (182 days) for knee replacement

The 95.0% annual result in this performance indicator was well above the 2014/15 negotiated target of 90% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. An explanation of the Central East LHIN's performance relative to this indicator can be found in the details above regarding hip replacement. To address the increasing demand for knee replacements over hip replacements, hospitals were able to move volumes from hips to knees during the 2014/15 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 Magnetic Resonance Imaging (MRI) scans

The 55.0% annual result in this performance indicator exceeded the 2014/15 negotiated target of 50% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. As noted above, the Central East LHIN has relied generally on the WTSWG for performance advice. For the purposes of improving performance relative to this specific indicator; however, the Central East LHIN relied on advice of the Diagnostic Imaging (DI) Working Group. The DI Working Group examines systemic issues that affect diagnostic imaging wait times, such as the education of primary care physicians, radiologists, referral patterns and testing best practices. Together the hospitals and the Central East LHIN implemented ongoing data quality improvement initiatives through an analysis of Performance Improvement Plans (PIP) and, where appropriate, mitigation strategies were implemented to improve performance overall. Where funding permitted, volumes (operating hours) were allocated among hospitals to optimize wait time performance and unmet volumes were reallocated to hospitals that had additional capacity on an ongoing basis in order to improve on this performance indicator.

Performance Indicator #10 – TARGET MET
Percent of priority IV cases completed within access target (28 days) for Computed Tomography (CT) scans
The 92.0% annual result in this performance indicator exceeded the 2014/15 negotiated target of 90% and reflected the fact that all Central East LHIN hospitals performed above the LHIN target. An explanation of the Central East LHIN's performance relative to this indicator can be found in the details above regarding MRI. The Central East LHIN continued to closely monitor hospital performance and began to explore a Diagnostic Imaging software solution to assist with the management of Wait Times. In preparation for the launch of the Wait Time Expansion Project, hospitals began to work collectively to confirm the additional Diagnostic Imaging (MRI and CT) data elements that will be captured in 2015/16 and began to define software upgrades that will support meeting the project mandate while minimizing resource impacts.

Performance Indicator #12 – TARGET MET
90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)
Despite some challenges experienced in the third quarter of 2014/15 related to hospital surge, resulting in the Central East Community Care Access Centre (CECCAC) having to bring patients home earlier and in some cases with high services need, the LHIN met this performance target at the end of 2014/15. This was a result of the ongoing commitment of the CECCAC to the LHIN's Home First and the Alternate Level of Care and Emergency Department (ALC/ED) strategies as well as their ongoing work with the Assisted Living for High Risk Seniors (ALHRS) program on the timely identification of patients that could be moved from the Personal Support Services (PSS) waitlist to ALHRS program, most specifically in Haliburton. The LHIN and the CCAC recognized that there will be continued demand for personal support services from patients discharged from hospital and those already in the community and will continue to balance demand for service with performance priorities in 2015/16.

At the end of 2014/15, the Central East LHIN was **unable to achieve six of the fifteen performance targets** identified in its MLPA. A description of these six 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 trended below the median (36.6 hours) for ER admitted patients in fiscal year 2014/15 which is consistent with historical patterns and once again reflects the fact that ER volumes at Central East LHIN hospitals continued to grow at a significant pace. A fire that closed a Durham Region long-term care facility in October 2014, combined with the early appearance of a longer and more virulent flu season, also impacted the achievement of this performance deliverable as the system dealt with the net loss of close to one hundred long-term care beds. With LHIN facilitation the system worked together, in partnership with the local Public Health Units, to respond to these unique pressures and ensured that local residents still had access to the local health care system over the winter of 2014/15. Additional mitigation strategies to address this performance target included the ongoing implementation of Emergency Department Medical Short Stay Units at Rouge Valley Ajax Pickering and the Peterborough Regional Health Centre, the facilitation of the early identification by case managers from the Central East Community Care Access Centre (CECCAC) of individuals who could be better supported in the community (thereby averting an admission), investments in complex in-patient discharge teams at Lakeridge Health, and additional emergency department resources (i.e. Physician-Enhanced coverage, Nurse Practitioners).

Performance Indicator #3 – TARGET UNMET
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients
In 2014/15, the Central East LHIN had met the MLPA target of 4.0 hours in eleven of the twelve months for 90th percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients. As noted above, the earlier appearance of a longer and more virulent flu season saw the system slightly exceed the performance

target in the month of March and resulted in the LHIN not meeting this performance target. Mitigation strategies being implemented for 90th Percentile ER Length of Stay for Admitted Patients performance target will also support the ongoing achievement of this performance target in 2015/16.

Performance Indicator #11 – TARGET UNMET
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:
The ongoing inability of the LHIN to meet this performance target reflects the fact that the Central East LHIN continued to have one of the lowest rate of long-term care beds for the age 65+ population in the province. This limited the ability to appropriately discharge patients from acute, post-acute and complex continuing care hospital beds. To respond to this challenge, Ministry and LHIN funding for the Home First initiative continued to support the delivery of enhanced service levels in the community and extensive education and training was undertaken with staff, physicians, patients and family members.

Performance Indicator #13 – TARGET UNMET
Readmission within 30 Days for Selected CMGs
The Central East LHIN continued to monitor this performance target in 2014/15 and supported ongoing initiatives to better meet the readmission rate deliverable. These included collaboration between the Regional Cardiac Care Program and the Centralized Diabetes Intake initiative to increase access and streamline referrals in order to better coordinate care for patients with diabetes, complex diabetes and cardiac patients, and the establishment of Health Links to develop coordinated care plans for complex patients with Chronic Obstructive Pulmonary Disease (COPD), Cardiac, and diabetes problems. All hospitals identified strategies to reduce readmission rates for patients with Pneumonia, Congestive Heart Failure (CHF) and COPD in their 2014/15 hospital quality improvement plans. These improvements are expected to show a decrease of readmissions within 30 days for Selected CMGs in 2015/16.

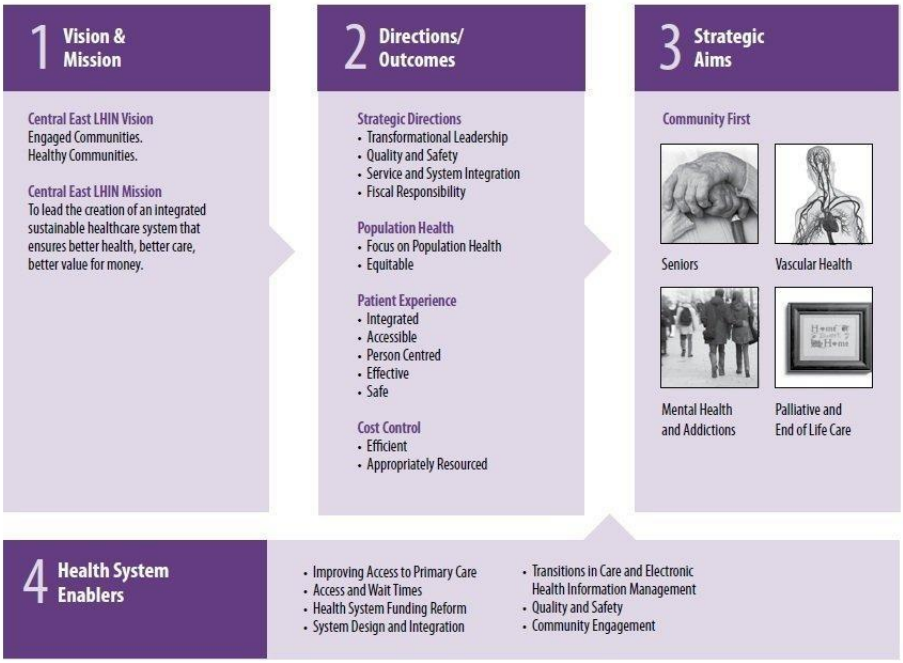
Performance Indicator #14 – TARGET UNMET
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
In 2014/15, the Central East LHIN completed an internal evaluation of the existing initiatives that were implemented in order to support the achievement of this MLPA indicator. This included a review of the Hospital to Home (H2H) Program and the Opiate Strategy as they continued to be spread across the entire LHIN region. The ongoing implementation of the Central East LHIN's Mental Health and Addictions Strategy focused on the implementation of quality initiatives related to Assertive Community Treatment Teams (ACTT) and Hospital Based Child and Adolescent Services, as well as the Community Crisis Review Project that developed recommendations designed to improve that system across the LHIN. The appointment of a Mental Health and Addictions Physician Lead in April 2014 and the launch of the Central East LHIN Mental Health and Addictions Coordinating Council in June 2014 supported outreach with physician leaders and providers, and combined with significant community investments in mental health and addiction services in December 2014 to better position the Central East LHIN to meet this performance target in 2015/16.

Performance Indicator #15 – TARGET UNMET
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions
Aligned with the activities outlined in Performance Indicator #14, the Central East LHIN undertook planning in 2014/15 that supported additional targeted investments in the existing Hospital to Home (H2H) program and new "Housing Now" strategies. It is expected that the LHIN will be able to improve upon its performance for this indicator in 2015/16.

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN 2013-2016

The Central East LHIN is now at the end of year two of its 2013-2016 Integrated Health Service Plan. With the support of its partners, the Central East LHIN continued to demonstrate strong progress in meeting its objectives and remained committed to ongoing improvement to create a better 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 continued to provide the basis for decision making that is supporting a high performing system to 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***".



Our strategy is further broken down into four aims which are continuing to guide the system into 2016:

- 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 2014/15 during the implementation of our second 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 as the aging population grew and seniors complex health care needs increased. Through a LHIN-wide regional approach to coordinating, organizing and governing existing and new specialized geriatric services, the LHIN again worked with its health service providers to foster improvements in the health care experience of older adult patients and their caregivers, as well as in the overall quality and sustainability of the health care system.

Seniors Care Network

This was done in partnership with the Seniors Care Network (previously known as Central East LHIN's Regional Specialized Geriatric Services entity) a group of senior health care leaders representating hospitals, community service providers, seniors' advocates and others from across the Central East LHIN. Supported by the LHIN, the Seniors Care Network is working along with health service providers (HSPs) on the development, delivery and monitoring of an integrated regional system of Specialized Geriatric Services for frail seniors.

As a regional system, the mission of the Seniors Care Network and its membership is to work together to create and maintain a high quality, integrated, person-centered network that ensures the best quality of life for frail older adults and their families by improving care, fostering excellence and increasing awareness of age-related health needs.

In 2014/15 the Seniors Care Network continued to develop and support the implementation of a number of regional programs and initiatives:

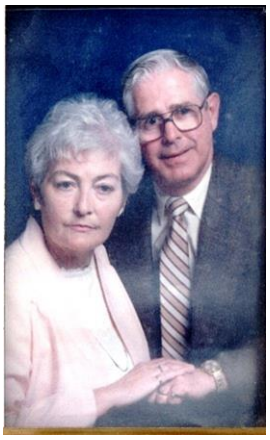
Geriatric Assessment and Intervention Network (GAIN)

Access to the Geriatric Assessment and Intervention Network (GAIN) clinics was significantly increased in 2014/15 as the six new community-based GAIN Teams became operational. Paired with the four existing hospital-based GAIN clinics, work began to

In the fall of 2014, Frank Fitzgerald, of Montreal, found himself in the difficult position of having to be caregiver to his parents who lived in Peterborough.

He had no knowledge of what care options were available in Ontario and had no idea where to start.

The local GAIN clinic in Peterborough was able to provide his parents Elizabeth Fitzgerald, 77 and Frank Fitzgerald, 82, the support and care they needed.



Elizabeth was provided with Personal Support Worker (PSW) care and a nurse practitioner that monitored her medical care.

Frank Sr., Elizabeth's main caregiver, suffered weight loss as his wife's health worsened and was not able to cope when she passed away. GAIN addressed his nutritional needs and his personal loss was greeted with compassion.

Frank, Jr. could not be more grateful for the GAIN team.

"They held my hand and they walked beside me," Frank said. "They were a guiding light and a support system."

fully operationalize the inter-professional teams in Scarborough, Durham Region, Lindsay, Peterborough and Northumberland in order to continue to support patients at home in the community. To increase access to specialized geriatric care in rural communities, the Central East LHIN funded two rural community GAIN teams based at the Haliburton Highlands Health Services and Campbellford Memorial Hospital. These teams will be fully operational early in 2015/16. Using gerontological best practices, standardized assessments and protocols, GAIN teams create individualized integrated care plans for high risk seniors and provide Intensive Case Management to clients who require such level of care.

Geriatric Emergency Management (GEM)
GEM nurses provide specialized geriatric emergency management services to frail older adults in the Emergency Department (ED). The goal of the GEM program is to deliver targeted geriatric assessments to high-risk seniors in the Emergency Department and to help seniors' access appropriate services and/or resources that will enhance functional status, independence and quality of life. In 2014/15, GEM nurses continued to build geriatric and senior-friendly capacity within Central East LHIN hospitals through knowledge transfer and education opportunities for staff. There were nine GEM nurses working at nine hospitals within the Central East LHIN in 2014/15, uniquely positioned within the Emergency Departments to identify and assess at-risk seniors and connect them with services to better meet their health needs.

Behavioural Supports Ontario (BSO)
This provincial and LHIN initiative to improve care for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions continued in 2014/15. This initiative is comprised of dedicated behavioural support staff who were embedded in 18 of the LHIN's 68 long-term care homes (LTCH). Thirteen early adopter LTCHs continued to have ongoing responsiblity to mentor and coach "buddy" homes to guide implementation of the value stream process and associated tools. Integrated Care Teams (ICT) along with Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT), Geriatric Mental Health Outreach Teams (GMHOT) and Psychogeriatric Resource Consultants (PRC) and existing system resources continued to collaborate to support LTCH residents with responsive behaviours. Key achievements in 2014/15 included the restructuring of the BSO Design Team, the articulation of key strategies to guide work plans, quality improvement initiatives to spread and sustain the program, a continued emphasis on building capacity, implementation of streamlined metrics collection, the revision and implementation of the key process tool (Behavioural Assessment Tool), Phase 2 of the LTCH qualitative evaluation, stakeholder engagement events, embedding BSO resources in all GAIN teams, and the initial spread of BSO philosophy to the hospital sector through the Senior Friendly Hospital Working Group.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
In 2014/15, NPSTAT continued to include a team of six full-time Nurse Practitioners (NPs) and five part-time NPs who were actively engaged in 61 of the 68 Long-Term Care homes(LTCH) in the Central East LHIN. Based at the Central East Community Care Access Centre (CECCAC), the team continued to work with the Long-Term Care homes and other partners to ensure that long-term care home residents had access to timely, high quality care within their homes, continued to prevent potentially avoidable hospital transfers from long-term care and built capacity for long-term care home staff to support resident clinical care. Through hundreds of face-to-face encounters, telephone consultations and capacity building events with LTCH staff, the NPSTAT team supported the delivery of timely care to long-term care residents for medical conditions in their own home and also ensured that patients were discharged from the hospitals and back to the long-term care homes in a timely manner.

Community-Based Investments

There is no place like home to recover from illness, regain strength and make important lifestyle decisions. That is 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. In 2014/15, 10,118 patients were discharged to home on enhanced CCAC services through the Home First initiative.

Aligned with the expansion of the GAIN Model, the Central East LHIN also 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, increasing the number of frail, elderly clients in existing adult day programs, including expansion to programs funded in FY 2013/14; implementing a mental health and addictions strategy and, increasing the number of specialized teams supporting mental health clients receiving care in their homes.

Assess and Restore

Assess and Restore (A&R) is an approach to care introduced by the province to support frail seniors to live independently in their communities for as long as possible. In 2014/15, the Central East LHIN continued to support this initiative by providing five hospitals and one community-based health service provider with the funding to support people with individualized bundles of short term rehabilitative and other restorative care services delivered by teams that included regulated health professionals with expertise in geriatrics.

Expanding Physiotherapy for Seniors and Patients

In April 2013, the Ministry of Health and Long-Term Care announced improved access to high-quality physiotherapy services and exercise and fall prevention classes for more than 200,000 additional seniors and patients across the province. In 2014/15, the Central East LHIN, in conjunction with the MOHTLC and local health service providers, expanded the sites for Exercise and Falls Prevention Classes to 165 locations across the Central East LHIN; implemented physiotherapy in primary care settings; ensured the Central East Community Care Access Centre (CECCAC) was the single point of access for all publically funded one-on-one in home physiotherapy services; and continued to provide funding for community-based physiotherapy clinics as well as physiotherapy and exercise activities in the LHIN's long-term care homes.

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 and specialty care, the CECCAC and community agencies and stronger partnerships with patients and their families, the Central East LHIN continued to lead the system in 2014/15 to deliver on the regional coordination of diabetes education and care, vascular services, cardiac rehabilitation, stroke care and stroke rehabilitation.

Diabetes Education Programs

The LHIN continued to work with the Diabetes Education Programs (DEP) on an indepth analysis of their Quality Improvement Plans with the goal of improving the flow of patients within the system and increasing access to diabetes care throughout the LHIN. Each cluster (Scarborough, Durham, Northeast) developed a diabetes network to review metrics, identify service gaps and strategies to improve the coordination of care and reported their progress to the LHIN each quarter. The Central East LHIN's Vascular Health Strategic Aim Coalition, in partnership with health care providers, continued to monitor the implementation of the Vascular Health Strategic Aim strategy and initiated projects with a regional integrated approach to care.

Complex Diabetes Care Centres

The Central East LHIN's three Complex Diabetes Care Centres (CCDC), originally opened in November 2012, are located within The Scarborough Hospital, Lakeridge Health and Peterborough Regional Health Centre. In 2014/15, 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 CCAC's Centralized Diabetes Intake Service assesses patient referrals.

Centralized Diabetes Intake and Referral

The Central East LHIN and Central East CCAC led the development and implementation of a centralized diabetes intake and referral process. In 2014/15, this service was integrated with the Cardiac Rehabilitation and Secondary Prevention services to increase access and streamline referrals. Local residents, providers and/or caregivers are able to contact one telephone number resulting in increased access and navigation through available services. The service surpassed their referral target of 880, with a total number of 1,009 referrals for 2014/15.

Stroke Quality Based Procedure (QBP)

The Stroke Quality Based Procedure (QBP) planning process made significant progress in 2014/15. A working group was developed and reviewed the flows across the stroke care continuum to help identify best practices and models of care delivery using the Decision Making criteria. In October 2014, the working group reported and presented final ratings of conceptual models for each LHIN cluster to the Health System Funding Reform Local Partnership (HSFR-LP). Through the Hospital/CCAC Financial Leadership Group, LHIN staff collaborated with affected health service providers to initiate the next step in the Decision Making criteria framework.

Ontario Telemedicine Network (OTN) teleopthalmology program

The Central East LHIN approved funding for a two-year Ontario Telemedicine Network (OTN) teleopthalmology program hosted at Carefirst Seniors. This service was implemented in 2014/15 to improve eye care by overcoming barriers and increasing access to eye screening for people with diabetes.

Central East Self-Management Training Program

The Central East CCAC continued to deliver the "Central East Self-Management Training Program" in 2014/15. The six-week self-management *Living a Healthy Life with Chronic Conditions* workshop continued to empower participants and care givers to develop the skills to improve the management of chronic conditions and take control of their health. A total of 80 workshops were attended by 971 participants across the LHIN in 2014/15. Additionally the CCAC held 22 Choices and Changes workshops for clincians, training a total of 271 health care professionals.

Ken McCaw was 47 when he had his stroke and found his right side completely paralyzed.

While in Lakeridge Health recovering, one of the therapists suggested Ken attend the optional group therapy session.

An IT specialist by trade, he had his recovery planned out with a focus on practical accomplishments like relearning how to shave and play the guitar.

But the therapist persisted saying just his presence in the group session would encourage others.

For Ken it was a personal epiphany.

"For the first time during that whole experience, it caused me to look and even consider other people and their health," he said. "I could be helpful to them."

Ken has gone on to be a March of Dimes hospital volunteer, counseling other stroke patients, a Heart and Stroke Foundation spokesperson, a Durham District Stroke Council member and a Central East Vascular Health Strategic Coalition participant.

In the Fall of 2014, he played his guitar single-handedly (his right hand never did regain its original strength) and spoke to over 600 health care workers at a Stroke Collaborative Event.

Regional Cardiovascular Rehabilitation and Secondary Prevention Program (CRSP)

In 2014/15, the Regional Cardiovascular Rehabilitation and Secondary Prevention Program (CRSP) received a substantial investment from the LHIN and the Ministry of Health and Long-Term Care to increase the number of patients served by this program to ensure greater patient access throughout the Central East LHIN. The program hub continued to be located at the Rouge Valley Health System Centenary with additional satellite sites opened in Scarborough, Ajax, Whitby and Oshawa.

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 2014/15, 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 re-admissions.

Mental Health and Addictions Physician Lead

In 2014/15, the LHIN appointed Dr. Ian Dawe, Physician-in-Chief, Ontario Shores Centre for Mental Health Sciences (Ontario Shores) to the role of Mental Health and Addictions, Physician Lead for the Central East LHIN to provide expert advice on performance and improvement opportunities that would result in more people with mental health and addictions issues having access to timely, high quality care.

Central East LHIN Mental Health and Addicitions (MHA) Strategic Aim Coordinating Council

In the spring of 2014/14, the LHIN established Central East LHIN Mental Health and Addictions (MHA) Strategic Aim Coordinating Council. Comprised of individuals living in the Central East LHIN who self-identified as having "lived experience" or experience as a supporter of a person who is dealing with either a mental health and/or addictions issue, addictions service providers, community-based service providers, hospital service providers and a primary care provider, the Council concentrated its work on the development and implementation of innovative service delivery models that will lead to improvements in child and adolescent hospital based services, opiate and addictions service expansion and the delivery of community crisis services.

Jewel was diagnosed with mental health issues when she turned thirty, but she can recall having depression as early as 11 years old.

She has accessed crisis intervention in the past, has been treated with Electro-Compulsive Therapy (ECT) and has had a number of hospitalizations and medication changes.

But she has been able to access ongoing services in the Central East LHIN and is an active participant at New Leaf which she has been attending faithfully for two years.

New Leaf is a social recreational program designed to provide opportunities for individuals who are socially isolated and/or living with mental health issues in West Durham.

"I can't even tell you the value of the group. It provided almost like a family for me to lean on," said Jewel.

Hospital to Home Team (H2H)

An integrated Hospital to Home Team (H2H), embedded in the emergency department at Lakeridge Health Oshawa, links the hospital with its community partners. In 2014/15, the Central East LHIN carried out an internal evaluation of the program, identifying specific elements of the Durham H2H Team that were fundamental to its success. In 2014/15, funding was provided to Northumberland Hills, Rouge Valley Centenary, The Scarborough Hospital and Peterborough Regional Health Centre that will support the "spread" of the model throughout the LHIN.

Mental Health and Addictions Aboriginal Outreach

In 2014/15, Mental Health and Addictions Aboriginal Outreach Positions that specifically focused on an accessibility strategy for Aboriginal Peoples were funded in the Durham and Northeast Clusters with implementation of these new positions expected in 2015/16.

Opiate Strategy

In 2014/15, an internal evaluation of the Opiate Strategy was undertaken, including the expansion of Opiate and Substance Abuse Withdrawal Services to the Scarborough and North East Clusters. Performance targets for Community Substance Abuse Withdrawal Management Services were exceeded in the Scarborough Cluster by 141% for unique individuals served and by 217% for overall visits. The North East Cluster outcomes were also very positive with the target of unique individuals served exceeded by 113%. This strategy was shown to be highly successfully in addressing the treatment needs of those requiring substance abuse services in both clusters.

Assertive Community Treatment Teams (ACTT)

The Assertive Community Treatment Teams (ACTT) *Together Quality Improvement* project entered its first year of implementation in 2014/15 after stakeholders had earlier identified opportunities for improvement in the ACTT services offered throughout the Central East LHIN. Significant investments in 2013/14 had supported the establishment of "Step Down" services in Scarborough, Durham and the North East Cluster to increase the quality of services, provided alternatives for those ACTT clients who were ready to receive less intensive services, and improved the level of integration of ACTT into the larger system. Based on the positive establishment of these process, 90 clients were transitioned to Step Down services in the first year of implementation, exceeding the project's target of one or two clients per month over the eight Teams. In addition, 104 new clients were admitted to ACTT during the first year of implementation with 95% of those transitioned to Step Down supported to maintain their level of recovery in the community.

Transitioning Mental Health clients from hospital into the community

With a goal of safely transitioning long stay patients from a hospital to a community setting**,** Ontario Shores initiated several strategies with community partners to ensure that clients were well supported in the community. This included Ontario Shores integrating their intake processes with those of Durham Mental Health in order to ensure that housing placements were timely and appropriate and the creation of a housing partnership that saw the establishment of a new four-bed housing program in the community. The ongoing application of the Home First philosophy at Ontario Shores was highly successful in bringing the Central East CCAC and Community Mental Health partners together to strategize around supporting the most complex clients to move from hospital to community and these processes will be expanded in 2015/16.

Community Crisis Review Project

Completed on schedule at the end of 2014/15, this project included the development of a detailed current state scan of Community Crisis Services across the LHIN and extensive community consultations on how service delivery could be improved. The report proposed 10 key recommendations many of which were related to standardization of processes and increasing access. The Central East LHIN has approved the proposed next stage

of the project, which will be to develop an implementation plan for the recommendations. This next stage will conclude as of March 31, 2016.

Housing and Homelessness

In 2014/15 the LHIN initiated partnerships with municipalities for the purpose of jointly planning a Housing and Homelessness Strategy to address local needs and fit with Municipal Homelessness Plans. Rental Supplement/Intensive Case Management Support recommendations were submitted to the Ministry of Health and Long-Term Care late in the year. By March 2015, the Central East LHIN had received 12 Rental Supplements with attached Intensive Case management supports that were allocated to the Northeast Cluster and complemented the new resources allocated by the municipalities located in this Cluster. The Central East LHIN provided funding to three innovative "Housing Now" projects involving cross-sectoral partners. Each project addressed the needs of the most vulnerable people in the LHIN, particularly those who are either homeless or precariously housed.

Child, Youth and Adolescent Mental Health

The Central East LHIN conducted an extensive community consultation process with funded and cross sectoral partners that looked at the availability of Developmental Assessment and Treatment Services for Children and Adolescents residing in the Central East LHIN in 2012/13. Based on that process, one-time investments were made to increase the capacity of The Scarborough Hospital in partnership with The Rouge Valley Health System, to increase the number of annual Children's Developmental Assessments. In 2014/15, based on a Best Practice Model developed by the two organizations, the LHIN provided additional base funding to increase the capacity of the current providers in Scarborough to ensure that children have earlier access to the services that they require and improved clinical outcomes. Funds were also set aside to support the development of a Youth Mental Health Strategy for South Durham when the Oshawa CHC and The Youth Centre integrated into the South Durham CHC in late 2015. It is expected that the strategy will be finalized and implemented by the end of 2015/16.

Ontario Telemedicine Network (OTN) Mental Health Delivery

The Central East LHIN continued to invest in increased OTN capacity in the North East Cluster in 2014/15 to make direct treatment and consultation services more available to residents of this largely rural area. This allowed increased access to Psychiatric and Addictions Treatment Services that were otherwise difficult to access due to transportation and other challenges. This increase in OTN capacity also permitted those with highly complex issues, who faced challenges in travelling outside of the LHIN, to access the services they require in familiar and supportive environments.

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 2014/15 to make investments and implement initiatives that would support the achievement of the aim.

Central East Regional Palliative Care Plan

The CEHPCN developed the Central East Regional Palliative Care Plan which was approved by the Central East LHIN Board in April 2014. Priority areas for investment and implementation were identified including the creation of dedicated Palliative Care Community Teams; promoting Hospice Palliative Care Education and Training; establishing Integrated Hospice Palliative Care Hospital Programs; establishing Integrated Hospice Palliative Care Programs in Long-Term Care Homes, and; promoting Community Hospices as central hubs for access to information, patient, family and caregiver volunteer support in partnership with hospitals, long-term care homes and other community agencies.

Palliative Care Community Teams

Three Palliative Care Community Teams were funded across the LHIN in Scarborough, City of Kawartha Lakes and Haliburton. These interdisciplinary team-based models provide clinical and non-clinical community-based care to palliative and end of life patients allowing patients to remain in their homes for as long as possible and die at home by choice.

Interdisciplinary Palliative Education

Interdisciplinary Palliative Education continued to be an area of focus in 2014/15 with numerous physicians, nurses and allied health professionals taking the "Learning Essential Approaches to Palliative and End of Life Care (LEAP)" course. A Central East Hospice Palliative Care Education Plan was developed which includes recommendations to enhance hospice palliative and end of life care

Paula Kydd was at school in Toronto when an emergency call came that her mother Joyce Jones, 86, had been rushed to the hospital.

Joyce had collapsed and had been found after lying on the floor for several hours.

The attending doctor told Paula her mother only had two weeks to live but her mother improved.

The family accessed palliative services including a wound specialist who treated an ulcer Joyce sustained while in the hospital.

A nurse practitioner arranged for Joyce's blood tests to be done at home instead of at the local doctor's office.

Today the nurse practitioner and the PSWs continue to come and care for Joyce, 91.

A single mother, with 10 year-old twin boys, Paula says she would not have been able to look after her mother Joyce without the palliative team's much needed assistance.

"They [the team] are tremendously helpful," said Paula. "We are able to work together and do the best for mom."

education and training opportunities across Central East communities.

Palliative Care in Long Term Care

A sub-committee of the Central East Hospice Palliative Care Network (CEHPCN) developed a plan for the creation of integrated hospice palliative care programs in Long Term Care and will begin by involving two long term care homes in the LHIN. In partnership with the Palliative Pain and Symptom Management Consultant (PPSMC) and the Nurse Practitioner Supportive Teams Averting Transfers (NPSTAT) nurse practitioner, capacity for providing quality palliative care in the long term care homes will be the focus of their work in 2015/16.

Palliative Care Physician Lead

The Central East LHIN partnered with the Central East Regional Cancer Program (CERCP) in the development of a Palliative Care Physician Lead position for the Central East Region. With joint accountability and partnership to the Central East LHIN and the CERCP, the Palliative Care Physician Lead (PCPL) will provide leadership across the Central East region, championing both provincial and local strategies within the Central East context. The PCPL will collaborate with local partners to improve palliative care across all patient populations, illness trajectories and health care settings.

Integration

One of the main goals of each LHIN across the province 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 for clients, patients and caregivers 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:

- Voluntary Integrations where a HSP, at their own initiative, plans to integrate services funded by the LHIN;
- 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;
- Minister's Order where the Minister orders an HSP to integrate i.e., cease to operate, dissolve, wind up its operations, amalgamate or transfer operations with/between health service providers.

Significant integrations that were initiated or completed in 2014/15 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.

Through enhanced collaboration among *Health Link* partners, patients with complex health care needs, along with all their health care providers who are part of the *Health Link*, work together to develop individual care plans that more effectively meet the patients goals and ensure smoother transitions between care providers.

The Central East LHIN Board approved the creation of seven *Health Links* covering the entire Central East LHIN and six of the seven Health Links were at some stage of implementation in 2014/15. Six Health Links submitted

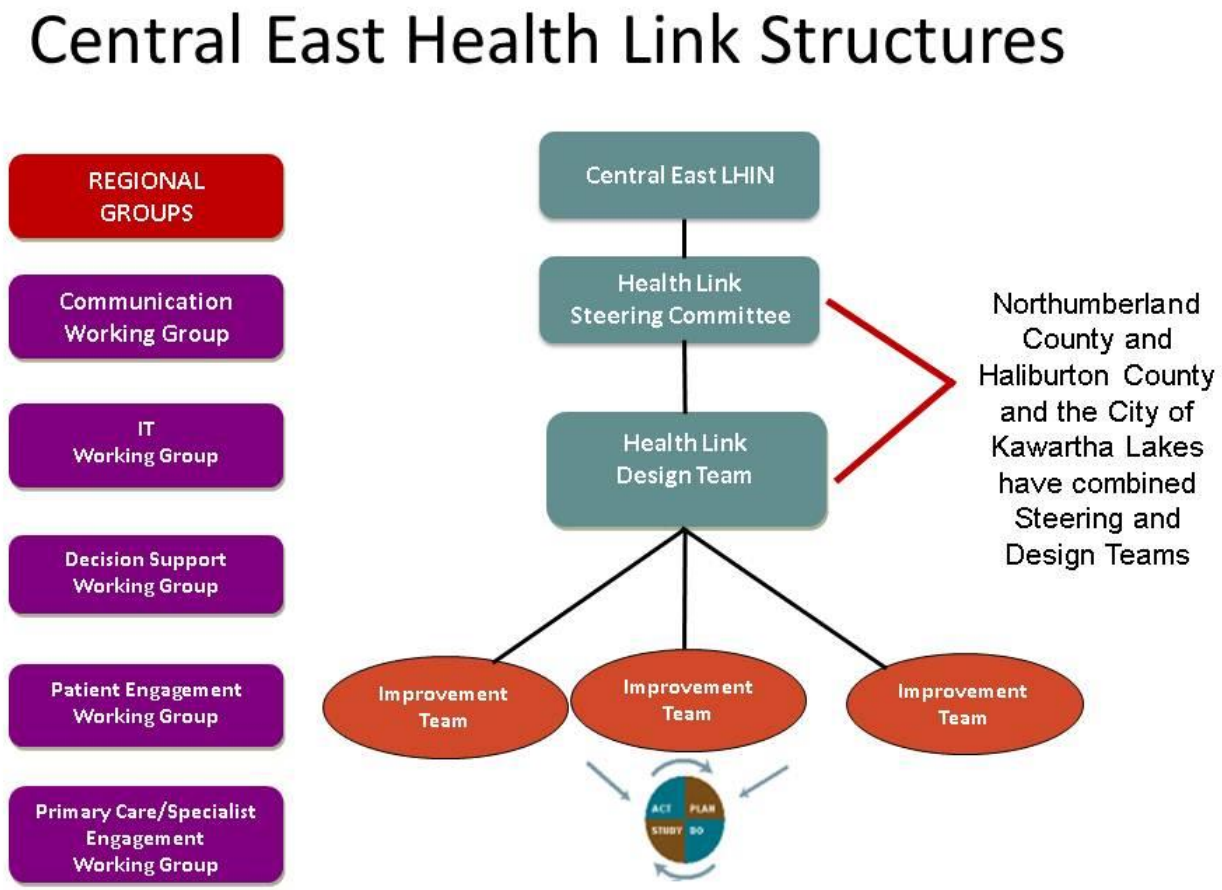
readiness assessments and business cases to the Ministry of Health and Long-Term Care for approval. Two of the six received approval from MOHLTC to move forward with their business cases. The Central East CCAC Project Management Office worked with the LHIN team to support all Health Links.

The deliverables for each Central East *Health Link* include:

- Ensure the development of coordinated care plans for all complex patients
- Reduce the number of 30-day re-admissions to hospital
- Ensure connection with primary care
- Ensure improved patient experience

On January 20, 2015, over 140 health care providers in the Central East LHIN met and were encouraged to have patients and caregivers as active participants in their health care planning in order to improve the quality of care. The "Working Better Together: Engaging Patients in Central East Health Links" forum was hosted by the Central East LHIN and the Change Foundation, an independent health care think tank providing expertise in patient-centred health care.

The Central East's Health Link Steering Committees, Design and Improvement Teams are working together to realize these goals.



Peterborough Health Link

The Peterborough Health Link (PHL), in conjunction with other regional health care providers, established the Service Resolution Protocol (SRP) pilot project to provide an integrated service response, improve access to necessary services and support within the existing support/service system. This was done to better understand the unique needs of patients with complex mental health and/or addictions issues. The role of a Service Resolution Facilitator (SRF) was introduced to provide individual support to people with complex mental health and/or addictions issues and to connect or re-connect with programs and services in the area. The Decision Support Working Group (DSWG) worked collaboratively with CECCAC to look at ways to operationalize Coordinated Care Plan (CCP) tracking within the CECCAC electronic system utilizing the *Care Coordinated Plan Central East Community Care Access Centre (CCP CECCAC) Tracking Tool*. The *Transitions Improvement Team* continued to move forward with building sustainable referral patterns. As a result of a thorough assessment by the Ministry and Health Link LHIN leads, the Peterborough Health Link was selected by the Ministry as one of the *Health Links* in the Care Coordination Tool (CCT) proof of concept.

Durham North East Health Link

In December 2014, the approval for the Durham North East Health Link was officially announced. Durham North East Health Link partners worked together to design and plan patient-centred process improvements to address the needs of the community. The Transitions Improvement Team developed a process and supporting tools to ensure patients with complex health care needs receive a follow-up appointment with their primary care provider within seven days of discharge from hospital. In addition, the Improvement Team worked to develop a process to ensure primary care providers are notified of a patient's admittance to hospital. The Coordinated Care Plan (CCP) Improvement Team and the Transitions Improvement Team merged into one improvement team and continued to work on several PDSA (Plan, Do, Study, Act) cycles, including consent processes, development of a survey for feedback from care conference participants, and use of the CCP.

Durham West Health Link

Work on this Health Link is expected to commence in 2015/16. Phasing of the Durham West Health Link was delayed to provide an opportunity to improve readiness of various partners to participate and provides an opportunity for the Community Health Centre integration process, which impacts two significant partners to be completed.

Northumberland County Health Link, the Haliburton County – City of Kawartha Lakes Health Link, Scarborough North and Scarborough South Health Links.

In 2014/15, all four emerging Health Links submitted business plans to the Ministry and are awaiting MOHLTC approvals in 2015/16 and under the LHIN-wide Project Management Office all Health Link teams began to move forward in anticipation of these funding approvals. With their Steering and Design Teams active in 2014/15, the emerging Health Links prepared to begin tests of change through their Quality Improvement Teams including recruiting their Improvement Team membership; identifying the first areas of focus and beginning the Quality Improvement training in collaboration with the Health Quality Ontario Specialist assigned to the Central East region. As noted above, Peterborough Health Link and the Durham Northeast Health Link were identified as Wave 1 and Wave 3 sites for piloting of the provincial electronic Coordination Care Tool (CCT) and teams began to work directly with the provincial team and the vendor (ORION). The remaining Health Links worked to identify a consistent interim solution to support collaborative care and the development of Coordinated Care Plans (CCP).

Next steps in 2015/16 include the identification of physician leads within each *Health Link* and the development of a consistent patient and family engagement approach.

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 to be completed by 2015. With the Peterborough and Scarborough facilitated integration CHS planning processes completed in 2014/15, implementation of CHS integrations were underway across all LHIN clusters (Durham, Haliburton/CKL, Northumberland, Peterborough, Scarborough). A Move Forward Strategy for Phase 2 of the CHS Integration Strategy was presented to the Central East LHIN Board in October 2014 with the roll out expected to occur in 2015/16.

Durham Cluster - Durham North Zone Collaborative

The 2014/15, the focus of this integration implementation was on the delivery of Falls Prevention and Exercise classes to increase mobility for seniors, one of the cluster's larger population groups. With the shared goal of delivering on a collaborative and client focused approach based on evidence and best practice and rooted in the promotion of health and well-being to build a healthier north Durham Region, the partnership continued to work together.

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

On April 1st, 2015 Durham Hospice successfully transitioned the delivery of its Information and Education, Bereavement, Palliative Care, and Day Hospice programs to VON Durham (Victorian Order of Nurses). Under the new program name, *VON Durham Hospice Services*, support will continue to be provided to existing clients with no interruption and access to all services remains the same. VON also announced that all staff and volunteers of Durham Hospice were warmly welcomed as new members of the VON family. Transition of Durham Hospice staff and volunteers enabled VON to continue to offer a wider variety of programs and services and to identify unmet needs in the community.

Durham Cluster - Community Care Durham and Faith Place Support Services

Staff teams from Faith Place and Community Care Durham (CCD) developed a transition plan that transferred the accountability for delivering Congregate Dining and Supportive Housing from Faith Place to CCD effective April 1, 2014. Together the two organizations developed a plan that saw services completed the transfers without any disruption to the residents of the Faith Place building.

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

Staff teams from VON and CCD worked together to ensure that the transition of Volunteer Visiting Services that had been provided by Victorian Order of Nurses Canada, Ontario Branch, in Durham Region (VON) was seamlessly transferred to Community Care Durham (CCD) effective April 1, 2014. The transfer of services enhanced the range of services available to clients, better integrated services with other community based support services and ensured that services are sustainable for the long-term.

Durham Cluster – The Youth Centre and Oshawa Community Health Centre

On January 28, 2015, the Board Chairs from the Oshawa Community Health Centre (OCHC) and The Youth Centre (TYC) presented an integration and transition plan at the Open Meeting of the Central East LHIN Board of Directors that will see their two organizations amalgamate into a single Community Health Centre by November 2015. In their presentation to the LHIN Board, the Board Chairs of both the Oshawa Community Health Centre and The Youth Centre stated that their Boards agreed that the creation of an integrated Community Health Centre, that builds on the combined strengths and capacities of both organizations, will allow a new organization to achieve a continuum of consistent, quality services and resources for clients in South Durham including Whitby and Pickering.

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

In Haliburton County, Haliburton Highland Health Services (HHHS) and Community Care Haliburton County (CCHC) moved forward with their transition planning to form One Entity, through the voluntary integration of CCHC into HHHS, after the LHIN approved their Transition Plan at its June 25, 2014 Board Meeting. The Transition Plan outlined the key transition planning activities, timelines and milestones to be achieved as the organizations worked towards an implementation date of October 1, 2014. This included developing a governance structure, including a community advisory committee, developing a comprehensive human resources plan to transfer staff to HHHS, transitioning clients and volunteers and determining facility requirements for programs and staff.

The Transition Plan also included the processes required to transfer the accountability for the delivery of hospice services from Supportive Initiatives for Residents in the County of Haliburton (SIRCH) Community Services to the One Entity and Haliburton County adult day programs from the Victorian Order of Nurses (VON) – Ontario Branch, Peterborough, Victoria and Haliburton to the One Entity.

In the City of Kawartha Lakes, the accountability for the delivery of the Acquired Brain Injury Adult Day Service program was transferred from the Victorian Order of Nurses – Ontario Branch, Peterborough, Victoria and Haliburton to Four Counties Brain Injury Association effective August 1, 2014 after the LHIN Board approved the two agencies' Transition Plan. Service volumes remained the same and clients now have access to strengthened expertise in delivering this type of specialized program.

On December 3, 2014 the Central East LHIN Board approved the Transition Plan developed by Victorian Order of Nurses for Canada – Ontario Branch (VON) and Community Care City of Kawartha Lakes (CCCKL) which will see CCCKL become accountable for the delivery of the Adult Day Program in Lindsay by April 1, 2015.

On March 7, 2014 Ross Memorial Hospital and HHHS announced the appointment of a new Director, Integrated Mental Health Services as a joint initiative to create a broader, more integrated and inclusive Mental Health Services program. This had been included in the "Strategic Alliance" recommendations between Ross Memorial Hospital and Haliburton Highlands Health Services in the Final Integration Plan and was one of a number of new initiatives that is having a positive impact on the residents of Haliburton County and the City of Kawartha Lakes including shared service partnerships in areas such as Laboratory Services, Medical Device Reprocessing, Mental Health Leadership, Diagnostic Imaging Management and much more.

On January 13, 2015, HHHS announced that seniors and residents from across Haliburton County will now have access to new and expanded services with an investment of more than $1 million by the Central East LHIN and the Ontario government in new inter-disciplinary teams providing more community health services to individuals with complex medical, social and/or cognitive issues.

North East Cluster – Campbellford Memorial Hospital/Campbellford Memorial 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

On June 25, 2014, the Northumberland County Integration Planning Team presented an update on their Transition planning as they worked together to develop a Rural Health Hub in Trent Hills, establish a co-ordinated approach for Assisted Living and Supportive Housing, expand on the work of the Collaborative Palliative Care committee, develop an integrated strategy for diabetes throughout Northumberland, develop opportunities for a strategic alliance between Northumberland Hills Hospital (NHH) and the Port Hope Community Health Centre, integrate

Information Technology across community and acute sectors and develop a Transformation Council to lead the transition work.

The outcome of this transition planning was demonstrated on March 6, 2015 when the LHIN and the government jointly announced the creation of a new Rural Geriatric Assessment and Intervention Network (GAIN) Community Team, an interdisciplinary team of health care professionals that will be working out of the Campbellford Memorial Hospital (CMH). Similar to the team announced in Haliburton in January 2015, the CMH team was established to support frail seniors and their caregivers so they can continue to live in their homes and their communities. Additionally, the concept of the Northumberland Transformation Council was aligned with the work of the emerging Northumberland County Health Link.

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
On June 25, 2014 the Central East LHIN Board endorsed the creation of a Peterborough City and County Community Health Services (CHS) Leadership Council, a key element of the Final Integration Plan. Since that time the Leadership Council was established and, with the support of a Project Manager, prepared a Master Transition Plan for phased implementation of all key elements. The Leadership Council provided a progress report at the LHIN's Board meeting in March 2015 and will provide a subsequent report in September 2015 to ensure progress against the Peterborough Integration Plan. The Leadership Council will be involved in the implementation of the LHIN-wide CHS Phase 2 projects related to Intake and Referral, CSS Program Standards and IT Enabling Technologies.

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
On July 23, 2014, the Central East LHIN Board of Directors received the Scarborough CHS Integration Planning Team's (IPT) Final Integration Plan and directed LHIN staff to do a further review on the recommendations including a cost benefit analysis to support the IPT's financial requests. On October 22, 2014, LHIN staff presented information to the Central East LHIN Board of Directors on the Community Health Services Integration (CHS) Phase 2 with recommendations on how to move forward. Two of the elements from the Scarborough CHS Integration Plan, specifically "Defining standard Community Support Services (CSS) through a CSS Program Standards Committee" and "Intake and Referral - Determine standard tools and processes for seamless intake and referral across programs and providers throughout the LHIN" will be addressed through Phase 2 of the CHS Integration Strategy.

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 two hospitals advised the LHIN that they would not be moving forward with their proposed Preferred Integration Plan; however, a number of regional planning opportunities had been identified for programs and services i.e., vascular, diabetes, oncology, cardiology, nephrology, orthopedics, thoracic services, mental health and addictions, maternal/newborn and pediatric services, vision care, and information technology.

The LHIN staff continued to work with both hospitals, their administrative and physician leaders and their staff to integrate appropriate back office services and clinical programs to improve access and quality and support the ongoing transformation of the health care system. This included the LHIN's facilitation of a cross-organizational project team to develop a Service Delivery Model for Maternal-Child-Youth (MCY) services in the Scarborough cluster and an Advanced Maternal Child and Paediatric Service Delivery model for the Central East LHIN. At the end of 2014/15, agreement on next steps related to implementation of these two developed models had not been achieved.

Integrated Orthopaedic Capacity Planning

In 2014/15, the cluster-based Orthopaedic Planning and Implementation Committees (OPICs) continued to meet on a quarterly basis with key stakeholders and provided detailed meeting outcomes to LHIN staff to support LHIN-wide discussions. Continued collaboration by the stakeholders from the North East OPIC (Peterborough Regional Health Centre, Ross Memorial Hospital and other health care providers) included the siting and sizing of highly specialized shoulder surgery and the development of trauma and repatriation process. Stakeholders from the Durham and Scarborough OPICs held their first meeting in February 2015. Continuing activities for all OPICs in 2015/16 include identifying sites for specific orthopaedic procedures; processes for trauma and repatriation access; standardized care for orthopaedics and coordinated care plans; identification of performance measurement system for orthopaedics; coordinated intake system; aligning rehab services to patients need in local community and health human resource planning.

Hospital Information System (HIS) Vision

Across the province, LHINs are working with health service providers on integration initiatives that will lead to a more sustainable and accessible health care system. In some LHINs, this includes looking at back office integrations such as shared information technology systems that support the work of front line health service providers working in acute and community based settings. By working in partnership, health care organizations can identify integration opportunities related to the collection, analysis and dissemination of health information that will improve patient access, lead to better population health and ensure value for money.

On February 26, 2014, the Central East LHIN Board of Directors passed a motion to invite the hospital leadership to participate in a facilitated integration planning process to develop a regional Hospital Information Systems (HIS) Vision. Given the significant investment in hospital IT being planned across the LHIN, the Central East LHIN Board wanted to ensure that whatever investments are made are sustainable and support the LHIN's mission to lead the creation of an integrated sustainable health care system that ensures better health, better care, better value for money. Consequently the LHIN's nine acute care hospitals participated in an HIS Vision facilitated integration to identify the best course of action for the ongoing delivery of hospital health information.

The three key objectives of this project were:

1. Create alignment amongst the Central East LHIN hospitals and the LHIN around the path for investment required to achieve a hospital technology vision in the next 3 – 10 years.
2. Develop a detailed understanding of each hospital's current plan and the impact of these plans on achieving a common future vision that enables improved patient care.
3. Develop a recommendation to the LHIN Board on the best option(s) for a roadmap for future HIS investments.

On October 22, 2014 the Central East LHIN Board received a Directional Plan entitled "Central East LHIN Shared HIS Vision" and directed that further work be undertaken to determine the governance requirements as well as financial analysis on the required costs to further the initiative. In January 2015 the Central East LHIN responded to a request from the Deputy Minister for additional information on the HIS facilitated integration and a pause on procurement related to Hospital Information System was communicated to all Central East LHIN hospitals. Next steps on this project are expected in 2015/16.

Vision Care Strategy

In alignment with the *Ontario's Action Plan for Health Care* to improve patient care by gaining better value from Ontario's health care system, the Ministry of Health and Long-Term Care (MOHLTC) established a Provincial Vision Strategy Task Force with respect to ophthalmology services. The Provincial Task Force developed a provincial planning framework along with 34 strategic recommendations for ophthalmology in Ontario in its May 2013 report, *A Vision for Ontario: Strategic Recommendations for Ophthalmology in Ontario.* Since the work of the Provincial Vision Strategy Task Force, the Central East LHIN had established a Central East LHIN Vision Plan Working Group (VPWG) to guide the development of a strategy and implementation plan that will foster a system of accountability and value for money, contributing to Ontarians' access to high quality ophthalmology services when they need them most.

A "Directional Plan - Vision Care Strategy" for the Central East LHIN was endorsed by the Central East Executive Committee and then the Central East LHIN Board of Directors at its December 17, 2014 Board meeting. The Vision Care Strategy is limited to inpatient and outpatient ophthalmic surgeries currently delivered by Central East LHIN hospitals and/or ophthalmic surgeries that are required by the Central East LHIN catchment area.

With the December 17, 2014 endorsement of the Vision Care Directional Plan by the Central East LHIN Board of Directors, the Central East LHIN has now established an advisory committee to oversee the implementation of the recommendations identified in the plan and make any additional recommendations going forward. This advisory committee will support the LHIN in 2015/16 to deliver on quality and sustainability commitments.

Francophone Initiatives

In 2015/15, the Central East LHIN continued to implement initiatives and projects to better support health care access for the LHIN's French-speaking population through the 2014/15 Joint Action Plan between the Central East LHIN and the Entité 4.

Engagement of the Francophone Community in the Central East LHIN

In 2014/15 the Central East LHIN worked in collaboration with Entité 4 to increase francophone community participation in health service planning. Two working groups, the Coalition for Healthy Francophone Communities in Scarborough and the Francophone Community Table on Health in Durham Region continued to facilitate a French language health-focused dialogue between the LHIN, health service providers and the Francophone community. The Provincial French Language Service Commissioner's 2014/15 Annual Report, gave the Central East LHIN's collaborative model with Francophone Stakeholders an "Honorable Mention."

Improving Access and Accessibility to Care for Seniors

In 2014/15 the Central East LHIN funded a Francophone Seniors' Day Program at "*Les Centres d'Accueil Heritage*" in Durham and an Open House was held in November 2014. In conjunction with the Central East Community Care Access Centre, efforts were also underway to increase the level of francophone in-home services. The Central East LHIN, the Entité 4 and community stakeholders worked together to perform a feasibility study for a Francophone Memory Centre for adults in the Greater Toronto Area and the Central East LHIN expects to receive recommendations from Entité 4 on how to proceed with any next steps in 2015/16.

Improving Access and Accessibility to Mental Health and Addictions Services

In 2014/15 the Central East LHIN, the Entité 4 and LHIN partners worked together to develop a vision for a *Mental Health Care Continuum for Adults* as a key project. The Entité 4 recommended that the Central East LHIN provide funding to support each HSP's formal assessment of their capacity to offer French mental health and addictions services and offered up models to optimize existing centralized access systems tools and processes.

Improving Access to Information

In 2014/15 the Central East LHIN formed a committee of LHIN partners, including Entité 4, to ensure that the web-enabled Central East Health Line – www.centraleasthealthline.ca - was accessible to the Francophone Community.

Identification and Designation of Health Services Providers for the provision of French Language Services

In 2014/15 the Central East LHIN in conjunction with its Francophone partners assessed the current distribution of French Language Services, the appropriateness of currently identified HSPs, and how to meet future needs. The Provincial Network of LHIN French Language Service Coordinators finalized its set of identification and designation criteria when identifying HSPs for French Language Services to be used by all LHINs, including the Central East LHIN.

Improving Access to Care

The Central East LHIN and the Entité 4 worked together with TAIBU Community Health Centre to conduct a needs assessment survey to determine the demand for French primary care services among their clientele. TAIBU CHC also developed and delivered French Self-Management of Chronic Diseases workshops in 2014/15. In addition, the Central East LHIN supported the Entité 4 in developing and offering an interactive workshop to Central East LHIN Health Service Providers in 2015/15 that examined the role of language in patient-centred care.

Constant Oaupo Wapo, originally from Cote D'Ivoire, attends TAIBU's cooking class conducted in French by Chef Cheg Guy Dongue.

TAIBU (meaning "be in good health" in Kiswahili) Community Health Centre, in Scarborough, is committed to providing Primary Health Care Services to the Black Community in the GTA as its priority population.

Good nutrition is not only easier when the lessons are taught in one's native language but it also helps newcomers adjust to a very different culture than the ones they knew in their African and Caribbean homelands.

"When people move to Canada, first they are really stressed because it is a kind of cultural shock; they don't understand the culture they are in," Constant said.

"So being here in this environment and having the opportunity to meet people from the same country (or continent) and the same culture, the same language, it gives those people a kind of relief."

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 receive 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 February 2015, the Central East LHIN Aboriginal Lead was honoured to attend the 9th Annual Chiefs of Ontario (COO) 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. That same month, the Central East LHIN Aboriginal Lead, and the CEO were invited to attend the first annual Metis Nation of Ontario Health Forum held in Toronto. The purpose of the forum was to provide information and learning opportunities to the Metis people and their partners regarding the health issues faced by Metis people living in Ontario.

In 2014/15 both advisory groups continued to meet bi-monthly and their work centred on four major themes:

- Relationships with the Central East CCAC
- Development of Cultural Competency Indicators
- Increasing Culturally Safe Services by working with Health Service Providers
- Mental Health and Addictions issues facing the First Nations Communities located within the LHIN, with a particular emphasis on children and youth.

Relationships with the Central East CCAC

In 2013, a Memorandum of Understanding was finalized during a Signing Ceremony between the Alderville First Nation and the Central East Community Care Access Centre. Since that time, the other four First Nations within the Central East LHIN boundaries have expressed an interest in developing and implementing an MOU that will articulate their working relationships with the CCAC. The MOU will provide the policies and protocols that will permit the CECCAC and the First Nations to work together in supporting and providing health care services to those communities. It will also outline the cultural protocols that differ across First Nations, but are fundamental to working relationships with all healthcare and service providers. The Curve Lake First Nation initiated the process of developing their MOU with the CE CCAC late in the 2014/15 and the goal is to have it finalized by the end of 2015/16.

Development of Cultural Competency Indicators

The annual joint meeting of the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee was held in

Concurrent Discourse Capacity (CDC) Training, an innovative training program sponsored by the Central East LHIN in the winter of 2013, has made aboriginal teachings an ongoing integral part of everyday treatment in today's mental health and addictions field.

For some participants like John Mattson, a mental health worker at the Alderville First Nation Health and Social Services, traditional healing comes naturally.

"It is something we have always practiced, it is feeding your spirit fire," John said.

John explained the significance of putting people in touch with themselves, "including their experiences, their trauma, strengths and weaknesses, goals and histories."

John was particularly pleased to share his people's healing traditions with members of the larger mental health treatment community.

"It is encouraging to know our models are being employed, adapted and positively received," he said.

John continues to share his people's healing teaching with the wider community and recently gave a presentation to a local hospital.

Peterborough on October 29, 2014. 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. The Advisory Circles also committed to reviewing their Terms of Reference over the next year.

Increasing Culturally Safe Services by working with Health Service Providers

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. Since that time about 45 Health Service Providers and Central East LHIN staff have completed the Cultural Safety, IOC Training offered via the South West LHIN. This has provided participants with a foundation from which to develop their skills in supporting the Aboriginal communities local to their LHIN. At of the end of the Fiscal Year, both Central East LHIN Aboriginal Advisory Circles arrived at the elements of a template that would be used by the Central East LHIN to evaluate Health Service Provider compliance with the requirement to offer Culturally Safe services. The template will be finalized in 2015/16 by both Aboriginal Health Advisory Circles.

Mental Health and Addictions issues facing the First Nations Communities located within the LHIN, with a particular emphasis on children and youth.

With the support of the LHIN, meetings were held at the Curve Lake, Mississaugas of Scugog Island 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 2015/16. Base funding was provided to Durham Mental Health Services and to FOURCAST to provide Mental Health and Addictions Outreach Services to Aboriginal communities in the Durham and Northeast Clusters. These positons will be fully operational in FY 15/16.

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.

In the guidelines, it is recognized that stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of an initiative. They are either affected by, or can have an effect on, any project or initiative. Anyone whose interests may be positively or negatively impacted by the project or initiative, or anyone that may exert influence or results is considered a stakeholder. For the purpose of stakeholder identification in the Central East LHIN, "communities" has been interpreted to mean geographic locations (i.e. Scarborough, Durham Region, North East), communities of interest or communities of practice.

The definitions of these stakeholders include:

- *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.

The definition of levels of engagement includes:

- *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.)

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 all supported the LHIN as it worked with local community stakeholders on enhancing the public health care system.

These engagement structures and activites include:

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 governors' 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. On May 1, 2014 the Central East LHIN and its Governance Advisory Councils hosted a "Governance Forum on Quality" for Board Members from all LHIN-funded health service providers from across the Central East LHIN region. 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 LHIN Board served as Governor Liaisons as part of the Community Health Services Integration Strategy and the Hospital Information Systems Visioning project.

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" (2009), continued in 2014/15 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 the Central East LHIN region.

Health Professionals Advisory Committee (HPAC)

Each LHIN has established a Health Professionals Advisory Committee. These committees are responsible for assisting LHINs in carrying out its responsibilities by providing advice on how to achieve patient-centered health care. In 2014/15, the Central East LHIN HPAC continued to meet on a quarterly basis, providing input into a number of iniatives and areas of interest. This included 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 year, 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)

A 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 (QBPs). 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. Within the context of promoting an integrated health system providing accessible, high-quality services, the purpose of the Central East LHIN Local Partnership is to inform, coordinate, and advance HSFR implementation and change management at the local level, and to give appropriate voice to Central East LHIN issues, concerns, and perspectives at the provincial level. The Local Partnership's annual work plan embodies both local and provincial elements.

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 continued 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 2014/15 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 2014/15, 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. Where appropriate, the DIWG also identified potential risk and collaboratively developed strategies to address any risks related to timely access to care. 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 – Toronto Public Health, Durham Region Health Department, Peterborough County-City Health Unit and Haliburton, Kawartha, Pine Ridge District Health Unit. 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 primary care providers share their balanced perspectives from different primary care settings. 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. In 2014/15 this included providing input on the development of Central East LHIN Health Links, Health Records Management, electronic medical records (EMR) solutions, the Central East LHIN Vision Care Strategy and the Health Information Systems (HIS) facilitated integration.

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's membership includes 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 vascular 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.

Senior Care Network

The Central East Local Health Integration Network (Central East LHIN) is committed to building a network of services to meet the needs of its rapidly growing and aging population of seniors. This direction is being achieved in part through a LHIN-wide regional approach to coordinating, organizing and governing existing and new specialized geriatric services in partnership with the Seniors Care Network, previously known as the Central East LHIN's Regional Specialized Geriatric Services entity. Working together with Central East LHIN-funded health service providers and others who deliver services to seniors, the Seniors Care Network is focused on developing a comprehensive, coordinated system of specialized health and mental health services for frail seniors in the Central East Region of Ontario. The integrated "Systems of Care" will provide ongoing additional support required to help more seniors to live independently at home and will reduce home care wait times, as well as increase access to community supports including mental health services.

The Seniors Care Network is comprised of a group of senior health care leaders representing hospitals, community service providers, seniors' advocates and others from across the Central East LHIN. Supported by the LHIN, the Seniors Care Network is working along with health service providers (HSPs) on the development, delivery and monitoring of an integrated regional system of Specialized Geriatric Services for frail seniors.

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 of the Network 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 the LHIN on palliative care planning and co-ordination to support the LHIN's strategic aim.

Central East LHIN Mental Health and Addictions (MHA) Strategic Aim Coordinating Council

The newly established Central East LHIN Mental Health and Addictions (MHA) Strategic Aim Coordinating Council concentrated its work on the development and implementation of innovative service delivery models that will lead to improvements in child and adolescent hospital based services, opiate and addictions service expansion and the delivery of community crisis services. The Central East LHIN MHA Strategic Aim Coordinating Council included individuals living in the Central East LHIN who self-identify as having "lived experience" or experience

as a supporter of a person who is dealing with either a mental health and/or addictions issue, addictions service providers, community-based service providers, hospital service providers and a primary care provider.

Central East LHIN Diabetes Education Programs and Networks

The responsibility of Diabetes Education Programs (DEPs) within the Central East LHIN is to coordinate and identify regional and local services needed to support long term planning of diabetes care. This is achieved through the alignment of provincial and LHIN priorities, engagement of stakeholders to facilitate the adoption of evidence-based standards and best practices in diabetes management. Program goals are reviewed each quarter by the Central East LHIN and strategies to improve care are implemented 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 stroke Quality Based Procedures (QPBs) across the LHIN. This group continues to review the needs of stroke care, build on the successes of best practices and evidence based care across 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. 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 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) to support the adoption of evidence-based practice with the goal of improving the health of mothers and newborns. The overall role of the Advisory Committee is to promote standardization, implementation of evidence and best practices within women's and children's programs.

Central East LHIN Emergency Management Leads

A planning group, facilitated by the Central East LHIN, the Emergency Management Leads from all Central East LHIN hospitals, the Central East Community Care Access Centre and local Public Health Units met on a bi-weekly basis to share knowledge and pro-actively plan for how to prepare and respond to shared emergencies. In 2014/15 this included implementing a workplan to reach "operational readiness" in advance of the 2015 PanAm and Parapan Games.

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.

Sector Based Providers

Targeted engagement with sector based providers in the Central East LHIN supported the sharing of information as the 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. In the fall of 2014/15, the Central East LHIN, in collaboration with the Ministry of Health and Long Term Care, hosted a forum for acute care providers across the region. The primary purpose of this forum was to provide a positive environment for learning, collaboration, and discussion between the Ministry, the LHIN, its hospitals and the CCAC on Health System Funding Reform (HSFR), the impacts related to clinical quality (Quality Based Procedures) and the relationship of funding and quality. A similar forum with the LHIN's Long-Term Care Homes focused on capital renewal.

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. The development and implementation of Health Links continued to be a major area of focus for physician engagement in the Central East LHIN in 2014/15. Through strong physician engagement, the Central East LHIN will continue to form partnerships and collaborations between all members of a patient's 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 2014/15 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 2014/15 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.

ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE

The Central East LHIN organization is comprised of three distinct units – Corporate (Governance, Communications & Community Engagement, Business Support); System Design and Integration (Integration, Quality Improvement, System Planning) and System Finance and Performance Management (Finance, Performance and Risk Management). 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 and with additional support from Health Force Ontario and Enabling Technologies.

In 2014/15 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. 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 Physician LHIN Leads - Primary Care, Mental Health and Addictions, Emergency Medicine, Vascular Health, Critical Care - and the French Language Services and Aboriginal initiatives.

In 2014/15 the LHIN also conducted an organizational health review to assess our progress as a healthy organization and to see how it could better facilitate the ongoing implementation of the 2013-2016 IHSP. This included documenting an overall organizational health goal - "The Central East LHIN will be a healthy culture, and a productive and accountable workplace that attracts, retains and motivates healthy and engaged employees". The principle of employee involvement and participation was underscored by drivers such as employee empowerment, leadership, planning, programs, risk management, and financial accountability and continued to be supported by the LHIN's Values, Code of Conduct and management practices.

Since the review the LHIN has implemented a new organizational structure to facilitate a culture of teamwork and improved group dynamics with specific roles and teams supported and facilitated by supervisors, Human Resources Management practices and training and development initiatives. A major initiative which began in 2014/15 was the LHIN's Succession Planning Program, a key element which has enabled the LHIN to retain and motivate healthy and engaged employees. Through the existing Performance Management Program and new Succession Planning Program, the LHIN continued to ensure that all staff positions were supporting the organization's goals in 2014/15 through the achievement of their specific goals and objectives and identification of development opportunities.

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 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 to work more effectively together. In 2014/15, the structure to support the successful implementation of the Code included promotion of staff, implementation of a compliance procedure, policy review and development and education initiatives.

In 2014/15, the LHIN continued to complete detailed agency risk assessment tool reports used to assess the agency risks, identify mitigating options and provide context for a risk management plan. Submitted to the Ministry on an annual basis, this report was used by the LHIN to continue to identify and mitigate any identified risk by ensuring compliance with directives, business processes, governance practices and applying appropriate issues management strategies.

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, 2015, 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, 2015, and the results of its operations, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
June 24, 2015

Central East Local Health Integration Network

Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	**453,531**	672,385
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 9)	**5,111,730**	14,644,300
Accounts receivable	**54,928**	46,133
Due from LHIN Shared Services Office ("LSSO") (Note 4)	**-**	7,266
	5,620,189	15,370,084
Liabilities		
Accounts payable and accrued liabilities	**435,373**	533,612
Due to LSSO (Note 4)	**5,116**	1,464
Due to Health Service Providers ("HSP") (Note 9)	**5,111,730**	14,644,300
Due to MOHLTC (Note 3b)	**81,715**	44,335
Due to Central West LHIN (Notes 3c, 4)	**25,892**	172,238
Deferred capital contributions (Note 5)	**169,513**	211,679
	5,829,339	15,607,628
Net debt	**(209,150)**	(237,544)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**39,637**	25,865
Tangible capital assets (Note 7)	**169,513**	211,679
	209,150	237,544
Accumulated surplus	**-**	-

Approved by the Board

Original Signed By

_____Wayne Gladstone, Chair, Board of Directors

Original Signed By

_____David Sudbury, Chair, Audit/Finance Committee

Central East Local Health Integration Network

Statement of financial operations
year ended March 31, 2015

	Budget (Note 8)	2015 Actual	2014 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	**2,171,798,277**	**2,211,843,510**	2,207,469,168
Operations of LHIN	**4,534,130**	**4,510,790**	4,472,532
Project Initiatives			
Emergency Department ("ED") Lead (Note 10a)	**-**	**75,000**	75,000
Emergency Room/Alternative Level of Care (Note 10a)	**-**	**100,000**	100,000
Aboriginal Planning (Note 10a)	**-**	**20,000**	20,000
Enabling Technologies (Note 10a)	**-**	**644,000**	802,027
Critical Care (Note 10a)	**-**	**75,000**	75,000
French Language Services (Note 10a)	**-**	**106,000**	106,000
Diabetes & Vascular Health (Note 10b)	**-**	**823,706**	779,061
Diabetes & Vascular Health OT (Note 10b)	**-**	**-**	30,000
Physio Funding (Note 10a)	**-**	**-**	27,344
Primary Care (Note 10a)	**-**	**75,000**	75,000
Amortization of deferred capital contributions (Note 5)	**-**	**83,101**	124,356
	2,176,332,407	**2,218,356,107**	2,214,155,488
Funding repayable to the MOHLTC (Note 3a)	**-**	**(107,607)**	(216,573)
	2,176,332,407	**2,218,248,500**	2,213,938,915
Expenses			
Transfer payments to HSPs (Note 9)	**2,171,798,277**	**2,211,843,510**	2,207,469,168
General and administrative (Note 11)	**4,534,130**	**4,584,508**	4,586,844
Project Initiatives			
ED Lead (Note 10a)	**-**	**73,706**	72,000
ER/ALC (Note 10a)	**-**	**100,000**	91,753
Aboriginal Planning (Note 10a)	**-**	**20,000**	11,489
Enabling Technologies (Note 10a)	**-**	**618,108**	629,789
Critical Care (Note 10a)	**-**	**72,000**	72,000
French Language Services (Note 10a)	**-**	**106,000**	106,000
Diabetes & Vascular Health (Note 10b)	**-**	**823,706**	767,528
Diabetes & Vascular Health OT (Note 10b)	**-**	**-**	30,000
Physio Funding (Note 10a)	**-**	**-**	27,344
Primary Care (Note 10a)	**-**	**6,962**	75,000
	2,176,332,407	**2,218,248,500**	2,213,938,915
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, 2015

	Budget	2015 Actual	2014 Actual
	$	$	$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	**(40,935)**	(123,833)
Amortization of tangible capital assets	-	**83,101**	124,356
Change in other non-financial assets	-	**(13,772)**	6,015
Decrease in net debt	-	**28,394**	6,538
Net debt, beginning of year	-	**(237,544)**	(244,082)
Net debt, end of year	-	**(209,150)**	(237,544)

Central East Local Health Integration Network

Statement of cash flows
year ended March 31, 2015

	2015	2014
	$	$
Operating transactions		
Annual surplus	**-**	-
Less items not affecting cash		
Amortization of tangible capital assets	**83,101**	124,356
Amortization of deferred capital contributions (Note 5)	**(83,101)**	(124,356)
	-	-
Changes in non-cash operating items		
Due from MOHLTC	**9,532,570**	(10,136,870)
Accounts receivable	**(8,795)**	(453)
Due from LHIN Shared Services Office ("LSSO")	**7,266**	33,001
Accounts payable and accrued liabilities	**(98,239)**	(7,541)
Due to LSSO	**3,652**	1,464
Due to HSPs	**(9,532,570)**	10,136,870
Due to the MOHLTC	**37,380**	(224,653)
Due to Central West LHIN	**(146,346)**	172,238
Prepaid expenses	**(13,772)**	6,015
	(218,854)	(19,929)
Capital transaction		
Acquisition of tangible capital assets	**(40,935)**	(123,833)
Financing transaction		
Capital contributions received (Note 5)	**40,935**	123,833
Net (decrease) increase in cash	**(218,854)**	(19,929)
Cash, beginning of year	**672,385**	692,314
Cash, end of year	**453,531**	672,385

Notes to the Financial Statements

1. Description of business

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

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

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

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

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

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

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

2. Significant accounting policies

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

2. Significant accounting policies (continued)

Basis of accounting

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

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

Government transfer payments

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

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

Funding payments to Health Service Providers in the LHIN geographic area flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2015.

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.

3. Funding repayable to the MOHLTC

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

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

			2015	2014
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**2,211,843,510**	**2,211,843,510**	**-**	-
LHIN operations	**4,593,891**	**4,584,508**	**9,383**	10,044
ER/ALC	**100,000**	**100,000**	**-**	8,247
ED/Lead	**75,000**	**73,706**	**1,294**	3,000
Critical Care	**75,000**	**72,000**	**3,000**	3,000
Aboriginal Planning	**20,000**	**20,000**	**-**	8,511
French Language Services	**106,000**	**106,000**	**-**	-
Primary Care Lead	**75,000**	**6,962**	**68,038**	-
Repayable directly to MOHLTC	**2,216,888,401**	**2,216,806,686**	**81,715**	32,802
Enabling technologies repayable to MOHLTC through Central West LHIN	**644,000**	**618,108**	**25,892**	172,238
	2,217,532,401	**2,217,424,794**	**107,607**	205,040

3. Funding repayable to the MOHLTC (continued)

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

	2015	2014
	$	$
Due to MOHLTC, beginning of year	**44,335**	268,988
Recovery by MOHLTC during the year	**(44,335)**	(268,988)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**81,715**	44,335
Due to MOHLTC, end of year	**81,715**	44,335

c) 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:

	2015	2014
	$	$
Revenue	**644,000**	802,027
Expenses	**618,108**	629,789
Accumulated surplus due to the Central West LHIN	**25,892**	172,238

4. Related party transactions

LHIN Shared Services Office, Local Health Integration Network Collaborative

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.

Enabling Technologies for Integrated Project Management Office

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 Office for its Cluster and related expenses. During the year, the LHIN received funding from the Central West LHIN of $644,000 (2014 - $802,027).

5. Deferred capital contributions

	2015	2014
	$	$
Balance, beginning of year	**211,679**	212,202
Capital contributions received	**40,935**	123,833
Amortization	**(83,101)**	(124,356)
Balance, end of year	**169,513**	211,679

6. 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:

	$
2016	251,511
2017	254,721
2018	257,948
2019 and beyond	677,433
	1,441,613

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	2,184,338,418
2016	2,183,122,618

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

7. Tangible capital assets

			2015	2014
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office furniture and fixtures	**748,928**	**621,485**	**127,443**	184,740
Computer equipment	**330,939**	**313,507**	**17,432**	17,522
Web development	**36,100**	**36,100**	**-**	7,593
Leasehold improvements	**688,283**	**663,645**	**24,638**	1,824
	1,804,250	**1,634,737**	**169,513**	211,679

8. 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, 2014. 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 $2,211,843,510 is made up of the following:

	$
Initial HSP funding budget	**2,171,798,277**
Additional funding due to announcements made during the year	**40,045,233**
Total HSP funding budget	**2,211,843,510**

The total revised operating budget of $6,470,431 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	**644,000**
Aboriginal Planning	**20,000**
French Language Services	**106,000**
Diabetes & Vascular Health	**841,301**
Primary Care	**75,000**
Total budget	**6,470,431**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $2,211,843,510 (2014 - $2,207,469,168) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2015 as follows:

	2015	2014
	$	$
Operation of hospitals	**1,231,015,066**	1,260,843,365
Grants to compensate for municipal taxation - public hospitals	**280,275**	279,675
Long term care homes	**437,367,196**	428,323,700
Community care access centres	**274,137,192**	252,697,822
Community support services	**47,571,175**	41,483,398
Assisted living services in supportive housing	**15,224,305**	14,634,683
Community health centres	**28,772,419**	29,231,688
Community mental health addictions program	**59,756,096**	64,683,560
Specialty psychiatric hospitals	**116,062,017**	113,654,937
Acquired brain injury	**1,632,344**	1,610,915
Grants to compensate for municipal taxation - psychiatric hospitals	**25,425**	25,425
	2,211,843,510	2,207,469,168

9. Transfer payments to HSPs (continued)

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As a March 31, 2015, an amount of $5,111,730 (2014 - $14,644,300) was receivable from the MOHLTC and payable to HSPs.These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

10. Project Initiatives

The LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses incurred by object:

a) Initiatives Expenses

	2015	2014
	$	$
Consulting services	**152,668**	252,054
Salaries and benefits	**410,553**	493,448
Public relations and community engagement	**4,800**	1,337
Meetings	**1,548**	1,297
Supplies and other	**418,686**	316,874
Mail, courier and telecommunications	**1,260**	826
Other	**7,261**	19,540
	996,776	1,085,376

b) Diabetes & Vascular Health

The LHIN received funding of $841,301 (2014 - $841,301, base and $30,000 one-time funding), of which $823,706 is included in the Statement of operations and $17,595 is included in Deferred capital contributions on the Statement of financial position. Expenses incurred of $823,706 are made up as follows:

	Budget 2015	**Actual 2015**	Actual 2014
	$	**$**	$
Salaries and benefits	**841,301**	**692,582**	539,126
Others	**-**	**131,124**	258,402
	841,301	**823,706**	797,528

In addition, capital asset purchases of $17,595 are included in tangible capital assets on the Statement of financial position.

11. General and administrative expenses

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

	2015	2014
	$	$
Salaries and benefits	**3,406,786**	3,431,592
Occupancy	**320,410**	254,138
Amortization	**83,101**	124,356
Shared services	**444,449**	406,019
Community engagement	**14,905**	12,048
Consulting services	**50,129**	29,702
Supplies	**52,362**	131,616
Board member expenses	**106,627**	90,405
Mail, courier and telecommunications	**562**	1,922
Other	**105,177**	105,046
	4,584,508	4,586,844

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

	2015 Budget	**2015**	2014
	$	**$**	$
Board chair per diem expense	**50,000**	**36,750**	30,100
Other board members per diem expense	**74,000**	**49,550**	36,525
Governance costs and travel	**50,000**	**20,327**	23,780
Total expenses	**174,000**	**106,627**	90,405

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 42 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 2015 was $353,604 (2014 - $329,175) 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, 2014. At that time, the plan was fully funded.

13. Guarantees

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

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

14. Comparative figures

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

STAFF MEMBERS

Front Row
Linda Henry, Christine Laity, Tapas Kar, Sheila Rogoski, Jina Mintsinikas, Jai Mills, Chantelle Vernon, Usha Cithiravel, Barbara Millar, Janice Kelly, Monika Smith

Second Row
Karen O'Brien, Sue Wojdylo, Ritva Gallant, Marco Aguila, Jennifer Persaud, Vinitha Navarathinam, Kate Lowndes, Lisa Kitchen, Kelly Sanders, Katie Cronin-Wood

Third Row
Deborah Hammons, Kasia Luebke, Meaghan McCloy, Natasha Yussuf, Marilee Suter, Indra Narula, Sheila Stirling, Sherry Harvey, Heidi Winkelmann

Back Row
Dieufert Bellot, Suzette Stines-Walford, Pauline Rahaman, Karol Eskedjian, Dionne James, Brian Laundry, Jennifer Kerswill, Jeanne Thomas

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