



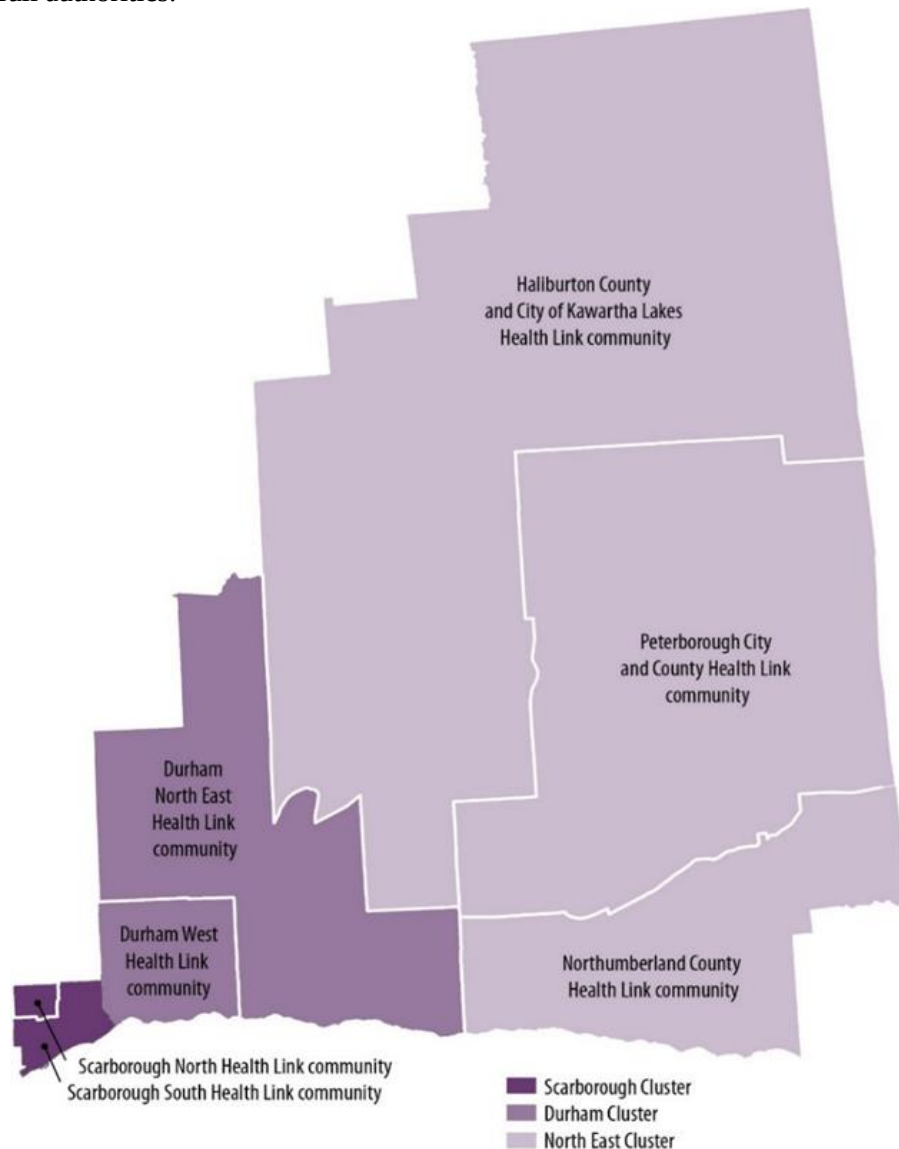
Leading System Evolution

Engaged Communities. Healthy Communities.

Central East LHIN 2015-16 Annual Report

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 ninth 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

TABLE OF CONTENTS	2
MESSAGE FROM OUR CHAIR AND CEO	4
MEMBERS OF THE BOARD	5
INTRODUCTION	6
MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA)	7
What is an MLAA?	7
MLAA Performance Indicators.....	7
CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN 2013-2016	10
Implementation of the IHSP	11
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.....	11
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.	13
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.	14
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.	18
Integration.....	19
Francophone Initiatives.....	22
Aboriginal Initiatives.....	24
Community Engagement Activities.....	25
ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE.....	31
Independent Auditor's Report	32
Statement of Financial Position	33
Statement of Financial Activities	34

Statement of Changes in Net Debt.....	3535
Statement of Cash Flows	36
Notes to the Financial Statements	37
STAFF MEMBERS.....	45
CONTACT INFORMATION.....	46

MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report is titled "*Leading System Evolution*" and is once again reflective of the evolving system journey the Central East Local Health Integration Network (Central East LHIN) continued to lead in 2015/16 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.

In 2015/16, the Central East LHIN was continuing to work with its health care service providers and other partners on the goals set out in its 2013-2016 "Community First" Integrated Health Service Plan as the plan entered its final year. These goals included:

- Reducing the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.
- Continuing to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
- Strengthening 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.
- Increasing the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

Additionally the LHIN, with the support of its planning partners, was actively engaging patients and caregivers, health care service organizations and other health and social service partners, Indigenous and Francophone stakeholders, municipal and provincial leaders and local residents on the development of the LHIN's fourth Integrated Health Service Plan (IHSP 4) which was to come into effect as of April 1, 2016.

Once again, this Annual Report outlines the progress that was made in 2015/16 on the four goals, as evolving projects and initiatives, informed by local and provincial engagement, continued to be planned, funded, implemented and monitored.

This included tracking the performance and financial accountability of the LHIN and its health service providers to ensure that the system was meeting the four key Ministry objectives as laid out in the *Patients First: Action Plan for Health Care* 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, residents, 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

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 three-year 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.centraleasthin.on.ca>



Sitting (l-r)

Samantha Singh, Member

Term of Office:

June 17, 2010 – June 16, 2016

Amorell Saunders N'Daw, Member

Term of Office:

April 2, 2014 – April 2, 2017

Wayne Gladstone, Chair

Term of Office:

June 2, 2010 – June 14, 2016

Standing (l-r)

Joanne Hough, Member

Term of Office:

May 4, 2011 – May 3, 2017

S. Gopikrishna, Member

Term of Office:

October 22, 2014 – October 21, 2017

Margaret Risk, Member

Term of Office:

May 17, 2011 – May 16, 2017

Absent

David Sudbury, Vice-Chair

Term of Office:

June 17, 2010 – June 16, 2016

INTRODUCTION

The Central East LHIN is the second largest LHIN in population (1,603,200 people) in the province and is projected to remain so over the next 10 years. It is growing at a rate slightly below the provincial average at 4.6% vs. 5.1% for Ontario (2011). The Central East LHIN is the sixth largest LHIN in land area at 16,673 km².

Geography and health care referral patterns and utilization practices are used to organize the LHIN into (for purposes of health system planning and integration) three large service cluster areas - Scarborough, Durham and North East and seven Health Link communities.

Cluster	Scarborough		Durham		North East		
Health Link Community	Scarborough North	Scarborough South	Durham West	Durham North East	Haliburton County and City of Kawartha Lakes	Peter-borough	Northum-berland County
Land Area (sq km)	42.4	138.3	449.1	2,172.1	7,893.8	4,215.2	1,766.9
Population Density (persons per square kilometre)	4,207	3,144	713	132	11	32	41
Population							
Population (Census 2011, based on Dissemination Areas)	178,395	434,815	320,400	287,800	89,310	135,085	72,475
Population 65+	30,705	59,615	32,525	40,980	20,370	27,165	15,305
Population 75+	15,490	28,535	14,200	19,055	9,165	13,195	6,940
% population age 65+	17.2%	13.7%	10.2%	14.2%	22.8%	20.1%	21.1%
% population age 75+	8.7%	6.6%	4.4%	6.6%	10.3%	9.8%	9.6%
Language, Census 2011							
% who include English as their mother tongue	30.8%	56.5%	81.7%	90.1%	94.4%	93.7%	94.3%
% who include French as their mother tongue	0.8%	1.3%	1.9%	2.1%	1.2%	1.3%	1.4%
% with no knowledge of English or French	16.3%	3.6%	0.8%	0.3%	0.1%	0.2%	0.1%
Immigration, Census 2006							
% who are immigrants	69.5%	53.0%	26.6%	13.7%	8.4%	9.5%	11.0%
% who arrived within 5 years	15.9%	10.3%	2.6%	0.9%	0.3%	0.7%	0.4%
Visible minorities and identity, Census 2006							
% who are visible minorities	81.6%	62.4%	26.9%	5.9%	1.5%	2.4%	2.3%
% who self-identify as Aboriginal	0.1%	0.6%	0.9%	1.5%	1.9%	3.2%	2.0%

Source: IHSP 2016-2019 – Common Environmental Scan

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA)

What is an MLAA?

Since 2006, the Central East LHIN and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed an accountability agreement which outlines the obligations and responsibilities of both the LHIN and the Ministry over a defined period of time with respect to planning, integrating and funding local health care services.

The Ministry/LHIN Accountability Agreement (MLAA) 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 MLAA is mirrored in the Service Accountability Agreements that LHINs negotiate with all health service providers.

MLAA Performance Indicators

In 2015, a new 2015-2018 MLAA template was negotiated between the LHINs and the Ministry to better reflect alignment with new government priorities and initiatives including the Patients First Action Plan for Health Care, Health System Funding Reform (HSFR), Health Links, Home and Community Care, the Comprehensive Mental Health and Addictions Strategy and Palliative Care.

The new MLAA includes fourteen (14) performance indicators and seven (7) monitoring indicators. It reflects the direction from the Ministry that all LHINs should strive to achieve a single provincial target and therefore targets have now been set at a provincial level rather than at a LHIN level which had previously been the case.

At the end of 2015/16, the Central East LHIN achieved or made progress (as compared to the 2014/15 results) on eleven (11) of the fourteen (14) performance indicators and five (5) of six (6) of the applicable monitoring indicators.

The achievement of the performance indicators is directly attributable to the ongoing engagement and collaboration with stakeholders in the Central East LHIN. These include acute, community-based and long-term care home providers and their staff, primary care and specialty physicians, patients and caregivers along with targeted investments in programs and new initiatives.

Performance Indicators – Achieved/Progress Made

- Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services
- Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing service
- 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)

The Central East LHIN has the largest number of seniors (65+) in the province. This priority population is growing and impacting the demand for health care services.

In 2015/16 the Central East LHIN rate for Percentage of Alternate Level of Care (ALC) Days showed an improvement of 13.1% as compared to 2014/15 and the ALC rate improved by 1.88% because of the continued investments in specialized geriatric services initiatives currently implemented.

The Central East LHIN has the highest waitlist and 2nd highest long-term care (LTC) demand rate in the Province, it is recognized that the LHIN will have to continue its system focus on supporting frail seniors to live healthier at home and spend fewer days in hospital as it moves forward with the implementation of IHSP 4 if it is to meet the provincial ALC targets.

- 90th percentile emergency department (ED) length of stay for complex patients
- 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients
- Percent of priority 2, 3 and 4 cases completed within access target for CT scans
- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement
- Percentage of Alternate Level of Care (ALC) Days
- ALC rate
- Readmission within 30 days for selected HIG conditions

*The ongoing achievement of the Emergency Department Length of Stay performance and monitoring indicators in 2015/16 highlights the results that continued to be achieved by hospitals participating in the **provincial Pay-for-Results program** and their community-based partners.*

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.

Monitoring Indicators - Achieved/Progress Made

- Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery
- Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery
- Rate of emergency visits for conditions best managed elsewhere per 1,000 population
- Hospitalization rate for ambulatory care sensitive conditions per 100,000 population
- Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge

The Central East LHIN Wait Time Strategy Working Group (WTSWG), with representation from all hospitals delivering wait times services, meet on a regular basis to discuss, identify and resolve pressures and risks as well as share best practices.

*The **upgrade of the SUBMIT tool in 2015/16**, used to manage the electronic scheduling of surgeries across all Central East LHIN hospitals in order to improve wait times, improved the quality of data being tracked by the hospitals and supported the allocation of surgical volumes to improve performance.*

The setting of a single provincial performance target for all LHINs in-year presented some implementation challenges for hospitals in achieving the MRI access target.

*In 2015/16, hospital staff continued to collaborate with their radiologists and other stakeholders to ensure the standardized assignment of procedure priority while the LHIN worked with the Ministry to identify **ongoing investment opportunities to achieve higher and more consistent performance in the current and future fiscal years.***

Performance Indicators – Not Achieved/Progress Not Made

- Percent of priority 2, 3 and 4 cases completed within access target for MRI scans
- Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
- Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions

Monitoring Indicators – Not Achieved/Progress Not Made

- CCAC wait times from application to eligibility determination for long-term care home placements: from community setting
- CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting

*In 2015/16, the Central East LHIN continued to be challenged in meeting the Ministry-LHIN Accountability Agreement performance target for Repeat Unscheduled ED Visits within 30 Days for Mental Health Conditions and Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions as it continued to work with its stakeholders on **strengthening co-ordination between acute and community-based providers** so that individuals requiring ongoing care for these illnesses could be better served. In 2016/17, the LHIN will be working with its providers to launch new and/or expanded peer support programs, community-based crisis beds and indigenous and shelter outreach strategies.*

Central East LHIN MLAA Indicators 2015/16

No.	Indicator	Provincial target	Provincial			LHIN		
			2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
1. Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	87.88%	88.17%	88.65%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	95.67%	94.33%	95.70%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21.00	29.00	29.00	30.00	23.00	38.00	28.00
4	90th percentile emergency department (ED) length of stay for complex patients	8.00	10.13	10.48	9.97	9.62	9.83	9.47
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4.00	4.03	4.28	4.07	4.02	4.00	3.92
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	57.17%	55.67%	50.43%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	87.07%	89.02%	87.88%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	95.63%	92.66%	94.27%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	94.03%	91.91%	90.70%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	16.84%	13.57%	14.63%
11	ALC rate	12.70%	13.70%	14.12%	13.98%	18.13%	17.45%	17.79%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	19.63%	18.90%	19.67%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	25.18%	27.29%	27.50%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	16.69%	16.66%	16.96%
2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	88.79%	87.94%	90.24%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	NA	NA	NA
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	98.03%	94.70%	95.10%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	21.00	21.00	22.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	10.00	10.00	11.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	14.85	3.72	10.19
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	322.50	80.88	232.74
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	47.54%	45.86%	47.21%

Note:

Green = indicator met the provincial target; Yellow = indicator did not meet the provincial target but progress has been made against the 2014/15 results; Red = indicator did not meet the provincial target

Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery is not applicable in the Central East LHIN.

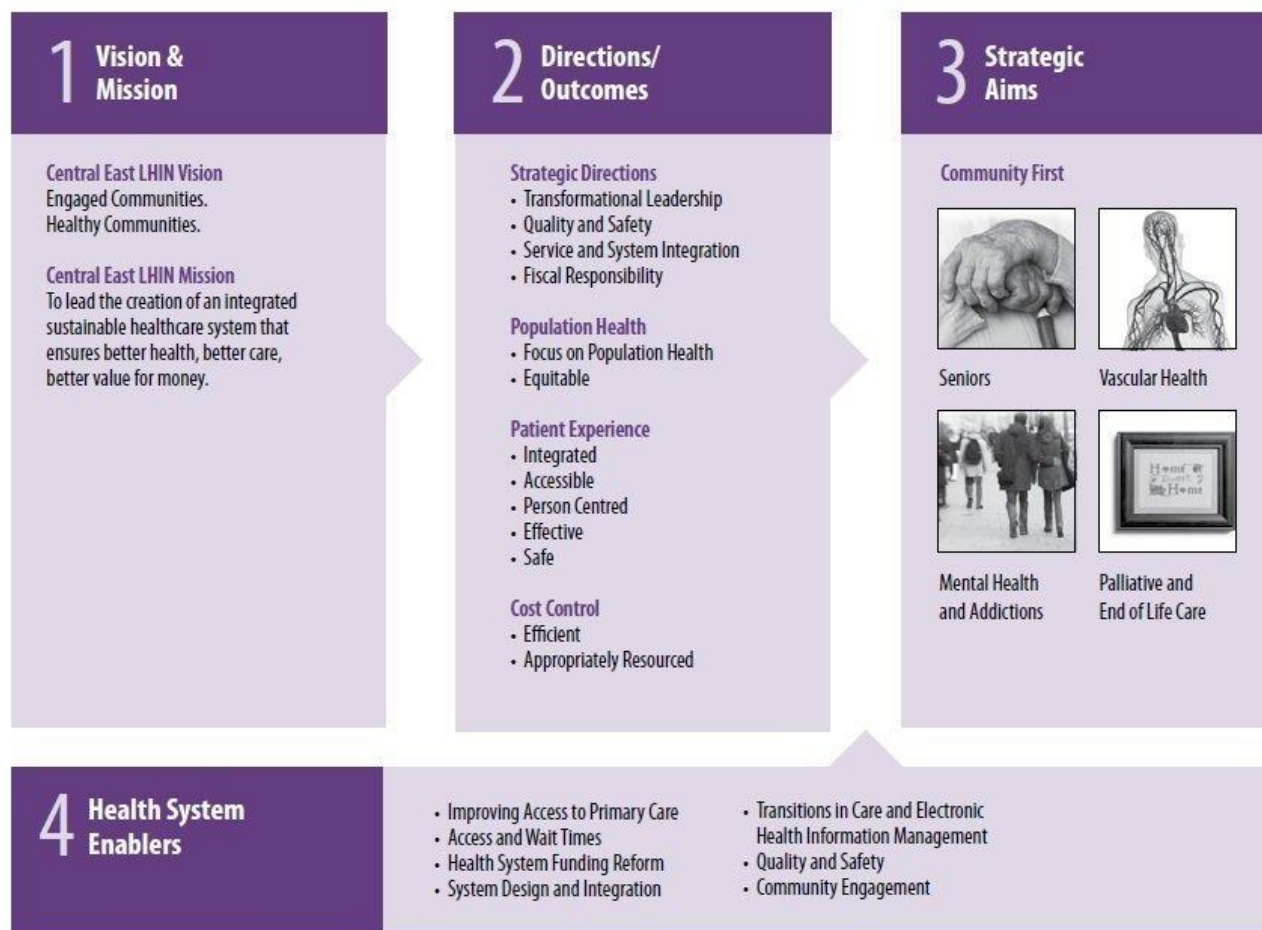
*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)

**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN 2013-2016

In 2015/16, the Central East LHIN and its partners continued to be guided by the strategic aims set for the system in the 2013-2016 Integrated Health Service Plan (IHSP) in meeting the shared goal of ***“Community First – Help Central East LHIN residents spend more time in their homes and their communities”***.

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 to achieve objectives through ongoing improvements to create a better local health care system.



With the passing of a motion on July 22, 2015, the Board of the Central East LHIN updated the wording of the LHIN’s Mission, Vision and Strategic Directions and reconfirmed the values of the LHIN as first approved in 2007 and again in 2012. Effective as of April 1, 2016, the updated Vision, Mission and Strategic Directions will better reflect the evolving accountabilities of the LHIN organization and the health service providers who deliver services in the Central East region.

Implementation of the IHSP

Below are just a few of the initiatives and accomplishments from 2015/16 that highlight the final year of implementing 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.

In 2015/16, the Central East LHIN remained committed to building a network of services to meet the needs of its rapidly growing and aging population of seniors. With over 14% of Central East LHIN's population consisting of seniors aged 65+, the Central East LHIN had the largest number of seniors (65+) in the province in 2015/16 and the population continues to increase.

Seniors are impacted everywhere in our health care system, and as such benefited from the full range of initiatives of the IHSP related to vascular health, mental health and addiction, and end-of-life/palliative care. Seniors and their caregivers also directly benefitted from the integration and quality improvement initiatives undertaken by the Central East LHIN, including Health Links and the Community Health Services Integrations.

In 2015/16, the focus of IHSP activities specific to the Seniors Strategic Aim, were centered on addressing – and where possible – reversing frailty:

Seniors Care Network

The Seniors Care Network is 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 works 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 2015/16, the Seniors Care Network continued to provide leadership input and policy advice on a number of Central East LHIN initiatives as well as participating in a number of task groups looking at ageism, age-friendly community development, training needs and capacity development for specialized geriatric services and dementia planning.

Home First approaches and transitions in care

Home First is a philosophy that helps patients transition from the hospital back to their homes. By continuing to work with patients and their families in 2015/16, the CECCAC and Community Support Services (CSS) agencies helped discharged hospital patients stay in their own homes or, if necessary, move to a more appropriate place for care if required.

Geriatric Assessment and Intervention Network (GAIN) – hospital and community teams

GAIN teams are inter-professional hospital and community-based teams providing comprehensive assessments and home-based care to assist seniors to remain in their homes. Located in each of the four largest hospitals in the Central East LHIN including Lakeridge Health (Oshawa), Peterborough Regional Health Centre, The Rouge Valley Health System (Centenary Site) and The Scarborough Hospital (General Campus) and eight community-based teams in Scarborough



CentralEastLHIN @CentralEastLHIN - 16 Jun 2015

thanks Lou, #trenthills is latest location for this highly successful @SeniorsCareNet led #LHIN initiative

Lou Rinaldi @LouRinaldiMPP

@CentralEastLHIN Congratulations to #trenthills as they welcome & celebrate their new GAIN Team & cut the ribbon for their new location!

(Carefirst Seniors and Community Services Association and St. Paul's L'Amoreaux Centre), Durham Region (Oshawa Community Health Centre), and the North East Cluster (Community Care City of Kawartha Lakes, Peterborough Regional Health Centre, Port Hope Community Health Centre, Haliburton Highlands Health Services and Trent Hills Community Team), GAIN teams collaborate with primary care providers and other services in the implementation of care plans for high-risk seniors. In 2015/16, over 4,000 referrals were made to one of the 12 GAIN teams with over 8,000 patients being seen in total. Referrals came from primary care physicians, community agencies and Geriatric Emergency Management (GEM) nurses located in Central East LHIN Emergency Departments.

Increasing capacity to support seniors in the community

While Long-Term Care (LTC) is a critical resource for the frail older adult population, it is well-supported that older adults prefer living at home and makes it all the more important to advance care to support older adults living healthier at home. In 2015/16 targeted investments in Adult Day Programming and Assisted Living for High Risk Seniors investments by Health Link community continued to provide alternative options for families and caregivers.

Adult Day Programs (ADPs) provided social activities, meals, and health care assistance for close to 2,500 high-risk seniors, relief to family caregivers, and the opportunity to cluster services with GAIN Community Teams, as a contact point for other health and social services.

Assisted Living Services for High Risk Seniors (ALS-HRS) hubs in Scarborough North and South, Durham North East, Haliburton County and the City of Kawartha Lakes, Peterborough City and County and Northumberland County continue to operate successfully and address the needs of over 1,000 high risk seniors to support them to reside at home through the assistance of both scheduled and non-scheduled personal support, homemaking, security checks, and reassurance services on a 24/7 basis.

Behavioural Supports Ontario (BSO)

The Central East LHIN BSO initiative to enhance services for residents with behaviours associated with complex and challenging mental health, dementia, or other neurological conditions wherever they live, at home, in long-term care, or elsewhere continued in 2015/16. With dedicated support staff now fully trained to support all the LHIN's 68 long-term care homes, over 5,000 referrals were received to support over 9,000 patients and their family members. Additionally, trained staff in the community received over 300 referrals for support with over 1,000 patients and their family being offered information and strategies in dealing with responsive behaviours.

Exercise and Falls Prevention Classes

In the Central East LHIN, the delivery of free Exercise and Falls Prevention Classes were supported by eight Community Support Service (CSS) agencies LHIN to improve and maintain functional performance of seniors, as well as provide instructions to reduce the risk of falling. In 2015/16 over 400 classes were offered across the Central East LHIN with more than 12,000 seniors being better supported to continue to live in their own homes and communities.

*A **GAIN** patient with moderate dementia was reluctant to participate in an **Adult Day Program** (ADP), much to the distress of his exhausted wife. After several attempts to encourage him to attend, with the support of the **Community BSO Clinician**, he arrived at an ADP one morning and promptly ran away from his wife.*

Fortunately, his wife had coordinated with the Community BSO clinician who was waiting for the couple at the ADP program and leaped into action to encourage the man to stop running. He agreed and was coaxed into the ADP program with the BSO clinician, who stayed with him to help him settle in and talked about his unique needs with the ADP staff.

She joined him again at his next ADP program day and helped him get accustomed to the program. He is now participating regularly and his wife is getting a break from her caregiving duties.

"My husband and I have been attending "Stretching & Strengthening" & "Balance & Fall Prevention" classes three times weekly since September, 2015. My husband had a stroke 4 years ago which left him with considerable balance issues. He has experienced quite a noticeable improvement since participating in this excellent community care exercise program. I am benefitting by taking part in the program as well. The instructors are very knowledgeable and encouraging. We both feel fortunate to have this service available to us."

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.

Vascular diseases are a broad group of health conditions that affect almost all parts of the body. Vascular disease includes cardiovascular (heart), cerebrovascular (brain) including vascular dementia and stroke and peripheral vascular disease which presents in other areas of the body such as kidneys, arms and legs. Vascular disease impacts our individual health and our health care system. Vascular disease is characterized by a thickening or narrowing of the arteries that move blood through our bodies (atherosclerosis). Atherosclerosis is a disease that affects the entire circulation system.

In 2015/16, through vascular health priority projects and investments, there continued to be increased awareness of and access to:

Regional Cardiovascular Rehabilitation and Secondary Prevention Program (CRSP)

In 2015/16, the expansion of the Regional Cardiovascular Rehabilitation and Secondary Prevention Program (CRSP) to 13 hospital and community sites across the LHIN resulted in over 3,000 patients receiving access to this free six-month exercise and education program.



CentralEastLHIN @CentralEastLHIN · 20 Jul 2015

Hasting Field House in Trent Hills latest site for the #LHIN's #cardiovascular rehab and secondary prevention program bit.ly/1ec6WF5



CentralEastLHIN @CentralEastLHIN · 3 Sep 2015

Great day to announce latest #communitybased cardio rehab site in #peterborough @JeffLeal_MPP



A \$1 million investment announced in June 2015 led to the establishment of new sites in Cobourg, Peterborough and Campbellford as well as the ongoing delivery of the program in Pickering, Scarborough, Ajax, Whitby, Port Perry, Oshawa and Lindsay. Over 95% of the patients were able to access the program within a 30 minute travel time from their homes and over 93% of the patients waited less than two weeks to be admitted to the program after being referred.

Diabetes Education Programs

The Central East LHIN continued to work with the Diabetes Education Programs (DEP) on an in depth 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. The diabetes networks in each cluster (Scarborough, Durham, North East) reviewed metrics, identified service gaps and strategies to improve the coordination of care, and reported their progress to the Central East LHIN each quarter.

Complex Diabetes Care Centres

The Central East LHIN's three Complex Diabetes Care Centres (CCDC), are located within The Scarborough Hospital, Lakeridge Health and Peterborough Regional Health Centre. In 2015/16, the Central East 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.

Centralized Diabetes Intake and Referral

The Central East LHIN and Central East CCAC monitored the performance of the centralized diabetes intake and referral process. 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 1,180, with a total number of 1,608 referrals for 2015/16.

Ontario Telemedicine Network (OTN) Teleophthalmology Program

The Central East LHIN approved funding for a two-year Ontario Telemedicine Network (OTN) teleophthalmology program hosted at Carefirst Seniors and Community Services Association. This service was implemented in July 2015, to improve eye care by overcoming barriers and increasing access to eye screening for people with diabetes. Mobile screening locations were established at Carefirst Seniors and Community Services Association, Scarborough Academic Family Health Team, Scarborough Centre for Healthy Communities and TAIBU Community Health Centre. In 2015/16, 50 clients were screened through this program.

Telehomecare

The Central East Telehomecare (THC) program launched on February 16, 2016. The focus of the program is to support patients with mild to moderate Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF) through remote health monitoring and coaching by trained Telehomecare Clinicians. Patients are provided with easy-to-use in-home monitoring equipment and will engage in 6 months of health coaching aimed at improving self-management for chronic conditions. Initial target geography: patients living in Durham, Northumberland, Haliburton and City of Kawartha Lakes.

One of Lucy's primary caregivers for helping her manage her chronic condition is her ex-daughter-in-law Sarah. Sarah was feeling burnt out, and trying to cope with Lucy's needs while working full time and raising her own child. She was initially reluctant about Telehomecare, thinking that it would be a burden on her already stretched time, adding yet another responsibility.

Three weeks into the program, Sarah cannot believe the positive results. Together Lucy and Sarah are learning about Lucy's condition and now understand her symptoms, medications and what they are for; and Lucy now knows how to speak to the doctor in an informed manner.

Lucy is more confident in how to manage symptom exacerbations, making her better able to decide when to visit the doctor. Telehomecare has decreased Sarah's stress and she is now less overwhelmed by the Lucy's needs saying "I am a better caregiver".

Central East Self-Management Training Program

The Central East CCAC continued to deliver the "Central East Self-Management Training Program" in 2015/16. 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 83 workshops were attended by 1,006 participants across the LHIN in 2015/16.

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 2015/16, the Central East LHIN continued to lead the system to deliver programs and initiatives through ongoing investment and implementation of

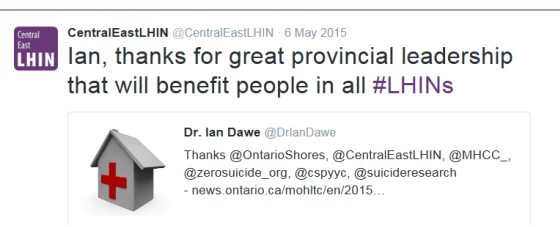
more “upstream” solutions that were tracked through the performance targets of reducing unscheduled ED visits within 30 days and reducing in-patient re-admissions.

In 2015/16, the focus of IHSP activities specific to the Mental Health and Addictions Strategic Aim continued to focus on supporting people to live in their own homes and communities:

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. In this capacity, Dr. Dawe acted as the co-chair of the Central East LHIN Mental Health and Addictions Coordinating Council and chair of the Central East LHIN Chiefs of Psychiatry group.

Dr. Dawe’s leadership on both a local and a provincial level in such initiatives as the “Big White Wall”, a virtual site offering information and services to people with Mental Health and/or Addictions issues and the Ontario Hospital Association Suicide Strategy, along with his advice and leadership to the system was extremely valuable. Dr. Dawe left his position as of March 31, 2016 to relocate to another area of the province.



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

In the spring of 2014/15, the LHIN established the Central East LHIN Mental Health and Addictions (MHA) Strategic Aim Coordinating Council. The Council is 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. In 2015/16, 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.

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 Hospital, Rouge Valley Centenary, The Scarborough Hospital and Peterborough Regional Health Centre to support the “spread” of the model throughout the LHIN. In 2015/16 the H2H Teams were fully implemented across the LHIN. Preliminary results in terms of ED revisit mitigation were extremely encouraging at the conclusion of March 31, 2016.

*Jason is a single Asian male now in his late 50s. He has been living with schizophrenia for more than 3 decades. He lived alone and had no children. He was referred to the **Hospital to Home (H2H)** program due to his frequent use of the emergency room and the crisis line at the Scarborough Hospital (TSH). Well educated, Jason had been struggling with mental health challenge and in his mid-40s was no longer able to work fulltime.*

With ups and downs in his mental health journey, the H2H worker found that the root cause for Jason’s frequent visits to the ER was his lack of social support. The great thing about the H2H program is that H2H workers are on site in the hospital. Working with the hospital team, including psychiatrists, mental health nurses and social workers to gain a better understanding of Jason’s major issues, the H2H worker encouraged him to join activities and expand his social connections.

Initially challenged to go out due to the stigma of mental health disorders, Jason is now making friends and attending community activities. While he occasionally uses the Crisis Line, Jason has not visited the ER in nearly 2 months and has now been connected to a therapist at TSH who he sees regularly.

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 North East Clusters. Each position was fully implemented early 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 second year of implementation in 2015/16 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 this process, ninety (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. As of the end of Year 2, a total of 725 clients had been transitioned to Stepped Care, and a total of 240 new clients were admitted to ACTT as of the end of Year 2 of implementation. Ninety five percent (95%) of those transitioned to Step Down were 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 Services 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 2016/17 to include additional “wrap around care” resources.

Community Crisis Review Project

Phase Two of the project is scheduled for completion as of June 30, 2016. Phase One 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 approved the proposed next stage of the project, which is to develop an implementation plan for the recommendations. Central East LHIN staff collaborated in a Greater Toronto Area Community Crisis Project to develop recommendations for improving these services across LHIN borders. This project concluded as of March 31, 2016. The resulting recommendations are currently under review.

Housing and Homelessness

In 2015/16 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 2016 the Central East LHIN had received 45 Rental Supplements with additional Intensive Case management supports allocated across the three clusters of the LHIN.

Child, Youth and Adolescent Mental Health

Funds that were 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 were deployed in 2015/16 to support new and enhanced Mental Health Services to children, youth and families in the Durham Cluster.

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. OTN access related to Mental Health and Addiction services continued to be in high demand throughout 2015/16 as they functioned to capacity throughout the year.

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 a philosophy of care aimed to relieve suffering and improve the quality of life for people living with a life limiting 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.

In 2015/16, the focus of IHSP activities specific to the Palliative Aim continued to be on working with its health service providers and specifically its Central East Hospice Palliative Care Network (CEHPCN) to implement ongoing initiatives:

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 (PCCT) 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.

In anticipation of funding three more PCCTs across the LHIN and to build on successes and improve on lessons learned from the original three teams, the LHIN organized a two-day Quality Improvement Planning event in February 2016. The event was hosted by the Central East LHIN, supported by Health Quality Ontario (HQO) and attended by over 80 hospice palliative care and end-of-life stakeholders from across the LHIN. The intent was for communities to come together to share and discuss lessons learned and build on best practices, all within regional and provincial contexts.

Discussions were designed to lead to a level of standardization across teams and sub-LHIN Health Link geographies in terms of:

- A shared understanding of the how PCCTs will function across the region and at the system level.
- Developing one standardized model of care that all teams would work to implement across the region.

Sherry had been successfully dealing with her cancer diagnosis and treatments for a number of years when a final round of chemotherapy and radiation led to a visit with the palliative physician.

*Admitted to the hospital for shortness of breath and accumulated fluid, Sherry and her family agreed that she wanted to die at home but weren't sure if the family could cope. Once discharged home, her care was transferred to the **Palliative Care Community Team (PCCT)** who provided daily nursing assessments, visits from Personal Support Workers three times a day and education and support for family members.*

Because of the strong partnership between Sherry's family and friends, the PCCT system navigator, the palliative physician, the hospice volunteer, the CCAC, PSWs and visiting nurses, she was able to die comfortably and calmly at home with her husband and friends at her bedside and access to grief and bereavement services supported her husband and family once she had passed.

Interdisciplinary Palliative Education

Interdisciplinary Palliative Education continued to be an area of focus in 2015/16 with numerous physicians, nurses and allied health professionals enhancing palliative expertise through palliative education courses. Three “Learning Essential Approaches to Palliative and End-of-Life Care (LEAP)” courses were held providing education to 89 health professionals across the LHIN. Based on the development of a LHIN-wide education plan built in collaboration with health service providers, 19 Fundamentals of Hospice Palliative Care course, seven (7) Fundamentals Enhanced of Hospice Palliative Care courses and five (5) Comprehensive Advanced Palliative Care Education (CAPCE) courses were held in the Central East LHIN. These courses resulted in more than 600 participants enhancing their palliative care expertise across the LHIN. Courses were also provided for long-term care home staff and caregivers.

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 and in August 2015 named Dr. Edward Osborne as the new Regional Palliative Care Physician Lead for the Central East Region. With joint accountability and partnership to the Central East LHIN and the CERCP, Dr. Osborne provided leadership across the Central East region, championing both provincial and local strategies within the Central East context. Additionally, he collaborated 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 2015/16 include:

Health Links

In December 2012, the Ministry of Health and Long-Term Care released its Action Plan for Health Care. Complementing the release of the Action Plan in 2012, and in an effort to highlight the need for more patient-focused, coordinated care for the highest cost and most complex users of health care resources, the Ministry launched the province-wide Health Links initiative.

A **Health Link community** is comprised of the patients, family caregivers, providers, and broader system partners who reside or work within the Health Link geography who are committed to working better together to improve health outcomes for patients.

A **Health Link** is a local health care **network** consisting of patients, caregivers, health care providers and community support agencies that are committed to working better together to effectively identify every patient with complex health care needs and improve their health outcomes.

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 successfully submitted business plans and were operational by 2015/16. The Central East Health Link Project Management Office worked with the Central East LHIN to support all Health Links.

The deliverables for Central East Health Links 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

Central East Health Link Steering Committees, Design and Quality Improvement Teams work together to realize the Health Links mission: working better together to create a coordinated health system that improves outcomes and meets the goals of patients with complex health care needs.

Peterborough City and County Health Link – 131 Coordinated Care Plans initiated in 2015/16

Peterborough City and County Health Link network developed project plans, business processes, and communication strategies to implement the Coordinated Care Plan within network organizations current processes. Peterborough City and County Health Link network researched the Medication Reconciliation process and improvement ideas from hospital to community and developed a current state process map and ideas for improvement in 2015. As a result of a thorough assessment by the Ministry and Health Link LHIN leads, Peterborough City and County Health Link was chosen for Wave 1 of the Orion Coordinated Care Tool (CCT) Provincial Proof of Concept and went live September 25, 2015.



Durham North East Health Link – 158 Coordinated Care Plans initiated in 2015/16

The Durham North East Health Link funding letter was received on July 17, 2015 from the Ministry of Health and Long-Term Care approving the Durham North East Health Link. The funding letter also outlined key commitments and deliverables. In September 2015, the Durham North East Health Link Steering Committee with assistance from the Central East Health Links Project Management Office developed a business plan to assist organizations in developing coordinated care planning processes in 2015/16. As a result of a thorough assessment by the Ministry and Health Link LHIN leads, Durham North East Health Link was chosen for Wave 3 of the Orion Coordinated Care Tool (CCT) Provincial Proof of Concept and went live November 17, 2015.

Northumberland County Health Link – 92 Coordinated Care Plans initiated in 2015/16

Haliburton County – City of Kawartha Lakes Health Link – 83 Coordinated Care Plans initiated in 2015/16

Scarborough North and Scarborough South Health Links – 505 Coordinated Care Plans initiated in 2015/16

Northumberland County Health Link, Haliburton County – City of Kawartha Lakes Health Link, and Scarborough North and Scarborough South Health Links networks continue to develop and test processes to coordinate care for patients with complex health care needs. Health Link networks have participated in

community sharing events and education and training sessions to improve collaborations between organizations and to learn more about the tools and resources available to support coordinated care planning.

Durham West Health Link

Durham West Health Link launch is expected in 2016/17. The Health Links Project Management Office and the Central East LHIN are working together to gather patient experience data and supporting Health Link network organizations in Durham West to enable an effective and operational launch of the Health Links initiative.

Next steps in 2016/17 include the identification of physician leads within each Health Link, implementing a physician engagement strategy, engagement of new network partners, and the roll-out of a Coordinated Care Plan electronic solution.

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. In January 2014, the two hospitals submitted a joint Notice of Intent to Merge to the Central East LHIN and in March 2014 the two hospitals advised the LHIN that they would not be moving forward with their proposed Preferred Integration Plan but instead would be focusing on service delivery integrations.

In April 2015, the Minister of Health and Long-Term Care announced that a panel had been created to address infrastructure needs as well as improve access and integration of acute health care services in the Scarborough and West Durham region. Throughout 2015/16, the group worked in collaboration with the Central East LHIN, other neighbouring LHINs and local health care service providers, including Rouge Valley Health System, The Scarborough Hospital and Lakeridge Health to develop a report which provided recommendations to improve integration and access to hospital services in the Scarborough and West Durham.



The report was submitted to the Minister of Health and Long-Term Care in December 2015.

VON Durham (Victorian Order of Nurses) – Durham Hospice Voluntary Integration

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, services continued to be provided to existing clients with no interruption and access to all services remained the same. Transition of Durham Hospice enabled staff and volunteers to offer a wider variety of programs and services and continue to identify unmet needs in the community. This integration was a result of the LHIN-facilitated Community Health Services Integration Strategy, started in the spring of 2012.



Oshawa Community Health Centre – The Youth Centre – Voluntary Integration

In November 2014, the Boards of The Youth Centre (TYC) and Oshawa Community Health Centre (OCHC) confirmed their intent of a full merger of the two organizations. A time-limited, focused process facilitated by the Central East LHIN was begun. In January 2015, the Final Integration Plan was approved by both boards and accepted by the Central East LHIN Board. The implementation process of



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there's an energy as we head to launch and expanding CHC model across South Durham - stated at #LHIN Board meeting bit.ly/1NbIX5O

this new amalgamated company was started in February. A Transition Governance Committee (TGC) was established to oversee governance throughout the transition period and to ensure that board members were recruited for the new Board, strategic planning with clients, staff and other stakeholders took place and the organizational structure was finalized. On November 1, 2015 the new Durham Community Health Centre was launched.

Ross Memorial Hospital – Peterborough Regional Health Centre Voluntary Integration of Lab Services

In December 2015 it was announced that Ross Memorial Hospital (RMH) and Peterborough Regional Health Centre (PRHC), would move forward with a new laboratory partnership after the Central East LHIN Board passed a motion to not stop the Voluntary Integration of Laboratory Services between the two organizations. RMH and PRHC had submitted a Notice of Voluntary Integration to the Central East LHIN in order to ensure RMH Lab services met new quality guidelines for pathology set by Cancer Care Ontario and the College of Physicians and Surgeons. Pathology and microbiology services transition from RMH to PRHC effective March 2016.

Northumberland Hills Hospital – Hospital Improvement Plan

In January 2016, the Central East LHIN Board of Directors held a special open board meeting to review a revised version of the Northumberland Hills Hospital (NHH) Hospital Improvement Plan, approved by the NHH Board of Directors at its meeting on January 7th. Based on an analysis done by LHIN staff, which confirmed that most of the initiatives contained in the revised HIP provided the additional detail so that the hospital's progress could be measured, the LHIN Board passed a motion that saw NHH move forward with implementation of the HIP.

With that approval, the hospital, which contemplated no reductions to its current volumes or types of services, began working collaboratively with its physicians, staff, volunteers, patients and others to pursue improvement initiatives in five key areas including Enhancing Board Governance and Management; Utilization Efficiencies; Clinical Efficiencies; Operational Efficiencies and Integration. In recognition of the significant savings that NHH could achieve related to the integration initiatives, the LHIN Board motion directed NHH to accelerate the development and implementation of concrete action plans with a report back to the LHIN Board in April 2016.

Francophone Initiatives

In 2015/16, 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 2015/16 Joint Action Plan between the Central East LHIN and the Entité 4.

Engagement of the Francophone Community in the Central East LHIN

In 2015/16 the Central East LHIN worked in collaboration with Entité 4 to increase Francophone community participation in health service planning. This included engagement with Francophone stakeholders on the proposed "Living Healthier at Home" aim to be included in the LHIN's 2016-19 Integrated Health Service Plan, in order to ensure that direct care priority and health equity was addressed for the Francophone Community as a priority

population. Additionally, Francophone stakeholders were directly engaged by the LHIN on the Ministry's *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* discussion paper that outlined proposed changes for the health system

Improving Access and Accessibility to Primary Care and Chronic Disease Support

In 2015/16, the collaborative work of the Coalition for Healthy Francophone Communities in Scarborough led the Central East LHIN to allocate funding to TAIBU Community Health Centre to appoint a Nurse Practitioner to develop primary care services in French for Francophone of Scarborough cluster. With this funding TAIBU CHC began to enhance the provision of timely, culturally appropriate and bilingual community based primary health care services and programs identified through the collaborative efforts of the Central East LHIN, Entité 4, the Coalition for Healthy Francophone Communities in Scarborough (CHFCS) and TAIBU CHC. The Central East LHIN continued to support the Entité 4 and TAIBU CHC in implementing and delivering French language, chronic disease training self-management modules in the LHIN's Scarborough, Durham and North East clusters.



Improving Access and Accessibility to Care for Seniors

In 2015/16 the Central East LHIN continued to support the enhancement of the Francophone Seniors' Day Program at "Les Centres d'Accueil Heritage" in the Durham Cluster and collaborative efforts between the Central East Community Care Access Centre and "Les Centres d'Accueil Heritage" to increase the level of Francophone in-home services also continued.

The Central East LHIN also worked with three other LHINs - Central, Toronto Central and Mississauga Halton LHINs - and both Entité 4 and Reflet Salveo (Entité 3) to support the development of a *Cognitive Health Project* that will help to meet the increasing needs of the aging Francophone population of the Greater Toronto, including the Central East region. Based on developing options for service models for virtual memory clinics focusing on early detection and intervention, prevention and treatment tools for mild cognitive impairment, the project aligned with developing LHIN priorities to be included in the LHIN's 2016-19 IHSP, the province's dementia strategy and provincial Patients First initiatives.

Improving Access and Accessibility to Mental Health and Addictions Services

In 2015/16, the Central East LHIN worked together with two other LHINs - Central and Toronto Central LHIN - and both Entité 4 and Reflet Salveo (Entité 3), to support the development of a *Mental Health and Addictions (MH&A) Navigation and Coordinated Access to Community MH&A Services for Francophones* project. This project will enable Francophones to have access to linguistically and culturally appropriate community MH&A services in the GTA and will help to raise awareness and maximize the use of existing French language capacity and support the delivery of culturally appropriate MH&A French language services through the use of a centralized access programs by referral sources. With the collaborative efforts of the



Francophone Community Table on Health-Durham (officially launched in April 2015), the Central East LHIN allocated funding to CMHA Durham in 2015/16 to provide Mental Health First Aid in French to the Francophone community in the Durham Cluster. This funding supported CMHA in extending their certification training program to the French language community thus increasing accessibility of mental health services to a priority population. This was the first-ever Mental Health First Aid course provided completely in French. Members of the French community were provided this opportunity to learn about mental health and mental illness interventions at no cost.

*"It is wonderful to see a course such as **Mental Health First Aid** now available in French. I learned so much and I think this course should be offered again" - Participant from Peterborough.*

"It was amazing to see the French community come together to talk mental health. The group bonded and they were able to speak candidly about their experiences with mental health both personally and as a collective group- FLS Facilitator-CMHA-Durham.

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.

The Central East LHIN provided training to each staff and board member in order to support their competency in planning and managing health care services in a manner that is culturally sensitive to the needs of Indigenous Peoples residing within the LHIN. In addition, funds were provided to the health service providers tasked with offering Community Crisis Services across the LHIN geography. Other health service providers, including hospitals have taken the initiative to train their staff in Indigenous Cultural Safety in order to ensure that the services they offer are accessible to Indigenous Peoples.

In 2015/16 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 (MOU) 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 health care and service providers. The Curve Lake First Nation initiated the

process of developing their MOU with the CE CCAC late in 2014/15 and, in 2015/16, requested the assistance of the LHIN in completing this work. Other First Nations have made similar requests of the LHIN.

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 the Hiawatha First Nation on October 23, 2015. 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, ICS (Indigenous Cultural Safety) training. This has provided participants with a foundation from which to develop their skills in supporting the Aboriginal communities local to their LHIN. At the end of 2015/16, 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 2016/17 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.

Base funding was provided to Durham Mental Health Services and to FOURCAST to provide Mental Health and Addictions Outreach Services to Aboriginal communities in 2014/15 in the Durham and North East Clusters. These positions were fully operational in 2015/16.

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.

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.

Some of the Central East LHIN's engagement structures and activities include:

Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

On December 17, 2015, the Ministry of Health and Long-Term Care (the ministry) launched a discussion paper titled *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The discussion paper outlined proposed changes for the health system. Working together, the ministry and the Central East LHIN sought feedback on the discussion paper by meeting with local residents, Francophone and Indigenous stakeholders, primary care providers, public health partners, patients and caregivers and health service providers. In the Central

East LHIN, this engagement was supported by online surveys, focus groups and town halls conducted in each of the LHIN's three clusters.

Development of Fourth Integrated Health Service Plan

In 2015/16, the Central East LHIN began developing its fourth Integrated Health Service Plan (IHSP), a document that sets out shared goals for the organizations and service providers who make up the local health care system including hospitals, community support service agencies, community health centres, the community care access centre, community mental health and addiction agencies and long-term care homes.

As the Central East LHIN worked with its planning partners to develop IHSP 4, the LHIN also wanted to hear from patients, clients, consumers, residents and caregivers about their experiences with the health care system, their goals for living a healthier life in their homes and communities and how that can be achieved. The LHIN also heard from health care service providers about the challenges they faced in delivering co-ordinated and comprehensive care to their patients, clients, consumers, residents and their families and the opportunities they saw in better supporting them to live healthier lives in their homes and their communities and how that could be achieved. The LHIN held numerous engagement sessions, supported by web-enabled and paper based surveys, to gather that feedback which was incorporated in the final IHSP.

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 North East clusters. Membership has been open to governors from each of the over 130 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 12, 2015 the Central East LHIN and its Governance Advisory Councils hosted a "Bringing Care Home" for Board Members from all LHIN-funded health service providers from across the Central East LHIN region with a presentation from Dr. Gail Donner, Chair of the Ministry of Health and



CentralEastLHIN @CentralEastLHIN - 30 Sep 2015

The second of five #LHIN Health Huddles underway in #scugog. Engaging providers and patients on next #IHSP.



CentralEastLHIN @CentralEastLHIN - 12 May 2015

Gail Donner begins to address governors from #LHIN health service providers on home and community care report



Long-Term Care's Expert Group on Home and Community Care.

Central East Executive Council (CEEC)

Senior Administrators from 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 Terms of Reference, 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 2015/16 with adhoc meetings between the LHIN and this group and other physician groups including the LHIN's six physician leads.

Vice President and Chief Nursing Executive Steering Committee (VP/CNE)

The VP/CNE Steering Committee facilitates the provision of safe, quality, seamless, consistent and efficient patient care within the Central East LHIN. Through collaboration and open and joint decision making, the Steering Committee seeks out opportunities to enhance the patient experience and makes recommendations around practice directions, with the aim of optimizing patient care. The Steering Committee also seeks out opportunities for ongoing development of health care professionals within the Central East LHIN, including, but not limited to, standardization of policies, processes and protocols 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 2015/16, the Central East LHIN HPAC continued to meet on a quarterly basis, providing input into a number of initiatives and areas of interest. This included the Community First strategic aims and discussing the ongoing recruitment of health human resources. The membership 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 continued to meet 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 and 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 nearly 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 2015/16 the WTSWG continued to meet 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 2015/16, the DI Working Group continued to meet 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.

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 Care Engagement - 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 to build on past and current efforts to involve physicians, nurse practitioners and other health care professionals in the LHIN change agenda.

In June 2015, the Central East LHIN appointed Dr. Paul Caulford as its Primary Care Lead to work with the LHIN, its primary care providers and Health Links— to develop an integrated system of primary care that will better meet the health care needs of local residents.



CentralEastLHIN @CentralEastLHIN · 2 Jun 2015

#LHIN names Dr. Paul Caulford, well known #Scarborough doc as new #primarycare lead to work with #HealthLinks bit.ly/1SRbcdO

As the Central East Primary Care Lead, Dr. Caulford reached out to his colleagues in 2015/16 to ensure that primary care continued to actively inform the design and implementation of system solutions to health care challenges including improving access to services, chronic disease prevention and management, and reducing avoidable emergency department visits for frail seniors and people with mental health and addiction issues through community-based alternatives.

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, diabetes and stroke care.

Senior Care Network

The 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. Comprised of a group of senior health care leaders representing hospitals, community service providers, seniors' advocates and others from across the Central East LHIN, the Seniors Care Network is working along with health service providers 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 Central East LHIN Mental Health and Addictions (MHA) Strategic Aim Coordinating Council includes 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.

System Surge Management Committee - Central East LHIN Emergency Management Leads

In previous years, the Central East LHIN System Surge Management Committee had been 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 Integration, Communications Lead, Implementation Consultant, Health Planner) who met on a bi-monthly basis 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). Available as required, the System Surge Management Committee now works in partnership with the Central East LHIN Emergency Management Leads, a planning group, facilitated by the Central East LHIN, that in 2015/16 met on a bi-weekly basis to share knowledge and pro-actively plan for how to prepare and respond to shared emergencies. In 2015/16 this included implementing a workplan to reach “operational readiness” for the Pan Am/Parapan Games, the seasonal Holiday Surge experienced during the Flu Season and working with the provincial and federal levels of government to support the successful resettlement of Syrian refugees.

Open Board meetings

Board meetings and board committee meetings (Audit and Finance Committee, Governance, Quality and Community Nominations Committees) 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 are 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 once again 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.

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 to support the co-ordinated care of complex patients continued to be a major area of focus for physician engagement in the Central East LHIN in 2015/16.

Regional, County and Municipal Councils

In 2015/16, the Central East LHIN visited all regional, county and municipal councils 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 and to seek their feedback on the development of the 2016-2019 Integrated Health Service Plan.

MPP Engagement

In 2015/16, regular meetings between LHIN leadership and the Members of Provincial Parliament from all Central East ridings continued to ensure that these provincial leaders were aware of LHIN initiatives that would be benefitting their local constituents. Constituency staff continued to regularly contact LHIN staff to support any health care related inquiries.

Speakers' Bureau

LHIN staff and board members attended a number of third-party events in 2015/16 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 manages a \$2.2 billion health service system on behalf of the residents of the Central East LHIN with additional staff support funded by Health Force Ontario and Enabling Technologies.

In 2015/16 the Central East LHIN received a total operating budget of \$6.2 million which included operations at \$4.5 million and additional funding of \$1.7 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 along with staff to oversee health planning and engagement for French Language Services and Aboriginal initiatives. Special projects funding also provided continued support for the provision of Central East LHIN Physician LHIN Leads in the areas of Primary Care, Mental Health and Addictions, Emergency Medicine, Vascular Health and Critical Care.

In 2015/16 the LHIN conducted an organizational health review to assess its progress as a healthy organization and to see how it could better facilitate the ongoing implementation of the 2016-2019 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”.

This past fiscal year all LHIN employees and Board Members participated in the Indigenous Cultural Safety Online Training Program (ICS) delivered by the Provincial Health Services Authority of British Columbia. The ICS training is a facilitated on-line training program designed to increase knowledge, enhance self-awareness and strengthen the skills of those who work directly and indirectly with Aboriginal People. The goal of the ICS training is to further develop individual competencies and promote positive partnerships with our indigenous communities.

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. It supports day-to-day interactions and decision making and helps employees and the Board to work more effectively.

In 2015/16, the LHIN completed 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 a bi-annual basis, this report was used by the LHIN 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, 2016, 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, 2016, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in black ink that reads "Deloitte LLP". The signature is stylized, with the "D" being particularly large and the letters "LLP" written in a simpler, more upright style.

Chartered Professional Accountants
Licensed Public Accountants
May 25, 2016

Statement of Financial Position

Central East Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	\$	\$
Financial assets		
Cash	521,950	453,531
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 9)	1,606,348	5,111,730
Accounts receivable	26,831	54,928
	2,155,129	5,620,189
Liabilities		
Accounts payable and accrued liabilities	438,217	435,373
Due to LSSO (Note 4)	7,801	5,116
Due to Health Service Providers ("HSP") (Note 9)	1,606,348	5,111,730
Due to MOHLTC (Note 3b)	137,108	81,715
Due to Central West LHIN (Notes 3c, 4)	-	25,892
Deferred capital contributions (Note 5)	112,366	169,513
	2,301,840	5,829,339
Net debt	(146,711)	(209,150)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	34,345	39,637
Tangible capital assets (Note 7)	112,366	169,513
	146,711	209,150
Accumulated surplus	-	-

Approved by the Board

Original Signed By

Wayne Gladstone, Chair, Board of Directors

Original Signed By

David Sudbury, Chair, Audit/Finance Committee

Statement of Financial Activities

Central East Local Health Integration Network

Statement of financial operations
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	\$	\$	\$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	2,218,613,663	2,228,309,856	2,211,843,510
Operations of LHIN	4,534,130	4,491,739	4,510,790
Project Initiatives			
Emergency Department ("ED") Lead (Note 10a)	-	75,000	75,000
Emergency Room/Alternative Level of Care (Note 10a)	100,000	100,000	100,000
Aboriginal Planning (Note 10a)	20,000	20,000	20,000
Enabling Technologies (Note 10a)	-	406,892	644,000
Critical Care (Note 10a)	-	75,000	75,000
French Language Services (Note 10a)	106,000	106,000	106,000
Diabetes & Vascular Health (Note 10b)	824,475	842,070	823,706
Primary Care (Note 10a)	-	75,000	75,000
Amortization of deferred capital contributions (Note 5)	-	81,943	83,101
	2,224,198,268	2,234,583,500	2,218,356,107
Funding repayable to the MOHLTC (Note 3a)	-	(55,393)	(107,607)
	2,224,198,268	2,234,528,107	2,218,248,500
Expenses			
Transfer payments to HSPs (Note 9)	2,218,613,663	2,228,309,856	2,211,843,510
General and administrative (Note 11)	4,534,130	4,564,544	4,584,508
Project Initiatives (Note 10)			
ED Lead	-	72,000	73,706
ER/ALC	100,000	74,745	100,000
Aboriginal Planning	20,000	20,000	20,000
Enabling Technologies	-	406,892	618,108
Critical Care	-	72,000	72,000
French Language Services	106,000	106,000	106,000
Diabetes & Vascular Health	824,475	842,070	823,706
Primary Care	-	60,000	6,962
	2,224,198,268	2,234,528,107	2,218,248,500
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, 2016

	Budget	2016 Actual	2015 Actual
	\$	\$	\$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(24,796)	(40,935)
Amortization of tangible capital assets	-	81,943	83,101
Change in other non-financial assets	-	5,292	(13,772)
Decrease in net debt	-	62,439	28,394
Net debt, beginning of year	-	(209,150)	(237,544)
Net debt, end of year	-	(146,711)	(209,150)

Statement of Cash Flows

Central East Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	81,943	83,101
Amortization of deferred capital contributions (Note 5)	(81,943)	(83,101)
	-	-
Changes in non-cash operating items		
Due from MOHLTC	3,505,382	9,532,570
Accounts receivable	28,097	(8,795)
Due from LHIN Shared Services Office ("LSSO")	-	7,266
Accounts payable and accrued liabilities	2,844	(98,239)
Due to LSSO	2,685	3,652
Due to HSPs	(3,505,382)	(9,532,570)
Due to the MOHLTC	55,393	37,380
Due to Central West LHIN	(25,892)	(146,346)
Prepaid expenses	5,292	(13,772)
	68,419	(218,854)
Capital transaction		
Acquisition of tangible capital assets	(24,796)	(40,935)
Financing transaction		
Capital contributions received (Note 5)	24,796	40,935
Net increase (decrease) in cash	68,419	(218,854)
Cash, beginning of year	453,531	672,385
Cash, end of year	521,950	453,531

Central East Local Health Integration Network

Notes to the financial statements

March 31, 2016

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 km²). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park. The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics. The LHIN has also entered into an accountability agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

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

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

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

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

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:

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, 2016.

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:

			2016	2015
	Funding received	Eligible expenses	Excess funding	Excess funding
	\$	\$	\$	\$
Transfer payments to HSPs	2,228,309,856	2,228,309,856	-	-
LHIN operations	4,509,334	4,482,601	26,733	9,383
ER/ALC	100,000	74,745	25,255	-
ED/Lead	75,000	72,000	3,000	1,294
Critical Care	75,000	72,000	3,000	3,000
Aboriginal Planning	20,000	20,000	-	-
French Language Services	106,000	106,000	-	-
Diabetes and Vascular Health	824,475	842,070	(17,595)	-
Primary Care Lead	75,000	60,000	15,000	68,038
Repayable directly to MOHLTC	2,234,094,665	2,234,039,272	55,393	81,715
Enabling technologies repayable to MOHLTC through				
Central West LHIN	406,892	406,892	-	25,892
	2,234,501,557	2,234,446,164	55,393	107,607

3. Funding repayable to the MOHLTC (continued)

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

	2016	2015
	\$	\$
Due to MOHLTC, beginning of year	81,715	44,335
Recovery by MOHLTC during the year	-	(44,335)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	55,393	81,715
Due to MOHLTC, end of year	137,108	81,715

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:

	2016	2015
	\$	\$
Revenue	406,892	644,000
Expenses	406,892	618,108
Accumulated surplus due to the Central West LHIN	-	25,892

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.

The amount due to the LSSO as at March 31, 2016 was \$7,801 (2015 - \$5,116).

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 \$406,892 (2015 - \$644,000).

5. **Deferred capital contributions**

	2016	2015
	\$	\$
Balance, beginning of year	169,513	211,679
Capital contributions received	24,796	40,935
Amortization	(81,943)	(83,101)
Balance, end of year	112,366	169,513

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:

	\$
2017	254,721
2018	257,948
2019	260,254
2020	263,481
2021	153,698
	1,190,102

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:

	\$
2017	2,221,888,728
2018	2,220,681,128

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

7. **Tangible capital assets**

			2016	2015
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	757,176	(682,485)	74,691	127,443
Computer equipment	367,742	(338,838)	28,904	17,432
Web development	36,100	(36,100)	-	-
Leasehold improvements	668,028	(659,257)	8,771	24,638
	1,829,046	(1,716,680)	112,366	169,513

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, 2015. 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 \$2,228,309,856 is made up of the following:

	\$
Initial HSP funding budget	2,218,613,663
Additional funding due to announcements made during the year	9,696,193
Total HSP funding budget	2,228,309,856

The total revised operating budget of \$6,216,497 is made up of the following:

	\$
Initial budget as represented on the statement of financial activities	5,584,605
Additional funding received for one time initiatives	
ED/Lead	75,000
Critical Care	75,000
Enabling Technologies	406,892
Primary Care	75,000
Total budget	6,216,497

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of \$2,228,309,856 (2015 - \$2,211,843,510) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2016 as follows:

	2016	2015
	\$	\$
Operation of hospitals	1,214,275,231	1,231,015,066
Grants to compensate for municipal taxation - public hospitals	280,275	280,275
Long term care homes	444,462,828	437,367,196
Community care access centres	290,035,602	274,137,192
Community support services	51,361,299	47,571,175
Assisted living services in supportive housing	15,446,254	15,224,305
Community health centres	29,799,929	28,772,419
Community mental health addictions program	63,353,629	59,756,096
Specialty psychiatric hospitals	117,692,037	116,062,017
Acquired brain injury	1,576,447	1,632,344
Grants to compensate for municipal taxation - psychiatric hospitals	26,325	25,425
	2,228,309,856	2,211,843,510

The LHIN also received \$323,438 (2015 - \$Nil) in base funding to support the Centralized Diabetes Intake Service, as part of the Regional Coordination of Diabetes Services function and allocated the full amount to the Central East Community Care Access Centre (CECCAC).

9. Transfer payments to HSPs (continued)

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2016, an amount of \$1,606,348 (2015 - \$5,111,730) 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

	2016	2015
	\$	\$
Consulting services	276,000	152,668
Salaries and benefits	1,037,608	1,103,135
Public relations and community engagement	1,500	4,800
Meetings	1,213	1,548
Supplies and other	-	418,686
Mail, courier and telecommunications	-	1,260
Other	337,386	138,385
	1,653,707	1,820,482

b) Diabetes & Vascular Health

The LHIN received funding of \$824,475 (2015 - \$843,301 base funding). \$17,595 of deferred capital contributions from 14/15 was recognized as revenue in 15/16. Expenses incurred of \$842,070 which are included in the table above are made up as follows:

	Budget 2016	Actual 2016	Actual 2015
	\$	\$	\$
Salaries and benefits	685,314	702,909	692,582
Others	139,161	139,161	131,124
	824,475	842,070	823,706

11. General and administrative expenses

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

	2016	2015
	\$	\$
Salaries and benefits	3,372,126	3,406,786
Occupancy	266,604	320,410
Amortization	81,943	83,101
Shared services	426,342	444,449
Community engagement	11,490	14,905
Consulting services	53,730	50,129
Supplies	69,523	52,362
Board member expenses	94,175	106,627
Mail, courier and telecommunications	1,514	562
Other	187,097	105,177
	4,564,544	4,584,508

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

	Budget 2016	Actual 2016	Actual 2015
	\$	\$	\$
Board chair per diem expense	50,000	28,000	36,750
Other board members per diem expense	74,000	44,650	49,550
Governance costs and travel	35,000	21,525	20,327
Total expenses	159,000	94,175	106,627

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 2016 was \$319,691 (2015 - \$353,604) 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, 2015. At that time, the plan was fully funded.

13. Guarantees

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

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

STAFF MEMBERS



Front Row

Irem Ali, Sue Wojdylo, Jina Mintsinikas, Tapas Kar, Usha Cithiravel, Linda Henry, Karen Poon, Marco Aguila, Jennifer Persaud, Meaghan McCloy, Karen O'Brien

Second Row

Wendell Mak, Sheila Rogoski, Romina Vicente, Emily Van de Klippe, Deborah Hammons, Kelly Sanders, Melissa Chard, Antoinette Larizza

Third Row

Stewart Sutley, Pauline Rahaman, Ritva Gallant, Katie Cronin-Wood, Janice Kelly, Natasha Yussuf, Monika Smith, Kasia Luebke, Brian Laundry

Back Row

Karol Eskedjian, Marley Budreau, Marilee Suter, Jenny Greensmith, Suzette Stines-Walford, Dionne James, Scott Macpherson, Sheila Stirling, Debbie Hoy, Jai Mills, Jeanne Thomas

Absent

James Draper, Alex Ruppert, Dieufert Bellot, Lauren Chitra, Vinitha Navarathinam, Chantelle Vernon

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