Central East **LHIN**

Strengthening Connections

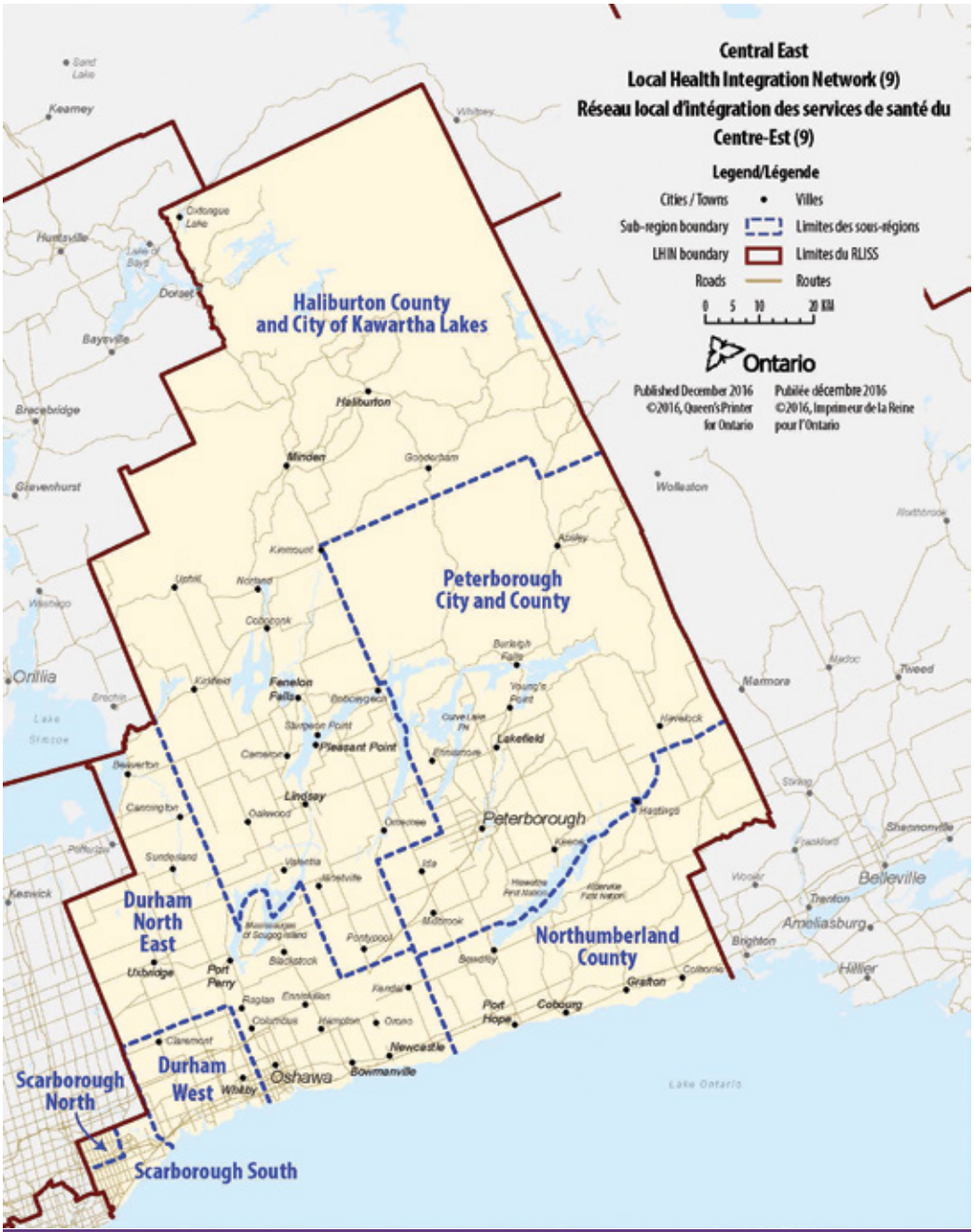
Engaged Communities. Healthy Communities.

Central East LHIN 2016-17 Annual Report

Ontario
Local Health Integration Network

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)

The Local Health System 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.



In the Central East LHIN, seven (7) sub-regions provide a geographic foundation for the development of local integrated systems of care.

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

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MESSAGE FROM OUR CHAIR AND CEO

In June 2016, the Board of the Central East Local Health Integration Network (Central East LHIN) submitted its Annual Business Plan (ABP) to the Ministry of Health and Long-Term Care. In that document, the Central East LHIN outlined the steps it would be taking, in partnership with its health service providers, patients and caregivers and other partners, to achieve the performance targets set out in the Ministry-LHIN Accountability Agreement (MLAA) and pursue its four Central East LHIN 2016-19 Integrated Health Service Plan (IHSP) Strategic Aims:

1. Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.
2. Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.
3. Continue to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.
4. Continue to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

This year's Annual Report is titled "Strengthening Connections" and highlights the deliberate and constructive steps that the LHIN has taken with its partners to continue to lead the advancement of an integrated sustainable health care system that ensures better health, better care and better value so that local residents are Living Healthier at Home.

In Fiscal Year 2016/17 (April 1, 2016 - March 31, 2017), integrated systems of care at the LHIN sub-region level continued to evolve as health service providers, patients and caregivers developed Coordinated Care Plans. Acute care and home and community care providers began to seamlessly integrate with primary care/family medicine in the collaborative delivery of inter-professional care for patients with complex health care needs. Performance monitoring by the LHIN led to targeted funding investments in high needs areas so that local residents had better access to community-based services. Local physician champions were recruited to advance system and sub-region objectives. The LHIN launched its Patient and Family Advisory Committee to build on the work it has undertaken since 2006 to ensure that the voice of patients and their families is captured and reflected in the implementation of Health care initiatives. Structural and service integrations supported by the LHIN and the Minister of Health laid the foundation for the delivery of more effective, efficient, quality and sustainable service delivery models.

This past year was also a year of transition as we worked with the Ministry of Health and Long-Term Care (MOHLTC), the staff and leadership of the Central East Community Care Access Centre, physician champions and our sister LHINs to advance the changes needed to bring the Patients First: Action Plan for Health Care, Patients First: A Roadmap to Strengthen Home and Community Care and Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario to fruition. The approval of Bill 41, the Patients First Act, on December 7, 2016, confirmed for the Central East LHIN that the time for transition and transformation had arrived and we focused additional efforts on supporting the seamless transition of Home and Community Care services from the CCAC to the LHIN.

As a Board and a leadership team, we are honoured to work with so many patients and caregivers, health service providers, physicians, nurses, front line providers, community leaders and other organizations, to ensure that the health care system is effectively managed.

LHINs and other partners will continue to play a critical role as Bill 41, *Patients First Act*, transforms and improves the health care system. Once again this year's Annual Report shows the progress made to date. We look forward to continuing to build locally-driven solutions around the people and populations in our seven sub-regions and to engaging our communities and individuals in future health care design and delivery.

Original Signed By

Louis O'Brien,
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. The role of the LHIN Board of Directors is to oversee, advise and govern the strategic directions and priorities of the LHIN. Directors are appointed by the Lieutenant Governor in Council through a process administered by the Public Appointments Secretariat for a term of up to three years, and may be appointed for one further term. The Chair and the Directors are appointed based on their expertise, experience, leadership skills and the needs of the LHIN and are accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds and for its results in the local health system. 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: **www.centraleastlhin.on.ca**.

Sitting (l-r)

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

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

Michael Nettleton, Member
Term of Office:
March 8, 2017 - March 7, 2020

Bonnie St. George, Member
Term of Office:
November 2, 2016 – November 1, 2019

Standing (l-r)

Aileen Ashman, Member
Term of Office:
May 18, 2016 – May 17, 2019

Amorell Saunders N'Daw, Vice Chair
Term of Office:
April 2, 2014 – April 1, 2020

David Barlow, Member
Term of Office:
March 8, 2017 – May 7, 2020

Louis O'Brien, Chair
Term of Office:
October 5, 2016 – October 6, 2019

Glenn Rogers, Member
Term of Office:
May 30, 2016 – May 29, 2019

Debbie Doherty, Member
Term of Office:
February 2, 2017 – February 1, 2020

S. Gopikrishna, Member
Term of Office:
October 22, 2014 – October 21, 2017

Not Pictured

David Sudbury, Vice-Chair
Term of Office:
June 17, 2010 – June 16, 2016

Wayne Gladstone, Chair
Term of Office:
June 2, 2010 – June 14, 2016

Samantha Singh, Member
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 km^2.

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 sub-regions that helps the LHIN to better understand and address patient needs at the local level.

Cluster	Scarborough		Durham		North East		
Health Link Community	Scarborough North	Scarborough South	Durham West	Durham North East	Haliburton County and City of Kawartha Lakes	Peterborough	Northumberland 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*

CENTRAL EAST LHIN AREA PROFILE

Serves an area of over **16,673** sq. km. with **1.7** million residents

9 hospitals operating out of **15** sites

131 Total Health Service Providers

Most Home and Community Care patients served provincially **3rd** largest based on budget

68 Long-Term Care Homes with **9,957** beds

2nd largest based on area population

6th largest LHIN based on geography

9 school boards and **2** Children's Treatment Centres

7 Family Health Teams, **6** Community Health Centres

47 Community Support Service Agencies

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 MOHLTC 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.

The Agreement also identifies the MOHLTC's strategic priorities for the health system and reflects the continued evolution of the LHIN model as well as the LHINs' maturity in managing the local health system. It recognizes that the MOHLTC and the LHINs have a joint responsibility to achieve better health outcomes for Ontarians and to effectively oversee the use of public funds in a fiscally sustainable manner.

MLAA Performance Indicators

The 2015-2018 MLAA template, negotiated between the LHINs and the MOHLTC, is aligned with 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 MLAA includes fourteen (14) performance indicators and seven (7) monitoring indicators grouped into four specific categories including Home and Community Care; System Integration and Access; Health and Wellness of Ontarians: Mental Health; and, Sustainability and Quality. The LHINs are expected to make incremental progress towards achieving provincial targets.

Performance targets are based on best practice and clinical evidence where possible. LHINs must report to the MOHLTC on their performance against these targets on a quarterly and annual basis.

Monitoring targets often provide important supplemental or explanatory information about the performance measures.

Central East LHIN MLAA Indicators 2016/17

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 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%	85.36%	82.10%	85.58%	87.88%	88.69%	85.50%	87.72%
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%	94.00%	93.83%	94.53%	95.67%	95.84%	93.27%	95.56%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	29.00	31.00	23.00	30.00	56.00	50.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	11.03	10.38	9.62	9.47	10.82	10.33
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.23	4.15	4.02	3.92	4.17	4.08
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	57.17%	50.43%	68.44%	57.64%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	87.07%	87.88%	95.90%	93.17%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	95.63%	94.27%	90.15%	91.86%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	94.03%	90.70%	88.73%	88.67%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.85%	15.16%	16.84%	15.22%	17.89%	17.61%
11	ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	18.13%	17.79%	26.27%	23.62%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	19.63%	19.58%	20.52%	20.57%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	25.18%	26.03%	27.75%	26.80%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	16.69%	17.33%	16.90%	16.77%
2. Monitoring Indicators										
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	88.79%	90.24%	86.73%	90.26%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	95.00%	93.00%	93.00%	NA	NA	NA	NA
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.32%	85.01%	98.03%	95.10%	94.14%	95.53%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	14.00	21.00	20.00	21.00	20.00
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	8.00	10.00	10.00	10.00	11.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	4.58	12.28	14.85	14.52	3.46	9.30
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	322.50	317.86	76.66	233.65
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.46%	47.81%	47.54%	47.32%	48.37%	48.83%

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)

**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

Performance Indicators - Home and Community Care

To prevent or delay visits to Emergency Departments (EDs), hospitalizations, and applications to Long-Term Care (LTC), and to enable discharge from hospital, Community Care Access Centres (CCACs) provide a variety of in-home support services in addition to assisting local residents to navigate a host of additional community services. The performance goal is to reduce wait time for home care (improve access) and ensure residents are spending more days at home (including end of life care.) LHINs are measured on the time it takes for a resident to receive CCAC support services, after having applied for the service. This period includes both the time from application to assessment and from assessment to delivery of services.

In 2016/17:

- Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services - target achieved
- 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 - result has not improved/ target not achieved
- 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) - result has not improved/target not achieved

The Central East LHIN continued to work with the Central East Community Care Access Centre and other stakeholders throughout 2016/17 to achieve the Home and Community Care performance indicators. Marked improvements in Q4 resulted in the achievement of the "Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services" target. A concerted effort to remove patients from both the Personal Support and Therapies wait lists, along with a small percentage of patients who choose to delay their choice for personal support services outside of the 5 day target, negatively impacted the achievement of the other two performance targets. It is anticipated that the significant targeted Community Investment made in 2016/17 for waitlist elimination combined with new investments in 2017/18 after the CCAC is transitioned into the LHIN will contribute materially to improving performance.

Performance Indicators - System Integration and Access

Performance targets under this heading are designed to measure whether care is being provided in the most appropriate setting with the goal of improving the coordination of care and reducing wait times for specialists and needed surgeries.

In 2016/17:

- Percent of priority 2, 3 and 4 cases completed within access target for CT scans – target achieved
- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement – target achieved
- 90th percentile emergency department (ED) length of stay for complex patients - result has not improved/ target not achieved
- 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients - result has not improved/target not achieved
- Percent of priority 2, 3 and 4 cases completed within access target for MRI scans - result has not improved/ target not achieved
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement – result has not improved/target not achieved
- Percentage of Alternate Level of Care (ALC) Days - result has not improved/target not achieved
- ALC rate – result has not improved/target not achieved

In 2016/17 the Central East LHIN continued to work with its Diagnostic Imaging Working Group (DIWG) to ensure that process changes and additional scheduling oversight of diagnostic procedures such as CT scans had their intended effects, and that growing wait lists remained manageable. These same strategies will be applied to support the future achievement of the MRI target as all HSPs continue to review their MRI protocols in order to standardize protocol criteria, and improve quality outcomes based on best practice. Additionally an in-depth analysis of coded patient chart abstract data, as well as a more comprehensive review related to a variety of efficiency reports generated by Access to Care by the LHIN's Wait Time Strategy Working Group resulted in the achievement of the access target for hip replacement. This same analysis will now be applied to the knee replacement target.

The higher volume of complex patients (or CTAS I-III volume ratio), the effect of the Influenza (flu) season on the health system over the winter months and the limited Long-Term Care Home (LTCH) bed capacity meant that the Central East LHIN did not meet the remaining System Integration and Access performance targets.

The Central East LHIN is supporting implementation of eCTAS to assist with the triaging of patients and supporting ambulance offload through Ambulance Offload Nurse initiatives. Physician Assistants and Nurse Practitioners have been implemented in EDs to improve patient flow and patient experience. The Central East LHIN and its hospital partners commissioned a report received in April 2016 to examine strategies to improve Alternative Level of Care (ALC) rates in the Central East LHIN. Based on that report, the LHIN continued to work with the hospitals to develop strategies that would better serve lower acuity patients with the increasing partnership with primary care providers being one approach to reduce lower acuity ED visits. However, the fact that 38 of 68 LTCHs within the Central East LHIN will be redeveloping will continue to put pressure on the ALC rate. Without further investment in LTC bed capacity or policy changes that provide supported living alternate options to increase capacity, this pressure will continue.

Performance Indicators - Health and Wellness of Ontarians: Mental Health

Visits to hospital EDs may be the appropriate point of access to care for individuals with mental health and substance abuse conditions who are in crisis. Repeat emergency visits can result from premature discharge, a lack of coordination with post-discharge care and/or inadequate supports in housing. Given the chronic nature of the mental health and substance abuse conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits for Ontario residents. This indicator attempts indirectly to measure the availability and quality of community services for patients with mental health and substance abuse conditions. It also supports the future development and improvement of data collected that could be used to measure the quality and availability of community mental health and substance abuse services directly, especially relating to wait times.

In 2016/17:

- Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions - result has not improved/target not achieved
- Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions - result has not improved/target not achieved

The Central East LHIN has been consistently challenged in meeting these two performance indicators. Performance is largely influenced by the high numbers of new patients seeking care for mental health and/or addiction issues and the LHIN's ability to respond to this increasing volume given that it receives the second lowest per capita funding rate for Mental Health and Addictions in Ontario. However, despite these challenges, Health Service Providers are continuing to work together and deepen their collaborations in order to address the needs of those seeking their services.

In 2016/17, the Central East LHIN engaged Deloitte to conduct a system-wide scan of the Central East LHIN Mental Health and Addictions System in order to identify gaps and opportunities for improvement. It is the LHIN's intention to identify two lead organizations to work with health service providers, people with lived experiences and other stakeholders to create an integrated and collaborative system of mental health and addictions services in acute and community-based settings in order to achieve these performance targets. It is anticipated that four other improvements will have a positive effect on this indicator in 2017/18. These include the opening of the community crisis facility in downtown Oshawa in close proximity to the Lakeridge Health Oshawa (LHO) ED (opening April 1, 2017); the installation of a specialized eight-bed Mental Health Emergency Unit at LHO (with a planned opening of June 26, 2017); the development of a LHIN-wide opioid strategy; the integration of the Rouge Valley Ajax Pickering hospital site with Lakeridge Health (which is currently in process) with additional mental health in-patient beds planned; continued collaboration with our Consolidated Municipal Service Managers and health service provider partners to invest in increase options for affordable housing with intensive case management supports. These anticipated system improvements, including new Provincial investments in Psychotherapy, Housing and Youth, should lead to the Central East LHIN meeting the Provincial Target by Q4 2017/18.

Performance Indicators - Sustainability and Quality

Performance targets under this heading are designed to support the ongoing improvement of patient satisfaction and whether unnecessary readmissions are being reduced for selected chronic conditions. The combination of appropriate care while in hospital, seamless handoff of care to community providers, and appropriate follow-up and preventative care in the community can prevent recurrence of exacerbations and repeated admissions to either the ED or the hospital.

In 2016/17:

- Readmission within 30 days for selected Health-Based Allocation Model Inpatient Grouper (HIG) conditions - result has not improved/target not achieved

While the Central East LHIN did not achieve the provincial target of 15.5% for Readmission within 30 days for selected HIG conditions in 2016/17, it was within the 10% corridor and will continue to be an area of focus in 2017/18. This will include increasing the number of coordinated care plans for complex patients (vascular, COPD, cardiac, and diabetes) and better managing these conditions in the community; increasing access and streamlining referrals to the Regional Cardiac Rehabilitation Secondary Prevention program; ongoing care delivery through the Diabetes Education Programs and Centres for Complex Diabetes Care; continuing to provide education and skills training workshops to patients and caregivers through the Central East LHIN Self-Management program; and, supporting patients with mild to moderate Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) with remote health monitoring and self-management coaching by clinicians through the Central East LHIN Telehomecare Program. Additionally, hospitals across the Central East LHIN will continue to implement identified strategies to reduce readmission rates for patients with Pneumonia, COPD and CHF in their Quality Improvement Plans (QIPs).

Monitoring Indicators - System Integration and Access

Like the performance targets under Sustainability and Quality, the following monitoring indicators provide supplemental information on whether care is being provided in the most appropriate setting and whether wait times for specialists and needed surgeries are being reduced.

In 2016/17:

- Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery – target achieved
- Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery – target achieved
- Rate of emergency visits for conditions best managed elsewhere per 1,000 population - progress made
- Hospitalization rate for ambulatory care sensitive conditions per 100,000 population - progress made
- Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge - progress made
- CCAC wait times from application to eligibility determination for long-term care home placements: from community setting - result has not improved
- CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting - result has not improved

With the exception of the CCAC wait times monitoring indicators, the results would suggest that LHIN residents do have timely access to cancer and cataract surgeries and that LHIN residents have better mechanisms for dealing with urgent, but non-emergent, health care issues and are receiving treatment in settings other than the emergency department (ED), including primary care.

CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN 2016-2019

In 2016/17, the Central East LHIN released its fourth Integrated Health Service Plan (IHSP). Entitled *Living Healthier at Home*, IHSP 4 is a strategic planning document that from 2016 to 2019 will guide and direct the ongoing transformation of how health services are delivered in the Central East LHIN and inspire health system change.

The strategies and improvements outlined in IHSP 4 are rooted in the vision and priorities of the Ontario Ministry of Health and Long-Term Care (MOHLTC), pan-LHIN imperatives, as well as in evidence-based and leading-edge practice in the planning and delivery of health services.

The strategies and improvements also build on the three preceding IHSPs that, since 2007, have engaged providers and patients in the shared creation of an integrated system:

IHSP #1 – 2007-2010 Engaged Communities. Healthy Communities.	Improving the health of communities through an integrated health care delivery system focused on wellness, equitable and timely access to care that delivers high quality outcomes.
IHSP #2 – 2010-2013 Save 1 Million Hours – Save 10,000 Days	Supporting hospitals and community organizations to integrate service to reduce emergency department use for all residents, and hospital admissions and length of stays for people with vascular conditions.
IHSP #3 – 2013-2016 Community First	Creating an integrated community-based health system, so that Central East LHIN residents spend more time in their homes and their communities, and fewer days in hospitals and long-term care homes.

Based on an extensive environmental scan, a robust community engagement strategy, and in alignment with provincial directions, the LHIN developed an overarching goal for IHSP 4 and four strategic aims:

Overarching Goal: *Living Healthier at Home – Advancing integrated systems of care to help Central East LHIN residents live healthier at home.*

Strategic Aims:

- Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.
- Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.
- Continue to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.
- Continue to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

Implementation of the IHSP

In 2016/17, the first year of IHSP 4, we were challenging not only our health care system service providers, patients and family caregivers, but our broader health and social service system partners, to work with us in establishing and attaining our living healthier at home goal for Central East LHIN residents.

Below are just a few of the initiatives and accomplishments that supported the implementation of the first year of the 2016-2019 Integrated Health Service Plan:

Physician Leadership

To achieve its mission to lead the advancement of an integrated sustainable health care system that ensures better health, better care and better value, the Central East LHIN continues to work with stakeholders from across the Central East region and throughout the province. Since its inception, the LHIN has recognized the valuable role that physicians play in the development and implementation of activities that will lead to an integrated and sustainable health care system. In 2016/17 Central East physicians continued to provide leadership and input into the implementation of the LHIN's Integrated Health Service Plan and the obligations set out in its Ministry-LHIN Accountability Agreement.

Dr. David Borenstein

Clinical Quality Lead, Central East LHIN and Health Quality Ontario

Dr. Gary M. Mann

Emergency Medicine Physician Lead, Central East LHIN

Dr. Paul Caulford

Primary Care Physician Lead, Central East LHIN

Dr. Ed Osborne

Regional Palliative Care Physician Lead for the Central East Region

Dr. Ilan Fischler

Mental Health and Addictions Physician Lead, Central East LHIN

Dr. Randy S. Wax

Critical Care Physician Lead, Central East LHIN

Dr. K. Jennifer Ingram

Seniors Physician Lead, Central East LHIN

Sub-Regions in the Central East LHIN

The designation of seven Health Link communities or sub-regions in the Central East LHIN was central to our change structure as they form the geographical foundation for the development of local integrated systems of care. Sub-regions had been in place informally in the Central East LHIN for many years and were formalized in 2016/17.

Now, by looking at care patterns through a smaller, more local lens, the Central East LHIN is better able to identify and respond to community needs and ensure that patients across the entire LHIN have access to the care they need, when and where they need it. This includes the needs of Francophone Ontarians, Indigenous communities, newcomers and other individuals and groups within the Central East LHIN whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

As of March 2017, the LHIN had successfully appointed Primary Care Physician Leads in all seven of its sub-regions. Working in partnership with Dr. Paul Caulford, Central East LHIN Primary Care Physician Lead, the seven Primary Care Physician Leads began working with their local physician colleagues and other health service providers to improve system access in their local communities.

Dr. Judith A. Armstrong

Primary Care Physician Lead - Peterborough City and County sub-region

Dr. Susan Taylor

Primary Care Physician Lead - Scarborough North sub-region

Dr. Rahim Ladak

Primary Care Physician Lead - Durham North East sub-region

Dr. Lubna Tirmizi

Primary Care Physician Lead - Durham West sub-region

Dr. Avnish Mehta

Primary Care Physician Lead - Scarborough South sub-region

Dr. Sheila-Mae Young

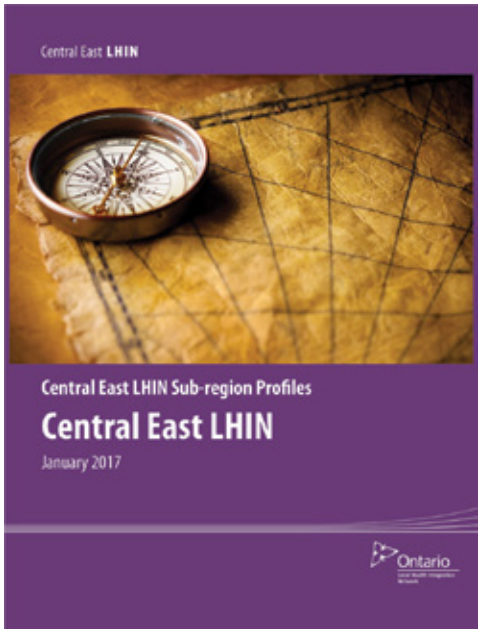
Primary Care Physician Lead - Haliburton County and City of Kawartha Lakes sub-region

Dr. Phil Stratford

Primary Care Physician Lead - Northumberland County sub-region

In February 2017, the Central East LHIN published new Central East LHIN Sub-region Profiles, a comprehensive environmental scan of demographics, population health, social determinants of health and health system information. The profiles were released to ensure that information is available to support health service providers – clinicians, hospitals, community-based agencies, long-term care homes, primary care providers – along with other community organizations and decision makers to identify any service gaps and to better collaborate in the development of local integrated systems of care. The environmental scan consists of eight chapters and includes information on the location and utilization of health care services in the 97 neighbourhoods across the 7 sub-regions in the Central East LHIN.

In 2016/17, health service providers, supported by the Primary Care Physicians Leads, continued to come together to focus on how to better care for the most complex patients in their communities, reduce the number of 30-day re-admissions to hospitals, improve the patient experience and share in the development and implementation of co-ordinated care plans.



Health Links approach to Coordinated Care Planning

Complementing the release of the Patients First Action Plan for Health Care 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 MOHLTC launched the province wide Health Link initiative. In the Central East LHIN, the Health Links approach to Coordinated Care Planning brings together local health care networks consisting of patients, caregivers, health care providers (including primary care physicians and physician groups who are voluntarily participating) that are committed to working better together to effectively identify patients with complex health care needs and improve their health outcomes. These organizations cover a variety of sectors and include hospital, primary care, mental health and addictions, community and social services, supportive housing and assisted living, and long-term care representatives. These organizations actively collaborated to develop Coordinated Care Plans (CCPs) for patients with complex care needs to improve health outcomes. The development of CCPs has also extended to Central East LHIN regional programs such as Geriatric Assessment and Intervention Network (GAIN) Clinics and Community Teams, Hospital to Home, and Palliative Care Community Teams.

In the 2016/17, Central East Health Link network organizations initiated the following numbers of CCPs in each of the LHIN's seven sub-regions:

- Scarborough North: 815
- Scarborough South: 868
- Durham West: 90
- Durham North East: 250
- Northumberland County: 252
- Haliburton County and City of Kawartha Lakes: 174
- Peterborough City and County: 116

Client Health and Related Information System (CHRIS)/Health Partner Gateway (HPG) Coordinated Care Tool (CCT) Interim Electronic Solution

The implementation of the CHRIS/HPG Interim Electronic Solution to facilitate the joint authoring and editing of electronic Coordinated Care Plans began in 2016/17. The Interim Electronic Solution went live in the Scarborough North in November 2016. The CHRIS and HPG Interim Electronic Solution will go-live in Scarborough South, Northumberland County, Haliburton County and City of Kawartha Lakes, Durham North East, Durham West, and Peterborough City and County in 2017/18.

Seniors Patient Story:

Mrs. M is an 89-year-old female living with her spouse in a Central East LHIN community. She has one daughter living close by who is very supportive. Mrs. M was recently diagnosed with late stage Alzheimer's.

Mrs. M tends to be awake throughout most of the night and recent episodes saw her wandering outside in the cold which has left Mr. M unable to sleep in order to ensure his wife's safety.

Mr. M is now able to access caregiver respite hours provided by the Central East Community Care Access Centre, allowing Mr. M to get the rest he needs. Now with the peace of mind knowing that Mrs. M is getting the support she needs through the night, Mr. M and his daughter are better able to care for Mrs. M during the day. The availability of the caregiver respite services also ensures that Mrs. M is able to be cared for at home, avoiding the need to go to hospital.

"It is important to acknowledge and recognize those individuals who do so much for their loved ones to help them remain healthier in their homes. Providing additional support to caregivers to ensure that the stress of caregiving is decreased will further action the government's commitment to put patients first."

- Deborah Hammons, Chief Executive Officer, Central East LHIN

Integrated Health Service Plan Strategic Aim #1: Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.

In 2016/17, the Central East LHIN remained committed to caring for frail seniors in the Central East LHIN. However, with over 16% of the Central East LHIN's population now consisting of seniors aged 65+, the Central East LHIN remained challenged by having the highest waitlist and 2nd highest long-term care (LTC) demand rate in the province. The LHIN continued to prepare for a projected estimate of 32,700 Central East LHIN residents who will be living with dementia by 2020, the second highest in Ontario.

In 2016/17, the focus of IHSP activities specific to the Seniors Strategic Aim, continued to centre on addressing – and where possible – reversing frailty:

Central East LHIN Seniors Physician Lead

In January 2017, the Central East LHIN was pleased to announce the appointment of Dr. K. Jennifer Ingram as the Seniors Physician Lead for the Central East LHIN. Dr. Ingram works with other Central East LHIN physician leads, the LHIN's Seniors Care Network, regional and local health service providers and other partners involved in caring for older adults. She provides leadership to increase the involvement of primary care physicians in supporting seniors, ensuring the use of best practices for seniors care and participates in provincial initiatives that focus on seniors care. Since her appointment, Dr. Ingram has been recruiting specialized geriatricians to the Central East LHIN, supporting Memory Clinics and the development of skills among primary care to appropriately manage seniors' needs; and identifying opportunities for enhanced collaboration with geriatric psychiatry and geriatric medicine.

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 many older adults prefer living at home making it all the more important to advance care to support older adults to live healthier at home. In 2016/17 the LHIN continued to work closely with LTC homes to ensure that planning and engagement supported the least amount of disruption to our seniors since 38 of 68 LTC homes in the LHIN are slated for redevelopment.

Adult Day Programs (ADPs) play a key role in supporting individuals and their caregiver(s) in leading active and meaningful lives. A key benefit of Adult Day Programs includes caregiver respite and support such as social activities, meals and health care assistance. The individuals who may benefit from an ADP are older adults with complex and long-term medical, physical, social and/or cognitive conditions. These individuals are at risk of avoidable hospital admission/readmission, emergency departments visits, ALC, or other care issues, if not adequately supported in the community. In 2016/17 the Central East LHIN supported the ongoing delivery of ADP programs offered in numerous languages, including French, for **over 2,500 frail**, at risk individuals across its sub-regions by **investing $9,980,923 in annual base funding.**

Assisted Living Services for High Risk Seniors (ALS-HRS) hubs in Scarborough North and South, Durham West and North East, Haliburton County and the City of Kawartha Lakes, Peterborough City and County and Northumberland County continued to operate successfully in 2016/17 as the Central East Community Care Access Centre and Community Support Services agencies worked together to address the needs of **over 1,240 high risk seniors**. With an annual base funding **investment of over $14 million**, high risk seniors were supported 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.

Community Physiotherapy Clinics

Community physiotherapy clinics are directly accountable to the Ministry of Health and Long-Term Care with **approximately $5.3 million in funding** directed to the community-based physiotherapy clinics in the Central East LHIN. These clinics, which predominantly serve seniors over the age of 65, provide time-limited, goal-oriented physiotherapy services for patients that meet specific condition criteria through an Episode of Care (EOC). In total the Central East LHIN has 23 Community Physiotherapy Clinics, which are located across the sub-regions and provide over 17,300 EOCs each year. In 2016/17, the Central East LHIN **provided $110,760 to Haliburton Highlands Health Services** to provide 355 EOCs for out-patient physiotherapy services for patients in Haliburton County.

Exercise and Falls Prevention Classes

In the Central East LHIN, free exercise classes focus on helping seniors stay active and improve and maintain balance, strength, and mobility. Additionally free falls prevention classes are taught by a physiotherapist or other health professional, and include the sharing of information on preventing falls. In 2016/17, the Central East LHIN provided **$1.3 million in base funding** to support **248 exercise** and **634 falls prevention classes** across the seven sub-regions, benefitting over 12,000 older adults. Nine Lead Agencies have implemented exercise and falls prevention classes, including classes specifically offered for Francophone, cardiovascular patients, and individuals with dementia.

Attending Nurse Practitioners in Long-Term Care Homes

In 2015/16 and again in 2016/17, the MOHLTC provided funding for Attending Nurse Practitioners (NP) to work in long-term care homes (LTCHs) across the province. The Central East LHIN was **allocated $614,275**, which supports five full time Attending NPs. In prior years, NPs were hired directly by the identified LTCH partner. In 2016/17, the MOHLTC permitted the allocation of the funds directly to the LHIN's Nurse Practitioner Supporting Teams Averting Transfer (NPSTAT) program for deployment to selected homes. This change equips new NPs with a community of practice through the established NPSTAT team while addressing concerns identified in Phase I, including NP coverage for vacations and after-hours care, funding and remuneration pressures, and consistency of practice across the LTC community. In 2016/17, the Central East LHIN began to utilize this centralized model by incorporating three of the Attending NP positions into the existing NPSTAT program to help strengthen the primary care that residents receive when living in a long-term care home including the Altamont Care Community and The Wexford Residence (Scarborough), Victoria Manor (Lindsay), Golden Plough Lodge (Cobourg), Ballycliffe Lodge Nursing Home (Ajax) and Bay Ridges Long-Term Care (Pickering).

Seniors Care Network (SCN)

Integral to achieving the aim and improving seniors' health is the Seniors Care Network, formed and funded by the Central East LHIN to improve the organization, coordination and governance of specialized geriatric services (SGS) for frail seniors in the Central East LHIN.

Through their leadership, and with the continued financial support of the Central East LHIN, the following specialized geriatric services continued to contribute to achieving the LHIN's Seniors Aim:

Behavioural Supports Ontario (BSO)

Behavioural Supports Ontario (BSO) is focused on helping older adults in LTCHs and the community with responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers. Through BSO, timely supports are provided to identify and reduce triggers, provide non-pharmacological interventions, foster engagement and quality of life and enable inter-professional collaborations while sustaining positive relationships with caregivers at home, in long-term care or elsewhere.

In 2016/17, the provision of **over $5.2 million** in funding from the Central East LHIN allowed local health service providers to hire additional staff –nurses, personal support workers and other health care providers, bringing the total staffing to 59.2 BSO staff serving in LTCHs, plus 11 BSO GAIN RPNs for a total of 70.2. These staff now have the specialized skills necessary to provide quality care to these residents in long-term care and clients in the community. This led to over 3,700 long-term care home residents being supported each quarter to live successfully in their homes. Further, in 2016/17 over **2,100 BSO patients were served** in the community and **more than 1,680 staff were trained in BSO approaches**.

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

GAIN teams are inter-professional hospital and community-based teams providing comprehensive geriatric 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 and eight community-based settings, GAIN teams collaborate with primary care providers and other services in the implementation of care plans for high-risk seniors.

In 2016/17, the LHIN **invested over $10.8 million in GAIN teams** to provide specialized geriatric care to frail seniors living at home. Through this investment **over 13,900 patients** were served through **over 28,800 visits**. Close to **2,500 patients received case management** with the GAIN teams serving **more than 800 people** with moderate to severe dementia and close to **1,500 people served with advanced frailty**. Through the GAIN team approach, these frail older adults were able to receive the support they needed to remain in their home in the community.

Geriatric Emergency Management (GEM) Nurses

Through the LHIN's **annual investment of more than $1.2 million** in 2016/17, Geriatric Emergency Management (GEM) programs continued to provide specialized geriatric emergency management services to frail seniors in the Emergency Department (ED) across nine hospital locations in the Central East LHIN. GEM nurses are uniquely positioned within an ED to identify and assess at-risk seniors and connect them with services to better meet their health needs. In 2016/17, the GEM program delivered targeted, **emergency geriatric assessment to over 4,300 frail seniors in the ED**, supporting approximately **9,000 referrals** for seniors to access other appropriate sources of care. Of patients seen by GEM in the ED in 2016/17, **over 1,300 were safely discharged** to the community directly from the ED, thereby avoiding in-patient admission.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)

The Central East LHIN's Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) team provides direct clinical care to long-term care home residents across all sub-regions in the Central East LHIN to reduce unscheduled transfers to hospital and help residents receive care where they live. Supported by the LHIN's **annual investment of more than $1.1 million** in 2016/17, the NPSTAT team provided care to **more than 5,000 patients**, responding to acute and episodic changes in the residents' condition, coordinating transitions for those requiring hospitalization, and enhancing the interprofessional care plan for both new and existing residents in the home. In addition to supporting reductions in hospital lengths of stay, the NPSTAT team provided over 196 capacity building activities to support long-term care home staff to help manage residents with increasingly complex medical needs, and kept the **ED transfer rate for LTC patients below 1.7%**.

Primary Care Collaborative Memory Services (PCCMS)

In 2016/17, the Central East LHIN **invested over $700,000 in a primary care-based regional program** to enhance the capacity for timely detection, diagnosis, and treatment of dementia. In collaboration with the SCN and hosted by the Alzheimer Society of Durham Region, a mobile team, consisting of Social Workers, Behavioural Supports Ontario Nurses, and Occupational Therapists works collaboratively with primary care physicians in their memory clinic locations in Scarborough and Durham to support cognitive health and quality of life for adults and seniors living in the community. In 2016/17 the PCCMS program saw **465 patients** with **less than 10%** of the patients needing to be referred on to specialized services.

Dementia Strategy

Leveraging the work of the Central East LHIN Dementia Strategy Team, an action plan for three of the Team's recommendations was developed in 2016/17, for consideration in 2017/18. These recommendations include sub-region planning to identify gaps and opportunities for dementia care and caregiver support, and the development of a plan for an integrated care pathway for access to dementia care from assessment/diagnosis of dementia to specialized services for the Central East LHIN. With the support of the Central East LHIN Physician leads, engagement with primary care providers in 2017/18 will allow the Central East LHIN to understand the current resources that support primary care provider assessment and diagnosis at the sub-region level, including primary care-based memory services and coordinated care planning as well as to explore education opportunities for primary health care providers to increase their knowledge of dementia.

Vascular Patient Story:

Bill and Sylvia McNabb have been married for 52 years; have two children, two grandchildren and one on the way.

Bill suffered a stroke in April 2015 and has been left with very little short term memory. Life became more challenging after the stroke as Bill was then diagnosed with Vascular Dementia, Alzheimer's disease and Obsessive Compulsive Disorder.

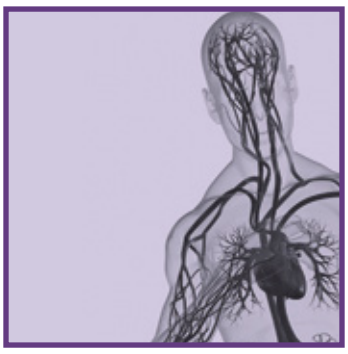
As his primary caregiver, Sylvia had been having a difficult time coping with the changes in Bill. During a Stroke Survivors Support Group with the March of Dimes she was told about the Central East LHIN Self-Management Program's free Powerful Tools for Caregivers Workshop, and registered to attend.

With the new skills Sylvia learned during the Powerful Tool for Caregivers Workshop, the McNabb house is now a calmer and well-managed household.

"I would stress very strongly how important the Powerful Tools for Caregivers workshop has been to those of us that have this very huge and sometimes overwhelming responsibility of being totally responsible for the care of another person. I cannot recommend this series of workshops highly enough."

- Sylvia McNabb

Integrated Health Service Plan Strategic Aim #2: Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.



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 2016/17, 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)

The Regional Cardiovascular Rehabilitation and Secondary Prevention Program (CRSP) is a multi-factorial, integrated secondary prevention program, delivered in all seven of the LHIN's sub-regions that has been shown to reduce morbidity and mortality related to cardiovascular disease. Using a centralized referral model, patients with vascular disease who are at high risk for cardiovascular complications are assessed, accepted and booked into one of the 14 existing sites, with a new site slated to open in 2017/18. Accomplishments in 2016/17 included the addition of chronic disease management for diabetes, renal, stroke, cardiovascular disease, and heart failure; greater integration within clinical care pathways and communication to primary care and other vascular disease stakeholder providers and the provision of Exercise and Falls Prevention classes at 11 sites and opening of a new site in Bobcaygeon. With a total annual **investment of $2,235,125**, the CRSP Program surpassed its 2016/17 patient volume target of 3,100 by 15% or **3,577 patients served**.

Vascular Surgical Programs

The Central East LHIN Vascular Surgical Services Steering Committee operates under the formal agreement of a Vascular Surgery Regional Services Memorandum of Understanding (signed by member organizations on June 25, 2014) and acts as a champion for advancing the regional model. Members of the Steering Committee

participate in planning and advocacy for the expansion/continuation of vascular services and work together to ensure that high quality, consistent, and equitable vascular surgical services are delivered in the Central East LHIN. In 2016/17, Scarborough and Rouge Hospital received approval from the Ministry of Health and Long-Term Care for an allocation of specialized Quality Based Procedures (QBPs) for vascular services. This allowed them to provide 24/7 support by Interventional Radiologists for Endovascular Aneurysm Repair (EVAR) volumes. Peterborough Regional Health Centre (PRHC) recruited their third Vascular Surgeon in January 2017 and increased their vascular consult clinic visits from 850 to 1,132 through year end (October to March). Additionally the PRHC vascular surgeons began to provide increased coverage in the LHIN's North East and Durham clinics, operating 3-4 times per month from once per month, with the continued 24/7 physician coverage of these same areas.

Ontario Renal Network

The Ontario Renal Network (ORN), a division of Cancer Care Ontario, manages the delivery of chronic kidney disease services. The decisions and advice are based on the best evidence available, enabling ORN to provide effective planning, programs and funding to support a continuously improving kidney care system in Ontario. ORN is also responsible for establishing consistent standards and guidelines to support quality kidney care, and putting in place information systems to measure performance. In the Central East LHIN the ORN regional program is hosted at Lakeridge Health (LH), and the three Renal Programs are located at Scarborough and Rouge Hospital (SRH), Lakeridge Health, and the Peterborough Regional Health Centre. In 2016/17, the three Renal Programs worked together to establish nephrology services at SRH's Centenary site; implement a Palliative Care Clinic at LH and open a newly renovated renal unit at PRHC. By taking an active role in primary care engagement, nephrologists from across the LHIN worked with their clinical partners to increase home modalities and, in partnership with the Central East Community Care Access Centre, sought out interested Long-Term Care Homes for Peritoneal Dialysis (PD) service delivery.

Stroke Report Card and Progress Report

Each year the Ontario Stroke Evaluation Program produces a LHIN Stroke Report Card to provide a comprehensive evaluation of the Ontario Stroke System. The intentional selection of system-level indicators, across the care continuum, supports the identification of gaps and opportunities for collaboration with system stakeholders to drive improvement. Released on November 22, 2016, the "Ontario Stroke Evaluation Report 2016: A Focus on Stroke Rehabilitation" found **positive improvement in access** to stroke rehab across the province specifically for those with severe strokes. Compared to the province, the Central East LHIN had the **lowest proportion of moderate stroke survivors admitted** to inpatient rehab (35.5%); the **shortest median active length of stay in inpatient rehab** (16 days); the **highest admission to inpatient rehab** for residents who had a stroke (42.7%); and the **shortest time to inpatient rehab** (6 days). These positive findings in 2016/17 set the stage for the continuing focus on outpatient and community-based rehabilitation in 2017-18 by specifically applying models that can serve both urban and rural populations.

Centralized Diabetes Intake (CDI) and Referral

The Centralized Diabetes Intake and Referral program provides accessibility to both health care providers and those living with or at risk of developing diabetes through a single phone call or faxed referral. As the host agency for CDI, the Central East Community Care Access Centre's Care Coordinators assess clients' eligibility and provide them with access to 18 Diabetes Education Programs (DEPs) and 3 Centres for Complex Diabetes Care (CCDC). In addition they provide them with linkages to other Services including: CRSP; Community Care Access Centre services; Community Support Services; Health Care Connect and the Central East LHIN Self-Management Program. In 2016/17, the referral process to CDI by the Central East CCAC Care Coordinators was streamlined and transitioned from paper to electronic. This had the potential to increase referrals to CDI by the Care Coordinators. The Central East CCAC Community

Education and Outreach Representatives continued to promote CDI at various health events and activities across the Central East LHIN.

Diabetes Education Programs

Diabetes Education Programs (DEPs) provide basic to intermediate level diabetes education and management services through a model that is needs-based and community-based. Based on the current Canadian Diabetes Association's Clinical Practice Guidelines, patients have access to effective community-based approaches to prevent and manage diabetes-related complications through a standard approach to care and management of diabetes, including screening. DEPs are staffed by a multidisciplinary team of trained health professionals that includes Registered Nurses and Registered Dieticians.

In Scarborough, the Taibu Community Health Centre DEP offered virtual/online care to members of the Black community and worked with community partners to raise awareness of diabetes prevention and care, specifically with black men. The Scarborough Centre for Healthy Communities provided education support to residents in Long-Term Care Homes and Seniors' Housing. The Scarborough and Rouge Hospital DEP was recognized as an Insulin Pump Centre and worked to more effectively refer patients to the Centralized Diabetes Intake program. In Durham, both the Carea Community Health Centre and Lakeridge Health Ajax and Pickering provide education and support to local residents through outreach programs. In addition, DEPs in the LHIN's North East cluster took steps to increase accessibility and quality by moving programs to a more accessible location (Brock Community Health Centre), recruiting a new endocrinologist (Port Hope Community Health Centre), offering a comprehensive 5-day Healthy Heart Education Program (Campbellford Memorial Hospital), collaborating with Mental Health Centres to develop weekly metabolic clinics (Ross Memorial Hospital), and providing more services in two communities on a weekly basis and one on a bi-monthly basis (Haliburton Highland Health Services.) In total these DEPs **surpassed their target of 17,552 clients served** by over 26%, **serving a total of 22,253 in 2016/17.**

Centres for Complex Diabetes Care (CCDC)

Centres for Complex Diabetes Care (CCDC) deliver a program for patients living with complex diabetes and who need more contact, more resources and more follow-up across the health care and social service systems. Designed to focus on self-management and the reduction of Emergency Department (ED) visits and hospitalizations, patients are provided with a shared model of care that includes an inter-professional team consisting of Nurse Practitioners, Registered Dietitians, Social Workers, Registered Nurses and Pharmacists. The team at the CCDC works on transitions and discharge planning with each patient's primary care provider and Diabetes Education Program (DEP). CCDC sites are located at the Scarborough and Rouge Hospital (SRH), Lakeridge Health Whitby (LHW) and the Peterborough Regional Health Centre (PRHC). In 2016/17 the three sites saw an average of 144 patients each with SRH and LHW surpassing their projected targets. Working as a system, the three organizations continued to develop partnerships with other specialized services such as mental health, cardiac and renal programs, to initiate co-ordinated care plans and to ensure that patients were having regular vision check-ups and foot assessments.

Telehomecare

The Central East Telehomecare (THC) program launched on February 16, 2016 in the LHIN's North East cluster and then across the entire LHIN. 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. In 2016/17, a total of 671 patients were referred to the Central East CCAC's THC program and 202 were enrolled. A new partnership with the Regional Cardiac Rehabilitation and Secondary Prevention Program ensures that THC patients are also able to improve their vascular health, supporting them to live healthier at home and reducing hospital readmissions.

Central East Self-Management Training Program

The Central East Self-Management Program is one of the 14 Self-Management Programs across the Province of Ontario that offers training and workshops to participants, caregivers and health care professionals. Hosted by the Central East CCAC and funded by the Central East LHIN, seven staff and 150 to 200 volunteers lead workshops and training sessions to empower participants and care-givers to develop the skills to improve the management of chronic conditions and take control of their health. By holding **over 80 workshops** and training and/or providing **mentorship to more than 600 health professionals**, the program surpassed the projected number of individuals who were to be provided with peer support/coaching by **over 439%**. In total **658 individuals** who had or were at risk of developing chronic diseases, including diabetes, were provided with support with an average of 847 hours spent per activity instead of the projected 600. Two new programs - Powerful Tools for Caregivers and Getting the Most from your Health Care Appointment – were introduced in 2016/17 and materials were translated into French in order to offer Self-Management training programs to one of the LHIN's priority populations.

Mental Health and Addictions Patient Story:

Tom was admitted to hospital after a number of emergency room visits due to mental health and addiction struggles. His instability resulted in job loss which affected his housing, mental health, and struggles with addictions. While in hospital, Tom received support from a Hospital-To-Home Case Manager who facilitated a Coordinated Care Plan with the Pinewood Centre, Durham Mental Health Services, and CMHA Durham, along with social work and psychiatric support from Lakeridge Health Oshawa. Tom's apartment was again secured and plans were set in place to cover his arrears. He accepted addictions services supports, CMHA Durham's Intensive Case Management, and was provided crisis resources.

Today, Tom has successfully maintained his housing subsidy for close to a year. He has secured temporary employment and recovered by better managing his mental health. He has aspirations of going back to school, and has welcomed supports from a debt counsellor to better manage his finances. He has experienced no relapses since his hospitalization last year, and continues to seek support through the Pinewood Centre to remain abstinent.

Integrated Health Service Plan Strategic Aim #3: Continue to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.

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. With approximately 20% of Canadians experiencing a mental illness during their lifetime, and the remaining 80% affected by an illness in family members, friends or colleagues, a continuing focus on those with mental health and addiction issues by the Central East LHIN and its stakeholders is paramount. Quality based and flexible health care can have a profoundly positive effect on those who are affected by mental health and addiction (MHA) issues. These people experience significant barriers in accessing the primary health care system and other broader health supports, such as housing and food, raising their risk of other health problems such as diabetes and other vascular diseases.

In 2016/17, the focus of IHSP activities specific to the Mental Health and Addictions Strategic Aim continued to focus on supporting people to achieve an optimal level of mental health in order to successfully live in their own homes and communities through the program examples below:

Community Crisis Review Project

In 2016/17 the Community Crisis Review Project moved into its third phase as health service providers developed an implementation plan for defining a basket of services, increasing the efficiency of crisis programs, reducing hospital days and ED visits and strengthening partnerships and collaboration. Low cost initiatives were the initial focus of the implementation plan with business cases for further investment submitted throughout the year.

Assertive Community Treatment Teams (ACTT)

The Assertive Community Treatment Teams (ACTT) Together Quality Improvement project entered its third year of implementation in 2016/17 and continued to implement opportunities for improvement in the ACTT services offered throughout the Central East LHIN. More than fifty new clients were accepted into the program, with 33 of them presenting with complex needs and eligible for a co-ordinated care plan. 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. By September

of 2016, 146 clients were enrolled in the Stepped Care Program which sees ACTT clients who are ready to receive less intensive services integrated into the larger system and 10 had been discharged to maintain their level of recovery in the community. At the end of March 2017 the ACTT Together Steering Committee was working on an academic paper outlining the project and its outcomes and had been invited to return to the European Conference on Integrated Care to be held in Oslo, Norway later this year.

Community Crisis Beds

Durham Mental Health Services (DMHS) submitted an updated operational plan to the LHIN in October 2016 as the building to hold its new crisis bed program underwent renovations. The six-bed crisis site, scheduled to open in early summer 2017, will complement DMHS' long-established crisis locations in Whitby and Ajax. Co-located across the street from Lakeridge Health Oshawa, the crisis beds will be integrated with LHO's Mental Health and Addictions Emergency Department to create an integrated system of hospital and community supports.

Housing and Homelessness

In 2016/17 the LHIN continued to partner with municipalities on Housing and Homelessness Strategies in co-ordinating the planning, implementation and evaluation of housing supports for the vulnerable and complex residents residing in the Central East LHIN. This included the **allocation of 21 Year 3 rent supplement** and **intensive case management** units, directed by MOHLTC policy to be allocated to those who are either homeless or precariously housed, and are intended as permanent housing offered from a Harm Reduction model. The largest number of supplements and supports were directed to Scarborough with 16 units. Durham received four units and Haliburton received one.

Mental Health Strategic Planning

To facilitate the development and implementation of a regional mental health system focused on improving performance and achieving the system's shared mental health targets, the Central East LHIN and Ontario Shores Centre for Mental Health Sciences (OSCMHS) hosted a Mental Health Strategic Planning Event in October 2016. At the event the LHIN announced the intention to ask Ontario Shores to take on a collaborative leadership role – working with its Health Service Provider partners and the LHIN – to facilitate the development and implementation of a regional mental health system focused on improving performance and achieving our shared MLAA targets as captured in the LHIN's IHSP 4 strategic aim. The LHIN also confirmed that Lakeridge Health had been asked to take on a similar collaborative leadership role with its peers around the addictions performance target.

With the support of a consultant, 194 stakeholders were engaged across 16 focus groups and 70 individuals attended a "Shaping the Future" workshop to support the development of recommendations that could lead to an integrated future system. It is expected that the Central East LHIN Mental Health and Addictions Review will be presented to the stakeholders and the Board of the Central East LHIN in early summer 2017.

Palliative Patient Story:

A patient of the Nurse Practitioner-Led Clinic (NPLC) at the Canadian Mental Health Association (CMHA) Durham branch had been receiving both Nurse Practitioner care as well as medication management and monitoring at the NPLC. The patient had multiple diagnoses including schizophrenia, COPD, high cholesterol, drug dependence, history of gastro-intestinal cancer and a terminal cancerous growth.

The NPLC initiated a Coordinated Care Plan for this patient and his family. His Nurse Practitioner, Consulting Physician, Outreach Nurse, CCAC Care Coordinator and Palliative Care Team member facilitated a Coordinated Care Conference, with his family present. It was an emotional meeting, but between all Care Team members, they were able to provide daily support to the patient and his family in his home until he passed away peacefully.

Integrated Health Service Plan Strategic Aim #4: Continue to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

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 2016/17, the LHIN began working with the new Central East Regional Palliative Care Steering Committee (CERPCSC) to support Patients First: Action Plan for Health Care, to achieve the mandate of the Ontario Palliative Care Network (OPCN) and the palliative care priorities of the Central East LHIN and the Central East Regional Cancer Program (CERCP).

Central East Regional Palliative Care Strategy

The Central East Regional Palliative Care Steering Committee developed a strategy in 2016/17 that was expected to be finalized in June 2017. The strategy focuses on advance care planning; coordination across transitions/ partnerships; education for health service providers and families/general public; and equitable access.

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. Through partnerships between hospitals, the Central East Community Care Access Centre, Family Health Teams, Community Health Centres and Palliative Pain and Symptom Management Consultants, over 650 unique clients received 3,285 visits (face-to-face or by phone). With over 74% of the patients requesting to die at home, the PCCTs were able to support 50% of them to achieve that goal. Three additional PCCTs in Durham, Peterborough City and County and Northumberland County were funded in early 2017 as the government announced its support of these teams.

Interdisciplinary Palliative Education

Interdisciplinary Palliative Education continued to be an area of focus in 2016/17 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 249 health professionals across the LHIN, a 300% increase from the previous year. Approximately 700 individuals - registered nurses, personal support workers and hospice volunteers - enhancing their palliative care expertise through standardized interdisciplinary education and the Palliative Pain and Symptom Management Consultants, offered consultation to service providers in person, by telephone, by videoconference or through e-mail regarding care, building capacity amongst front line service providers in the delivery of palliative care.

Residential Hospice Strategy

The LHIN released its Residential Hospice Strategy in 2016/17 with the goal of expanding options available to palliative patients in the Central East LHIN by increasing the number of operational residential hospice beds to 56 by 2019. Work got underway to pursue the development of beds across LHIN sub-regions; advance collaborative multi-sector partnerships to make best use of public investment; and recognize residential hospice as a key element to advancing Hospice as Hubs strategy. A July 2016 announcement increased annual funding for Hospice Peterborough's 10-bed hospice palliative care hub, a October 2016 announcement of operating funding for the three-bed Bridge Hospice in Warkworth and a second October 2016 announcement of final stage approval for the Palliative Care Centre at Haliburton Highlands Health Services were all significant highlights in 2016/17 as the LHIN and its partners worked toward the 56 bed goal.

Medical Assistance in Dying (MAiD)

The Central East LHIN recognizes MAiD as an end-of-life choice and has aligned its planning to support both palliative care and MAiD. In 2016/17 the LHIN began working with the Central East LHIN MAiD Working Group to plan for the seamless, integrated provision of Medical Assistance in Dying for patients in hospital or at home. Health service providers (e.g. hospitals, Central East CCAC, long-term care homes) set-up internal Working Groups for MAiD practices/policies as they worked on a regional plan in anticipation of Bill 84, Medical Assistance in Dying Statute Law Amendment Act being passed in the Ontario legislature.

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 System 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 2016/17 include:

The Scarborough Hospital – Rouge Valley – Lakeridge Health Integration

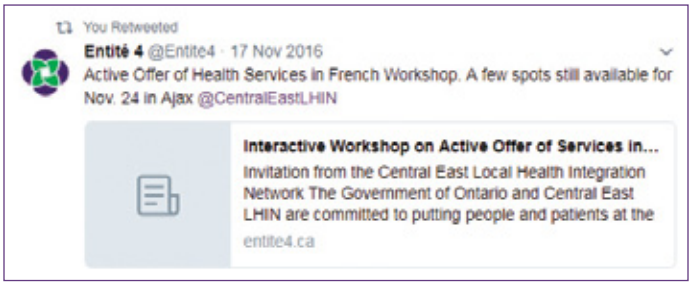
In April 2016, Dr. Eric Hoskins, Minister of Health and Long-Term Care, supported the implementation of recommendations from the final report of the Scarborough/West Durham Panel related to hospital governance, service delivery and planning and appointed a special advisor to advance the integration efforts between hospitals in the Scarborough and Durham regions. The goal of improving access and integration of health care services in the Scarborough and Durham Region communities then took another step forward in September 2016 when the Board of the Central East LHIN passed a motion to not stop the proposed integration of The Scarborough Hospital (TSH) with Rouge Valley Centenary (RVC) and Rouge Valley Ajax Pickering (RVAP) with Lakeridge Health (LH). On November 23, 2016, the Minister of Health and Long-Term Care issued a Final Minister's Order directing the integration of The Scarborough Hospital with Rouge Valley Health System and the transfer of the Rouge Valley Ajax and Pickering site to Lakeridge Health. On December 1, 2016, the Birchmount and General sites of The Scarborough Hospital and the Centenary site of Rouge Valley Health System merged to become one hospital corporation with the temporary name of Scarborough and Rouge Hospital. On the same day the Ajax-Pickering hospital became part of Lakeridge Health, forming a regional system of acute care for Durham Region.

Laboratory Integration - Peterborough Regional Health Centre and Northumberland Hills Hospital

In May 2016 it was announced that Northumberland Hills Hospital (NHH) and Peterborough Regional Health Centre (PRHC) would move forward with an expanded laboratory partnership following approval from the Central East LHIN Board. The integration will see NHH's microbiology needs delivered by PRHC and expanded upon a current service arrangement between NHH and PRHC for the provision of pathology and cytology services for NHH. This integration, combined with an earlier laboratory services integration with Ross Memorial Hospital in 2015/16, further expanded PRHC's role as the regional leader for the delivery of microbiology, cytology and pathology services.

Francophone Initiatives

In 2016/17, the Central East LHIN and the Entité 4 through a Joint Action Plan, continued to implement initiatives and projects to better support health care access for the 30,200 members of the LHIN's french-speaking population.



Improving Access and Accessibility to Primary Care and Chronic Disease Support

In July 2016, TAIBU Community Health Centre started providing primary health care services in French with funding provided by the Central East LHIN. The primary health care service is supported by an interdisciplinary team of health professionals including a Francophone health provider with the objective of providing high

quality service to meet the needs of the community. This new service, which saw 148 patients in 2016/17, followed after extensive Francophone community engagement, health promotion and French language chronic disease self management programs that TAIBU has implemented in the community since 2014. The majority of the members of the Francophone communities in the region are of African and Caribbean origin including new immigrants who are at high risk of developing chronic conditions such as hypertension, diabetes and other cardiovascular disease.

Improving Access and Accessibility to Care for Seniors

In 2016/17 the Central East LHIN continued to support the enhancement of the Francophone Seniors' Adult Day Program at "Les Centres d'Accueil Heritage" in the Durham Cluster with the introduction of Falls Prevention workshops with 12 to 15 participants per class. The LHIN also worked collaboratively with Entité 4 to increase the occupancy in the 37 francophone beds at Bendale Acres LTC in Scarborough.

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 (MHA) Navigation and Coordinated Access to Community MHA Services for Francophones project. In 2016/17 this project enabled Francophones to have access to linguistically and culturally appropriate community MHA services in the GTA through the provision of ongoing Mental Health First Aid in French to the Francophone community in the Durham and Scarborough Clusters with over 50 people participating in the classes.

Francophone Patient Story:

Before, I was a client at Centre Francophone de Toronto, but it took me around two hours to get to my family doctor, sometimes for an emergency I would go to the walk-in clinic although I can't always communicate properly. At the retirement home where I live, I found some information about services in French in Scarborough. I stopped in at TAIBU and since then I decided to become a client of the nurse practitioner there. She helped me with my health issues, but above all she helped me make a important decision about a difficult situation I was in.

Indigenous 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, Métis, Inuit and Non-Status people.

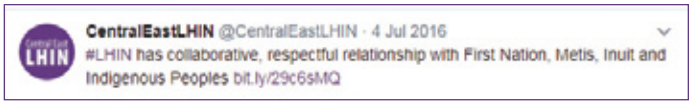
Since that time, through two advisory groups, the First Nations Health Advisory Circle and the Métis, Inuit, and Indigenous Peoples' Health Advisory Circle, the Central East LHIN has continued to receive advice on a variety of topics related to provincial and Central East LHIN priorities and how they pertain to the First Nations people represented.

In May 2016, the Provincial Indigenous Leads Network (PILN) developed a work plan. The four areas of focus were meant to be adapted to local and emerging priorities:

1. Improving partnership development with Indigenous communities and organizations;
2. Increasing access to primary care services for Indigenous communities;
3. Advancing Indigenous cultural safety training to health service providers and LHIN board and staff; and
4. Improving population health by addressing health equity.

In the spirit of the Truth and Reconciliation Commission Call to Action, the Central East LHIN collaborated with both Indigenous Health Advisory Circles in 2016/17 to develop detailed work plans based on the local priorities.

This led to the following accomplishments:



Partnering to provide Diabetes Services for First Nations

In 2016/17, the LHIN worked with the First Nations and other health care providers to ensure the provision of culturally safe diabetes services in many First Nations communities. Lakeridge Health began operating a half day satellite clinic every two weeks on Scugog Island, in partnership with the Mississauga's of Scugog Island First Nations. The Peterborough Regional Health Centre team began visiting Curve Lake for half a day each month for client counseling and are continuing to support the Indigenous community by attending monthly information sharing events at Curve Lake, Hiawatha, Southern Ontario Aboriginal Diabetes Initiative (SOADI) and Apsley clinics; and, at the Port Hope Community Health Centre. Three Registered Nurse (RN) Certified Diabetes Educators (CDE) and 1 Registered Dietician (RD) CDE completed the 8 week on-line Indigenous Cultural Safety Training Program offered by Provincial Health Services Authority in British Columbia and supported by the Central East LHIN. This will lead to a Diabetes 'support group' and individual client appointment service that will begin in the Health and Wellness Centre at the Alderville First Nations community in April, 2017.

Indigenous Cultural Safety Training

Through funding provided by the Ministry of Health and Long-Term Care, 324 training spaces were made available to the Central East LHIN for Indigenous Cultural Safety Training in 2016/17. The training was offered in an on-line, supported self-study format. There were two streams offered: Base and Mental Health. The spaces were offered initially to members of the hospital, CCAC and CHC sectors, based on the recommendation of the Central East LHIN Indigenous Health Advisory Circles. Those spaces not used by these providers were offered to the wider Health Service Provider groups and to cross-sectoral partners. These included the Durham Rape Crisis Centre, Violence Against Women and Homeless Shelters and the John Howard Society. The Central East LHIN was very pleased when each of the training spaces was reserved, and with the fact that demand was so great it was necessary to create a waiting list of over 25 potential participants. It is the Central East LHIN's understanding that an additional 200 spaces will be made available in 2017/18, which will be initially made available to those on the waiting list.

Indigenous Patient Stories:

Kathy MacLeod Beaver – Aboriginal Cancer Care Navigator, and Connie Spencer – Aboriginal Mental Health and Addictions Service Navigator attended the January 25, 2017 meeting of the Central East LHIN Board of Directors to share oral stories from Indigenous clients and patients and their experiences in accessing local health services. The stories highlighted the importance of respecting Indigenous cultural practices and providing culturally safe and accessible health care to our First Nations and Metis partners.

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. Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by an initiative or anyone that may exert influence over the initiative or its results is considered a project stakeholder.

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 community engagement structures and activities include:

Patient and Family Advisory Committee (PFAC)

In February 2017, the Central East LHIN was pleased to announce the establishment of the new Patient and Family Advisory Committee (PFAC). The Central East LHIN PFAC will begin its formal meetings in 2017/18 and will advise and collaborate with the Central East LHIN,

its leaders, health service providers and staff regarding system-level policies, practices, strategies, planning and delivery of patient and family-centred care within the Central East LHIN region.

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 providers 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 10, 2016 the Central East LHIN and its Governance Advisory Councils hosted the annual joint Governors' Forum. The keynote speaker was Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care. The event was a must attend for all Central East LHIN Health Service Provider (HSP) Board Chairs or delegate and each HSP's CEO or Executive Director as Dr. Bell provided information on the Ministry's Patients First: Action Plan for Health Care. The three councils met again separately in November 2016.

Central East Executive Committee (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 "Living Healthier at Home" aim outlined in the 2016-19 IHSP as well as the Ministry of Health priorities. Guided by a Terms of Reference, the council also considers programs, services, 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.

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 2016/17, 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 Living Healthier at Home strategic aims, the MOHLTC's Patients First: Action Plan for Health Care and 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. Efforts are continually 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.

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 2016/17 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 2016/17, 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 promoting health and preventing disease.

Primary Care Engagement - Primary Health Care Advisory Group (PHCAG)

Since its 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.

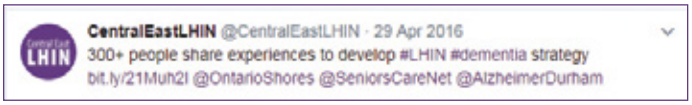
In 2016/17 Dr. Caulford continued to reach out to his colleagues sharing best practices, alerting them to the recruitment of new Primary Care Physician Leads in each of the LHIN's seven sub-regions and inviting their feedback and involvement in the rollout of Bill 41, the Patients First Act.

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 that includes initiatives such as BSO, GAIN, GEM Nurses and NPSTAT.



Central East Regional Palliative Care Steering Committee

The Central East Regional Palliative Care Steering Committee (CERPCSC) is a disease agnostic network designed to support a coordinated, standardized approach for the delivery of hospice palliative care services in the Central East region. With a mandate to provide collaborative leadership to advance high quality, integrated, patient-centred hospice palliative care across all sectors based on best practices in accordance with Ontario Palliative Care Network direction, and in alignment with both the Central East LHIN Integrated Health Service Plan (IHSP) and the Central East Regional Cancer Program Strategic Plan, the CERPCSC is jointly accountable to the Central East LHIN Chief Executive Officer and the CERCP Regional Vice President. The CERPCSC provides leadership to ensure accountability and alignment of activities to local, regional and provincial direction.

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. The Central East LHIN Mental Health and Addictions Strategic Aim Coordinating Council provides oversight to all MHA priority projects such as the ACTT Together project and the Bed Registry.

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 works in partnership with the Central East LHIN Emergency Management Leads, a planning group, facilitated by the Central East LHIN to share knowledge and pro-actively plan for how to prepare and respond to shared emergencies, including the ongoing welcoming of Syrian refugees to Canada.

The Central East LHIN, through Scarborough Centre for Healthy Communities and primary care providers, under leadership of Dr. Paul Caulford, Primary Care Physician Lead responded to Syrian refugees arriving to the Central East and Central LHINs from November 2016 to March 2017. The Central East LHIN, Central LHIN and health system partners collaborated to address and respond to the Syrian Refugee health needs in a timely manner. Upon arrival, Syrian refugees were connected to primary care, health care and social services as early as possible to address their needs and support safe transitions to settle into their communities. The model developed ensured Syrian refugees received the care and services required.

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 supports the sharing of information as the LHIN works with hospitals, community based agencies and long-term care homes on completing annual service accountability agreements. Information shared at these sessions is posted on the Central East LHIN website so that stakeholders from across the LHIN can 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 and the implications of the Patients First Act was a major area of focus for physician engagement in the Central East LHIN in 2016/17.

Regional, County and Municipal Councils

The Central East LHIN visits 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.

MPP Engagement

In 2016/17, 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

Central East LHIN staff and board members attended a number of third-party events in 2016/17 as part of the "Speakers' Bureau". This included many health service providers Annual General Meetings, Ontario Shores 10 Year Anniversary Celebration, Minister of Health and Long-Term Care and MPP funding announcements such as budget announcements, HIRF funding, and residential hospice groundbreaking announcements. Staff and board members also participated in numerous Seniors Fairs, and provided presentations to Durham College School of Health and Community Services – Gerontology Activation Class and at various hospital board strategic planning sessions. These events provide the LHIN with opportunities to hear from local stakeholders on local issues and opportunities for improvement, but also an opportunity for the LHIN to share information with the public and stakeholders about the LHINs role and the services it supports.

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 2016/17 the Central East LHIN received a total operating budget of $6.3 million which included operations at $6.1 million and additional funding of $180,000 to support planning and implementation of the Patients First Act 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 Indigenous 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 Indigenous initiatives. Special project 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 2016/17 the LHIN conducted its annual 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”.

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, was reviewed by an employee working group in 2016/17 and updated to enhance the principles and resources available to implement the Code. The Code will continue to serve as 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.

Independent Auditor's Report

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Deloitte.

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, 2017, 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, 2017, 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.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 24, 2017

Statement of Financial Position

Central East Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**354,998**	521,950
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 9)	**2,458,900**	1,606,348
Accounts receivable	**65,951**	26,831
	2,879,849	2,155,129
Liabilities		
Accounts payable and accrued liabilities	**307,298**	438,217
Due to LSSO (Note 4)	**-**	7,801
Due to HSSO (Note 4)	**3,338**	-
Due to Health Service Providers ("HSP") (Note 9)	**2,458,900**	1,606,348
Due to MOHLTC (Note 3b)	**84,268**	137,108
Due to Central West LHIN (Notes 3c, 4)	**51,584**	-
Deferred capital contributions (Note 5)	**83,787**	112,366
	2,989,175	2,301,840
Net debt	**(109,326)**	(146,711)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**25,539**	34,345
Tangible capital assets (Note 7)	**83,787**	112,366
	109,326	146,711
Accumulated surplus	**-**	-

Approved by the Board

ORIGINAL SIGNED BY

_____ Director

Amorell Saunders N'Daw, Vice Chair

ORIGINAL SIGNED BY

_____ Director

Louis O'Brien, Chair

Central East Local Health Integration Network

Statement of financial operations
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	**2,233,203,950**	**2,288,396,677**	2,228,309,856
Operations of LHIN	**4,534,130**	**4,487,883**	4,491,739
Project Initiatives			
Emergency Department ("ED") Lead	**75,000**	**75,000**	75,000
Emergency Room/Alternative Level of Care	**100,000**	**100,000**	100,000
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Aboriginal Planning	**20,000**	**20,000**	20,000
Enabling Technologies	**383,000**	**383,000**	406,892
Critical Care	**75,000**	**75,000**	75,000
French Language Services	**106,000**	**106,000**	106,000
Diabetes & Vascular Health	**824,475**	**824,475**	842,070
Primary Care	**75,000**	**75,000**	75,000
Amortization of deferred capital contributions (Note 5)	**-**	**74,826**	81,943
	2,239,396,555	**2,294,797,861**	2,234,583,500
Funding repayable to the MOHLTC (Note 3a)	**-**	**(80,459)**	(55,393)
	2,239,396,555	**2,294,717,402**	2,234,528,107
Expenses			
Transfer payments to HSPs (Note 9)	**2,233,203,950**	**2,288,396,677**	2,228,309,856
General and administrative (Note 11)	**4,534,130**	**4,552,834**	4,564,544
Project Initiatives (Note 10)			
ED Lead	**75,000**	**72,000**	72,000
ER/ALC	**100,000**	**100,000**	74,745
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Aboriginal Planning	**20,000**	**20,000**	20,000
Enabling Technologies	**383,000**	**331,416**	406,892
Critical Care	**75,000**	**72,000**	72,000
French Language Services	**106,000**	**96,000**	106,000
Diabetes & Vascular Health	**824,475**	**824,475**	842,070
Primary Care	**75,000**	**72,000**	60,000
	2,239,396,555	**2,294,717,402**	2,234,528,107
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

Central East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	Budget	2017 Actual	2016 Actual
	$	$	$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(46,247)	(24,796)
Amortization of tangible capital assets	-	74,826	81,943
Change in other non-financial assets	-	8,806	5,292
Decrease in net debt	-	37,385	62,439
Net debt, beginning of year	-	(146,711)	(209,150)
Net debt, end of year	-	(109,326)	(146,711)

Central East Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	74,826	81,943
Amortization of deferred capital contributions (Note 5)	(74,826)	(81,943)
	-	-
Changes in non-cash operating items		
Due from MOHLTC	(852,552)	3,505,382
Accounts receivable	(39,120)	28,097
Accounts payable and accrued liabilities	(130,919)	2,844
Due to LSSO	(7,801)	2,685
Due to HSSO	3,338	-
Due to HSPs	852,552	(3,505,382)
Due to the MOHLTC	(52,840)	55,393
Due to Central West LHIN	51,584	(25,892)
Prepaid expenses	8,806	5,292
	(166,952)	68,419
Capital transaction		
Acquisition of tangible capital assets	(46,247)	(24,796)
Financing transaction		
Capital contributions received (Note 5)	46,247	24,796
Net (decrease) increase in cash	(166,952)	68,419
Cash, beginning of year	521,950	453,531
Cash, end of year	354,998	521,950

Central East Local Health Integration Network

Notes to the financial statements
March 31, 2017

1. Description of business

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

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

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

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), 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, 2017.

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

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:

			2017	2016
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**2,288,396,677**	**2,288,396,677**	**-**	-
LHIN operations	**4,562,709**	**4,552,834**	**9,875**	26,733
ER/ALC	**100,000**	**100,000**	**-**	25,255
ED/Lead	**75,000**	**72,000**	**3,000**	3,000
Critical Care	**75,000**	**72,000**	**3,000**	3,000
Patients First Transition Planning and Implementation	**180,000**	**180,000**	**-**	-
Aboriginal Planning	**20,000**	**20,000**	**-**	-
French Language Services	**106,000**	**96,000**	**10,000**	-
Diabetes and Vascular Health	**824,475**	**824,475**	**-**	(17,595)
Primary Care Lead	**75,000**	**72,000**	**3,000**	15,000
Repayable directly to MOHLTC	**2,294,414,861**	**2,294,385,986**	**28,875**	55,393
Enabling technologies repayable to MOHLTC through Central West LHIN	**383,000**	**331,416**	**51,584**	-
	2,294,797,861	**2,294,717,402**	**80,459**	55,393

3. Funding repayable to the MOHLTC (continued)

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

	2017	2016
	$	$
Due to MOHLTC, beginning of year	**137,108**	81,715
Recovery by MOHLTC during the year	**(81,715)**	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**28,875**	55,393
Due to MOHLTC, end of year	**84,268**	137,108

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:

	2017	2016
	$	$
Revenue	**383,000**	406,892
Expenses	**331,416**	406,892
Accumulated surplus due to the Central West LHIN	**51,584**	-

4. Related party transactions

LHIN Shared Service Office, LHINC Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC was to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC was a LHIN-led organization and accountable to the LHINs. LHINC was funded by the LHINs with support from the MOHLTC.

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Service Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

4. Related party transactions (continued)

Enabling Technologies for Integrated Project Management Office

Effective February 1, 2012, the LHIN entered into an agreement with Central, Central West, Toronto Central, Mississauga Halton and North Simcoe Muskoka LHINs (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 $383,000 (2016 - $406,892).

5. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**112,366**	169,513
Capital contributions received	**46,247**	24,796
Amortization	**(74,826)**	(81,943)
Balance, end of year	**83,787**	112,366

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:

	$
2018	257,948
2019	260,254
2020	263,481
2021	153,698
	935,381

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:

	$
2018	2,268,310,703
2019	2,267,805,995

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

7. Tangible capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Office furniture and fixtures	**757,176**	**(729,650)**	**27,526**	74,691
Computer equipment	**413,989**	**(370,884)**	**43,105**	28,904
Leasehold improvements	**668,028**	**(654,872)**	**13,156**	8,771
	1,839,193	**(1,755,406)**	**83,787**	112,366

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, 2016. 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 $2,288,396,677 is made up of the following:

	$
Initial HSP funding budget	**2,233,203,950**
Additional funding due to announcements made during the year	**55,192,727**
Total HSP funding budget	**2,288,396,677**

The total revised operating budget of $6,372,605 is made up of the following:

	$
Initial budget as represented on the statement of financial activities	**6,192,605**
Additional funding received for one time initiatives	
Patients First Transition Planning and Implementation	**180,000**
Total budget	**6,372,605**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $2,288,396,677 (2016 - $2,228,309,856) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2017 as follows:

	2017	2016
	$	$
Operation of hospitals	**1,232,517,651**	1,214,275,231
Grants to compensate for municipal taxation - public hospitals	**280,275**	280,275
Long term care homes	**453,784,761**	444,462,828
Community care access centres	**311,112,562**	290,035,602
Community support services	**55,845,293**	51,361,299
Assisted living services in supportive housing	**15,968,925**	15,446,254
Community health centres	**30,520,928**	29,799,929
Community mental health addictions program	**66,738,936**	63,353,629
Specialty psychiatric hospitals	**120,003,326**	117,692,037
Acquired brain injury	**1,597,695**	1,576,447
Grants to compensate for municipal taxation - psychiatric hospitals	**26,325**	26,325
	2,288,396,677	2,228,309,856

The LHIN also received $323,438 (2016 - $323,438) 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).

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2017, an amount of $2,458,900 (2016 - $1,606,348) 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

	2017	2016
	$	$
Consulting services	**288,000**	276,000
Salaries and benefits	**1,306,519**	1,037,608
Public relations and community engagement	**-**	1,500
Meetings	**3,528**	1,213
Supplies and other	**-**	-
Mail, courier and telecommunications	**-**	-
Other	**169,844**	337,386
	1,767,891	1,653,707

10. Project Initiatives (continued)

b) Diabetes & Vascular Health

The LHIN received funding of $824,475 (2016 - $824,475 base funding). Expenses incurred of $824,070 which are included in the table above are made up as follows:

	Budget 2017	Actual 2017	Actual 2016
	$	$	$
Salaries and benefits	**704,000**	**705,684**	702,909
Others	**120,475**	**118,791**	139,161
	824,475	**824,475**	842,070

11. General and administrative expenses

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

	2017	2016
	$	$
Salaries and benefits	**3,417,881**	3,372,126
Occupancy	**301,426**	266,604
Amortization	**74,828**	81,943
Shared services	**411,366**	426,342
Community engagement	**11,792**	11,490
Consulting services	**43,031**	53,730
Supplies	**74,506**	69,523
Board member expenses	**116,976**	94,175
Mail, courier and telecommunications	**2,065**	1,514
Other	**98,963**	187,097
	4,552,834	4,564,544

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

	Budget 2017	Actual 2017	Actual 2016
		$	$
Board chair per diem expense	**50,000**	**35,050**	28,000
Other board members per diem expenses	**74,000**	**50,675**	44,650
Governance costs and travel	**35,000**	**31,251**	21,525
Total expenses	**159,000**	**116,976**	94,175

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 2017 was $354,366 (2016 - $319,691) 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, 2016. At that time, the plan was fully funded.

13. Guarantees

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

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

14. Subsequent event

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Central East Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employees of the CCAC.

Effective June 21, 2017 the LHIN will assume the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

STAFF MEMBERS

Front Row

Samiah Khan, Linda Henry, Jai Mills, Jennifer Persaud, Deborah Hammons, Vinitha Navarathinam, Sheila Rogoski, Karol Eskedjian

Second Row

James Draper, Marco Aguila, Isabel Fonseca, Emily Van de Klippe, Marilee Suter, Melissa Chard, Kasia Luebke, Suzette Stines-Walford, Sheila Stirling, Tapas Kar, Usha Cithiravel

Third Row

Stewart Sutley, Pauline Rahaman, Monika Smith, Jenny Greensmith, Jeanne Thomas, Meaghan McCloy, Debbie Hoy, Parisa Mehrfar, Natasha Yussuf, Karen O'Brien

Back Row

Katie Cronin-Wood, Suzanne Way, Sue Wojdylo, Alison Pickles, Dionne James, Jina Mintsinikas, Kelly Sanders, Chantelle Vernon, Antoinette Larizza, Irem Ali, Ron Blakey

Absent

Lauren Chitra, Ritva Gallant, Tunde Igli, Alex Ruppert, Romina Vicente

CONTACT INFORMATION

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