Central East **LHIN** | **RLISS** du Centre-Est

Strengthening Connections

Engaged Communities. Healthy Communities.

Central East LHIN Report to the Community

Fall 2018

Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé

Message from the Board Chair and Interim CEO

We are pleased to bring you the Fall 2018 edition of Strengthening Connections, our quarterly report to the community. Since our last report (**Spring 2018**), the Central East LHIN has celebrated its first anniversary as a renewed organization, with an expanded mandate that now includes responsibility for the delivery of home and community care services. We are continuing to bring together health service providers, patients, caregivers and other partners to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario.

As a renewed organization, we have a new Mission statement and set of Values which came into effect as of May 1, 2018 and now better reflect the LHIN's evolving accountabilities and the health service providers who deliver services in the Central East region.

Over the summer and into the fall, our transformation work has continued as we gathered feedback to support the development of our next local health system's strategic plan. Known as an Integrated Health Service Plan (IHSP), the IHSP provides the foundation for the Central East LHIN to define and outline how, in partnership with the Ministry of Health and Long-Term Care, providers and patients, we will continue to improve the health of our communities with a particular focus on Mental Health and Addictions, Long-Term Care, Home care, Capacity planning and hospital over-crowding.

As we develop the 2019-2022 IHSP (IHSP 5), we are connecting with our partners, patients, caregivers and residents across the seven sub-regions to hear their thoughts about our local health care system – what's working and where innovations and improvements can still be made. Health needs and priorities are best developed when the community, health care providers and the people they serve have input that supports local decision-making.

The LHIN continues to bring together health service providers, patients, caregivers and other partners to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario. At the Central East LHIN we are building on our rich history of planning, integrating and funding the local health system to continue to lead our communities in the achievement of excellence in health.

The Central East LHIN team looks forward to continuing to build locally-driven solutions around the people and populations in its seven sub-regions and engaging its communities and individuals in ongoing health care design and delivery. Thank you for your ongoing support and collaboration.

Dr. Barry Guppy,
Interim Chief Executive Officer

Louis O'Brien,
Chair, Board of Directors

- Because of LHINs, the local health care system and its partners are working together to improve access to quality care for Ontario residents.
- Because of LHINs, the health care needs of people in your community are being identified, co-ordinated and addressed as a truly integrated system.
- Because of LHINs, local decisions are being made to respond to local health care needs.
- Because of LHINs, health service providers are being held accountable for the taxpayer dollars they are given.

Mission

To lead our communities in the achievement of excellence in health.

Vision

Engaged Communities. Healthy Communities.

Values

Focused on Patients

We are focused on our patients, their families and caregivers. We make a positive, lasting impact on them in all our interactions.

Respecting People

We embrace the rich diversity of our population and treat everyone with dignity, compassion and respect, while offering and supporting access to equitable, culturally appropriate care.

Partnering with Purpose

We build collaborative relationships to support shared goals that lead to better health outcomes in our communities.

Accountability for Results

We are responsible to achieve results and make decisions grounded in equity, trust, and transparency.

Embracing Innovation

We courageously pursue excellence as we innovate and actively seek out opportunities for continuous quality improvement.

Integrated Health Service Plan

Over the course of the last several months, the Central East LHIN was in the planning and information gathering stages for its next Integrated Health Service Plan (IHSP). Engagement with patients, caregivers, residents and health service providers from sub-regions across the Central East Region took place in the form of a survey and focus groups with priority populations, including our Indigenous, Francophone and new immigrant stakeholders to ensure a diverse cross section of voices were heard and considered.

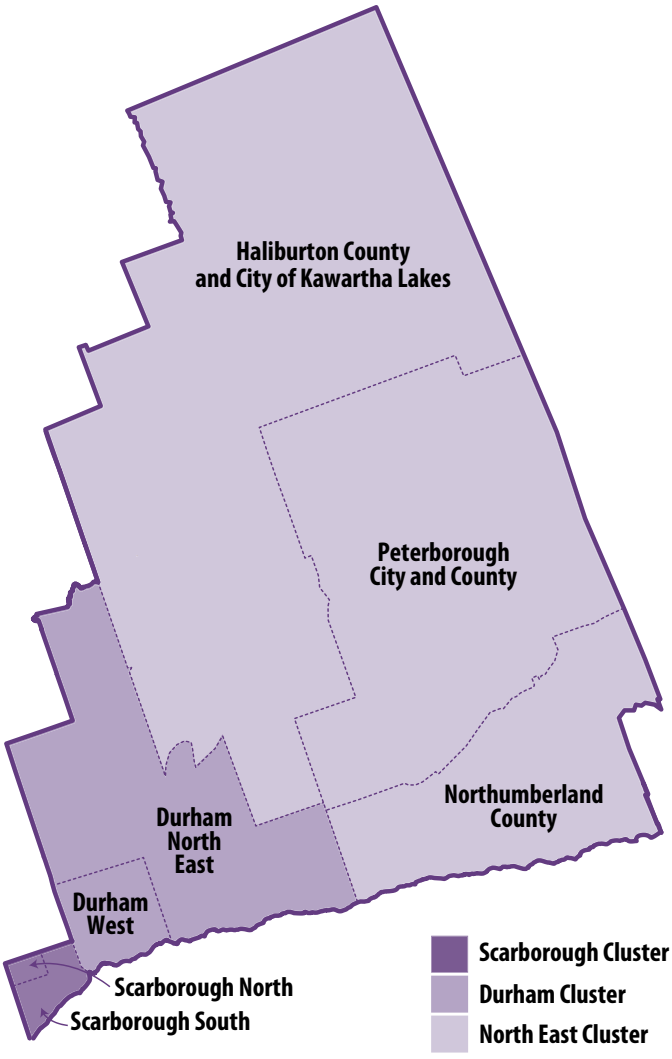
Over 1,000 respondents participated in the survey, which closed on October 5th. The feedback from these engagement activities is now supporting the development of the three year strategic plan, which will be submitted to the Central East LHIN Board of Directors at the end of October prior to final submission to the Ministry of Health and Long-Term Care.

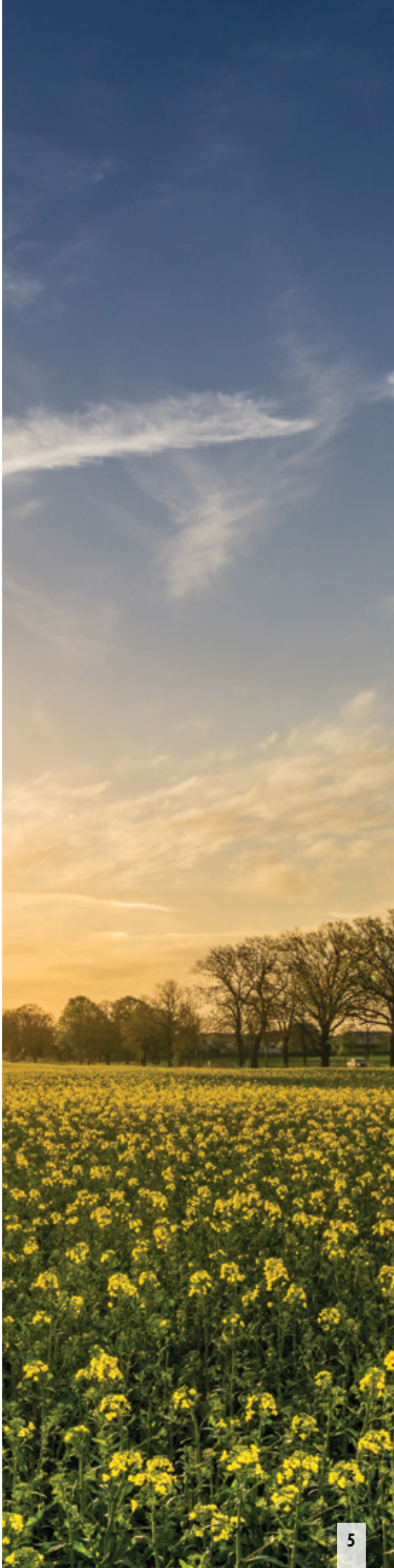
Thank you for your interest and participation!

Central East LHIN Sub-regions Create a Foundation for Local Health Planning

By looking at care patterns through a smaller, more local lens, the Central East LHIN is able to better 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.

To learn more about Central East LHIN Sub-regions and Sub-region Planning Tables, please visit the Central East LHIN website and click on Sub-regions, located under Priorities, or **click here**.





Funding, Accountability, Performance Monitoring

The Central East LHIN business planning cycle reflects the work of the LHIN in delivering on our strategic plan (IHSP) and is based upon a continuous cycle of Community Engagement, Local Health System Planning, Funding and Allocation/Service Delivery, and Accountability and Performance Monitoring with Patient Centred Integration and Service Coordination at the centre of everything we do.

Within each of these essential functions are numerous accountabilities, including:

- **Equitably allocating funding** based on patient need
- **Ensuring timely delivery of services** through volume acquisition and allocation
- Taking steps to make sure that organizations have **balanced budgets**
- Supporting **innovative service delivery models** and the capital construction that supports their implementation
- Building **stronger relationships** - with other parts of the health system, including Public Health - Municipal partners in local government, education, policing, and emergency services - Primary and specialty care providers - Priority populations – Francophone community, Indigenous communities, new immigrants - Patients and caregivers

- **Sharing and aligning best practices** with other LHINs
- Supporting, reviewing and facilitating **integrations**

Funding

LHINs are responsible for planning, funding and integrating health services. The Central East LHIN signs multi-year planning and funding Accountability Agreements with each of its providers, defining the obligations and responsibilities of both the providers and the LHIN and forming the basis on which funding is provided. For more information, please visit the **Funding** page, available through **centraleastlhin.on.ca**.

Accountability

The Central East LHIN, like all LHINs, is accountable to the Ministry of Health and Long-Term Care, and works with its health service providers and with people who live in the LHIN to manage the local health care system. To learn more about Accountability between the Ministry and the LHIN and the LHIN and its Health Service Providers, please visit the **Accountability** page and its related tabs, available at **centraleastlhin.on.ca**.

Community Engagement

The Central East LHIN Patient and Family Advisory Committee (PFAC)

The Central East LHIN Patient and Family Advisory Committee (PFAC) is growing! First established in 2016, the PFAC has expanded from an initial group of six dedicated patient and caregiver volunteers to an eleven member committee that reflects the diversity of the people and communities within the LHIN. The PFAC both advises and collaborates with the Central East LHIN, its leaders, health service providers and staff regarding system-level policies, practices, and strategy, planning and delivery of patient- and family-centred care within the Central East LHIN region.

Over the past year the PFAC has been participating in strategic co-design and co-management activities at LHIN Steering Committees and other engagement structures. The PFAC sponsors Patient Stories that are presented at the beginning of every Central East LHIN Board meeting. In the coming months, the PFAC will begin developing sub-region Communities of Practice for patients and caregivers to ensure that a multiplicity of voices are involved in the local strategic co-design and co-management of the health care system.

The Central East LHIN continues to seek additional community members to participate in its PFAC. A diverse committee will ensure that discussions reflect and respond to a broad range of lived experiences. At present, the PFAC includes geographic representation from a number of the LHIN's sub-regions with individuals with a variety of lived and professional experiences. We are currently encouraging patients and their family/caregivers who live within the Central East LHIN's **Haliburton County sub-region** and/or people who self-identify as a member of the **francophone**, **indigenous**, **new immigrant** and/or **LGBTQ communities** to complete and submit an **Expression of Interest** for consideration as a member of the Central East LHIN PFAC. For more information about the PFAC and the Expression of Interest, visit the Central East LHIN website and click on Community Engagement – **Patient and Family Advisory Committee**.

Members of the Central East LHIN Patient and Family Advisory Committee

Randy Filinski,
Pickering - Co-Chair

Anne-Marie Yaraskavitch,
Whitby - Co-Chair

Eta Berenzai,
Whitby

Mieko Ise,
Toronto

Andrew Lee,
Scarborough

Craig Lindsay,
Toronto

Ann MacLeod,
Peterborough

Art Seymour,
Cobourg

Patricia Teskey,
Lindsay

Kerrianne Thompson,
Whitby

Harry van Bommel,
Scarborough

Renewed Central East LHIN Engagement Structures

The **Central East LHIN Senior Team**, through a collaborative and constructive engagement process with LHIN staff, the LHIN Board and external planning partners, has remapped its Central East LHIN external engagement structures to support the development and implementation of the LHIN's 2019-22 Integrated Health Service Plan (IHSP 5).

This remapping has standardized the external engagement structures into three (3) engagement levels – Steering Committees (and associated sub-committees), Advisory Committees and Action Groups and six (6) areas of focus.

All three engagement levels and six areas of focus are integral to the achievement of the LHIN's system and organizational accountabilities through the strategic co-design and co-management of the local health care system. All external engagement structures are sponsored by a member of the LHIN Senior Team and will have a Terms of Reference.

Each of the external engagement tables is charged with having a population-health focus as they set and deliver on their respective strategies. External engagement structures use a **Project Management** approach in carrying out their work. In developing and implementing any strategies, external engagement structures use the applicable business tools and reference documents, already developed that support the LHIN organization in the achievement of its accountabilities. To read more, **click here**.

Indigenous Engagement

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 Indigenous Peoples represented. Membership in these groups has steadily grown and, through the respectful sharing of experiences and stories, closer relationships between the Central East LHIN and the Indigenous communities within its borders have developed.

Indigenous Cultural Safety Training

Starting in 2016/17, the MOHLTC funded **Indigenous Cultural Safety (ICS) Training** for health service providers across the province. The ICS Training focuses on providing the learner with knowledge, awareness and skills to work effectively with Indigenous people within the Ontario health care system. In the Central East LHIN, over 500 health service providers as well as LHIN Board, management and staff have participated in the training.

Indigenous Peoples Day Celebrations

In celebration of National Indigenous Peoples Day which takes place annually on June 21st, a number of Central East LHIN funded health service providers in collaboration with Indigenous partners hosted a series of celebrations at various hospital sites with the goal of promoting wellness, spiritual healing and cultural awareness.

Northumberland Hills Hospital
Indigenous Peoples Day Celebration – June 14, 2018
&
Central East Regional Cancer Program
Indigenous Peoples Day Celebration – June 15, 2018

Francophone Engagement

The Central East LHIN and Entité 4 have continued to implement initiatives and projects to better support health care access for the 27,065 Francophones living in the Central East LHIN.

On July 12, 2018 Entité 4 and the Central East LHIN hosted a Health Equity for Francophone Communities Forum in Ajax. Highlights included a welcome from Mr. François Boileau, French Language Services Commissioner of Ontario, a panel on building capacity for health service providers to offer health services in French, a workshop on bilingual human resources, opportunities to directly consult and get feedback from Francophones in the Central East LHIN on the development of IHSP 5, and exhibitors from the health sector and Francophone community organizations.

This forum was a significant event and attracted more than 100 participants from many different locations within Central East Local Health Integration Network (LHIN) sub-regions.

Central East LHIN Home and Community Care Coordinators Support Patients and Families to Navigate the Health Care System and Access High Quality Care in their Local Communities

Finding and accessing home care can sometimes be confusing and complicated. Central East LHIN Home and Community Care Coordinators help people find their way through Ontario's health care system, understand their options and get the highest quality care possible. They help people across their life spans from school children who have special health needs to seniors who need health services at home or access to a long-term care home. Care Coordinators support patients to receive the care they need when they need it. They provide information, direct access to qualified care providers and many comprehensive services to help people come home from the hospital sooner or live healthier at home longer.

Every day in communities in the Central East region, LHIN Care Coordinators and Direct Clinical Nurses work with doctors, nurses, therapists, personal support workers and many other health care and community support providers to ensure quality care for patients as well as support for families and caregivers.

Through a Home First philosophy, Care Coordinators, along with their hospital and Community Support Service agency partners will make every effort to ensure that resources are in place to support a patient to ultimately go home when discharged from hospital. Only when returning home with care is not possible or safe to do so, are other options considered, including Long-Term Care.

People who receive care in their homes are generally happier, more comfortable in a familiar setting and tend to heal more quickly. In addition, getting better at home eases pressures on hospitals and helps to reduce long wait times in our hospital emergency rooms.

There's no place like home to recover from illness, regain strength and make important lifestyle decisions. Home First is a philosophy that promotes safe and timely care to meet health care needs of patients and families in the most appropriate setting.

LHIN Care Coordinators support patients and caregivers through every transitional point on their health care journey. Whether living in the community and requiring support, transitioning back home after a hospital stay, or moving to a Long-Term Care Home when care needs can no longer be met in the home, and even through the palliative and end-of-life journey, Care Coordinators are available to support patients every step of the way.

How the Central East LHIN Provides Home and Community Care

Patient

If you are being discharged from hospital or living in the community and are eligible for health and personal support services in your home, the LHIN can help. A referral to the LHIN can be made by your family doctor or other primary care provider, neighbour, family member or you can refer yourself.

LHIN Home and Community Care Coordinators or Direct Clinical Nurses

Once you qualify for LHIN home and community care services, a care coordinator or a direct clinical nurse is assigned to you. LHIN care coordinators and direct clinical nurses are regulated health professionals who work collaboratively with you and your family and your care team, which may include LHIN service providers and community support agencies. They can also provide information and referral and serve as your single point of contact to other community and social services as appropriate. If you are an ambulatory LHIN patient, you will receive your nursing services in a LHIN Home and Community Care Nursing Clinic. Where demand exceeds available resources, you may be waitlisted.

LHIN Home Care Contracted Service Providers

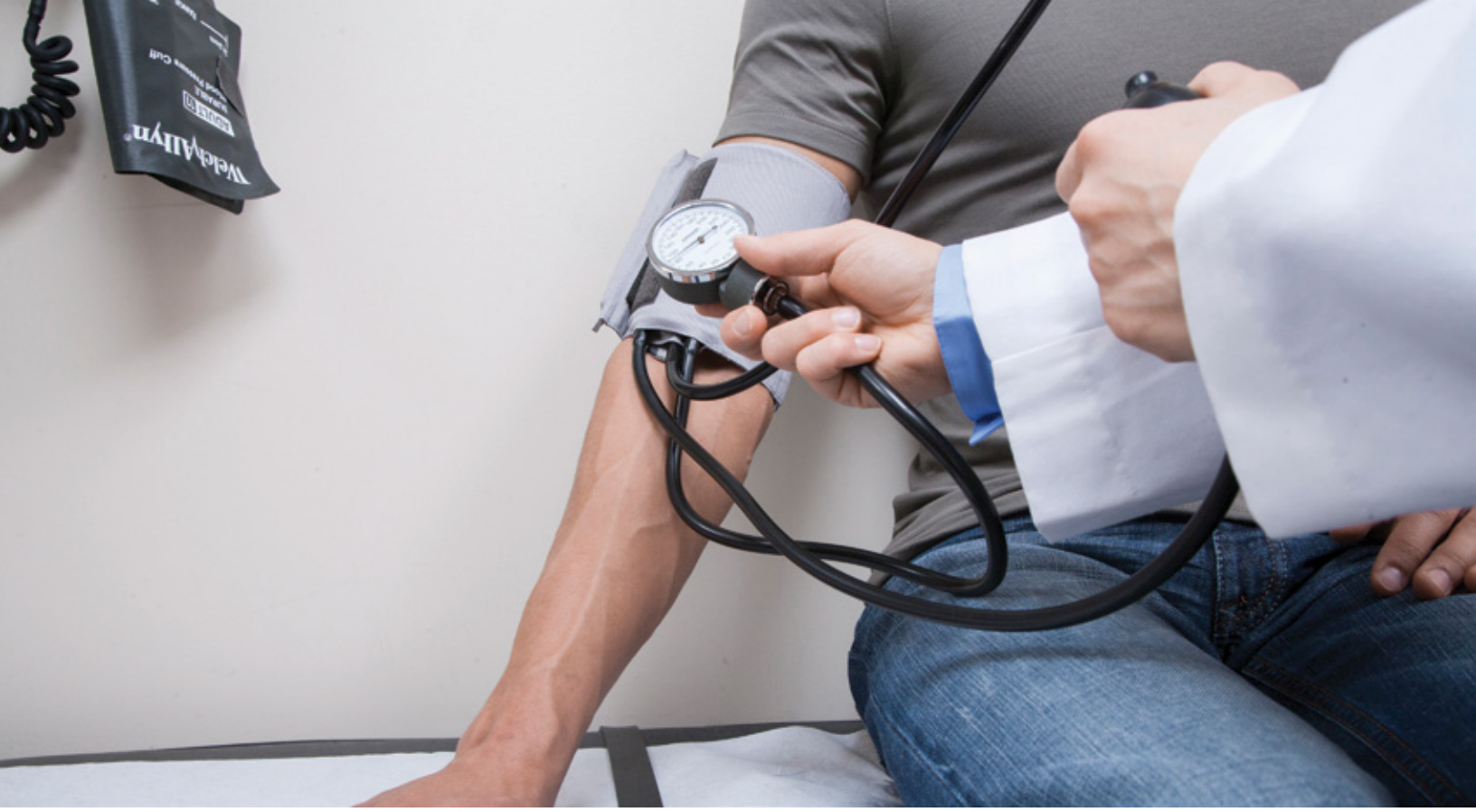
The LHIN has contractual agreements with service provider organizations to provide services to you such as nursing, physiotherapy, occupational therapy, social work and personal support as well as medical supplies and equipment.

Community Support and Social Service Programs

The LHIN can link you with a number of community and social service agencies to provide home, health and support services that may be purchased directly, covered by private insurance plans or publicly funded. Services could include such things as, transportation, Adult Day Programs, mental health services, Assisted Living, Meals on Wheels, supportive housing, housekeeping, snow removal or yard work.

Long-Term Care

When you can no longer manage at home, the LHIN care coordinator facilitates your application and admission into long-term care homes. The care coordinator conducts your assessment and helps determine your eligibility for long-term care.



Central East LHIN Home and Community Care Nursing Clinics

Patients receiving home and community care nursing services can receive that care at a Central East LHIN Home and Community Care Nursing Clinic, where teams of nurses provide ambulatory patients with services such as wound care and IV maintenance. With the aim of helping patients and families to take a proactive role in their own recovery and to manage their ongoing care, service plans and treatments are developed to promote and support patient independence through a teaching approach. Patients and their caregivers can book appointments to attend a Home and Community Care Nursing Clinic at a time that is most convenient for them and design their care schedule to best suit their personal needs.

Central East LHIN Home and Community Care Nursing Clinics provide nursing services seven days a week, including holidays, from 8:30 a.m. to 8:30 p.m. and offer numerous benefits, including:

- Booked appointment times
- Available parking at no cost
- Easy access and convenient location to other community services such as banking and shopping
- Wheelchair accessible

There are currently six Home and Community Care Nursing Clinic sites operating in communities across the Central East LHIN region, including two in Scarborough, two in the Durham area (Ajax and Oshawa), one in Peterborough, and one in Lindsay.

Nursing Clinic Locations

(visits are by appointment only and are not the same as visiting a walk-in medical clinic)

SITE NAME	LOCATION
Ajax Nursing Clinic Serving residents of Durham Region	Cornerstone Plaza 11 Harwood Avenue South Ajax ON L1S 2B9 **Map view** *Located across the street from Staples*
Lindsay Nursing Clinic Serving residents of the City of Kawartha Lakes	370 Kent Street West Unit 9, Whitney Town Centre, Lindsay ON K9V 6G8 **Map view** *Located across the street from Canadian Tire*
Oshawa Nursing Clinic Serving residents of Durham Region	475 Bond Street West, Unit 2 Oshawa ON L1J 5K6 **Map view** *Located near the Oshawa Centre, with free parking access from Bond Street, between Gibbons and Stevenson*
Peterborough Nursing Clinic Serving residents of Peterborough City and County	1135 Landsdowne Street West Unit 16, Parkway Mall Peterborough ON K9J 5Y9 **Map view** *Located in the Parkway Place plaza*
Scarborough East Nursing Clinic Serving residents of Scarborough Region	Torrance Plaza 2930 Eglinton Avenue East Scarborough ON M1J 2E4 **Map view** *Located across the street from Home Depot*
Scarborough North Nursing Clinic Serving residents of Scarborough Region	385 Silver Star Boulevard Unit 101A Scarborough ON M1V 0E3 **Map view** *Located in the Maxum Professional Centre*

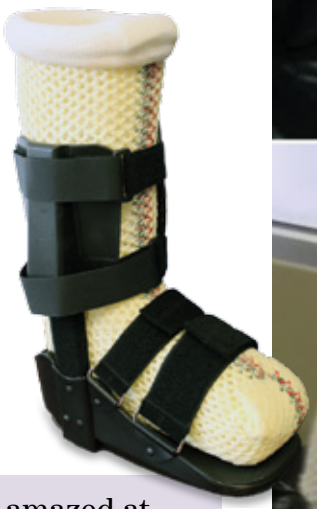
Innovative gold standard wound care treatment available in Central East LHIN Home and Community Care Nursing Clinics

Total Contact Casting (TCC) is an innovative treatment modality for treating Diabetic Foot Ulcers. The TCC system is a specially designed cast that takes the weight off the foot in order to minimize pressure and friction at the wound site. With TCC, patients who meet the eligibility criteria could potentially see their wound close within an average of 8-10 weeks, as opposed to many months or even years when conventional wound dressings are used.

The Total Contact Cast system is considered the best practice for the treatment of diabetic foot ulcers. Included among the benefits are:

- Improved wound healing
- Improved quality of life
- Improved self-management of chronic illness

Access to a Home and Community Care Nursing Clinic is through the Central East LHIN.



Praise for the Total Contact Casting treatment method

"I would recommend this to anyone. I am absolutely amazed at the results and [the wound] has remained closed since we took the boot off in February. I definitely would have lost my limb by now with the amount of times it would get infected, but I haven't had any problems with that foot since."

- Total Contact Casting patient

"I've seen amazing results after a few cases and how happy the patients are, especially those that had their ulcers for a year or more and to see the difference in the wound after a few cast applications. Amazing is what I have to say!"

- Nurse from Central East LHIN Home and Community Care Nursing Clinic

Central East Centralized Diabetes Intake

In 2012, people living with diabetes and health care providers providing diabetes services in the Central East LHIN worked together to establish a more streamlined and integrated system for the intake and referral of patients with diabetes. In addition to the established methods of referring patients living with diabetes to education, management and support, Centralized Diabetes Intake (CDI) is another way for patients to be referred across the Central East sub-regions.

CDI links patients living with or at risk of developing diabetes to Diabetes Education Programs (DEP) or the Central East Centre for Complex Diabetes Care (CCDC). Together, the patient and CDI Care Coordinator choose the most appropriate location for their diabetes services. CDI offers access as appropriate to:

- Diabetes Education Programs
- Centre for Complex Diabetes Care
- Central East Regional Cardiovascular Rehabilitation & Secondary Prevention Program
- Central East LHIN services such as Home and Community Care, Telehomecare, Central East Self-Management, etc.
- Community Support Services (i.e. Meals on Wheels)
- Basic-intermediate level diabetes education services for people living with diabetes or prediabetes
- Group classes or individual counseling
- Diabetes Education Teams consisting of one nurse and one dietitian
- Support for patients 18 years of age or older living with Type 1 or Type 2 diabetes who have complex needs
- And more.

How Do I Access Centralized Diabetes Intake?

Patients and caregivers can call 1-888-997-9996 to be connected with a Central East LHIN Home and Community Care Coordinator who will facilitate the referral. If you are a health care provider, please complete the Central East Centralized Diabetes Intake Referral Form, found on the Central East LHIN Home and Community Care website at **www.healthcareathome.ca/centraleast** and enter CDI in the search bar. Completed referral forms can be faxed to 905-444-2544 or 1-844-731-2161.

Nurse Practitioners Supporting Teams Averting Transfers

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) is the Central East LHIN's nurse-led outreach team to long-term care. Tasked with reducing potentially preventable hospitalizations for long-term care patients, NPSTAT provides support to all 68 long-term care homes in the Central East LHIN and their almost 9000 residents. The nine Nurse Practitioners (NPs) work to their full scope of practice, providing episodic, on-call intervention to long-term care patients experiencing acute changes of condition that might otherwise result in an emergency transfer to hospital. Over the past year, the NPSTAT team made 5,154 face to face visits in long-term care and directly assessed 4,277 unique patients while providing telephone consultation to 1,299 more. Only 1.7% of these patients were transferred to hospital, potentially saving more than 23,821 hours of time spent in LHIN hospitals and $4.5 million in hospital patient care costs.

In addition, NPs provide clinical and administrative leadership and work collaboratively with Long-Term Care Homes and hospital partners to both reduce length of stay for residents while in hospital and to build the capacity of long-term care staff to manage an increasingly complex, medically frail population. NPSTAT works with patients, caregivers and their health service provider partners to facilitate early repatriation for admitted long-term care patients from the hospital back to the long-term care home. In the past year, this resulted in earlier discharges for hospitalized patients with varying lengths of stay. Repatriation efforts resulted in potential savings of 294 hospital inpatient days and more than $300,000 in direct patient costs.

NPSTAT expanded its service mandate in 2017-18 to include the provision of new Ministry Attending NPs in LTC. Three positions were integrated into four LTC homes; Victoria Manor, Golden Plough Lodge, and a combined position for Bay Ridges and Ballycliffe Lodge. Operating as the primary providers of medical care in a collaborative relationship with the medical directors of care for each home, these NPs provide all legislated assessment and intervention for primary care needs of their LTC residents.

Learn more about NPSTAT by clicking here

Central East LHIN Home and Community Care Coordinators can also help to connect patients to a variety of other community resources such as Meals on Wheels, Adult Day Programs, and Home at Last. In addition to these resources, the following programs and services are also accessible, through the Central East LHIN.

Palliative Care Community Teams

Six Palliative Care Community Teams (PCCT) currently provide service across the Central East LHIN. These interdisciplinary team-based models provide clinical and non-clinical community-based care to palliative and end-of-life patients and their caregivers, allowing patients to remain in their homes for as long as possible and die at home by choice. PCCTs involve collaboration between hospitals, the Central East LHIN, Family Health Teams, Community Health Centres and Palliative Pain and Symptom Management Consultants. **Learn more**.

Inter-Professional Primary Care Teams – Coming soon

Inter-professional Primary Care Teams (IPCT) offer collaborative inter-professional primary health care across an expanded group of inter-professional primary health care providers. IPCTs support enhanced health equity, quality, and patient-centred care and reduce barriers for complex and vulnerable populations while helping provide access to patients without a regular primary care provider.

Coordinated Access to Musculoskeletal Care – Coming soon

To improve access for patients with musculoskeletal (MSK) concerns, the Ministry of Health and Long-Term Care has developed a Comprehensive MSK Access to Care Program. This program has been used to plan and implement proven MSK service delivery models within the Central East LHIN. On January 17, 2019, a Central Intake and Rapid Access Clinic (RAC) pathway will be available for residents of the Central East LHIN who have hip and knee osteoarthritis and low back pain (LBP). **Learn more**.

Coordinated Access Model for Mental Health and Addictions services – Under development

An Action Group has developed a Coordinated Access Model for Mental Health and Addictions (MHA) services that could improve access, enhance equity and better serve the diverse and growing population of people requiring MHA services and supports across the Sub-regions of the Central East LHIN.

The intent is to create a “one-door” access model for clients, families and health care providers seeking MHA services. This new access model would streamline access while ensuring clients are receiving the right care, at the right place, by the right provider, and at the right time.

The Health Links Approach to Coordinated Care Planning

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 collaborate in teams, along with patients and their caregivers, to develop Coordinated Care Plans (CCPs) for patients with complex care needs. The development of CCPs has also extended into Central East LHIN region-wide programs such as the Geriatric Assessment and Intervention Network (GAIN) program supporting frail seniors; Hospital to Home community teams supporting Mental Health and Addictions clients, and palliative patients to die in their own homes. Over the last year, this LHIN-led CCP initiative for improving transitions for patients between difference health sectors resulted in the initiation of 4,502 new, basic CCPs across the LHIN's seven Sub-regions:

- Scarborough North: 1,052
- Scarborough South: 1,494
- Durham West: 613
- Durham North East: 426
- Northumberland County: 447
- Peterborough City and County: 91
- Haliburton County and City of Kawartha Lakes: 379

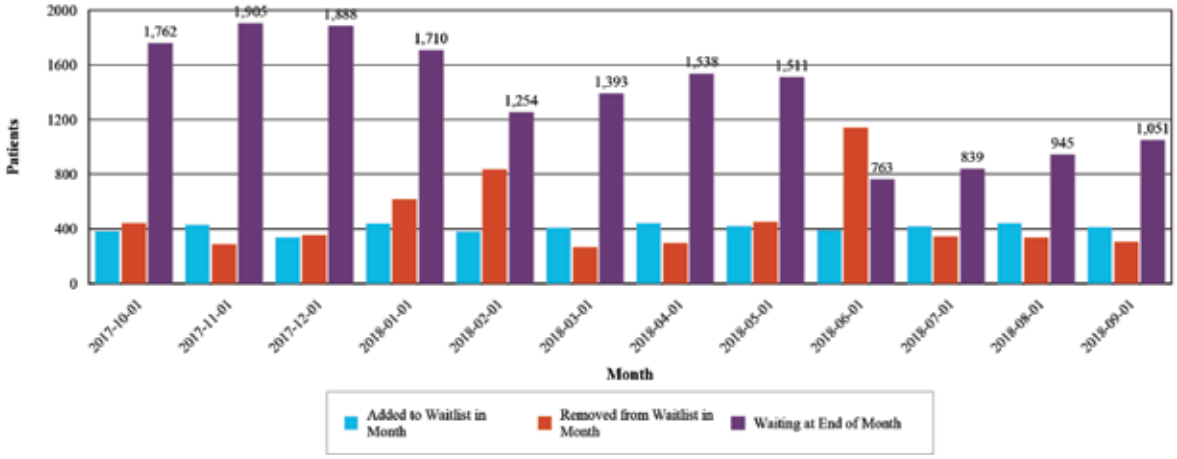
Over the past year

- The Central East LHIN provided home and community care services to an average of 44,892 patients each day
- Central East LHIN patients were supported to live healthier at home with over 6 million in-home nursing visits and more than 31 million hours of personal support services provided
- Through more than 1 million visits to a Central East LHIN Home and Community Care Nursing Clinic, patients were able to receive nursing services, including wound care and IV maintenance, at a time most convenient to them through booked appointment times
- More than 48,000 hours of service were provided by Palliative Care Nurse Practitioners to relieve suffering and improve the quality of life for people living with a life-limiting illness
- Family caregivers were supported through the provision of over 700,000 respite hours

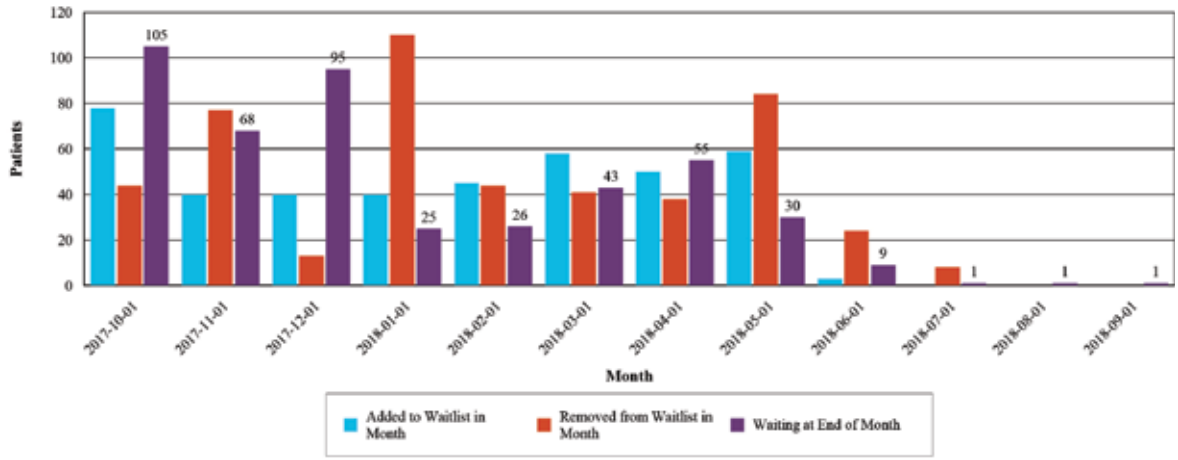
Many of the Central East LHIN's home and community care initiatives during 2017/18 focused on the implementation of strategies and programs to improve the patient and family experience by reducing wait times and improving coordination and consistency of home and community care, and supporting the delivery of digital solutions to improve patient access and navigation.

The Central East LHIN is an organization that has the capacity to action investments made by the government in meaningful ways as demonstrated by the significant reductions seen in our home and community care waitlist statistics:

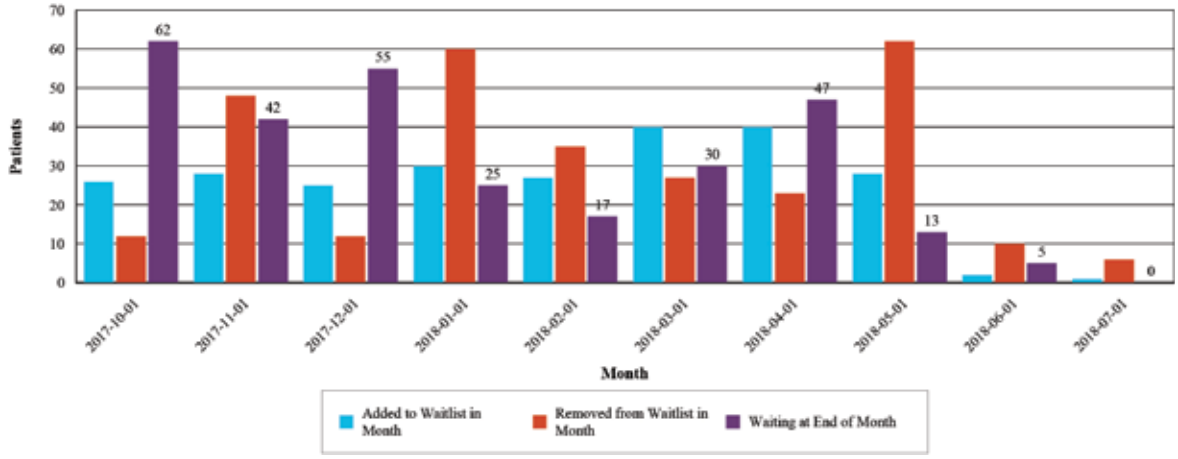
Personal Support Service Waitlist



Occupational Therapy Waitlist



Physiotherapy Waitlist



For more information about Central East LHIN Home and Community Care Waitlists, please visit **healthcareathome.ca/centraleast** and click on **Our Performance – Wait Time/Waitlist Information**

Resources at your finger tips

ConnexOntario

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 is paramount. To ensure that residents of Ontario achieve an optimal level of mental health, through funding from the Ministry of Health and Long-Term Care, people living in the Central East LHIN have instant access to detailed information through ConnexOntario.

ConnexOntario provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness or gambling. ConnexOntario information and referral service is live answer 24/7, confidential and free.

ConnexOntario maintains an up-to-date and accurate database of detailed drug, alcohol, problem gambling, and mental health service information. Through the use of leading edge technology, ConnexOntario provides hope, early help and a human voice 24-hours per day to all individuals seeking information on, for example, mental health, drug, alcohol, and gambling problems.

This information includes:

- where the service is located
- how to access the service
- how long the wait to access the service may be

ConnexOntario can be found at **www.connexontario.ca**. For more information on mental health and addiction resources in the Central East LHIN visit **www.centraleastlhin.on.ca** and click on "Priorities" and "Mental Health and Addiction".

Patient and Caregiver Resources

The Central East LHIN Home and Community Care website is an excellent resource for patients and caregivers to learn more about the home and community care services that are available to eligible patients through the Central East LHIN. To support patient and caregiver understanding, the Publications page includes electronic copies of many of our brochures, booklets and fact sheets that can be viewed online by clicking **here**.

Anyone can make a referral to us on your behalf: a family doctor, friend, family member, even you, yourself. If you think that you or someone you care about may benefit from our services, we encourage you to get in touch with us. Toll-free **1-800-263-3877**

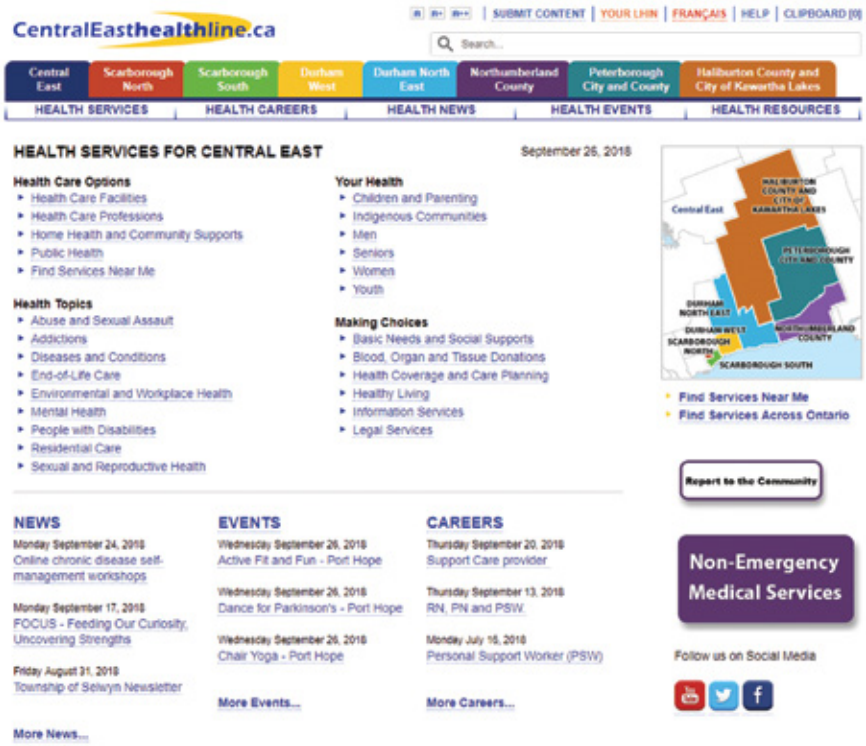
Centraleasthealthline.ca

Centraleasthealthline.ca is an innovative website that puts accurate and up-to-date information about health services at the fingertips of consumers and health care providers across the Central East LHIN sub-regions. Centraleasthealthline.ca provides easy access to a reliable source of data, and empowers consumers to find the services they need close to home.

Over 1700 service listings describe organizations and programs serving people who live in the Central East LHIN sub-regions – Scarborough North, Scarborough South, Durham West, Durham North East, Northumberland County, Haliburton County and City of Kawartha Lakes and Peterborough City and County. People can choose to receive local information first or search the entire Central East LHIN.

Centraleasthealthline.ca helps the Central East LHIN work to ensure people receive the right care in the right place, at the right time.

www.centraleasthealthline.ca



Working with Primary Care Providers to Connect Patients with Home and Community Care Services

If you are a primary care provider, the Central East LHIN Home and Community Care team can help by coordinating your patients' care in the home and the community. We offer:

Flexible hours: Home and Community Care Coordinators are accessible seven days a week, 8:30 a.m. to 8:30 p.m.

Services in the home and referral to resources in the community: When you refer a patient to our services, a Home and Community Care Coordinator will work with you and your patient to ensure continuation of the best possible care. The Care Coordinator will:

- Complete a comprehensive psycho-social, functional and health assessment
- Develop, or work with you to develop, a care plan to support transitions from hospital to home and to safely remain in the community
- Link the patient to appropriate health system and community resources (i.e. Meals on Wheels, transportation, day programs, etc.)

Dial **1-800-263-3877** to speak to a Home and Community Care Coordinator.

Referral Forms for Home and Community Care Services:

To refer patients, please complete the Request for Assessment Form, conveniently located on the Central East LHIN Home and Community Care website by clicking on **Partners-Health-care Providers-Primary Care**. Please fax completed forms to 1-855-352-2555.

Referral Forms For Community Referral Sources
Request for Assessment Form
Narcotic Infusion Therapy Referral Form
Infusion Therapy Referral Form

Referral Form for Centralized Diabetes Intake
Central East Centralized Diabetes Intake Referral Form

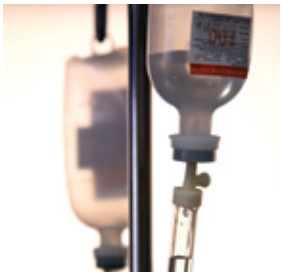
Referral Forms For Hospital Referral Sources
Hospital Narcotic Infusion Therapy Referral Form
Hospital Infusion Therapy Referral Form
Hospital Request for Assessment Form

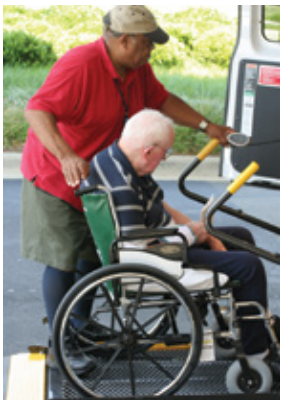
Telehomecare
COPD & Heart Failure Telehomecare Referral Form

Central East LHIN System profile

April 1, 2018 - August 31, 2018

FAST FACTS





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

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

8 hospitals operating out of **15** sites

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

$2.002 Billion Health Service Providers Operations Funding for Services

121 Total Health Service Providers

31 Community Support Service Agencies

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

4 Public Health Units

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

2nd largest based on area population

6th largest LHIN based on geography

Central East LHIN Home and Community Care services profile

Annual LHIN Operating Budget **$320 million**

- 93% - Home and Community Care service provider contracts and care coordination
- 3% - general administration
- 2% - information technology
- 2% - facilities costs operations

Supported **15,923** new applications to Long-Term Care Homes and facilitated the placement of **1,545** individuals

Centralized Diabetes Intake Care Coordinators assessed and referred **1,095** patients to Diabetes Education Programs and the Centre for Complex Diabetes Care

Provided **1,960** palliative patients with in-home end of life care

Served an average of **46,262** patients each day

Connected **1,826** patients to a Primary Care Provider through the Health Care Connect Program

Served **67,880** unique patients

22,473 visits were made to our nursing clinics

Provided **12,505** children with School Health Support Services

25,690 patient transfers were made from hospital to home

25

The flu shot is your best defense.

Every year the perennial increased holiday-related patient volumes in our hospitals has an impact on the delivery of emergency and acute care services just as Influenza-Like Illness (ILI) activity begins to rise.

The Central East LHIN, as the system manager, works with hospitals, primary care providers, Public Health, long-term care homes and local paramedic services to maintain access to the health care system.

In preparation for the 2018/19 flu season, the Central East LHIN has once again established a Regional Influenza Preparation Table with the support of the Ministry of Health and Long-Term Care Emergency Management Branch. Membership at this table includes the LHIN's Primary Care, Emergency Departments and Critical Care physician leads, LHIN staff, clinical and administrative representatives from all the hospitals, Community Health Centres, representatives from the Long-Term Care Home sector, along with representatives from the four Public Health Units, local paramedic services and local immigrant settlement agencies.

Based on shared learnings and best practices from previous years, the Regional Influenza Preparation Table works together to ensure appropriate emergency preparedness and response procedures are in place before the flu season begins.

To learn more about Influenza-Like Illness (ILI) activity and how you can protect yourself and others from catching or spreading this contagious virus, visit **www.ontario.ca/page/flu-facts**

The flu shot is:

- safe (including for kids and if you are pregnant or breastfeeding)
- free
- available from your doctor or nurse practitioner, and at participating pharmacies and local public health units across the province
- proven to reduce the number of doctor visits, hospitalizations and deaths related to the flu
- different each year because the virus changes frequently – so you need to get it every fall

Flu season runs from late fall to early spring. Be sure to get your shot as soon as it is available because it takes two weeks to take effect.

Find a flu shot clinic near you: www.ontario.ca/page/get-flu-shot

Subscribe to Strengthening Connections

Strengthening Connections is our quarterly report to the community. This publication highlights the deliberate and constructive steps that the Central East LHIN takes, in collaboration 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. Strengthening Connections is a resource for both health service providers, including primary care providers, and for patients and caregivers.

In case you missed it, here are some highlights from our previous editions:

Fall 2017

- Strategic Aim Updates: Seniors, Vascular, Mental Health and Addictions, Palliative
- Community Engagement - Update on Francophone and Indigenous Initiatives
- Introducing the Central East LHIN Patient and Family Advisory Committee

Winter 2018

- Health Equity – Diversity and Building Cultural Competency
- Using digital health technology to deliver on high quality, accessible health care
- Strengthening the role of patients and family caregivers in the health care system

Spring 2018

- Central East LHIN Sub-regions Create a Foundation for Local Health Planning
- Central East LHIN Opioid Strategy
- Supporting people with mild to moderate anxiety or depression
- Launch of Inter-professional Primary Care Teams

Be sure to subscribe to the Central East LHIN website to ensure you don't miss another edition of Strengthening Connections. **Click here** to be added to the Central East LHIN Stakeholder and Engagement database to be alerted when new content is posted on the website.

To learn more about the Central East LHIN or how you can access our programs and services, please call...

Ajax • Campbellford • Haliburton • Lindsay
Peterborough • Port Hope • Scarborough • Whitby

Toll-free
1-800-263-3877 • 310-2222

Local
905-430-3308

TTY
1-877-743-7939

Fax
905-427-9659

Email
centraleast@lhins.on.ca

Website
www.centraleastlhin.on.ca
www. healthcareathome.ca/centraleast

Twitter
@CentralEastLHIN

Subscribe to the Central East LHIN website to be added to our Central East LHIN Stakeholder and Engagement database.

Click here to subscribe and receive alerts when new content, including our quarterly Report to the Community, is posted on the website.

Si vous avez besoin d'accéder à ces renseignements en français, veuillez communiquer avec Lisa Gotell, Planificatrice, stratégie du système de santé, intégration, planification et performance du RLISS du Centre-Est, à LisaA.Gotell@lhins.on.ca.

If you need access to this information in French, please contact Lisa Gotell, Central East LHIN Planner, Health System Strategy, Integration, Planning and Performance at LisaA.Gotell@lhins.on.ca.

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé