2016-19 Integrated Health Service Plan Strategic Aim Update: Seniors

Central East LHIN Board of Directors Meeting
April 25, 2018

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Objectives

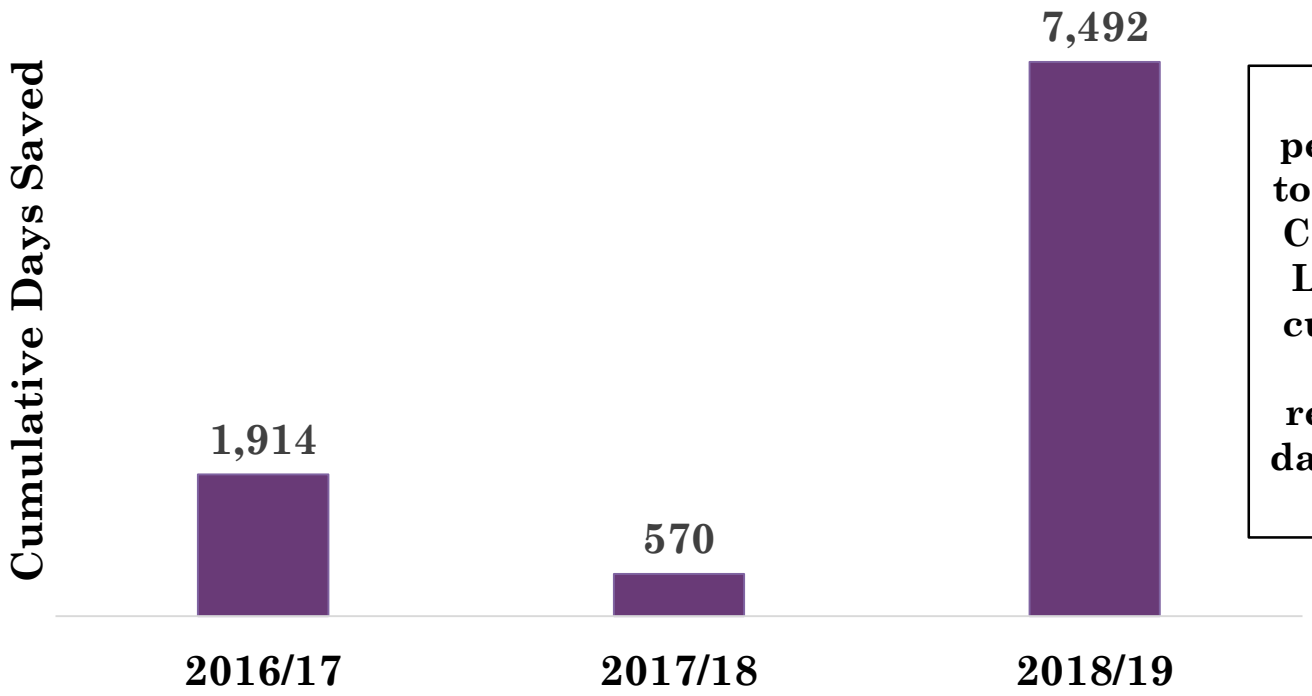
- Provide current status of Central East LHIN Strategic Aim Performance Metrics
- Provide an update on Central East LHIN Seniors Strategy-related initiatives
- Next Steps
- Appendix 1 – Supporting Metrics
- Appendix 2 – Investments

Acronyms

- Total Length of Stay (TLOS)
- Home and Community Care (HCC)
- Long Term Care Home(s) (LTCH)
- Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
- Behavioural Supports Ontario (BSO)
- Geriatric Emergency Management Program (GEM)
- Geriatric Assessment and Intervention Network (GAIN)

Central East LHIN Seniors Strategic Aim Performance Metrics

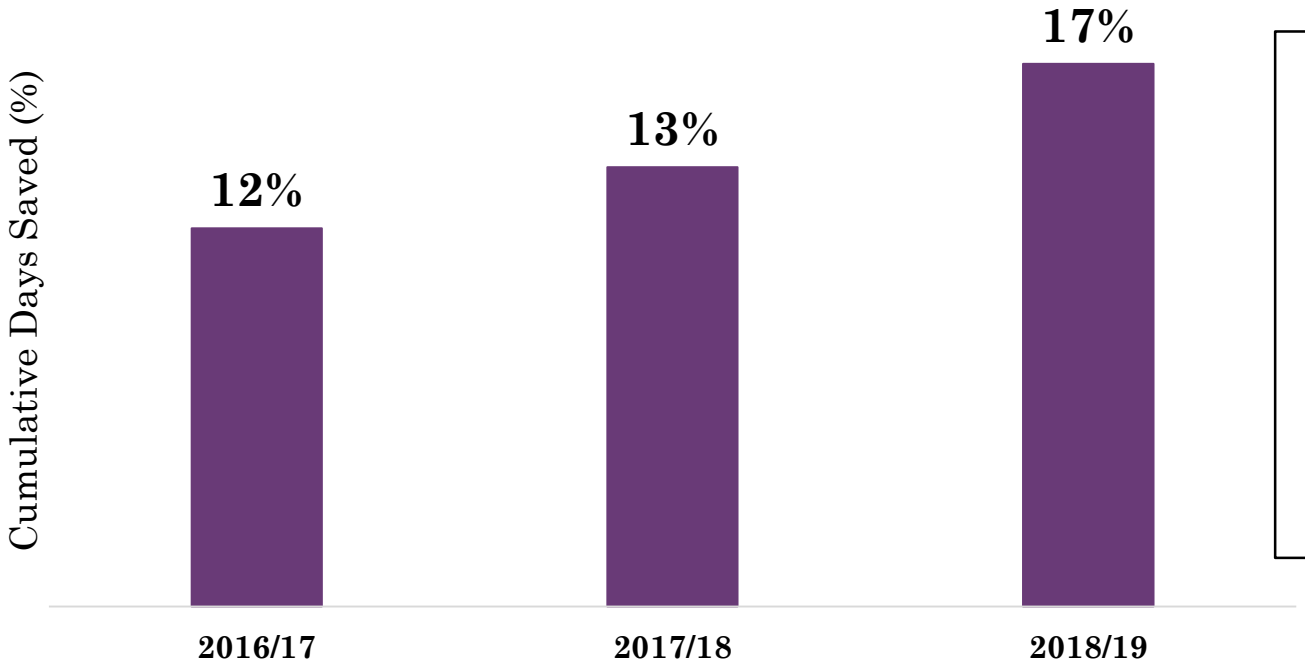
Seniors Strategic Aim: Cumulative Days Saved



Based on performance to Q2 2017/18, Central East LHIN is not currently on track to reach 20,000 days saved by 2019

	2016/17	2017/18	2018/19
Projected TLOS (days)	279,202	283,006	286,810
Estimated TLOS (days)	277,288	284,350	279,888
Cumulative Days Saved	1,914	570	7,492

Seniors Strategic Aim: Percentage of Alternate Level of Care Days for People Aged 75+



Based on performance to Q2 2017/18, Central East LHIN is not currently on track to reduce Alternate Level of Care days for people aged 75+ by 20% by 2019

	2016/17	2017/18	2018/19
Projected Alternate Level of Care (75+ (%)	30.0%	33.2%	36.3%
Estimated Alternate Level of Care 75+ (%)	26.6%	28.2%	28.4%
Cumulative (%)	11.5%	13.4%	16.5%

Seniors Strategic Aim: Supporting Metric Update

Indicators	Time Period for Current Performance	Baseline	CE LHIN Target*	Current Performance	Current Status	Direction of Trend
Home and Community Care (HCC) – 90th Percentile Wait Time for Home Care Services From Discharge to First Service (in Days for Hospital Clients) *(Goal is to decrease 90th percentile wait time)*	17/18 Q2	10.8	**6.5**	9.0	●	↘
Clients With MAPLe Scores High And Very High Living In The Community Supported by HCC *(Goal is to increase clients with MAPLe Scores high and very high living in the community with HCC support)*	17/18 Q2	8,533	**6,000**	12,661	●	↗
Falls-Related ED Visits in older adults aged 75+, Rate per 1,000 *(Goal is to decrease falls-related ED visits)*	17/18 Q2	17.7	15.9	21.9	●	↗
Low-Acuity Emergency Visits for Long Term Care Home (LTCH) residents, Rate per 1,000 *(Goal is to decrease low-acuity ED visits for LTCH residents)*	16/17 Q4	32.3	29.07	23.6	●	↘
Individuals on LTC Wait List, Rate per 1,000 (Goal is to decrease number of individuals on LTC wait list)	17/18 Q2	34.9	31.4	51.9	●	↗

*Targets that are shown in bold text are formal targets. Other targets are calculated as 10% greater or less than the baseline (depending on the desired direction of the indicator)

Seniors Strategy-related Initiatives

Central East LHIN Physician Lead

- In January 2017, the Central East LHIN announced the appointment of Dr. Jennifer K. Ingram as the Seniors Physician Lead, who works with the Seniors Care Network, and collaborates with regional and local health service providers to influence the system in caring for older adults.
- Key activities for 2017/18 have included:
  1. Recruitment and retention of geriatricians in the Central East LHIN; including active engagement with prospective geriatrician candidates and development of recruitment materials in collaboration with HSPs;
  2. Support of Primary Care Memory Services and the development of skills among primary care to appropriately manage seniors' needs, including coordination of specialized geriatrics support to memory clinics;
  3. Engaging physicians to provide input into dementia and geriatric services capacity planning; and
  4. Identification of opportunities for enhanced collaboration with geriatric psychiatry and geriatric medicine, including the co-development of guidelines for prescribing of antipsychotic medications in the community for patients experiencing responsive behaviours.

Adult Day Programs (ADP)

- ADPs play a key role in supporting individuals and their caregiver(s) in leading active and meaningful lives.
- The individuals who may benefit from ADPs include:
  - Older adults with complex and long-term medical, physical, social and/or cognitive conditions.
  - Seniors who are at risk of avoidable hospital admission/readmission, emergency departments visits, ALC, or other care issues, if not adequately supported in the community.
- The Central East LHIN supports ADPs across all sub-regions serving over 2,800 individuals across the Central East LHIN each year.
- In 2017/18, Central East LHIN received $306,000 in one-time funding to support enhancements to community dementia programs. This was directed to support efforts within ADPs to increase the overall inventory of spaces in ADP and reduce barriers to participation.

ADP Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served at Q3 2017/18	Service Delivery Relative to Lower Corridor of Target at Q3 2017/18
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	348	**140%**
	Les Centres d'Accueil Héritage	20	**88%**
	Scarborough Centre for Healthy Communities	104	**117%**
	Senior Persons Living Connected	287	**110%**
	TransCare Community Support Services	121	**97%**
	Yee Hong Centre for Geriatric Care	259	**131%**
Durham West/ Durham North East	Brain Injury Association of Durham Region	160	**117%**
	Community Care Durham	261	**133%**
	Oshawa Senior Citizens Centres	272	**99%**
	Regional Municipality of Durham	127	**130%**
Northumberland County/ Peterborough City and County	Four Counties Brain Injury Association	105	**125%**
	Victorian Order of Nurses for Canada - Ontario Branch	494	**100%**
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	192	**110%**
	Haliburton Highlands Health Services	55	**107%**
Total		**2,805**	

Assisted Living Services for High-Risk Seniors (ALS-HRS)

- ALS-HRS assist older adults to maintain their independence and remain in their homes for as long as possible.
- High-risk seniors are supported at home through the assistance of both scheduled and non-scheduled personal support services, homemaking, security checks, and reassurance services on a 24/7 basis.
- ALS-HRS hubs are located across all LHIN Sub-regions.
- The Central East LHIN invests more than $15M in annual base funding to support ALS-HRS across all seven Sub-regions.
- ALS-HRS serve over 1,500 individuals across the Central East LHIN each year.

ALS-HRS Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served at Q3 2017/18	Service Delivery Relative to Lower Corridor of Target at Q3 2017/18
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	332	**115%**
	TransCare Community Support Services	192	**112%**
	Yee Hong Centre for Geriatric Care	159	**127%**
Durham West/ Durham North East	Community Care Durham (Oshawa and Courtice)	314	**166%**
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	121	**128%**
	Haliburton Highlands Health Services	67	**156%**
Across Sub-regions	Victorian Order of Nurses for Canada	403	**123%**
Total		**1,588**	

Exercise and Falls Prevention Classes

- Exercise classes focus on helping seniors stay active and improve and maintain balance, strength, and mobility.
- Falls prevention classes are taught by a physiotherapist or other regulated health care professional.
- The Central East LHIN allocates $1.2M in annual base funding to support 248 exercise and 634 falls prevention classes across all sub-regions in the Central East LHIN.
- Exercise and falls prevention classes are also offered for Francophone patients, cardiovascular patients, and individuals with dementia.

Sub-region	Lead Agency
Scarborough North/ Scarborough South	Carefirst Seniors and Community Services Association
	TransCare Community Support Services
Durham West/ Durham North East	Community Care Durham
	Oshawa Senior Citizens Centres
Northumberland County	Community Care Northumberland
Peterborough City and County	Community Care Peterborough
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes
	Haliburton Highlands Health Services
Across Sub-regions	Cardiovascular Rehabilitation & Secondary Prevention Program

Central East LHIN Investments in Exercise and Falls Prevention Classes

Fiscal Year 2017/18

Sub-region	Lead Agency	# Exercise Classes	# Falls Prevention Classes	Total Class Summary
Scarborough North/ Scarborough South	Carefirst Seniors and Community Services Association	23	120	$ 170,400
	TransCare Community Support Services	50	140	$ 254,500
Durham West/ Durham North East	Community Care Durham	39	72	$ 162,720
	Oshawa Senior Citizens Centres	27	72	$ 133,920
Northumberland County	Community Care Northumberland	33	74	$ 151,200
Peterborough City and County	Community Care Peterborough	44	116	$ 216,960
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	21	28	$ 77,280
	Haliburton Highlands Health Services	5	12	$ 23,520
Across sub-regions	Cardiovascular Rehabilitation & Secondary Prevention Program	10	0	$ 24,000
Total		**248**	**634**	**$ 1,214,500**

Attending Nurse Practitioner in the Long-Term Care Home

- The Ministry of Health and Long-Term Care funded Attending Nurse Practitioners (NP) to work as primary care providers in Long-Term Care Homes (LTCHs) across the province in three phases (2015, 2017 and 2018).
- In a novel care model proposed by the Central East LHIN, Phase 2 and 3 NPs were allocated to the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) team. This includes 4 NPs providing care to all residents of 6 LTCHs:

Sub-Region	LTCH Supported (FTE)
Durham West	Ballycliffe Lodge (0.5) Bay Ridges LTC (0.5)
Haliburton County and City of Kawartha Lakes	Extendicare Haliburton (0.5 pending) Highland Woods (0.5 pending) Victoria Manor (1.0)
Northumberland County	Golden Plough Lodge (1.0)

- While metrics are developed to identify the system outcomes of the program, NPSTAT has begun its focus on quality indicators in the Continuing Care Reporting System for LTCH. Data will be available in Q3 2018/19.

Specialized Geriatric Services: Behavioural Supports Ontario (BSO)

- Behavioural Supports Ontario (BSO) is focused on supporting older people 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.
- In 3rd Quarter of 2017/18, BSO supported more than 3,000 care partners of LTC and community residents (combined).
- $892,828 of new base funding in 2017/18 brings the total annual Central East LHIN BSO investment to $6,285,790, which supports 86.3 FTEs in LTCH and the community.
- Using one-time in-year funding, HCC and Seniors Care Network have collaborated to develop a model of coordinated access for community BSO services to support community residents living with responsive behaviours and also to deploy one-time funding to Central East LHIN Adult Day Programs to deliver enhanced services for persons living with dementia.
- BSO Community of Practice events held in 4th quarter were attended by 500+ health care professionals.

Program accomplishments include:

Metric	2016/17 (Year-end)	2017/18 (Q3)
LTCH residents supported per quarter (average)	3,700+	4,450+
Community patients supported per quarter (average)	547+	384+
Staff trained in BSO approaches	1,689	1,100

Specialized Geriatric Services: Geriatric Assessment and Intervention Network (GAIN)

- Over $10.8 M in annual based funding invested in Central East LHIN Geriatric Assessment and Intervention Network (GAIN) teams to provide specialized geriatric care, which supports frail seniors, living at home or in retirement residences, who have multiple complex medical and social problems.
- Frail older adults experiencing changes in support needs, safety concerns, psychosocial and mental health concerns or frequent health service usage will benefit from these services.
- Continuing high volumes reported by all GAIN teams.
- Program accomplishments include:

Metric	2016/17 (Year-end)	2017/18 (YTD at Q3)
Visits provided	28,896	22,546
Patients receiving case management (12 month rolling caseload)	2,597	5,841
Patients with moderate to severe dementia	800+	667
Patients with moderate to advanced frailty	1,300+	1,138

Specialized Geriatric Services: Geriatric Emergency Management (GEM) Nurses

- Geriatric Emergency Management (GEM) programs provide specialized geriatric emergency management services to frail seniors in the Emergency Department (ED) within nine hospital locations in the Central East LHIN.
- GEM nurses are positioned within an ED to deliver targeted, emergency geriatric assessment to frail seniors in the ED.
- GEM nurses help seniors access appropriate services and/or resources that will enhance functional status, independence, and quality of life.
- Majority of patients seen are over the age of 85.
- Program accomplishments: A large proportion of referrals include specialized geriatric programs (i.e. GAIN, NPSTAT and BSO) and primary care. The majority of referrals (51.1%) are made to the Central East LHIN Home & Community Care.

Metric	2016/17 (Year-end)	2017/18 (YTD at Q3)
Individuals served	4,367	3,108
Referrals to alternate sources of care (following targeted geriatric assessment)	4,052	3,215

Specialized Geriatric Services: Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)

- Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) provide direct clinical care to LTCH residents across all sub-regions in the Central East LHIN by responding to acute and episodic changes in the resident's condition to reduce unscheduled transfers to a hospital.
- When LTCH residents are hospitalized, NPSTAT helps coordinate transitions back to the LTCHs, which can decrease hospital length of stay, enhance continuity of care, and provide support and resources to LTCH staff to help manage returning LTCH residents with increasingly complex medical needs.
- Program accomplishments include:

Metric	2016/17 (Year-end)	2017/18 (YTD at Q3)
Unique Patients Receiving Direct Clinical Care	5,611	4,319
ED Transfer Rate (average)	1.7%	1.8%
Capacity building activities provided	196	166
Facilitated LTC Repatriations from ED	35	112

Specialized Geriatric Services: Seniors Friendly Care (SFC)

- Overseen by a committee comprising representatives from all Central East LHIN hospitals who collaborate to promote and provide strategic direction and leadership for the Senior Friendly Care (SFC) Strategy.
- The vision is to move from discrete initiatives to a comprehensive, coordinated approach to seniors' care and to foster a culture where senior friendly care is woven into the fabric of an organization.
- Mandate is evolving to include non-acute care organizations providing health care to seniors.
- A Provincial Senior Friendly Care (sfCare) Framework has been developed and finalized with input from Central East health service providers and the Central East LHIN Patient and Family Advisory Committee.
- The sfCare Framework has been incorporated into Dementia Capacity Planning, to ensure that decisions about ideal state components for dementia care align with optimal care approaches for frail seniors.

Specialized Geriatric Services: Primary Care Collaborative Memory Services (PCCMS)

- This Primary Care-based regional program supports cognitive health and quality of life for adults and seniors living in the community while ensuring the patient's family physician maintains a central role in their patient's care.
- PCCMS enhances the capacity for timely detection, diagnosis, and treatment of dementia.
- A mobile team, hosted by Alzheimer Society of Durham Region in collaboration with Seniors Care Network, consists of Social Workers, Behavioural Support Ontario Nurses, and Occupational Therapists.
  - Works collaboratively with family physicians in memory clinic locations in Durham and Scarborough.
  - As of Q3, the Durham/Scarborough Teams have offered 561 visits to 289 patients.
- Recently approved base funding supports ($304,000) will enable the sustainable operation of teams in Northumberland and Haliburton County, in collaboration with the Alzheimer Society of Peterborough, Kawartha Lakes, Northumberland and Haliburton.

Dementia Capacity Planning

- The MOHLTC has developed and communicated expectations regarding a standardized process for dementia capacity planning. The MOHLTC has held three formal capacity planning learning sessions and a one-on-one session with each LHIN to learn from and disseminate learning.
- The MOHLTC commissioned a scoping review and is building a Regional Profile (data) Tool to assist local LHIN planning. The Regional Profile tool is anticipated to be available in Spring 2018.
- The Central East LHIN Dementia Capacity Planning Action Group has been established, with tri-partite leadership from Seniors Care Network, all three Alzheimer Societies, and the Central East LHIN. Seniors Care Network is assisting to project manage the process of developing the Dementia Capacity Plan.
- A draft logic model, including proposed **Ideal State** components, has been developed and the Action Group is presently engaged in broad consultations to seek input and validate planning assumptions.
- Compiling current services, program utilization and participant characteristics by program and LHIN sub-region to develop a **Current State** view.
- The Current State, in combination with the Ideal State and the Regional Profile Tool, will be used to identify gaps in dementia care and facilitate the development of recommendations.

Assess & Restore (A&R)

- Assess & Restore (A&R) initiatives support high risk frail seniors to live in the community and maintain their functional independence for as long as possible.
- The Central East LHIN previously funded four projects focused on facilitating independence for frail seniors through A&R initiatives; funding for these initiatives changed to base funding for 2018/19.
- The Central East LHIN issued an Expression of Interest (EOI) process and evaluated all project proposals based on A&R eligibility criteria set by the MOHLTC and priorities identified by the Central East LHIN to ensure a fair and transparent process for distributing base funds.
- Funding decisions have been made, and five programs have been selected to receive base funding beginning April 1, 2018.
- Funding letters and Service Accountability Agreements (SAAs) are in the process of being sent to Assess and Restore programs.

Seniors Care Network

Update on Seniors Care Network Service Plan 2017/18

Service Plan Activity	Update April 2018
1. Implement Coordinated Access	Model scaled to address persons living with responsive behaviours, implementation options completed
2. Engage the Central East LHIN to co-lead the development of an Accountability Framework of Specialized Geriatric Services (SGS) programs/providers	Seniors Care Network now designated as a Strategic Lead for the Seniors Aim
3. Develop and implement regional Performance Management systems	Ongoing development of system-level indicators
4. Participate in the development of provincial SGS Performance Management systems	Undertaking development of Provincial Seniors experience indicators
5. Continue to partner in the development of primary care based initiatives	Continued support and development of Primary Care Memory Services
6. Implement a Knowledge Translation Strategy	Framework developed and utilized to support development of caregiver education
7. Develop and implement the competency framework for interprofessional Comprehensive Geriatric Assessment	Competency Framework developed and published. Knowledge translation group established.

Update on Seniors Care Network Service Plan 2017/18 (Cont'd)

Service Plan Activity	Update April 2018
8. Advance the Dementia Action Plan	Co-leading the development of the Central East Dementia Care Strategy
9. Develop and implement an SGS research agenda	Currently engaged in five active applied research projects
10. Develop a SGS evaluation Framework	Framework developed and program evaluation commenced for GAIN and GEM
11. Support gerontology/geriatric related continuing professional development across the network	Launched the 3rd annual Geriatric education initiative, supporting 43 individuals and one organization Senior Friendly innovation grant
12. Implement the Citizen Engagement framework	Supporting engagement activities related to the Dementia Care Strategy, including concern citizen consultations
13. Advance the adoption of Senior Friendly Care across the Central East LHIN	Participating in provincial roll-out of Senior Friendly Care Framework
14. Develop a communication framework for SGS	Release of Annual Activity summary 2016/17

Next Steps

Next Steps

- Continue to implement Seniors Strategic Aim initiatives as outlined in the 2016-19 Integrated Health Service Plan and 2018/19 Annual Business Plan.
- Continue to collaborate with the Seniors Care Network, Seniors' Physician Lead, along with key stakeholders and partners, to design, implement and evaluate programs that strengthen integrative health services and their delivery for frail seniors.
- Better understand frail senior populations at a sub-region level and identify opportunities to meet their health needs to support them living at home.
- Integrate seniors health within sub-region planning.
- Conduct targeted program evaluation.
- Launch dementia capacity planning.
- Spread programming and address any gaps at the sub-region level.

Questions?

Appendix 1 – Supporting Metrics

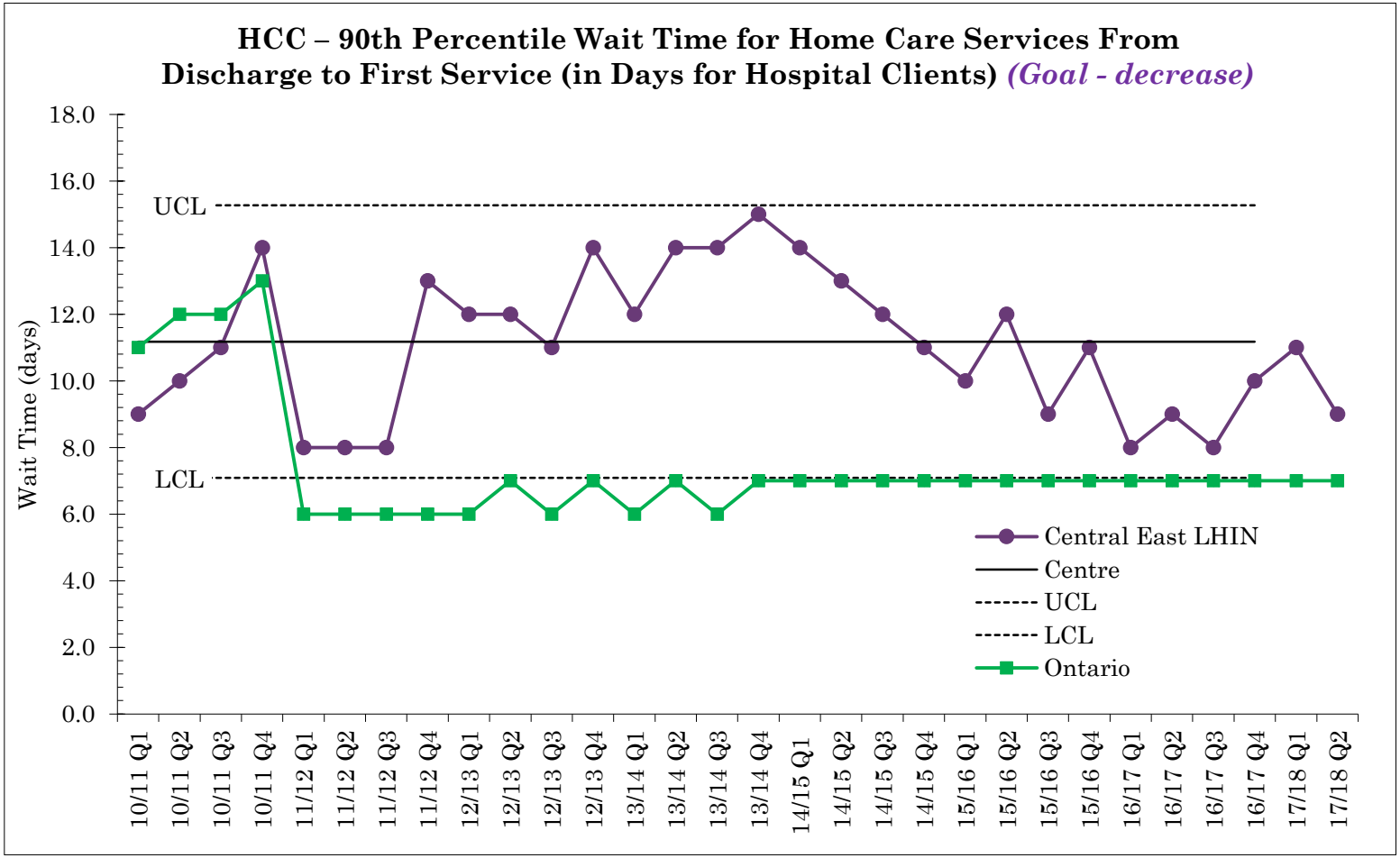
How are Savings Calculated?

Goal: Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital by 2019

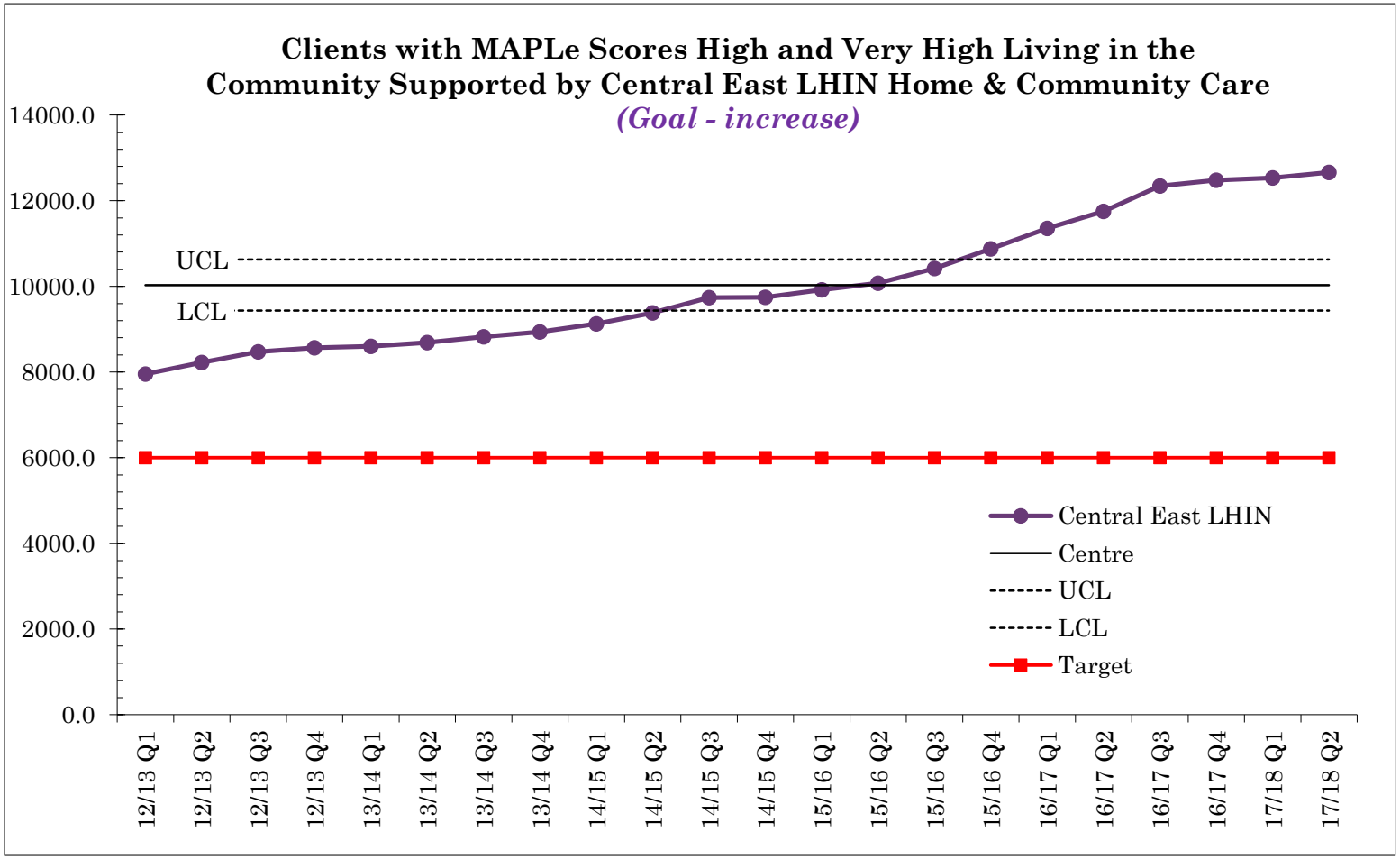
- Cumulative Days Saved = Projected Total Length of Stay – Estimated Total Length of Stay
- Projected Total Length of Stay (TLOS) represents a projection of what the total length of stay would potentially be based on three years of historical data
- Estimated TLOS represents the actual length of stay for each fiscal year. Estimated values based on aim assumptions are used until actual values are known. Values are known to Q2 2017/18

Goal: Reduce Alternate Level of Care (ALC) days for people aged 75+ by 20% by 2019

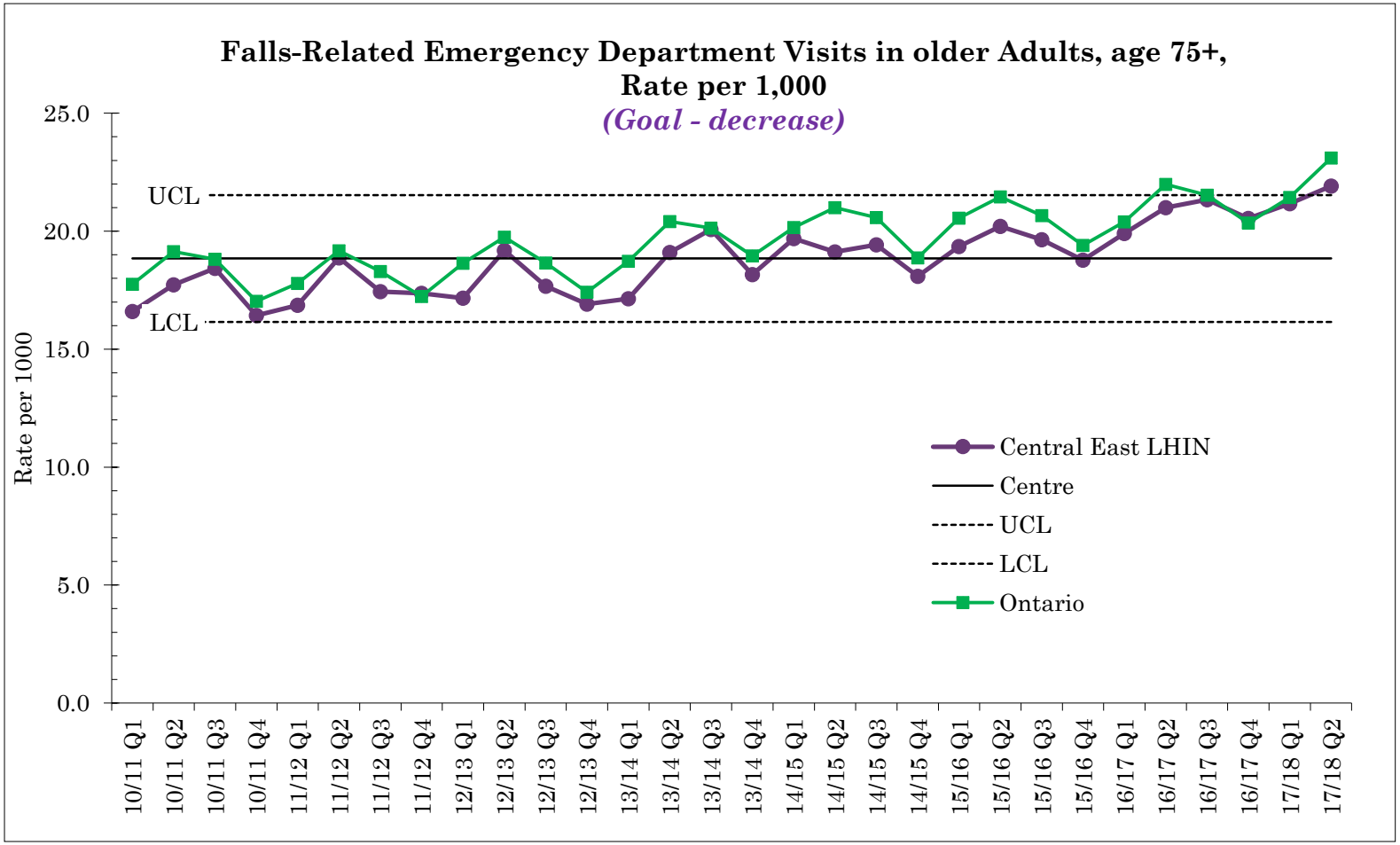
- Cumulative Days Saved (%) = (Projected ALC days – Estimated ALC days) / Projected ALC days
- Projected Alternate Level of Care (ALC) represents a projection of what the percentage of ALC days would be based on three years of historical data
- Estimated Alternate Level of Care (ALC) represents the actual percentage of ALC days for each fiscal year. Estimated values are used until actuals are known. Values are known to Q2 2017/18



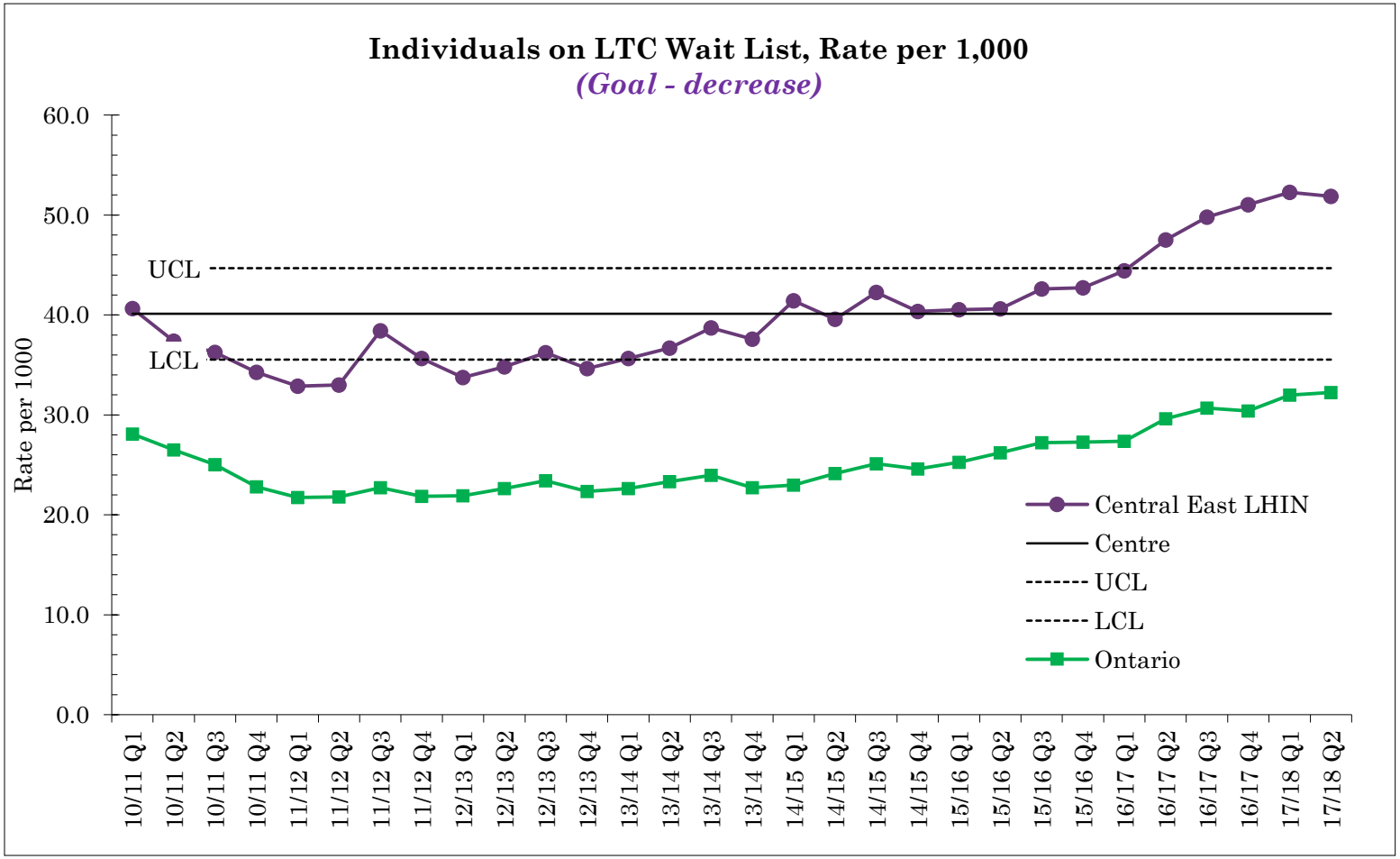
Analysis: In the 2nd Quarter of 2017/18, the 90th Percentile Wait Time for Home Care Services (Discharge to First Service) Hospital Setting (all clients) for Central East LHIN experienced a decrease from 11 days in the 1st Quarter. The 90th Percentile Wait Time across Ontario was 7 days during the same time period.



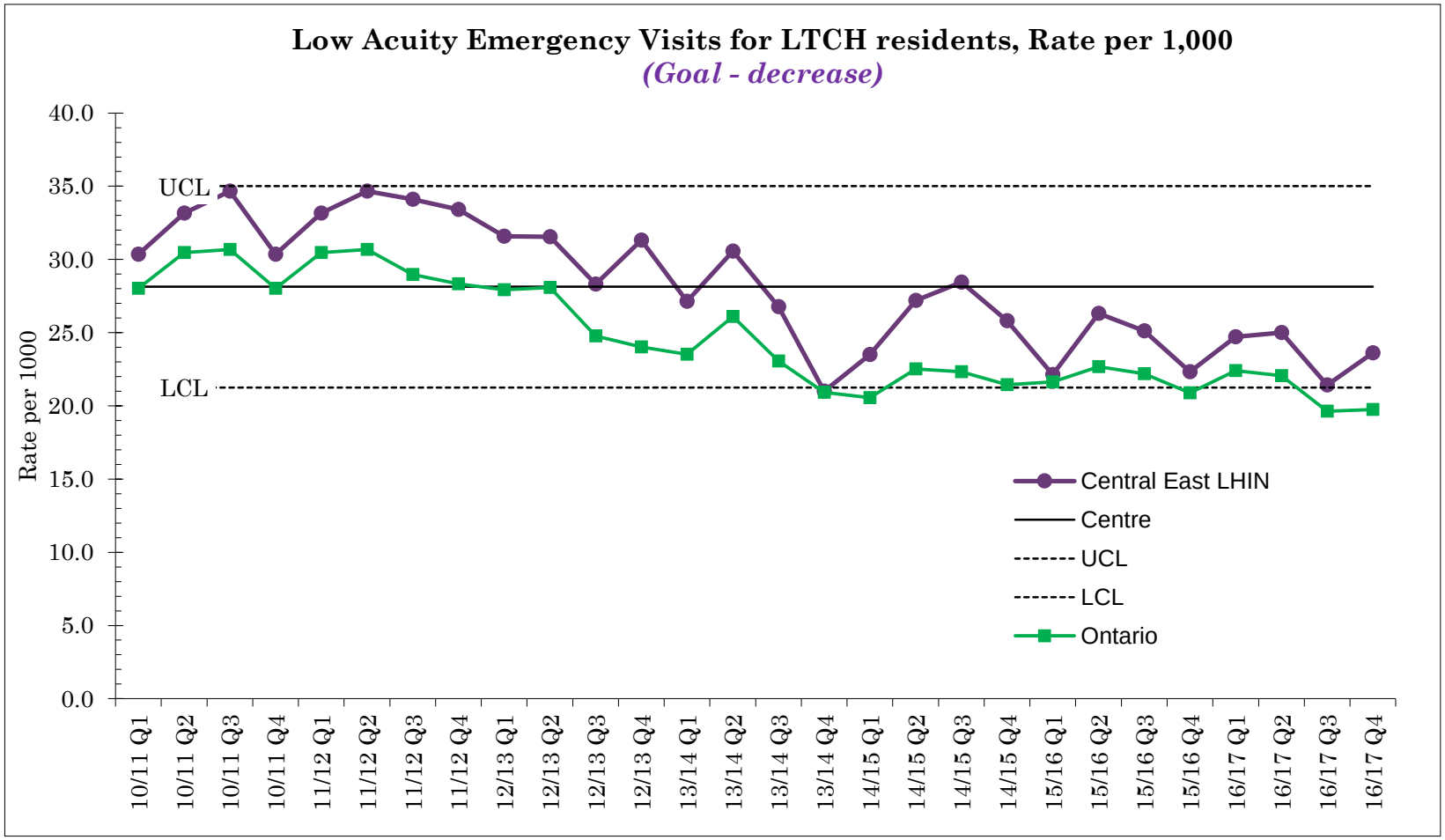
Analysis: Central East HCC client volume in 2017/18 continued to exceed the Multi-Sector Service Accountability target of 6,000. This would imply that the Central East HCC was doing a better job at keeping clients in the community than expected. The goal of the Seniors Aim is to keep clients in their homes and in their community and this is a positive correlation.



Analysis: The rate of falls-related Emergency Department visits in older adults in Central East LHIN continues to be comparable to the Provincial rate (21.5 per 1,000 versus 23.1 per 1,000 provincially in the 2nd Quarter of 2017/18). This indicator excludes patients living at home with homecare and patients living in Long-Term Care Homes. The goal is prevention of falls and subsequent visits to the Emergency Department.



Analysis: As in previous years, the rate of individuals on wait lists for Long-Term Care (LTC) per 1,000 in the 75+ population continues to increase. Across the 14 LHINs, Central East LHIN has the highest rate of waitlisted LTC patients per 1,000. This disparity has been highlighted by the Integrated Health Service Plan Environmental Scan and is one of the key reasons for identifying Seniors as a priority population.



Analysis: In the 4th Quarter of 2016/17, which is the most up-to-date reporting available, the Central East LHIN rate increased to 23.6 Low Acuity ED visits per 1,000 LTCH residents, which is above the provincial value of 19.7. However, the overall trend is a decrease. Initiatives such as LHIN sub-regions, Community Investments, and Hospitals and Community Health Services integrations are expected to reduce ED demand by facilitating ED avoidance and diversion, and by supporting individuals post-discharge. The goal is for the residential care population to receive quality and non-hospital end-of-life care in order to reduce transfers to the ED. NPSTAT collaboration is a key player in the Central East LHIN Behavioural Supports Ontario strategy, which will have a positive impact on ED diversions from LTCH for behavioural reasons.

Appendix 2 – Investments

Central East LHIN Investments in ADPs and Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served	2018/19 Allocation
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	348	$1,511,871
	Les Centres d'Accueil Héritage	20	$59,142
	Scarborough Centre for Healthy Communities	104	$341,189
	Senior Persons Living Connected	287	$1,163,672
	TransCare Community Support Services	121	$475,715
	Yee Hong Centre for Geriatric Care	259	$1,418,008
Durham West/ Durham North East	Brain Injury Association of Durham Region	160	$325,912
	Community Care Durham	261	$981,085
	Oshawa Senior Citizens Centres	272	$1,213,334
	Regional Municipality of Durham	127	$519,968
Northumberland County/ Peterborough City and County	Four Counties Brain Injury Association	105	$215,797
	Victorian Order of Nurses for Canada - Ontario Branch	494	$1,270,987
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	192	$554,586
	Haliburton Highlands Health Services	55	$210,212
Total		**2,805**	**$10,261,478**

Note: Central East LHIN did not issue any additional funding amendments to HSPs for the Adult Day Program in the 2017/18 Fiscal Year.

Central East LHIN Investments in ALS-HRSs and Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served	2018/19 Allocation
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	332	$2,345,456
	TransCare Community Support Services	192	$1,084,204
	Yee Hong Centre for Geriatric Care	159	$1,678, 604
Durham West/ Durham North East	Community Care Durham (Oshawa and Courtice)	314	$4,143,481
	Victorian Order of Nurses for Canada	403	$3,682,828*
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	121	$1,427,082*
	Haliburton Highlands Health Services	67	$912,885
Total		**1,588**	**$15,274,540**

Note: The targets for individuals served include Assisted Living Services for High-Risk Seniors (ALS-HRS) and Supportive Housing, as affected health service providers report combined numbers for these services to the Central East LHIN.

* The funding allocated to the Victorian Order of Nurses is recorded as part of the Durham West/ Durham North East sub-regions, but also supports service provision in four additional sub-regions.

* Only Community Care City of Kawartha Lakes received additional funding for the Assisted Living – High Risk Seniors program in 2017/18. The 2018/19 allocation includes the additional annualized base funding of $166,826. In Q3 2017/18, a pro-rated base of $51,448 was provided.