Ontario

Toronto Central Local Health Integration Network

ANNUAL REPORT | 2016-17

A Healthier Toronto

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Message from the Board Chair and the CEO

Dr. Vivek Goel
Board Chair

Susan Fitzpatrick
CEO

This past year was a pivotal one for the Toronto Central Local Health Integration Network (LHIN). We are pleased to present an overview of our achievements over the year in the Toronto Central LHIN's 201/62017 Annual Report.

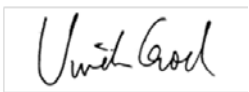
With the passing of The Patients First Act, Bill 41, a key area of focus for the LHIN has been on the transition with Toronto Central Community Care Access Centre to create a new integrated LHIN organization. Many key milestones have been delivered throughout the journey to integration. We have an updated organization structure, recruited our integrated executive leadership team and completed all tasks for the preliminary readiness and ongoing assessments through to transition. A key milestone unique to Toronto Central LHIN in this transition was the transfer of LHIN-Collaborative and LHIN Shared Support Ontario. This milestone saw both organizations transition from Toronto Central LHIN to form a new crown agency along with Ontario Association CCAC called Health Shared Service Ontario which will service the new LHIN organizations provincially. Planning continues into the new fiscal year to deliver a thoughtful transition that considers the needs of staff from both organizations, our stakeholders and provides continuity of care to our patients.

Transition is a key area of focus for the LHIN, however in the midst of this change the LHIN has taken on and continued to deliver key pieces of work. During the year, the LHIN established a One Team, One Plan approach to guide us toward achieving four strategic priorities

I. Designing Health Care for the Future
II. Taking a Population Health Approach
III. Transforming Primary Health and Community Care
IV. Achieving Excellence in Operations

The Board of Directors and Toronto Central LHIN staff has supported changes at the foundational level of our health care system by preparing for the integration of Community Care Access Centres. Throughout this year of change, we have maintained our commitment to building a strong local, regional and provincial health system that cares for the citizens of Toronto and everyone who accesses care here. While we recognize there is still work to be done, this report provides a sightline into progress we have made over the past year.

Dr. Vivek Goel
Board Chair



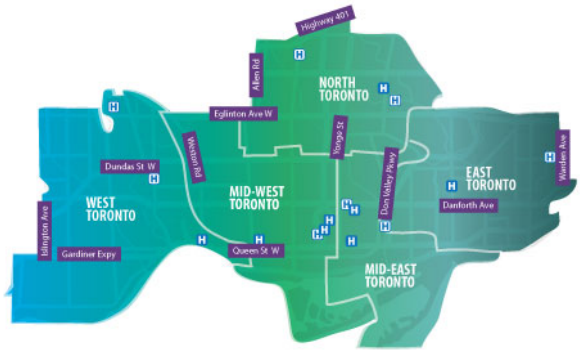
Susan Fitzpatrick
CEO

Toronto Central LHIN Profile

Uniquely Urban

Toronto Central LHIN represents a diverse population of 1.2 million people. Toronto has become North America's fourth largest city and the population is growing; in fact the downtown core is growing at four times[1] the rate of the rest of the City of Toronto. Some key characteristics to note:

- The fastest-growing age group in the City is seniors[2] and this group is expected to make up 22.6 percent of Toronto's population by 2041[3].
- Toronto remains a multicultural hub with the highest percentage of immigrants in Canada[4]. One-third of Toronto's immigrants arrived in Canada within the last 10 years[5]. 140 languages and dialects are spoken in Toronto[6].
- Approximately 5,000 people are homeless in the City of Toronto[7].
- This unique LHIN is home to some of the richest and poorest neighbourhoods in Canada. Roughly a quarter (26%) of Toronto's population is considered to be low income[8].
- Toronto Central LHIN's population includes 59,000 Francophones; the largest lesbian, gay, bisexual and transgender community in Canada; and a rapidly growing urban Indigenous population, many with complex health needs.



These characteristics shape how people interact with the health care system and consequently affect how we design the system to meet their needs.

There are many factors that contribute to the health of the population, some of which are a direct result of, or are compounded by, the unique characteristics of urban environments. These factors, which include geographic isolation, high population density, socio-economic status, language and cultural barriers, can contribute to poor access to primary care and community services. The challenges that these factors present for the health of our communities can be mitigated by smarter, more efficient delivery of services that are specifically targeted to reflect the needs of local communities.

What is also unique about Toronto is it is home to world class physicians, hospitals, and health research institutes; these assets and strengths can be leveraged to improve the health of its population.

High Growth in the Toronto Central LHIN

Since 2006 Toronto's downtown core has grown by 18 percent, four times the rate of the remainder of the city, while the population south of Queen Street has doubled in recent years.

Approximately 128,650 dwelling units have been built in the past decade, averaging 12,865 units per year over the last ten years.

The impact of this population surge has been felt by health service providers, to the point that hospitals now regularly operate in excess of 100 percent of their bedded capacity. For example, in recent years St. Michael's hospital reports a 60 percent increase in high acuity cases in its emergency department, with 8 percent of these being admitted, and the University Health Network indicates a 12 percent increase in admissions from the emergency department.

Capacity Challenges

Population growth in downtown Toronto has led to the commensurate increase in property values. As a result, when Long- Term Care (LTC) facilities need to be replaced or expanded, the provincial model for financing these important projects finds itself severely under-resourced in the face of the cost of land within the LHIN. This poses the risk of having insufficient infrastructure to support this vital resource as the population continues to grow.

To help address these issues, the Toronto Central LHIN is working closely with the other four LHINs in the Greater Toronto Area, as well as with the City of Toronto. The LHIN has created a new relationship with the City's Lead Planner, in order to have health concerns at the forefront of future development in the region. Basing future infrastructure investments on data driven planning will help ensure that the unique challenges faced in delivering health care to the city's core are taken into account, while also retaining the ability to honour the LHIN's commitment to support specialized care to patients across the province.

OUR PEOPLE: A DIVERSE POPULATION

Toronto Central LHIN has worked to identify key populations and more specifically, the challenges that certain populations experience in accessing or benefiting from services. These challenges result in gaps in health outcomes relative to the rest of the population. Recognizing that demographics provide significant insight to the current and future health care needs of a community, the LHIN has been working to ensure that its planning and implementation activities are reflective of both the local demographics, as well as the social determinants of health.

Seniors

Within our boundaries, those aged 65 years and older account for 15 percent of the population. Seniors are living longer than ever before. While this is testament to the successes of modern medicine, it also brings with it tremendous social and economic pressures. Health care use rises as people age and most costs are incurred during people's final years of life. With the large cohort of aging baby boomers reaching their senior years, health care costs will inevitably continue to grow. Our challenge is to manage the rate at which those costs grow by improving the quality and efficiency of care and investing in services that add value.

Indigenous Peoples

Indigenous communities have significant health disparities when compared to non- indigenous populations, and have been historically marginalized within the mainstream health system[9].

In addition, there is limited information about the health status and health care use of Indigenous peoples for a variety of reasons. For example, census data often does not include Indigenous people as this population group is highly mobile and has increased housing instability and homelessness.

According to Our Health Counts Toronto, the population of the Indigenous community is 34,000 to 69,000 for the City of Toronto[10]. This number is climbing; between 1971 and 2011, the Indigenous population grew 487 percent, compared to the overall Canadian total of 57 percent[11]. Collecting accurate health and social determinants of health data regarding their use of health care services and health status is an essential step in tailoring services for this population.

Recent findings from Our Health Counts Toronto also revealed that the number of Indigenous people living below the low- income cut-off is about 90%[12]. According to Statistics Canada, the low-income cut-off is when a family spends 20% or more (of their total income) on food, shelter and clothing than the average Canadian.

Francophones

Toronto's Francophone population is rich in diversity and is dispersed across the city. Likewise, French language health services are scattered across the LHIN, which contributes to challenges navigating the health care system for this particular population. According to Statistics Canada (2011), many Francophones are recent immigrants and/or visible minorities13. Almost half were born outside of Canada and may not be familiar with the Ontario

Newcomers

Newcomers often encounter barriers to care, particularly if they do not speak English. Evidence shows that people with limited proficiency in English tend to stay longer in hospital, as do those who are unable to communicate with care providers in their first language.

- Toronto is home to 52.6 percent of all immigrants living in the Greater Toronto Area and 36 percent of all immigrants living in Ontario[4].
- 8 percent of immigrants in Toronto arrived in Canada between 2006 and 2011[4].
- 5 percent of Toronto's population reports no knowledge of either official language[4].

Refugees

Refugees are a vulnerable group in need of quick and sustained access to health care, as well as resources and services related to mental health. In 2015/16 Toronto's health and social service providers worked hard to meet the health needs of thousands of refugees from all over the world, including more than 3,000 from Syria. Providing a boost to these efforts was the recent re- instatement of the Interim Federal Health Program, a program that provides temporary health benefits to refugees.

LGBT

The Toronto Central LHIN is home to the highest number of gay, lesbian, bisexual and transgender (LGBT) people in Canada. LGBT communities have some unique health concerns and may be at increased risk for certain health problems. Although some supports are in place, many gaps in care remain for this community. For example, the accumulated impact of stigma, prejudice, discrimination and isolation affects the mental health of LGBT people, leading to higher rates of depression, anxiety and suicide than the general population. Substance use such as alcohol and drugs is also higher among LGBT populations.

Another area of health concern for the LGBT community is in long-term care. Research shows that older LGBT people are five times less likely to use health and social services for fear of discrimination. Additionally, many people have diminished support networks and relocating to long- term care homes can be stressful.

People Affected by Mental Health and Addictions

Mental health and Addictions (MHA) affects a considerable proportion of Toronto Central LHIN's population who require ongoing treatment and supports. The prevalence of MHA issues is much higher among the top high cost users of the system and varies by Health Link. In 2012/2013, 80,759 (8.4 percent) of adults 20 years and older had MHA visits to physicians. However, this figure drastically underestimates the prevalence of mental health issues as it does not include non- Ontario Health Insurance Plan (OHIP) claims or people who do not seek treatment for their conditions.

The Toronto Central LHIN reported 42,549 mental health and substance use-related visits to the Emergency Department (ED) which accounted for approximately 4.1 percent of all ED visits (FY 2013/14). For the same year, the average length of stay in Toronto Central LHIN hospitals for mental health/substance abuse patients was 38.1 days. Repeat visits to the ED for mental health and substance use are high. The most recent data available (FY 2014/15, Q3) indicates a rate of 27.9 percent for mental health and 41.7 percent for substance use.

OUR HEALTH SERVICE PROVIDERS

Toronto Central LHIN has the highest concentration of health services in Canada, with 172 unique health service providers offering 202 unique programs and services. The following breakdown of services is based on the 2013-2014 fiscal year:

- 17 hospitals with a total of 2,163,008 inpatient days;
- 17 community health centres (CHCs) providing an estimated 449,759 face-to-face encounters;
- 61 agencies providing community support services (CSS) totaling an estimated 1,128,079 community visits and 924,799 resident days;
- 70 agencies that provide community mental health and addictions (CMHA) and problem gambling services totaling an estimated 1,409,503 visits;
- 1 Community Care Access Centre (CCAC) providing an estimated 164,124 visits for case management services; and
- 36 long-term care (LTC) homes accounting for almost 6,723 approved long-term care beds (equivalent to 2,453,235 bed days available for admission.
- In 2014/15, Toronto Central LHIN's total budget transferred to health service providers was$4.76 billion. Hospitals accounted for 80 percent of Toronto Central LHIN funding, followed by long-term care homes at 6 percent, the CCAC at 5 percent and community agencies at 5 percent.

STRATEGIC PLAN FOR 2015-2018

Launched in June 2015, Toronto Central LHIN's Strategic Plan will be guided by three overarching goals:

1. A Healthier Toronto
2. Positive Patient Experiences
3. Innovation & System Sustainability

We have also adopted four strategic priorities that will guide our investments and activities to drive the reforms needed to achieve our goals:

I. Designing Health Care for the Future
II. Taking a Population Health Approach
III. Transforming Primary Health and Community Care
IV. Achieving Excellence in Operations

The graphic below illustrates Toronto Central LHIN's strategic direction for the next three years.


Website redesign
17 Hospital Service Accountability Agreements (HSAAs)
30 Long-Term Care Home Accountability Agreements (LSAAs)
147 Multi-Sector Service Accountability Agreements (MSAAs)
Strategic Approach to Integration
Improve performance on LHIN MLAA indicators
Population-Based Planning
Improve Employee Satisfaction
Transition of the CCAC to new LHIN
Vision for Integrated Health Care
Financial Excellence
Model for Home and Community Care
City of Toronto Joint Partnership Table
Shared Accountability Agreement framework
Toronto Central LHIN Sub-Regions

Ontario's health care system is undergoing a fundamental shift in the way we think about, plan for and fund health care services. Our standard of excellence is no longer a system where each provider does a first-rate job on their discrete piece of patient care. We are now focused on whole episodes of care, ones that better reflect the way that patients see their journey through the system as they move from primary health care, to hospitals, to the community.

Redesign of services has already begun with collaborative multi-sector tables that bring together all relevant players to deliver more effective, integrated and seamless care for cardiac, palliative, stroke and orthopedic patients.

The system of the future is one that is designed to leverage the best available evidence identified through organizations such as Health Quality Ontario (HQO) or Provincial Expert Panels. This evidence is then brought to life by our health service providers who apply it to the local context. Our future system is characterized by the seamless flow of information and warm handoffs of patients as they move from one provider to another. It is designed through the incorporation of a diverse set of patient perspectives and is only complete if it manages to relieve suffering by reaching beyond the clinical interventions to capture many facets of the patient experience.

This redesigned system will be enabled by structural changes that align incentives with the objectives that have been set out. These include the continued implementation of new provincial funding models; strategic integration of services and health service providers; and new accountability measures introduced at the provincial and LHIN levels designed to measure integration of care.

Last year, we began putting some necessary pieces in place to be able to begin redesigning the health care system. The following sections show some of our main accomplishments as we move forward this Strategic Priority.

Our Citizens' Panel: Putting patients and caregivers at the forefront of our program design

In March 2016, the Toronto Central LHIN launched its Citizen's Panel to engage residents, patients, families and caregivers and to inform the planning of health service delivery through community engagement. The Citizens' Panel meets the Minister's mandate to establish and engage with a Patients and Family Advisory Council to ensure that patients and families are involved in health care system decision-making.

The panel consists of 18 diverse members of the Toronto Central LHIN who participated in 8 bi-monthly meetings. Over the past year, the Citizen's Panel has provided valuable advice and feedback into the development of our work. Most recently, the panel has provided feedback on our population health strategy, has participated in a ministry-led discussion on the Patients First Act, and has participated actively in the sub-region working groups and Local Collaboratives. Moving forward, the LHIN will continue to deepen its understanding of patient experiences by augmenting the skills and knowledge-base of panel members and by recruiting panel members to participate in co-design, Toronto Central LHIN leadership tables, and working groups.

City of Toronto Strategic Partnership

The LHIN and the City continue to expand collaborations to promote healthy communities from two perspectives: the City as a municipal government with the highest point of leverage on social determinants of urban health, and the LHIN as the planner and funder of local health care services. Recognizing that partnership can generate greater impact, the City and the Toronto Central LHIN have committed to an agreement for a Healthier Toronto.

Building on accomplishments to date, the agreement will create a framework for coordinating and directing shared projects and initiatives to improve health outcomes for residents of Toronto. By aligning our respective resources and efforts, we can leverage improved results that are not attainable separately. This past fiscal, the City and the LHIN established a joint Steering Committee and signed a Memorandum of Understanding to clarify respective responsibilities related to the development of the agreement. Engagement is underway to define joint priorities and actions that will improve outcomes for Torontonians.

Development of a Regional Framework

Over the last year the LHIN has completed an initial inventory of regional services in Toronto Central LHIN to inform the development of a regional framework. A working group was established to support this initiative, with Anne-Marie Malek (Westpark Health Care) and Mohamed Badsha (Reconnect) as co-chairs.

The initial working group meeting was followed by a stakeholder engagement session with Toronto Central LHIN Health Service Providers who had self-identified as regional service providers through the sub-region planning and engagement process.

Feedback from providers and connections with other stakeholders and partners (including Ministry of Health and Long-Term Care and Toronto Central LHIN Primary Care subcommittee on Access to Specialists) supported further development of the definitions and informed the scope of this framework to focus on specialized regional services.

Urban Growth and Capacity Planning

The City of Toronto has seen rapid growth from residential and non-residential development in recent years. Since 2006, the population of Toronto has grown by over eighteen per cent with population growth in the downtown area growing 4-times faster than the rest of the City.

In an effort to better understand how this growth is affecting hospital volume, Toronto Central LHIN commissioned a report, 'Impact of Urban Growth on Acute Care Hospitals in Toronto Central LHIN' to review the growth in emergency department visits and admissions in all Toronto Central LHIN acute care hospitals since 2006.

The Toronto Central LHIN sees this report as the first of several future projects aimed at understanding the impact of urban growth on health care services. Additional projects may focus on understanding the impact of growth from other communities in North York, Scarborough and Etobicoke; as well as the impact of growth on other parts of the health care system, such as community and primary care. More information and the report can be found here.

Regional Quality Table

In collaboration with Health Quality Ontario (HQO), the Toronto Central LHIN Regional Quality Table was launched as a cross-sectoral table with representation of quality experts from all the LHIN funded sectors; primary care, Toronto Public Health, patients and caregivers, and other organizations to lead quality improvement in the LHIN. The Table is tasked with bringing together both clinical experience and patient perspectives, to lead the implementation of system-wide quality initiatives and monitor the progress. A Quality Framework was developed which includes three main pillars:

- Performance Measurement focusing on reviewing and monitoring indicators to identify quality improvement opportunities;
- Performance Improvement focusing on development and facilitation of cross-sectoral quality improvement initiatives, and
- Capacity Improvement focusing on supporting building of quality improvement capacity in the LHIN, HSPs and patients/clients.

The Regional Quality Table has acted as a catalyst and helped to jumpstart several quality improvement initiatives. Based on the review of the strategic plan indicators, four indicators were identified that did not have any supporting strategies (Patient Experience, 18 month Well baby visit, Supportive housing wait times and Long-term care wait times). The Regional Quality Table helped to initiate a collaboration between Toronto Public Health and Primary Care Leads to address and improve performance of the well-baby visit indicator. The Regional Quality Table has begun to partner with the sub-region planning team to support building quality improvement capacity among the sub-regions to address their identified “hot spot” priorities.

Mental Health & Addiction Services

With the establishment of the Minister’s Mental Health and Addictions Leadership Advisory Council in 2014, the LHINs collectively saw an opportunity to collaborate more closely on system level planning across Mental Health and Addictions (MHA), and established the Provincial MHA System Table.

Over the past year, the Toronto Central LHIN has been an active participant at this system table as well as engaged with the three Systems Table Work Groups which have been formed to move the LHINs forward collectively in three shared priority areas: Coordinated Access, Supportive Housing and Primary Care. Work plans have been developed for each of these priority areas and work has begun to align these work plans with others across Toronto Central including, but not exclusive to, the Primary Care and Integrated Community Care strategies.

As well, Toronto Central LHIN made targeted investments to support enhanced services for those who identify with Mental Health and Addictions needs for example:

- *Stella’s Place Peer Support Training 2.0* - Stella’s Place Peer Support Training (PST) Program was first launched in 2015 to address the need to develop and grow peer support services in the Toronto mental Health community. The curriculum was developed by young adults, experts and education and mental health partner organizations and was delivered to 27 participants. Additional Toronto Central LHIN funding in 2016 enabled the delivery of a revised curriculum following participant feedback , to an additional 21 participants who were prepared to use their skills and knowledge to provide peer support to thousands of young adults annually across a variety of settings.

- Mental Health and Addictions Continuum for Francophone Adults. This initiative, led by Centre Francophone de Toronto, was funded in Q4 and will carry on into 17/18. It's intent is to build the continuum of services for French speakers through two approaches; increased case management support; and the provision of specialized health promotion programming designed to reach out to newcomers and engage them in activities that are culturally appropriate and designed to decrease stigma and isolation, improve health and educate about mental health and addictions.

Long Term Care Capacity Planning

In December 2016, a report on the current state of long term care service in the City of Toronto was submitted to Toronto Central LHIN. The report provided a description of the profile of clients requiring long term care services, within the context of the profile of patients and clients in Complex Continuing Care Beds, Rehabilitation Beds, Assisted Living / Supportive Housing sites, Adult Day Programs, In-Home services, and Long Term Care Homes.

Preliminary findings on the current state analysis include the following:

- Caregiver distress, living arrangements, cognitive impairments seem to be driving the need for long-term care. The presence / absence of a caregiver is a key determinant of admission to a long-term care home.
- Data support the prevalence of Alzheimer's disease, other dementias and cognitive impairments, among residents of long-term care facilities.
- Long-term care homes are serving a more medically complex population.
- Long-term care residents have moderate to severe functional impairments.

Toronto Central LHIN will complete the current state analysis by August 2017; and deliver a set of recommendations by November 30, 2017 to address the future needs of long term care residents in Toronto Central LHIN.

Risk Assessment: Long Term Care Bed Renewal Strategy

The Ministry of Health and Long Term Care Bed Renewal Strategy was announced in 2007 with the goal to require all long term care (LTC) homes, which do not meet the Ministry's current design standards, to redevelop by 2025. In Toronto Central LHIN, 20 of the 36 long term care homes currently operating are identified as needing to be rebuilt. This represents 2,800 long term care beds or approximately 47% of the entire long term care home capacity (5,878 beds) in the LHIN.

In 2016/17, Toronto Central LHN connected with each of the 20 long term care home operators to understand their redevelopment plans. Based on the discussions with LTC home operators, three groups have emerged.

- *Committed to Stay in Toronto Central LHIN – 6 LTC Homes and 1,011 beds*
- *At Risk of Leaving Toronto Central LHIN – 6 LTC Homes and 519 beds*
- *Intending to Leave Toronto Central LHIN – 8 LTC Homes and 1,270 beds.*

Toronto Central LHIN staff are planning to meet with representatives of the Ministry of Health and Long-Term Care and the City of Toronto to share the results of the capacity planning effort to-date, and the risk of potential significant loss of long term care capacity. Staff will also discuss strategies to mitigate loss of bed capacity including the development of appropriate alternatives to, and innovative models of long term care services.

Voluntary Integrations

Integration is a fundamental part of our work at the Toronto Central Local Health Integration Network (LHIN) and since our creation in 2006 we have supported and encouraged integration activity with the goal to produce better outcomes for patients and clients. We believe that advancing the closer integration of health care services around patients and clients is key to achieving a healthier Toronto, as outlined in our 2015-18 Strategic Plan.

There have been 29 integrations since 2008 and in 2016/17 there were a total of eight integrations - seven voluntary integrations and one funding transfer, which nearly doubles the numbers of integrations completed in the previous year. 82.5% of performance targets have been met, or are trending towards being met within the post integration period. An annual report on integrations will be provided to the Board at the June 28, 2017 meeting providing an overview of integration activity to date.

2016/17 Voluntary Integrations Summary			
Health Service Providers	Integration Objectives	Integration Date	Timeline for Completion
Access Alliance and Neighbourhood Centre	Increase access to primary care for unserved and unattached community members: • 50 – 75 new primary care clients from Neighbourhood Centre membership. Increase access for seniors to health and chronic disease management: • 50 – 75 new senior clients. Increase number of youth in health promotion and healthy living programs. Increase system navigaton supports for vulnerable families and seniors.	January 1, 2017	January 1, 2018
Hospital for Sick Children and Hincks Dellcrest Centre	Improve access to specialized mental health services: • Decrease in length of stay, decrease in wait times. Improve quality of care and outcomes for children and youth: • Patient and caregiver satisfaction, improvements in symptoms and functioning, achievement of client goals. Improve efficiency: • Increase in number of children and youth served, decrease in length of stay in care, reduction of duplication of processes. Specific targets will be set and reported to the LHIN in the Year 1 progress report.	February 1, 2017	February 1, 2020
Anne Johnston	Increase access to primary health care, health promotion and	April 1, 2017	April 1, 2020

2016/17 Voluntary Integrations Summary			
Health Service Providers	Integration Objectives	Integration Date	Timeline for Completion
Health Station and Tobias House	prevention services. • 100 new primary care clients. • 750 additional service encounters • 50 new clients in health promotion and prevention. • 75 new primary care clients. • 50 new clients in health promotion and prevention Expand care coordination and navigation capacity – Follow the Client model: • 20 new coordinated care plans.		
Parkdale Community Health Centre and Queen West Central Toronto CHC	Access to services for complex and vulnerable clients will be maintained or improved: • 15% increase in client interactions • 10% increase in panel size to access team-based primary care • 10% increase in number of clients who are Indigenous, youth, newcomer, LGBT, low income or homeless • 15% reduction in avoidable hospital admissions from baseline data. Quality of services will be maintained or improved. – Combining strengths of both organizations and reduce variability where appropriate: • Enhance client and staff experience.	April 1, 2017	April 1, 2020
Reconnect Mental Health Services and St. Clair West Support Services	Increase the number of clients served in all community support and mental health and addiction services: • 5,332 total clients, a 6% increase. Establish comprehensive care plans for all clients receiving both community support and mental health services: • 100% of all clients requiring a comprehensive care plan receive one. Decrease avoidable hospital visits for clients: • Decrease avoidable visits by 65. Staff cross-training on community support services for seniors, and mental health and addictions services: • 100% of all staff requiring cross training.	April 1, 2017	April 1, 2020
416 Community Services and Loft	Increase Case Management client volumes: • 1,052 clients served a 5% increase.	April 1, 2017	April 1, 2020

2016/17 Voluntary Integrations Summary			
Health Service Providers	Integration Objectives	Integration Date	Timeline for Completion
Community Services	Establish coordinated care plans for clients receiving case management services from both organizations: • Increase the number of coordinated care plans by a further 5%. Establish service protocols for sharing best practices among staff: • Accreditation of all services continues.		
South Riverdale CHC and Harmony Hall Centre of Seniors Call-A-Service	Sustain current programs and services in the community: • Meet or exceed current performance targets contained in the accountability agreements. Increase the number of clients receiving both community health centre and community support services: • 10 coordinated care plans. Increase number of clients providing feedback on satisfaction surveys: • Increase response rate by 5% to 595. Expand standardized staff training and support to former staff of Call A Service: • All staff requiring training are trained.	April 1, 2017	April 1, 2020
Baycrest Centre for Geriatric Care and New Horizons Day Centre	New Horizons Day Centre ceased operating an Adult Day Program for seniors. Toronto Central LHIN funding for the service was transferred to Baycrest Centre for Geriatric Care who is now running the program. No disruption of service occurred.	April 1, 2017	April 1, 2017

Also in 2016/17, the Toronto Central LHIN Integration Knowledge Centre was launched on the website. The Centre provides access to all integration business cases and Toronto Central LHIN reports on each integration. The site also contains all the accumulated reference material and tool kits on integrations as helpful resources for any organization interested in learning about or pursuing integrations. The website will be updated regularly with new and additional information as it becomes available.

Strategic Updates: Taking a Population Health Approach

Our mandate is to deliver quality health care to all and this commitment is reinforced by Ontario's Excellent Care for All Act. The act states that we "[s]hare a vision for a Province where excellent health care services are available to all Ontarians, where professions work together, and where patients are confident that their health care system is providing them with excellent health care." Toronto Central LHIN aims to fulfill this vision by addressing the needs of everyone who lives in or receives care within our geographic boundaries.

Planning across the health care system has generally been focused on meeting the needs of those actively receiving health care. Evidence suggests that adopting a population health approach and proactively planning for the health needs of all people will benefit both patients and the system. In taking this approach we are reorienting the work of Toronto Central LHIN towards activities that aim to improve the health status of the population as a whole, as well as its many sub-populations.

This work requires us to divide populations into sub-groups (or sub-populations) and understand the unique needs and challenges faced by specific sub-groups. Some of this work has already begun. For example, in 2012 the LHIN established nine Health Links across the city that focus on meeting the unique needs of the most complex clients and patients in the communities they serve (the top 1% and 5% of users of the system). This work will continue and be further refined to ensure our efforts and investments are directly benefitting patients. Lessons learned will be applied to other sub-populations. It is this type of targeted care that is required in order to address the unique needs of specific groups of people. Health care is personal and requires tailored approaches to be most effective.

We believe that good health is more than the absence of disease. Reorienting the health care system to take into consideration the broader social determinants of health that go beyond clinical and curative services is a major shift that can only be achieved through long-term strategic partnerships. This includes non- traditional partnerships with organizations outside the health care system, such as shelters, police, and housing and employment centres, to work toward addressing the full range of factors that impact health.

Last year, we made many strides as we continued to take a population health approach to our planning. The following sections offer a snapshot into these accomplishments.

Launching our Palliative Care Network

In the Fall 2016, Toronto Central LHIN and Toronto Regional Cancer Program jointly developed the Toronto Central Palliative Care Network with the goal of bringing together health service providers and stakeholders to collectively work towards developing a comprehensive, integrated and coordinated system of palliative care. The Toronto Central Palliative Care Network is supporting both provincial priorities as directed by the Ontario Palliative Care Network (OPCN) and local Toronto Central LHIN priorities.

The Toronto Central Palliative Care Network is:

- A Regional Advisor on high quality palliative care, informing Toronto Central LHIN and Regional Vice President decision making
- Accountable for local quality improvement, data and performance measurement
- Drives quality improvement across all sectors based on best practices in accordance with the OPCN direction and the Declaration of Partnership.

Over the last year the Toronto Central Palliative Care Network made significant strides in setting the stage for local palliative care improvement. This included:

- Recruiting Dr. Kirsten Wentlandt and Ms. Susan Blacker, Palliative Care Clinical Co-Leads, and establishing our governance structure
- Holding a Regional Palliative Care Consultation with over 60 service providers, family members and caregivers to define needs and prioritize local improvement efforts
- Leading a LHIN-wide palliative care services capacity planning survey
- Conducting a Homeless Palliative Care Needs Assessment
- Developing a Homeless Palliative Model of Care and Indigenous Palliative Supports Proposal
- Completing a Palliative Education & Training Needs Assessment for Primary Care

Residential Hospice

In October 2016, the Ministry of Health and Long-Term Care confirmed their support of moving forward with 23 new hospice beds by 2018/19 in the Toronto Central LHIN. The Toronto Central LHIN issued an Expression of Interest process in the summer of 2016, in anticipation of this new funding opportunity, and was quickly able to identify opportunities to allocate the new 23 new residential hospice beds.

- 10 beds: new adult residential hospice targeting the homeless/vulnerably housed. Led by Hospice Toronto, in partnership with Inner City Health Associates, St. Elizabeth Healthcare & other community partners
- 9 beds: adult residential hospice expansion at Kensington Hospice (going from 10 existing beds to 19 in total)
- 4 beds: pediatric residential hospice expansion at Emily's House (going from 6 existing beds to 10 in total). All health service providers are currently working on planning and delivering the requisite renovations/capital development associated with bringing these new beds online by 2018/19.

Neighborhood Data Profiles

The Toronto Central LHIN launched detailed profiles for its five sub-regions (North Toronto, East Toronto, Mid-East Toronto, Mid-West Toronto and West Toronto) at the neighborhood level on its website in 2016/17. The detailed profiles described the population characteristics including information on demographics such as the number of children/youth, seniors, visible minorities, aboriginal, francophone population, number of immigrants and information on cultural and socioeconomic characteristics. Along with the health status of the population, profiles also included prevalence of disease conditions. The number of providers by sector (Community Support Services, Community Mental Health Association, Community Care Access Centres, Community Health Centre, Hospital, and Long Term Care) and primary care physicians for each of the sub-regions was included.

Population Health and Equity Strategy

In January, we launched a Population Health and Equity Leadership Table co-chaired by Dr. Barbara Yaffe, Acting Medical Officer of Health, Toronto Public Health, and Dr. Kwame McKenzie, Chief Executive Officer of the Wellesley Institute and Director of Health Equity at CAMH. This Leadership Table will guide and advise on the LHIN's Population Health and Equity Strategy and its progress. There are four core components to the Population Health and Equity Strategy:

- Needs-Based Health Assessment: Advancing our understanding of the health of the population residing within the LHIN;
- Health Equity: Reducing health inequities within the LHIN;
- Practice-Based Population Health: Strengthening providers ability to take a holistic view of the populations they serve; and
- Strengthening our partnership with Toronto Public Health: Planning together where we have shared priorities.

Separate working groups have been established to advance the four components and providing quarterly status updates to the Leadership Table. These work groups met, set priorities and developed work plans to be implemented in 2017-18.

Indigenous Populations

The Toronto Central LHIN has been working with the Toronto Indigenous Health Advisory Circle and Toronto Public Health to share the Toronto Indigenous Health Strategy and discuss how to implement an Indigenous health equity lens. Over 40 presentations were given to government representatives this past year to share the strategy including the Associate Deputy Minister of Health and Long-Term Care and the Minister of Indigenous Affairs and Reconciliation.

Three separate proposals were submitted to the MOHLTC to support the implementation of the recommendations, which included requests for funding Patient Navigators for the Palliative Care strategy, administrative supports for the Toronto Indigenous Health Advisory Circle priorities, and an Indigenous Cultural Safety self-assessment tool.

Partnerships and Engagement

- Members of Toronto Indigenous Health Advisory Circle (TIHAC) participate on both the health equity table and the population health and equity strategy leadership table lead by the Toronto Central LHIN.
- The Toronto Central LHIN is also worked with two hospitals to enhance their current programming for the Indigenous community.
- Through our partnership with an Indigenous Trans and Two Spirited committee and Anishnawbe Health Toronto a survey was conducted to review the healthcare needs of Trans and Two Spirited community and leadership and stakeholders of the Indigenous Trans and Two spirited community.

Cultural Competency Training

The Toronto Indigenous Health Strategy has identified Indigenous cultural competency and safety training as an important resource for the community as many Indigenous people experience racism in health care settings, especially in Emergency Departments where there are assumptions made regarding Indigenous people that affect the kind of care they receive. The Toronto Central LHIN committed $475,000 in funding over the last four years and to date over 3000 health service provider staff members have been trained. From additional advance funding provided by the MOHLTC, Toronto Central LHIN has trained over 600 Health Service Provider staff in 2016/17 including 7 Toronto Central LHIN Board Members and 22 staff. Going forward into 2017/18, our strategy has identified Emergency Departments LHIN wide as the initial sites for the cultural competency training.

National Inquiry into Missing and Murdered Indigenous Women and Girls

Toronto Central LHIN has since held two meetings involving different stakeholders including the Ministry of the Attorney General to discuss the supports required around the inquiry and what could be provided by the LHIN. It was deemed necessary that trauma-engaged, culturally safe supports were required and following that meeting a draft proposal has been submitted to the Ministry of Indigenous Relations and Reconcilliation and MOHLTC. Next steps in this process will include the formalization of a lead agency, the roles of each partner and a scan of the readiness of Toronto-based Indigenous and non-Indigenous mental health and social service organizations to address the Inquiry-needs of their clients.

Mental Health & Addictions strategy

Toronto Central LHIN developed a funding proposal to survey the unmet MHA needs of Toronto's Indigenous population, develop a service map of existing Indigenous MHA services in Toronto and secure funding for key MHA service positions at both hospital and community levels. The LHIN also engaged Well Living House to provide up to date MHA data from the recent Our Health Counts Toronto survey for the proposal.

French Language Services

Toronto Central LHIN and Reflet Salvéo, the assigned French Language Health Services Planning Entity advising the LHIN, started the process of evaluating health service providers identified and designated for the provision of French language health services in the LHIN. Toronto Central LHIN asked fourteen funded identified agencies to complete a readiness assessment for designation. The assessment is designed to help them measure their progress in developing French Language Services and help prioritize and develop a strategic plan to create a roadmap to achieve full or partial designation.

Learning opportunities were offered to Health Service Providers (HSPs) on cultural competency and active offer. During the fiscal year 2016/2017, we organized in total 22 face to face training sessions on cultural competency. There were 16 sessions for institutions and six sessions for Francophone patients. In total 349 participants were trained including 287 health professionals and 62 Francophone patients. An additional four training sessions have been already booked for the next fiscal year 2017/2018.

To strengthen and build organizational capacity to address the health care needs of the Francophone population, the Toronto Central LHIN funded a Leadership Training in Active Offer in 2016-17. Reflet Salvéo, in partnership with Collège Boréal, Health Nexus, Les Centres d'Accueil Héritage and Rifssso (Regroupement des intervenants en santé et en services sociaux de l'Ontario), developed a three-day workshop for two cohorts of HSPs. The tools and strategies provided offer provider's a roadmap to the implementation of a systemic approach to Active Offer of French language services.19 healthcare professionals attended.

Quote from One of the Participants:

"The Leadership Training was an amazing opportunity to understand the history and reasons why it is important to plan and implement the Active Offer. The resource guide is a very helpful step-by-step tool with practical suggestions on how to make this happen. This all helped increase our abilities and skills to prepare, plan and implement the delivery of the Active Offer." HSP senior manager

Toronto Central LHIN also supported Coordinating Tables of agencies serving Francophones with particular attention devoted to services adapted to linguistic and cultural needs for seniors, new immigrants, women victims of violence and mental health, HIV/AIDS, early detection of memory loss, attachment to Primary care and Palliative care for complex care Francophones. Upon the adoption of the Patients First Act, the LHIN started reviewing the impact of the Toronto Central CCAC transition to the LHIN on provision of French Language Services (FLS) to maintain the quality of home and community care services offered to Francophone patients in their language.

Health Links

With the alignment of the Health Links approach within the Primary Care Strategy, Primary Care Clinical Leads submitted work plans that outlined planned activities to be undertaken within each of the five sub-regions.

In February 2017, the Toronto Central LHIN created a working group to review the Health Links approach and made recommendations on organizing and improving care for patients with complex needs within the Toronto Central LHIN. To advance the goal of improving care for these patients, five key areas of focus have been identified to underpin the future state planning work:

- Patient Identification:
- Coordination of Care
- Performance Measurement
- Patient Centered Care
- Strategic Alignment

Central to this work is to achieve a consistent implementation across all five Toronto Central LHIN sub regions for patients with complex needs in order to achieve Functional Excellence (Level 3) within the MOHLTC Health Link Maturity Model Domains by 2017/18.

In addition to the MOHLTC maturity model domains, there is an emerging focus on strategic alignment and planning related to the electronic coordinated care tool within the context of the digital health strategy and function of the Health Link Councils in the context of being a sub-set of Local Collaboratives.

With respect to Health Links, the 2017/18 activities correspond to the spread of patient identification approaches within hospital, primary care and community settings; improving transitions and attachment to primary care in addition to the utilization of promising practices to enhance coordinated care management for patients with complex needs.

Strategic Updates: Transform Primary Health and Community Care

For most patients, community-based care is the best option and is often less costly than institution-based care. Demand for community-based care is on the rise and, even with increased government spending in this sector, further investments in infrastructure will be required so the community can shoulder its increasing share of responsibilities.

A patient's long-term relationship with their primary health care team is the cornerstone of care. This relationship has the potential to anchor efforts to drive integration and coordination of the patient journey. In order for primary health care to make a meaningful contribution to system integration, the LHIN will need to find ways to engage primary health care providers in a shared accountability for patient outcomes.

Transforming primary health and community care means creating conditions that empower patients to get the care they need with ease. The LHIN will invest in strategies that make "every door the right door", simplifying access and driving integration.

We will focus on building common infrastructure, common spaces, shared services for IT and decision support in order to bring providers together.

Toronto Central LHIN is leveraging new investments from the provincial government to establish innovative models of care that are both patient-centered and cost-effective.

This is an ambitious yet pragmatic plan. The following sections show how we are beginning to make a difference in the last fiscal year.

Primary Care

Toronto Central LHIN established the core networks and mechanisms to support ongoing engagement with the approximately 1,400 physicians providing services in multiple primary care models within the LHIN. The LHIN partnered with physicians on solutions identified by the sector as key priorities for primary care, including: Attachment, Access and Continuity of Service, Access to Inter-professional teams, Discharge Planning, Access to Specialists and Secure Communications.

Within each sub-region, a physician champion has been identified to act as the LHIN's Primary Care Clinical Lead and chair a local Primary and Community Care Committee. Each local committee consists of physicians who practice in one of the multiple primary care models and serve the diverse populations within in each sub-region. To ensure alignment and integration with existing LHIN managed sectors, the committee includes representatives of the Mental Health, CCAC, and Community Support Sectors and is supported by a designated local hospital. The hospital provides assistance with human resources, work space and information technology support locally and across all sub regions in partnership with other "Hospital Resource Partners". This cross-sectorial partnership is designed to leverage existing strengths and resources to support engagement and innovative solutions that consider the local primary care landscape. This partnership model has also placed Toronto Central LHIN at an advantage to realize the Patient First mandate as related to Primary Care.

With strong local leadership and insights into care at the local level, in Q4 of fiscal 2016-17 the following programs were recommended and implementation has begun with the following key initiatives targeted to support primary care across the Toronto Central LHIN, including;

- Two new inter-professional teams to be placed in the West and East sub regions respectively. In the West a team serve the Mount Dennis neighbourhood and in the East, a team will serve the Oakridge neighbourhood, specifically a block containing four Toronto Public Housing Apartment Complexes each of which is targeted to serving higher needs populations. These inter-professional resources are being provided to primary care practices that serve high needs populations but currently do not have access to these resources
- Two new mental support workers are being provided in the West and East Toronto sub-regions to provide supports to existing primary care practices who do not have access to inter-professional resources. Thereby both enhancing existing patient care and providing greater capacity to these practices as clinicians will have time available to see more patients that require there service and expand capacity to accept new patients
- Grow the existing *Solo Physicians In Need* program which links Community Health Centre inter-professional services (dieticians, chiropodists, nurses, etc.) to solo practicing physicians across all sub-regions. Marking an expansion in the program from eight CHCs to all 17 CHCs in the Toronto Central LHIN
- Expand *Telemedicine Impact Plus*, a program that delivers inter-professional, patient-present, case consultation for community family physicians via secure telemedicine technology by adding a nursing resource
- Rollout the *Seamless Care Optimizing the Patient Experience* program currently delivered in one sub region to all five sub-regions in order to connect community based registered family physicians and nurse practitioners to local specialists, imaging, and community services to more effectively serve patients with complex care needs
- Add two additional *Care Connectors* bringing the total to five, and aligning the program to the sub-regions in order to increase the connection of residents to family practices. As part of this process it is expected that the current Health Care Connect program will be reviewed and updated to expand the number of residents served

Primary Care Digital Health projects

In support of the Primary Care Strategy's five identified priority areas of focus, a number of digital health projects were developed as enablers to advancing the strategy. Delivery partners were identified and funding was approved for three of these projects which were initiated to support: Access to Specialist Consults, Timely Discharge Summaries, and Secure Communications.

Bundled offering for secure communications:

The LHIN engaged University Health Network as our delivery partner to work with provincial partners to develop a streamlined and efficient process to onboard primary care providers to a bundle of solutions (ONE ID, ONE Mail, ConnectingOntario, eConsult). The aim is to ensure providers have one point of contact and support throughout the process and can quickly adopt and use these technologies, enabling them access to more comprehensive

patient information (ConnectingOntario), specialist support (eConsult) and secure communications with other providers (ONE Mail). The aim is to have at least 200 primary care providers to have adopted the bundle of technologies by the end of March 2018.

Development and dissemination of a specialists and services directory:

Currently primary care physicians don't have a central source of up-to-date information on specialists and other services (e.g. community and mental health services). This significantly impacts their ability to gain access to specialists and other services for their patients when and where they need it. The project aims to create a web based Specialist and Services Directory with advanced search functions that provides providers with comprehensive and up-to-date information on specialist and other health services available within the Toronto Central LHIN region by the end of March 2018.

Framework for secure provider and patient communications:

Improved secure communications of personal health information between health care providers and patients is a critical element of the Toronto Central LHIN primary care strategy as it improves patient access to primary care. The project aims to assess existing gaps in communication, understand currently available solutions in the market, explore policy and privacy frameworks and evaluate potential return on investment of secure patient and provider communications.

E-notifications

St. Michael's Hospital and St. Joseph's Health Centre have now successfully implemented eNotifications and University Health Network and Bridgepoint successfully completed their implementations of Hospital Report Manager. These hospitals can now send near real-time electronic notifications through Hospital Report Manager to primary care providers to inform them when their patients are admitted or discharged from the hospital emergency departments or in-patient units. These notifications enhance communication and care coordination between hospitals and primary care, enabling faster and safer follow-up care. A total of 3 hospitals in Toronto Central LHIN are now sending notifications to over 700 clinicians in our region who have implemented Hospital Report Manager.

The LHIN continues to work with OntarioMD to engage our hospital sites to support full adoption of both systems. HRM implementations are currently underway at 5 additional hospitals which are projected to be live within the first two quarters of FY 17/18.

HSP Supplemental Information Initiative

The HSP Supplemental Information Initiative was launched in order to compile comprehensive data about services provided at the community level across our LHIN. This information will be leveraged to inform future planning opportunities, integration efforts and empower providers with data to collaboratively address challenges and opportunities in community care. Data related to, service location, access, geography served, priority populations, priority conditions and quality improvement have been collected through this initiative.

An input form with some existing data pre-populated was sent to all HSPs in February 2017. The response rate from HSPs for the main submission was approximately 99% and around 97% of submissions have passed two rounds of data quality checks. As well, HSPs were requested for data around quality improvement and 95% of HSPs' submissions are ready for analysis. The Health Analytics and Innovation team is currently processing the data and will make it available to all providers on the LHIN website as part of the 'open data' initiative.

Integrated Community Care

This strategy drives the design and implementation of a citizen-centric, coordinated system of care that will simplify access and navigation for those in need of community-based services, their caregivers, as well as other providers.

This is a first-of-its-kind, co-creation project that brings together all types of service providers to co-design home and community-based services. At every step of the process members from primary care providers, mental health, addictions, community support, and home care services have worked in collaboration and partnership with citizens and families to reimagine an improved user experience and a more efficient system of care delivery.

A key element of the co-design approach for this project is the ONE COMMUNITY Summit that took place in December 2016.

At the summit, over 200 clients and family members, care providers, community partners, and health leaders explored ideas to enhance our system of care. Summit participants also defined core areas of focus, including improvements to person experience and ways to increase system efficiency. These areas of focus are now being designed and implemented by the Toronto Central LHIN through our sub-region planning approach. Providers within the sub-regions will promote effective information sharing, leverage agency perspectives, and better integrate local services to meet the needs of those in need of community-based services.

Building on the work accomplished over the last year, The ONE COMMUNITY project is now moving towards implementation to achieve the vision of 'integrated community care'. Each area of focus highlighted will have action teams comprised of members from across home and community care, and citizen and family groups. The action teams will bring their objectives to life by working with community partners for on the ground implementation – building an integrated community care system that is easier to navigate, access, and use for citizens and providers alike.

Toronto Seniors Helpline

Toronto Central LHIN continues to support and invest in initiatives that better support seniors and other Ontarians who come into Toronto Central for care. One such example is the Toronto Seniors Helpline (TSH).

TSH is a phone line that streamlines access to community, homecare and crisis services for seniors, their caregivers and their health care providers through one single number.

Delivered in collaboration with Toronto Central CCAC and Wood Green Community Services, TSH is available to all seniors, their caregivers and health care providers 365 days a year to improve health care for seniors and their families across the Toronto Central region.

Staffed by certified professionals TSH offers free assistance navigating the health care system, provides warm transfers to partners and standardizing assessments. It also provides short-term crisis support as well as providing support in overcoming other social determinants of poor health such as social exclusion/loneliness, housing, income supports, food security, access to appropriate health care, and social safety networks/circles of care.

To achieve this strategic plan, Toronto Central LHIN will need to strengthen its own capacity. Over the last nine years, the LHIN model has matured, evolving over time from simply carrying out the management of contracts for the provision of health care services to an organization that is leading data driven planning for the populations we serve.

Toronto Central LHIN has a proven track record of leveraging emerging technology and building analytic capacity to carry out effective planning. We believe there are further opportunities to strengthen our role and effectiveness in the system. There are a number of specific areas that we intend to focus on over the next four years to improve our overall performance. To effectively manage the health care system we will need to invest in the following areas:

- Enhanced data and analytics: In the current fiscal environment, making informed decisions about investments is more important than ever. We know that ready-access to comprehensive data is essential to effectively manage the health care system, but this is one area where the system has fallen behind. To improve access to information and facilitate integration, Toronto Central LHIN will support the identification of IT solutions that can be leveraged across the system.
- Evaluation methodologies: We need to properly assess our work, so we can maximize our investments and make informed decisions.
- Community engagement activities with priority and at-risk populations: We need to understand individual needs and challenges so we can tailor solutions and facilitate access to appropriate care.
- Policy and strategy frameworks: These will be developed to create consistency and clarity of purpose to guide decision making for managing growth, implementing funding reform, brokering service changes and driving strategic integration.
- Cross-sectoral partnerships: Adopting a population health approach requires us to work with a number of health and non-health partners so we can maximize our effectiveness and reach.

From the perspective of the transition, Toronto Central LHIN's foremost priorities as the LHIN and CCAC become one organization on June 7th 2017, is to ensure that patient care remains intact, business continuity is maintained and staff feel well supported.

Emergency Management Communications Tool

The Emergency Management Communications Tool (EMCT) enables health service providers to better coordinate and manage planned or unplanned emergency situations by providing them with communications and key information regarding the health system. Implemented in seven LHINs in preparation for the 2015 Pan Am and Parapan Am Games, the system was further expanded to the remaining seven LHINs over the last year providing a unified platform for health service providers across Ontario. IT facilitates better management of emergency preparedness and enables the Ministry of Health and Long-Term Care to better coordinate incidents provincially.

Toronto Central LHIN Transition

On December 7th, the Patients First Act, 2016 was passed, which marked a critical milestone in our path toward patient centred health care. The Act expands the mandate of LHINs in home care, primary care, and public health, and strengthens LHIN responsibilities in planning, health equity and engagement with patients, families and Indigenous and French-language health care partners.

Toronto Central LHIN and Toronto Central CCAC Joint Planning

In preparation for the passage of Bill 210, and later Bill 41, a collaboration framework was developed to prepare the Toronto Central LHIN and Toronto Central CCAC for transition and is led by Transition Co-Leads from both organizations. Nine workstreams were created to provide ownership over deliverables and work in preparing the organizations for transition; each workstream is co-led by a member of the Toronto Central LHIN and Toronto Central CCAC leadership teams.

Transition Planning and Readiness

The Toronto Central LHIN and Toronto Central CCAC have worked diligently internally and provincially to prepare both organizations for the transition to a new organization including a comprehensive due diligence process across both organizations with risk mitigation. On January 16 and 17, Toronto Central LHIN underwent a Readiness Assessment facilitated by a third-party consultant, which confirmed to the Ministry at the end of March 2017 that Toronto Central LHIN was on-track with its preparations for transition. The Toronto Central LHIN Board of Directors approved a resolution at their March 28, 2017 board meeting, attesting to the readiness of the LHIN and CCAC to transition.

LHINC and LSSO Transition

On March 1, 2017 LHIN Collaborative and LHIN Shared Services Ontario transferred from Toronto Central LHIN and successfully merged with the Ontario Association of Community Care Access Centres (OACCAC) to create a new crown agency - Health Shared Services Ontario (HSSOntario). HSSOntario is an agency of the Government of Ontario that provides shared services to support Ontario's 14 LHINs in meeting the health care needs of their local communities and has an integral role in enabling the transition of all LHINs and CCACs.

Staff Engagement and Change Readiness

Supporting staff through transition has been a priority for both organizations. In fall 2016, the Toronto Central CCAC and LHIN locally performed change readiness and resiliency training with their respective staff. Building upon this initial work, a joint change readiness plan was developed and a third-party consultant group ran focus groups with over 200 staff were engaged from the LHIN and CCAC

Integrated Leadership Team

In December 2016, the Toronto Central LHIN submitted its integrated leadership structure for approval to the Ministry. Upon receiving Ministry approval in January, the LHIN commenced recruitment for the newly created Vice President positions. Recruitment was conducted through a combination of direct offers and internal competition. A new integrated leadership team was introduced to the organization on March 28, 2017.

Improving Digital Communications

Throughout 2016/17, the Toronto Central LHIN enhanced our digital presence by better utilizing our corporate website as a digital communications vehicle, building our social media channels by engaging on twitter and communicating directly with our health service providers through a bi-monthly e-newsletter.

Toronto Central LHIN Corporate Website Improvements:

- Introduced rotator content on the Toronto Central LHINs corporate website homepage with five local stories being displayed at any one time
- Provided a detailed plan for the corporate website revamp with updated content, navigation bar, additional pages, and content that is public friendly
- Introduced more multimedia elements to website to break up content, prevent pages from being too text heavy and be more user friendly
- Consulted with internal subject matter expects and organized external website focus groups to consult on website improvements and enhancements
- There has been an overall 56.25% increase in website traffic from 2015/16 fiscal year to 2016/17 fiscal year.

Website Redevelopment:

- Website re-development is underway as of March 2017. Many new elements have been introduced including a navigation bar, landing pages and revamped sub-region site, integration knowledge center and complaints process page.
- The website redevelopment is enabling our corporate website to become more user - friendly and has improved navigation through the introduction of a secondary navigation bar, which acts as a legend for content making it easier to see where everything is located on the website.
- The improvement to the website also gives teams and projects the opportunity to have a location to display their work, provide updates on this work to the community and also become accountable to report back on progress to the public. A few examples of this include the Integrated Community Care pages, the updated Citizen's Panel bios (putting a name to a face of our Citizen's Panel) and the Integration Knowledge station.

Twitter @TC_LHIN:

- From Nov 2016 until March 2017 Twitter has seen a large increase in followers and engagements with over 200 new followers.
- This period has also seen increase utilization of this channel moving from 1 tweet a month before Nov 2017 to at least one tweet a day.
- Increasing our followers by 55% since November 2016.
- From February 2017, live tweets were introduced at all of our open board meetings. This is helpful for stakeholders who are not able to attend to follow along and understand what is being discussed and agreed within these meetings.

Twitter by the Numbers:

	Profile Visits	Tweets	Tweet Impressions	Mentions	Retweets	New Followers	Number of followers (as of month end)
November 2016	610	18	10.8K	15	42	46	2762
December 2016	687	17	10.2K	41	30	33	2795
Jan 2017	788	16	10.7K	18	28	47	2842
February 2017	775	18	9,840	14	14	37	2879
March 2017	702	17	11.3K	11	26	36	2915
April 2017	583	11	10.5K	20	24	35	2957
	4,145	97	63.5K	119	164	234	195+

Financial Excellence

In fiscal year 2016/217 Finance successfully delivered against all strategic and operational performance measures including the delivery of a balanced budget of Toronto Central LHIN operations, clean audit for the organization, fully implemented Auditor General's recommendations in investments, exceeded target by delivering 96% of funding letters within 10 working days and completed all Ministry reporting requirements including Program Review Renewal and provides a more transparent and standardized process through the ability to rank business cases and prioritize funding requests against criteria aligned to the PAN-LHIN Decision Making Framework for funding decision making. This FMS also increases visibility to health service providers as they are able to view and track their funding and Transformation Report for staffing and operating budget planning.

Funding Management System

Following the Auditor General's recommendations Toronto Central is the leading LHIN to design and implement a Funding Management System (FMS). The FMS centralizes streamlines the complete funding management process from initiating funding requests to final reporting to Finance and Audit Committee. The FMS increases quality control and

performance information through real-time reporting ensuring accountability of the use of funds.

Transition

Finance delivered actions required as part of the LHIN-Collaborative and LHIN Shared Services de-coupling from Toronto Central LHIN and transfer to Health Shared Services Ontario (HSSO) which included:

- Seamless transfer of assets including inventory and cash at transition date

- Co-design and setting up of new chart of accounts for financial statements and next year's budget for HSSO
- Issuing notification to existing vendors, ensuring all LSSO and LHINC contracts were in place, payment of all invoices and transfer all accruals
- Support audit & LSSO/LHINC assets and liabilities transfer approval from the Board & Finance and Audit Committee budgeting, insurance, banking, audit and investment plans into the next fiscal year to provide a seamless transition.
- Finance supported teams across Toronto Central LHIN in a number of different ways:
- Conducted analysis to benchmark all 170 HSPs cost per volume for functional centre and inter-HSP to inform planning/performance management
- Created a dashboard of all 170 HSP's clinical and financial performance, ranking their performance based on historical and current data to inform Hospital Service Accountability Agreement (HSAA) and Multi-Sector Service Accountability Agreement (MSAA) development
- Automation and streamlining of the HSP performance management follow-up process and managed 170 providers financial and clinical reporting
- Provided staff onboarding/ off-boarding, space allocation, organization's administrative readiness services and flood impact minimization on staff
- Transfer copies of seven years' invoices/ documents to HSSO

Alongside the transition of LHINC and LSSO, Finance has been engaged in delivering the transition for Toronto Central LHIN and Toronto Central Community Care Access Centre (CCAC) leveraging financial expertise to execute deliverables including but not limited to new policies, financial system, payroll, internal controls.

Community Engagement

In 2016/2017, the Toronto Central LHIN refined its Community Engagement strategy to develop a renewed Community Engagement strategy for 2017/18. The strategy continues to focus on strengthening how the Toronto Central LHIN meaningfully engages with patients and citizens to integrate the citizen voice in everything we do. Over the year, 13 formal community engagements took place – exceeded our annual target of 12.

The Toronto Central LHIN's renewed strategic plan prioritizes designing healthcare with patients. The Toronto Central LHIN is mindful that we enable purposeful engagement and that we are establishing our sub-regions in a way that moves us towards collaboration and local co-design. The 2017/2018 strategy consists of three areas of focus:

1) *The Toronto Central LHIN Citizens' Panel* will be strengthened as the panel will be engaged more actively to participate in co-design, Toronto Central LHIN working groups, and leadership tables. The panel will also be offered opportunities to augment their skills and knowledge as the Toronto Central LHIN commits to strengthening the capacity of the panel
2) *Local Geographic-Level Engagement* will involve members of our citizens' panel with the Toronto Central LHIN's sub-region development. The Toronto Central LHIN will drive engagement activities through the sub-region Local Collaboratives of providers
3) *Population-Based Targeted Community Engagement* enables planners to reach further into communities to engage populations who face specific barriers affecting their access to health care services.

As sub-regions identify priorities, they will require community engagement to refine and validate both the needs of the community and proposed interventions. The goal of our targeted engagements will be to:

a) Connect with established networks of marginalized groups and populations
b) Develop niche understanding of unique health concerns affecting particular groups.

Local Collaboratives

In May and June of 2016, we held an inaugural "cross-sector" meeting within each sub-region planning area. The purpose of these meetings was to bring all types of providers together, with our common element being the communities and people that we serve. This group of local providers within a sub-region planning area is our 'Local Collaborative'.

In the Spring 2016, all of our Health Service Provider (HSP) partners formed Local Collaboratives aligned with each of our 5 sub-regions. In most cases, these meetings were attended by administrative leaders.
The Local Collaboratives met again in Fall 2016 and Winter 2017 with over 200 providers in attendance in total. The purpose of these meetings was to provide a forum where service providers could network and learn about one another while spending focused time learning about the health status of the respective sub-region and our sub-region approach, as well as our population health strategy.

Two critical exercises were completed by the Local Collaboratives:

1. A *Collaboration Agreement* was developed by all participants that outlines a shared vision, mission, and key success factors for working well together.
2. *Initial opportunity areas for quality improvement* ("hot spots") were selected through a process that looked at the health of the neighbourhoods within each sub-region. As a start, each sub-region has identified one *initial* neighbourhood of focus for improvement in 2017/18. It is important to note that these are just starting points, and what we learn through these early efforts can be applied to the other opportunity areas that were identified.

Initial starting points for local quality improvement are:

- West Toronto – Chronic disease in Rockcliffe-Smythe
- Mid-West Toronto – Low urgency ED use and primary care attachment in Kensington Chinatown
- North Toronto – Seniors living alone and lone parent families in Mount Pleasant West
- Mid-East Toronto – Mental health and addictions in Moss Park
- East Toronto – Mental health and addictions in Oakridge

Francophone Community

Francophone communities were consulted on the LHIN Population Health Strategy and on Patients First Act (4 groups totaling 38 participants). Designated health service providers (HSPs) fully participated on the collaborative work within the LHIN implementation of the sub-regions. One Francophone participated on the Citizen's Panel advisory group.

In 2016-17 there were 4 meetings of the Liaison Committee held. The Joint Annual Action Committee that was agreed upon had three objectives.

This year, the LHINs and the French Language Health Planning Entity – Reflet Salvéo have agreed on four objectives:

1. Active Offer

Initiate or support actions that lead to a balance between Active Offer and Active Demand. Active offer is essential to French Language Services (FLS) successful implementation within the healthcare system in order to reduce barriers encountered by Francophone patients when accessing different services.

Toronto Central LHIN expanded training on Active offer to identified HSPs and sensitized them on including acquired knowledge in their drive for FLS quality improvement. 23 managers and staffs participated.

2. Mental Health

Mental health and addiction issues can stem from immigration status and process, different ethno-cultural taboos, feelings of isolation or the lack of knowledge regarding services available in French. It is vital to take appropriate measure to ensure newcomers have access to appropriate mental health resources and services.

Toronto Central LHIN will support streamline health services providers' partnership to update the availability of French language services in the various promotional and online databases. The LHIN will evaluate the feasibility of expanding exploratory work in order to:

- Develop mechanisms through which best practices on mental health and addictions services to newcomers can be identified, shared and implemented;
- Identify gaps in mental health and addiction services and programs for new immigrants.

3. Equity

Equity is at the core of all what Toronto Central LHIN does:

- Support HSPs in creating safe and positive spaces for LGBTQIA clients;
- Consider supporting projects recommended by francophone senior community organizations/coalitions to further explore and close gaps in services;
- Support the current inter-LHIN GTA initiative that aims to put in place a care model for early detection of Francophone seniors' cognitive impairments.

4. Integration of Francophone Lens

Crucial to integrate the francophone lens from the start and at every step of the way as changes are introduced in the healthcare system, Such FLS consideration should happen at Health Links, Sub-LHIN Regions and community Hubs.

Indigenous Community

The Toronto Indigenous Health Advisory Circle (TIHAC) launched the first ever Toronto Indigenous Health Strategy to the Indigenous community and partners in May 2016. The principle of self-determination informed every step in the creation of the strategy which was conceived by the Toronto Indigenous Health Advisory Circle (TIHAC). In this first Indigenous Health Strategy for Toronto, the TIHAC recommended a number of strategic activities that will impact what and how health programs and services are provided in addition to addressing health influencers such as the education, housing, food and justice systems. In May 2016, the Board of Directors received this strategy and endorsed the development of an action plan to respond to the recommendations.

With a diverse Indigenous population in Ontario, targeted engagement of the Indigenous community is crucial for understanding and responding to the needs of this group. The Toronto Indigenous Health Advisory Circle continues to meet monthly to provide advice and direction to the Toronto Central LHIN and Toronto Public Health on Indigenous health issues. Recent discussions have been had on how to increase awareness of the Toronto Indigenous Health Strategy on a National level.

Multiple engagement sessions with the Indigenous Trans and Two-Spirited community led to the development of an Indigenous-led community engagement process as well as community surveys for agencies who offer services for trans and two-spirited individuals and their clients. The anonymous surveys provided feedback on supports the community felt they needed and results were shared at a community engagement event that saw over 50 people in attendance.

The Toronto Central LHIN continues to work with our partners to develop and implement initiatives targeted at improving the 14 Ministry-LHIN Accountability Agreement (MLAA) performance measures. Over the past fiscal year, the LHIN has undertaken comprehensive root cause analyses on selected performance indicators including demand, supply and capacity which has led to new strategies and prioritization of action items.

The Toronto Central LHIN has been working with other LHIN's to identify promising practices across the province for all performance indicators including a collaboration with Champlain LHIN to better understand the Mental Health and Addictions readmission data. The LHIN is also working with the Ministry of Health and Long-Term Care to assess capacity related to MRI/CT wait times in order to develop targeted solutions to improve access for residents.

The Toronto Central LHIN is developing supplementary indicators to the MLAA Indicator Report submitted to the Board of Directors on a quarterly basis, to fully understand the complexity of performance in some of the clinical areas and provide a clearer picture of what is driving performance from a broader perspective. The supplementary indicator on HIG Readmissions has been shared with the ministry for further discussion.

With system focus and Toronto Central LHIN investments, the following MLAA indicators are projected to meet target when Q4 data is available:

- Community Personal Support Worker visits within 5 days (CCAC)
- Community Nursing visits within 5 days (CCAC)
- Hip replacement surgery Wait Time
- Knee replacement surgery Wait Time
- ALC rate in all hospitals
- Percentage of ALC days in acute hospitals (adjusted performance for the targeted uninsured patients that were transitioned to community settings)

Toronto Central LHIN should be within the 10% performance corridor for Readmissions within 30 days for selected clinical conditions

MLAA – Addiction Services

One of the MLAA areas of focus is addiction services in the hospital Emergency Departments. Toronto Central LHIN has targeted these services with recent investments that were initiated in Q4 and will continue into 2017/18.

Mentoring, Education and Clinical Tools for Addiction: Primary Care Hospital Integration (META PHI)

META PHI is a model for addiction care designed to increase access and improve quality of care for people with addictions. META: PHI Toronto aims to (a) develop rapid access addiction medicine (RAAM) clinics at five new sites across Toronto where patients can access medication-assisted treatment five days a week (b) establish an integrated addiction care pathway within Toronto between emergency departments, hospital units, RAAM clinics, primary care and community service providers; and (c) provide addiction medicine training and support to care providers in these settings.

With the new provincial MLAA targets, Toronto Central LHIN's 2015/16 performance is below target on many indicators; however, the performance results demonstrate fairly stable system performance when compared to 2014/15 performance, despite increased volume pressures. In many indicators, our performance is closely aligned to provincial performance.

Emergency Room Wait Times

Emergency Room Wait Times is a continuous focus of the Toronto Central LHIN and the LHIN continues to work closely with its Emergency Department Network to:

- Engage with all hospitals for Emergency Department related activities
- Focus on implementing the Pay for Results funding allocation among the eight (8) hospitals Emergency Department
- Collaborate with Toronto Paramedics Services to re-scope Patient Distribution System (PDS) among hospitals Emergency Department to ensure appropriate distribution of patients.

Wait Times for Surgical and Diagnostic Imaging procedures

As one of the priority MLAA indicators Wait Times for Hip & Knee Total Joint Replacements were a focus for Toronto Central LHIN particularly wait Time 1 tracking, to improve accuracy and the booking and queuing processes to better manage the Wait Time 2 results. Guided through the Toronto Central LHIN Orthoapaedic Planning Committee, a practice review was conducted to reduce variation in surgeon triage coding and developed guidelines to increase accuracy and consistency. By Q4 of 2016/17, Toronto Central LHIN had reached access targets for both Total Joint Replacements surgeries, an improvement of 15% since the beginning of the year.

For Diagnostic Imaging there was strong engagement with providers to develop a prioritized action plan. Agreed priorities included an MRI Priority Four strategy to manage the P4 referrals that were coming from the community. A central intake and appropriateness screen are being proposed as measures to balance capacity and demand pressures.

Health System Funding Reform

Toronto Central LHIN continued to foster maximum impact of Health System Funding Reform (HSFR) with our providers through the engagement of the Toronto Central LHIN Local Partnership – a committee that oversees the implementation of HSFR in our LHIN, promotes consistent knowledge translation & monitors unintended consequences.

Toronto Central LHIN promoted the ongoing evolution of HSFR to include an Integrated Funding Model and supported the implementation of one of six pilot projects testing Incremental Funding Methodology (IFM) methodology on clinical populations. Specifically working with providers on IFMs for Stroke and Congestive Heart Failure (CHF) & Chronic Obstructive Pulmonary Disease (COPD) populations. This project is over 50% complete and will inform local and provincial strategy in upcoming years.

Where available, the Toronto Central LHIN established performance monitoring committees to oversee clinical quality including Quality Based Procedures (QBP) indicators (i.e. the Orthopaedic Quality Scorecard). The system oversight of quality indicators related to QBP implementation have guided focused program reviews – for example looking at revision and readmission rates for total hip and knee replacement surgeries.

Performance Indicators:

Indicator	Provincial target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result
1. Performance Indicators									
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%	85.28%	82.10%	85.58%	85.47%	85.21%	96.44%	93.58%
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.66%	93.83%	94.53%	93.64%	93.68%	96.27%	96.2%
90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)**	21 days	29.00	30.00	29.00	31.00	25.00	26.00	24.00	25.00
90th percentile emergency department (ED) length of stay for complex patients**	8 hours	10.13	9.97	11.03	10.38	12.17	12.18	13.35	12.85
90th percentile emergency department (ED) length of stay for minor/uncomplicated patients**	4 hours	4.03	4.07	4.23	4.15	4.47	4.50	4.67	4.58

Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.41%	41%	40.17%	42.31%	32.53%	32%	31.29%
Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.60%	78%	75.89%	63.56%	63.89%	67%	64.46%
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%	85.53%-	80.19%	93.65%	90.28%
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%	85.61%	84.05%	92.45%	90.89%
Percentage of Alternate Level of Care (ALC) Days	9.46%	14.35%	14.16%	15.85%	15.16%	9.79%	10.01%	12.21%	12.24%
ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	10.33%	11.97%	11.53%	12.58%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	16.30%	19.62%	20.28%	20.39%	19.81%	26.59%	28.82%	27.78%	27.11%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	22.40%	31.34%	33.42%	31.15%	31.40%	40.84%	43.87%	42.43%	40.77%
Readmission within 30 days for selected HIG conditions***	15.50%	16.60%	16.51%	16.66%	16.51%	17.89%	18.40%	17.10%	17.53%

*The CCAC wait Times for PSW and Nursing Visits are adjusted for patient clinical readiness and availability date.

** 90th percentile emergency department (ED) length of stay for admitted patients and 90th percentile emergency department (ED) length of stay for admitted patients indicators in 2014/15 have been replaced by 90th percentile emergency department (ED) length of stay for complex patients and 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients in 2015/16; hence no data is available for these two indicators in 2015/16

***HIG Readmissions indicator is adjusted for children's hospitals

Home and Community Indicators

Wait times for patients to receive in-home services remained consistent from prior years, including for nursing and personal support services. For all three indicators we are meeting or exceeding provincial performance. Two of these indicators (nursing and personal support worker service) is a focused area of performance for the next fiscal year.

System Integration & Access

- Emergency Department performance remains constant despite increasing volumes.
- Access to Medical Imaging (MRI/CT) is a challenging target for the province and the Toronto Central LHIN. Our performance on this indicator mirrors trends at the provincial level and reflects the increasing demand for medical imaging to guide treatment plans, especially in hospitals that manage

complex diseases such as advanced cardiac disease and cancer.

- Access to Orthopaedic Surgery (Hip and Knee Replacement) is generally good in Toronto Central LHIN, which is similar to provincial performance and approaching the provincial target.
- Alternate Level of Care (ALC) performance continued to be a priority in Toronto Central LHIN and our LHIN is one of the best performing LHINs on this indicator. Maintaining stable performance requires continued efforts by partners across the continuum. Toronto Central LHIN has engaged acute and post-acute hospitals to identify new opportunities for improvement and further implementation of consistent practices to keep ahead of the mounting pressures to ensure patients are in the right place of care.

Health & Wellness of Ontarians – Mental Health

Repeat unscheduled emergency visits for mental health and substance abuse conditions indicators both have declined in performance with a difference within the range of 2-5% since last fiscal's performance.
These measures continue to be a challenge for Toronto Central LHIN and warrant focused attention. Subsequent analysis of the data showed that, among other findings, we have experienced a 20% increase of mental health visits since 2009/2010. The approach for us in the upcoming year will be to identify discrete opportunities to improve on these measures. This will require an evidence- based approach including how to get greater data accuracy, adjusting for patient complexity.

Sustainability & Quality

Readmission rates for patients with select chronic conditions remain relatively unchanged, and a focus on existing best practices and performance evidence through Quality Based Procedures are intended to driving decreasing readmissions in 2016/17.

Monitoring Indicators

Monitoring Indicators are indicators that LHINs are expected to monitor to ensure performance remains stable and it is important to note that many of these indicators do not have provincial targets at this point. Toronto Central LHIN is within 10% of the provincial target for Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery and cataract surgery and continues to work with its stakeholders to meet the provincial target of 90% for these two monitoring indicators in 2017/18.

For those indicators that do not have an associated provincial target, Toronto Central LHIN's result is better than the provincial results for the three indicators:

- Rate of emergency visits for conditions best managed elsewhere per 1,000 population
- Hospitalization rate for ambulatory care sensitive conditions per 100,000 population
- Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge

The monitoring indicators for CCAC wait times for long term care settings have not been reported due to validity of data. The Toronto Central LHIN continues to work with Toronto Central CCAC to obtain this data through the Resource Matching and Referral (RM&R) system.

Indicator	Provincial target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result
2. Monitoring Indicators									
Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.00%	88.03%	87%	87.23%	84.87%	87.50%	86%	86.59%
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%	98.17%	94.00%	94.00%	94.00%
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	92.00%	88.09%	85.32%	85.01%	88.43%	86.55%	81.42%	80.12%
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	3.00	NR	NR	NR
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	11.00	NR	NR	NR
Rate of emergency visits for conditions best managed elsewhere per 1,000 population	NA	NA	12.86	4.58	12.28	6.90	4.90	1.76	4.68
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population	NA	NA	235.64	81.88	241.40	259.37	183.94	63.80	186.19
Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge	NA	NA	46.58%	47.46%	47.81%	49.89%	50.74%	51.98%	51.93%

NA – Not Available

NR – Not Reported (data has not been reported due to concerns with data quality)

Performance Highlights

Based on the May 2017 data release, Toronto Central LHIN has achieved 5 of the 14 MLAA indicators:

Toronto Central CCAC Personal Support Worker (PSW) and Nursing Visits

Improved access to PSW and nursing home care services by adjusting the patient availability date. Clients now receive their personal support and nursing services within five days of service being authorized, decreasing the wait time for patients. Toronto Central LHIN have collaborated with Toronto Central CCAC to:

- Initiate services based on patients' personal preference date and clinical planning
- Prioritize services for populations with multiple chronic and complex health issues
- Deliver the most appropriate care to patients and their families to meet their health, social and economic needs
- Report this indicator with adjustment for patient clinical readiness and availability date.

Hip and Knee Replacement wait times

Reduced wait times for orthopaedic (hip and knee) surgeries being completed within access target.
TC LHIN have worked closely with its Orthopaedic Steering Committee to:

- Standardize the use of clinical priority rating across hospitals
- Re-establish protocols for wait list management
- Collaborate with hospitals to develop a balanced performance scorecard

Alternate Level Care (ALC) Rate

Toronto Central LHIN has developed a 3 year plan to support the ALC Task Group on Transition and Flow to:

- Assist and support hospital in implementing ALC avoidance and management practices
- Create new capacity in non-hospital settings to transition Non-OHIP patients from hospitals
- Implement 20 Short Stay Reintegration Beds over flu/surge season

Toronto Central LHIN has made significant progress on five indicators namely Wait Times for CCAC in home services from community, CT scan wait time, Repeat Emergency Department (ED) visits for patients with mental health needs and substance abuse needs and Readmissions within 30 days for selected clinical conditions compared to 2014/15.

Toronto Central LHIN is working diligently with its stakeholders to develop a strategy to meet the ED Length of Stay (LOS) for complex patients and minor/uncomplicated patients and Percentage of ALC Days.

The Path Forward

At Toronto Central LHIN we have always prided ourselves on our ability to support dynamic, patient-centred and strategic integrations across our city and nearly a decade after our creation we put our skills and expertise to the test as we readied ourselves to integrate with the Toronto Central Community Access Centre (CCAC). This year's success have truly been amplified by our efforts to prepare for the transition of home and community care staff and services from the CCAC. Looking back, we can take great pride in the collaborative effort that not only brought us to Transition Day, but is also helping to build a strong foundation for the collective work ahead of us through transformation.

This past year has included numerous milestones toward realizing Patient's First, transition being just one of them. A tremendous amount of effort has also been placed in achieving our organizational strategic priorities. We have been able to position ourselves well, by strengthening relationships with our providers and partners at the community level as we head into the final year of our 2015-2018 Strategic Plan.

Over the course of the year we focused our efforts on ensuring we have a strong understanding of local needs and have established key resources for successfully delivering on the priorities of Patient's First. These include, but are not limited to:

- Our Citizens' Panel is a grounding force that helps to provide clarity and diverse patient perspective that is reflective of the unique population living in and receiving care in the Toronto Central LHIN
- We have established leadership in primary and community care at the table working on LHIN-led initiatives that are aiming to support front-line providers across the LHIN and improve access to care for Torontonians
- And by taking a sub-region approach we have local knowledge to tackle issues, improve local health outcomes and address health inequities that reside outside of traditional health care boundaries.

Our staff, that includes both legacy LHIN and CCAC employees, health services providers, home and community care service provider organizations and the Board of Directors are all deeply committed to improving our local health care system. In the years ahead, Toronto Central LHIN aims to have a more integrated, responsive, and sustainable health care system – one that can better meet the needs of *everyone* who lives in, or receives care within our catchment area. With the support of our partners and communities, we feel confident that we will be able to deliver on our vision, and help make Ontario the healthiest place in North America to grow up and grow old.

Toronto Central LHIN Board of Directors

Name	Position	Appointed	End of Current Term	Length of Term
Vivek Goel	Chair	November 16, 2016	November 15, 2019	3 years
John Fraser	Vice Chair	June 27, 2011 June 27, 2014	June 26, 2014 June 26, 2017	3 years 3 years
Maurice Hudon	Director	April 10, 2013 April 10, 2016	April 9, 2016 April 9, 2019	3 years 3 years
Yasmin Meralli	Director	September 8, 2014	September 7, 2017	3 years
Christopher Hoffmann	Director	October 22, 2014	October 21, 2017	3 years
Felix Wu	Director	October 22, 2014	October 21, 2017	3 years
Jason Madden	Director	November 30, 2016	November 29, 2019	3 years
Pamela Griffith-Jones	Director	November 16, 2016	November 15, 2019	3 years
Carolyn Acker	Director	February 2, 2017	February 1, 2020	3 years
Myra Libenson	Director	May 10, 2017	May 9, 2020	3 years
Karen Sadlier-Brown	Director	May 10, 2017	May 9, 2020	3 years
Dunbar Russel	Director	June 2, 2017	June 1, 2020	3 years
Natasha VandenHoven	Director	June 27, 2017	June 26, 2020	3 years

Board Per Diems

	2017	
	Budget	**Actual**
	$	**$**
Board Chair per diem cost	**21,000**	**11,200**
Directors per diem cost	**56,500**	**50,025**
Board travel and development expenses	**22,500**	**4,407**
	100,000	**65,632**

Financial statements of

Toronto Central Local Health Integration Network

March 31, 2017

Toronto Central Local Health Integration Network

March 31, 2017

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Independent Auditor's Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the accompanying financial statements of the Toronto Central 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.

Chartered Professional Accountants
Licensed Public Accountants
May 31, 2017

1. Description of business

The Toronto Central 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 Toronto Central 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 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 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 LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"). These financial statements reflect the terms of the MLAA related to this funding.

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. Commencing April 1, 2007, all funding payments to LHIN managed HSPs 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 HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2017.

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

The LHIN is also funded for the Diabetes Regional Coordination Centre ("RCC") program in accordance with the Ministry-LHIN Performance Agreement. The operational mandate, functions and funding for delivery of the RCC Program were transferred to the LHIN in the 2012/13 fiscal year. The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was responsible for providing services to all LHINs. The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 as a division of TC LHIN to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment.

On January 31, 2017, a Transfer Order was issued by the Minister of Health and Long-Term Care transferring all assets, liabilities, rights, obligations, records and employees of the Ontario Association of Community Care Access Centres to Health Shared Services Ontario (HSSO) which was the beginning of a broader reorganization and consolidation of services and functions in Ontario's home and community care sector.

Consistent with this direction, Toronto Central Local Health Integration Network (TC LHIN) entered a Transfer Agreement with Health Shared Services Ontario dated March 1, 2017 which effectively transferred from TC LHIN to HSSO all assets, liabilities, rights, obligations, records and employees of TC LHIN related to the services and functions of the LSSO and LHINC divisions of TC LHIN. As such these financial statements include LSSO and LHINC transactions for the period from April 1, 2016 to February 28, 2017. See Note 17 for additional details

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 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.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are initially 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 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 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 tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

2. Significant accounting policies (continued)

Segmented financial reporting

The financial statements of the LHIN include the accounts of the LHIN Shared Services Office (the "LSSO") and LHIN Collaborative (the "LHINC") up to February 28, 2017 which are its divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

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. Related party transactions

LHIN Shared Services Office, LHIN 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.

Enabling Technologies for Integrated Project Management Office

Effective April 1, 2013, the LHIN entered into an agreement with the Central, Central West, Central East, 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 Offices for its Cluster and related expenses. During the year, the LHIN received MOHLTC funding through the Central West LHIN of $423,000 (2016 - $440,000).

3. Related party transactions (continued)

Patients First Transition Planning and Implementation

On June 13, 2016 an amendment to the MLAA resulted in an allocation of $1,080,000 of additional Pan-LHIN support funding to LHINC to be applied to salary and benefit costs related to the support of transition and implementation of the expanded LHIN mandate. LHINC directly incurred eligible expenses of $214,538, the LHIN directly incurred $180,000 of eligible expenses and the remaining $685,462 was distributed to the following LHINs:

	Total
	$
North East LHIN	**111,720**
South West LHIN	**107,619**
Central West LHIN	**178,680**
Mississauga Halton LHIN	**105,471**
South East LHIN	**181,972**
	685,462

4. Funding repayable to the MOHLTC

In accordance with the MLAA and the Transfer Payment Agreement ("TPA"), the 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.

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

			2017	2016
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**4,896,026,687**	**4,896,026,687**	**-**	-
LHIN operations	**5,762,871**	**5,761,683**	**1,188**	1,900
LHINC	**1,694,166**	**1,669,037**	**25,129**	-
E-Health	**423,000**	**423,000**	**-**	-
ED Lead	**75,000**	**75,000**	**-**	-
Aboriginal Health Transition Planning	**20,000**	**20,000**	**-**	-
ER/ALC	**100,000**	**100,000**	**-**	-
Critical Care Lead	**75,000**	**75,000**	**-**	-
FLHS	**106,000**	**106,000**	**-**	-
French Planning Entities	**568,713**	**568,713**	**-**	-
Primary Care lead	**75,000**	**75,000**	**-**	-
Diabetes RCC	**1,106,715**	**1,106,715**	**-**	-
EMCT	**200,000**	**200,000**	**-**	-
Patients First Transition Planning and Implementation	**180,000**	**180,000**	**-**	-
	4,906,413,152	**4,906,386,835**	**26,317**	1,900

During the year, the LHIN was provided net funding of $568,713 (Note 9) (2016 - $568,713) from the MOHLTC for the French Planning Entities which was flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

4. Funding repayable to the MOHLTC (continued)

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

	2017	2016
	$	$
Due to MOHLTC, beginning of year	**(4,707)**	(2,807)
MOHLTC payment	**2,807**	-
Funding repayable to the MOHLTC related to current year activities (Note 4a)	**(26,317)**	(1,900)
Due to MOHLTC, end of year	**(28,217)**	(4,707)

5. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**1,514,992**	2,213,523
Capital contibutions received during the year	**179,288**	581,953
Transfer of deferred capital contributions to HSSO	**(410,980)**	-
Amortization for the year	**(1,083,269)**	(1,280,484)
Balance, end of year	**200,031**	1,514,992

6. Tangible capital assets

			2017	2016
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office furniture and fixtures	**463,179**	**419,453**	**43,726**	109,511
Computer equipment	**1,129,103**	**972,798**	**156,305**	1,405,481
Leasehold improvements	**1,621,434**	**1,621,434**	**-**	-
	3,213,716	**3,013,685**	**200,031**	1,514,992

7. Budget figures

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. Budget amount for amortization is included for comparison purposes.

The following reflects the adjustments for the LHIN during the year:

	$
Initial HSP Funding budget	**4,762,138,875**
Adjustment due to announcements made during the year	**133,887,812**
Total HSP Funding	**4,896,026,687**

TC LHIN operating budget, excluding HSP Funding is $8,660,542.

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,896,026,687 (2016 - $4,799,105,830) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in the fiscal year as follows:

	2017	2016
	$	$
Operation of hospitals	**3,652,554,420**	3,580,546,410
Long-term care homes	**281,028,865**	274,101,551
Community care access centre	**250,537,181**	250,907,414
Community support services	**106,223,768**	104,091,661
Assisted living services in supportive housing	**60,388,749**	57,894,669
Community health centres	**97,270,624**	93,491,259
Community mental health addictions program	**143,110,762**	138,782,566
Addictions program	**37,951,625**	38,299,857
Specialty psychiatric hospital	**266,960,693**	260,990,443
	4,896,026,687	4,799,105,830

9. Operations of LHIN - Project Initiatives

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

	2017	2016
	$	$
Salaries and benefits	**1,843,471**	2,287,025
Professional services	**161,909**	158,180
Funding transferred (Note 4)	**568,713**	568,713
Other	**355,335**	384,759
	2,929,428	3,398,677

Diabetes Regional Coordination Centre operational expenses included in the above project fund expenses are as follows:

	2017	2016
	$	$
Salaries and benefits	**859,913**	930,944
Other	**246,802**	175,771
	1,106,715	1,106,715

10. General and administrative expenses

The Statement of operations presents the expenses by function; the following classifies general and administrative expenses:

	2017	2016
	$	$
Salaries and benefits	**4,234,918**	4,239,667
Occupancy	**293,586**	387,313
Amortization	**227,750**	316,271
Shared services	**335,478**	235,978
LHINC	**47,500**	47,500
Consulting services	**199,595**	206,106
Translation services	**28,341**	48,371
Professional services	**15,560**	15,560
Supplies	**25,844**	45,398
Computer expenses	**54,693**	27,397
Governance	**65,632**	56,884
Mail, courier and telecommunications	**40,481**	33,099
Other	**192,305**	189,948
	5,761,683	5,849,492

The following lists the Board Chair and Directors per diem costs as well as their travel and development expenses, which are included in governance expenses in the general and administrative expenses above.

		2017	2016
	Budget	**Actual**	Actual
	$	**$**	$
Board Chair per diem cost	**21,000**	**11,200**	17,675
Directors per diem cost	**56,500**	**50,025**	38,375
Board travel and development expenses	**22,500**	**4,407**	834
	100,000	**65,632**	56,884

11. LHIN Shared Services Office

The following presents the financial activities, by object, of the LHIN Shared Services Office for the year:

	12 months full year Budget	11 months ended February 28, 2017 Actual	12 months ended March 31, 2016 Actual
	$	**$**	$
Revenue			
Amounts recovered/recoverable from the LHINs	**5,343,296**	**4,518,734**	4,761,343
Amortization of deferred capital contributions	**896,599**	**855,519**	896,599
	6,239,895	**5,374,253**	5,657,942
Expenses*			
Salaries	**1,660,116**	**1,550,642**	1,501,996
Benefits	**343,576**	**302,026**	287,247
Supplies	**29,314**	**20,237**	28,266
Telecommunications	**11,508**	**11,646**	10,479
Recruitment and staff development	**15,623**	**17,326**	36,884
Consulting fees	**7,000**	**-**	21,275
Professional services	**23,500**	**21,500**	20,580
Meeting expenses	**4,000**	**259**	1,114
Amortization	**896,599**	**855,519**	896,599
Occupancy	**181,225**	**158,486**	145,620
Other	**35,715**	**26,736**	31,432
Outsourcing services and computer expense	**3,031,719**	**2,409,876**	2,676,450
Total common LHIN services expenses	**6,239,895**	**5,374,253**	5,657,942
Less: inter-entity transactions eliminated on combination**	**-**	**(335,573)**	(381,664)
	6,239,895	**5,038,680**	5,276,278

* Included in total expenses above are $747,960 (2016 - $755,297) related to legal department expenses, of which $670,121 (2016 - $658,794) are salaries and benefits expenses.

** Included in total expenses above are $335,573 (2016 - $381,664) related to inter-entity transactions and are eliminated upon combination.

12. LHIN Collaborative

The following presents the financial activities, by object, of the LHIN Collaborative for the year:

	12 months full year Budget	11 months ended February 28, 2017 Actual	12 months ended March 31, 2016 Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	**665,000**	**609,588**	665,000
MOHLTC funding	**670,000**	**1,694,166**	792,000
Amortization of deferred capital contributions	**67,614**	**-**	67,614
	1,402,614	**2,303,754**	1,524,614
Funding repayable to the MOHLTC related to operations	**-**	**(25,129)**	-
	1,402,614	**2,278,625**	1,524,614
Expenses*			
Salaries	**932,452**	**831,722**	1,038,056
Benefits	**189,633**	**371,123**	201,543
Patients First Pan-LHIN Support for Planning and Implementation (Note 3)	**-**	**865,462**	-
Supplies	**17,456**	**6,950**	11,157
Telecommunications	**10,283**	**7,510**	7,638
Recruitment and staff developments	**17,874**	**10,481**	10,370
Computer expense	**7,596**	**12,072**	8,356
Consulting fees	**32,885**	**27,857**	27,871
Meeting expenses	**13,826**	**2,945**	5,271
Amortization	**67,614**	**-**	67,614
Occupancy	**95,044**	**67,333**	94,406
Other	**17,951**	**75,170**	7,932
Shared services	**-**	**-**	44,400
	1,402,614	**2,278,625**	1,524,614
Less: inter-entity transactions eliminated on combination	**-**	**(47,500)**	(47,500)
	1,402,614	**2,231,125**	1,477,114

* Included in total expenses above are $47,500 (2016 - $47,500) in inter-entity transactions that are eliminated upon combination.

MOHLTC funding of $27,500 (2016 - $30,000) was attributed to the Provincial End-of-Life Network. No MOHLTC funding was attributed to the Personal Support Service Initiative (2016 - $122,000). MOHLTC funding of $1,080,000 (2016 - $Nil) was attributed to the Patients First Pan-LHIN Support for Planning and Implementation, $214,538 was directly incurred by LHINC and is reported in Salaries and Benefits above. The remaining $865,462 was allocated to various LHINs as detailed in Note 3.

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 87 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 $567,348 (2016 - $598,304) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2015. At that time, the plan was fully funded.

14. 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.

15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due over the next years are as follows:

	$
2018	726,478
2019	755,250
2020	763,749
2021	386,059
	2,631,536

Included in total commitments above is $951,908 related to office space for the former LSSO and LHINC for which the MOHLTC will ensure payment on due date.

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2016 and 2017. The actual amounts, which will ultimately be paid, are contingent upon actual LHIN funding received from the MOHLTC.

16. Subsequent event

On April 6, 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 Toronto Central Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employess of the CCAC.

Effective June 7, 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.

17. Transfer of LSSO, LHINC

Further to note 1, on March 1, 2017, assets, liabilities, rights and obligations of LSSO and LHINC were transferred to the HSSO. The transfer was at $Nil consideration, and the transaction was recorded using the carrying value of the assets and liabilities transferred. Details of amounts transferred are as follows:

	LHIN Shared Services Office	LHIN Collaborative	Total
	$	$	$
Financial assets			
Cash	**204,753**	**81,012**	**285,765**
Due from TC LHIN	**(24,171)**	**45,866**	**21,695**
	180,582	**126,878**	**307,460**
Liabilities			
Accounts payable and accrued liabilities	**294,904**	**109,526**	**404,430**
Due to MOHLTC	**-**	**25,129**	**25,129**
Deferred capital contributions	**410,980**	**-**	**410,980**
	705,884	**134,655**	**840,539**
Net debt	**(525,302)**	**(7,777)**	**(533,079)**
Non-financial assets			
Prepaid expenses	**114,322**	**7,777**	**122,099**
Tangible capital assets (Note 7)	**410,980**	**-**	**410,980**
	525,302	**7,777**	**533,079**
Accumulated surplus	**-**	**-**	**-**

Toronto Central Local Health Integration Network

Combined statement of financial position and operations by division - Schedule 1
as at March 31, 2017

Combined statement of financial position and operations by division - Schedule 1	**2017**	2016	**2017**	2016	**2017**	2016	**2017**	2016
	Toronto Central		**Shared Services Office**		**Collaborative**		**Total**	Total
	$	$	**$**	$	**$**	$	**$**	$
Financial assets								
Cash	**1,096,486**	782,212	**-**	543,202	**-**	90,893	**1,096,486**	1,416,307
Due from LSSO/LHINC/TC LHIN*	**-**	15,160	**-**	-	**-**	-	**-**	15,160
Due from Local Health Integration Networks ("LHINs")	**-**	9,446	**-**	70,118	**-**	-	**-**	79,564
Due from Health Shared Services Ontario	**25,129**	-	**-**	-	**-**	-	**25,129**	-
Due from MOHLTC regarding HSP transfer payments	**21,813,625**	18,030,794	**-**	-	**-**	-	**21,813,625**	18,030,794
Harmonized Sales Tax receivable	**197,765**	128,547	**-**	172,071	**-**	578	**197,765**	301,196
	23,133,005	18,966,159	**-**	785,391	**-**	91,471	**23,133,005**	19,843,021
Liabilities								
Accounts payable and accrued liabilities	**1,306,471**	945,388	**-**	863,577	**-**	87,323	**1,306,471**	1,896,288
Due to LSSO/LHINC/TC LHIN*	**-**	-	**-**	10,109	**-**	5,051	**-**	15,160
Due to HSPs	**21,813,625**	18,030,794	**-**	-	**-**	-	**21,813,625**	18,030,794
Deferred capital contributions	**200,031**	427,781	**-**	1,087,211	**-**	-	**200,031**	1,514,992
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**28,217**	4,707	**-**	-	**-**	-	**28,217**	4,707
	23,348,344	19,408,670	**-**	1,960,897	**-**	92,374	**23,348,344**	21,461,941
Net debt	**215,339**	442,511	**-**	1,175,506	**-**	903	**215,339**	1,618,920
Non-financial assets								
Prepaid expenses	**15,308**	14,730	**-**	88,295	**-**	903	**15,308**	103,928
Tangible capital assets	**200,031**	427,781	**-**	1,087,211	**-**	-	**200,031**	1,514,992
	215,339	442,511	**-**	1,175,506	**-**	903	**215,339**	1,618,920
Accumulated surplus	**-**	-	**-**	-	**-**	-	**-**	-

* Amounts due from/to the LHIN Shared Services Office, due from/to the LHINC and due from/to TC LHIN are eliminated upon combination. As at March 31, 2017, TC LHIN did not have any divisions following the transfer agreement with HSSO dated March 1, 2017.

Toronto Central Local Health Integration Network

Combined statement of financial position and operations by division - Schedule I (continued)
year ended March 31, 2017

	2017		2016	2017		2016	2017		2016	2017	2016
	Toronto Central Operations			Shared Services Office			Collaborative				
	Budget	Actual	Actual	Budget	Actual***	Actual	Budget	Actual***	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$	$
Revenue											
Amounts recovered/recoverable from the LHINs	-	-	-	5,343,296	4,518,734	4,761,343	665,000	609,588	665,000	5,128,322	5,426,343
MOHLTC funding	5,535,121	5,535,121	5,535,121	-	-	-	670,000	1,694,166	792,000	7,229,287	6,327,121
HSP transfer payments (Note 8)	4,762,138,875	4,896,026,687	4,799,105,830	-	-	-	-	-	-	4,896,026,687	4,799,105,830
Enabling Technologies funding (Note 3)	510,000	423,000	440,000	-	-	-	-	-	-	423,000	440,000
Emergency Department ("ED") Leads (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 9)	20,000	20,000	20,000	-	-	-	-	-	-	20,000	20,000
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 9)	288,993	-	125,000	-	-	-	-	-	-	-	125,000
French Language Health Services (Note 9)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 9)	568,713	568,713	568,713	-	-	-	-	-	-	568,713	568,713
Primary Care Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Regional Coordination Centre (Note 9)	1,106,715	1,106,715	1,106,715	-	-	-	-	-	-	1,106,715	1,106,715
Pan and Parapan Am Games (Note 9)	-	-	207,249	-	-	-	-	-	-	-	207,249
Emergency Mgmt Comm Tool (Note 9)	200,000	200,000	500,000	-	-	-	-	-	-	200,000	500,000
Patients First Transition Planning and Implementation (Note 3)	-	180,000	-	-	-	-	-	-	-	180,000	-
Amortization of deferred capital contributions (Note 5)	316,271	227,750	316,271	896,599	855,519	896,599	67,614	-	67,614	1,083,269	1,280,484
	4,771,115,688	4,904,718,986	4,808,355,899	6,239,895	5,374,253	5,657,942	1,402,614	2,303,754	1,524,614	4,912,396,993	4,815,538,455
Funding surplus repayable to the MOHLTC related to operations (Note 4(a))	-	(1,188)	(1,900)	-	-	-	-	(25,129)	-	(26,317)	(1,900)
	4,771,115,688	4,904,717,798	4,808,353,999	6,239,895	5,374,253	5,657,942	1,402,614	2,278,625	1,524,614	4,912,370,676	4,815,536,555
Expenses											
General and administrative (Note 10)	5,851,392	5,761,683	5,849,492	-	-	-	-	-	-	5,761,683	5,849,492
Common LHIN Services* (Note 11)	-	-	-	6,239,895	5,374,253	5,657,942	-	-	-	5,374,253	5,657,942
LHIN Collaborative** (Note 12)	-	-	-	-	-		1,402,614	2,278,625	1,524,614	2,278,625	1,524,614
Transfer payments to HSPs (Note 8)	4,762,138,875	4,896,026,687	4,799,105,830	-	-	-	-	-	-	4,896,026,687	4,799,105,830
Enabling Technologies (Note 3)	510,000	423,000	440,000	-	-	-	-	-	-	423,000	440,000
Emergency Department ("ED") Leads (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 9)	20,000	20,000	20,000	-	-	-	-	-	-	20,000	20,000
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 9)	288,993	-	125,000	-	-	-	-	-	-	-	125,000
French Language Health Services (Note 9)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 9)	568,713	568,713	568,713	-	-	-	-	-	-	568,713	568,713
Primary Care Lead (Note 9)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Regional Coordination Centre (Note 9)	1,106,715	1,106,715	1,106,715	-	-	-	-	-	-	1,106,715	1,106,715
Pan and Parapan Am Games (Note 9)	-	-	207,249	-	-	-	-	-	-	-	207,249
Emergency Mgmt Comm Tool (Note 9)	200,000	200,000	500,000	-	-	-	-	-	-	200,000	500,000
Patients First Transition Planning and Implementation (Note 9)	-	180,000	-	-	-	-	-	-	-	180,000	-
	4,771,115,688	4,904,717,798	4,808,353,999	6,239,895	5,374,253	5,657,942	1,402,614	2,278,625	1,524,614	4,912,370,676	4,815,536,555
Annual surplus and accumulated surplus, end of year	-	-	-	-	-	-	-	-	-	-	-

* These amounts will be adjusted by $335,573 for Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 11).
** These amounts will be adjusted by $47,500 for Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 12).
*** 2017 LSSO and LHINC statement of financial operations report eleven months of activities with period ended February 28, 2017.

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**1,096,486**	1,416,307
Due from Local Health Integration Networks ("LHINs")	**-**	79,564
Due from Health Shared Services Ontario (Note 3)	**25,129**	-
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**21,813,625**	18,030,794
Harmonized Sales Tax receivable	**197,765**	301,196
	23,133,005	19,827,861
Liabilities		
Accounts payable and accrued liabilities	**1,306,471**	1,896,288
Due to HSPs	**21,813,625**	18,030,794
Due to MOHLTC (Note 4b)	**28,217**	4,707
Deferred capital contributions (Note 5)	**200,031**	1,514,992
	23,348,344	21,446,781
Net debt	**(215,339)**	(1,618,920)
Commitments (Note 15)		
Non-financial assets		
Prepaid expenses	**15,308**	103,928
Tangible capital assets (Note 6)	**200,031**	1,514,992
	215,339	1,618,920
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 7)	2017 Actual	2016 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care (“MOHLTC”) funding	**5,535,121**	**5,535,121**	5,535,121
Ministry of Health and Long-Term Care (“MOHLTC”) funding to LHINC	**670,000**	**1,694,166**	792,000
Health Service Provider (“HSP”) transfer payments (Note 8)	**4,762,138,875**	**4,896,026,687**	4,799,105,830
Project Initiatives (Note 9)			
Enabling Technologies (Note 3)	**510,000**	**423,000**	440,000
Emergency Department (“ED”) Lead	**75,000**	**75,000**	75,000
Aboriginal Health Transition Planning	**20,000**	**20,000**	20,000
Emergency Room and Alternate Level of Care ("ER/ALC")	**100,000**	**100,000**	100,000
Critical Care ("CC") Lead	**75,000**	**75,000**	75,000
Resources Matching Referrals Leads	**288,993**	**-**	125,000
French Language Health Services ("FLHS")	**106,000**	**106,000**	106,000
French Planning Entities	**568,713**	**568,713**	568,713
Primary Care Lead	**75,000**	**75,000**	75,000
Diabetes Regional Coordination Centre	**1,106,715**	**1,106,715**	1,106,715
Pan and Parapan Am Games	**-**	**-**	207,249
Emergency Management Communication Tool ("EMCT")	**200,000**	**200,000**	500,000
Patients First Transition Planning and Implementation (Note 9)	**-**	**180,000**	-
Amortization of deferred capital contributions (Note 5)	**1,280,484**	**1,083,269**	1,280,484
Amounts recovered/recoverable from the LHINs to LHINC	**665,000**	**562,088**	617,500
Amounts recovered/recoverable from the LHINs to LSSO	**5,343,296**	**4,183,161**	4,379,679
	4,778,758,197	**4,912,013,920**	4,815,109,291
Funding repayable to the MOHLTC related to operations (Note 4a)	**-**	**(26,317)**	(1,900)
	4,778,758,197	**4,911,987,603**	4,815,107,391
Expenses			
Transfer payments to HSPs (Note 8)	**4,762,138,875**	**4,896,026,687**	4,799,105,830
General and administrative (Note 10)	**5,851,392**	**5,761,683**	5,849,492
LHIN Shared Services Office (Note 11)	**6,239,895**	**5,038,680**	5,276,278
LHIN Collaborative (Note 12)	**1,402,614**	**2,231,125**	1,477,114
Project Initiatives (Note 9)			
Enabling Technologies	**510,000**	**423,000**	440,000
Emergency Department (“ED”) Lead	**75,000**	**75,000**	75,000
Aboriginal Health Transition Planning	**20,000**	**20,000**	20,000
Emergency Room and Alternate Level of Care ("ER/ALC")	**100,000**	**100,000**	100,000
Critical Care ("CC") Lead	**75,000**	**75,000**	75,000
Resources Matching Referrals Leads	**288,993**	**-**	125,000
French Language Health Services ("FLHS")	**106,000**	**106,000**	106,000
French Planning Entities	**568,713**	**568,713**	568,713
Primary Care Lead	**75,000**	**75,000**	75,000
Diabetes Regional Coordination Centre	**1,106,715**	**1,106,715**	1,106,715
Pan and Parapan Am Games	**-**	**-**	207,249
Emergency Management Communication Tool ("EMCT")	**200,000**	**200,000**	500,000
Patients First Transition Planning and Implementation	**-**	**180,000**	-
	4,778,758,197	**4,911,987,603**	4,815,107,391
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

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

	2017	2016
	$	$
Annual surplus	**-**	-
Acquisition of tangible capital assets	**(179,288)**	(581,953)
Transfer of tangible capital assets to HSSO (Note 17)	**410,980**	-
Amortization of tangible capital assets	**1,083,269**	1,280,484
Acquisition of prepaid expenses	**(137,407)**	(103,928)
Transfer of prepaid expenses to HSSO (Note 17)	**122,099**	-
Use of prepaid expenses	**103,928**	71,869
Decrease in net debt	**1,403,581**	666,472
Net debt, beginning of year	**(1,618,920)**	(2,285,392)
Net debt, end of year	**(215,339)**	(1,618,920)

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central 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	1,083,269	1,280,484
Amortization of deferred capital contributions (Note 5)	(1,083,269)	(1,280,484)
Transfer of deferred capital contributions (Notes 5, 17)	(410,980)	-
Transfer of tangible capital assets to HSSO (Note 17)	410,980	-
	-	-
Changes in non-cash operating items		
Due from LHINs	79,564	52,543
Due from HSSO	(25,129)	-
Harmonized Sales Tax receivable	103,431	151,986
Due from MOHLTC regarding HSP transfer payments	(3,782,831)	16,248,218
Accounts payable and accrued liabilities	(589,817)	230,103
Due to HSPs	3,782,831	(16,248,218)
Due to MOHLTC	23,510	1,900
Prepaid expenses	88,620	(32,059)
	(319,821)	404,473
Capital transaction		
Acquisition of tangible capital assets	(179,288)	(581,953)
Financing transaction		
Increase in deferred capital contributions (Note 5)	179,288	581,953
Net change in cash	(319,821)	404,473
Cash, beginning of year	1,416,307	1,011,834
Cash, end of year	1,096,486	1,416,307

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Combined statement of financial position and operations by division - Schedule I (continued)
year ended March 31, 2017

		2017	2016		2017	2016		2017	2016	2017
		Toronto Central Operations			Shared Services Office			Collaborative		
	Budget	Actual	Actual	Budget	Actual***	Actual	Budget	Actual***	Actual	Total
	$	$	$	$	$	$	$	$	$	$
Revenue										
Amounts recovered/recoverable from the LHINs	-	-	-	**5,343,296**	**4,518,734**	4,761,343	**665,000**	**609,588**	665,000	**5,128,322**
MOHLTC funding	**5,535,121**	**5,535,121**	5,535,121	-	-	-	**670,000**	**1,694,166**	792,000	**7,229,287**
HSP transfer payments (Note 8)	**4,762,138,875**	**4,896,026,687**	4,799,105,830	-	-	-	-	-	-	**4,896,026,687**
Enabling Technologies funding (Note 3)	**510,000**	**423,000**	440,000	-	-	-	-	-	-	**423,000**
Emergency Department ("ED") Leads (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Aboriginal Health Transition Planning (Note 9)	**20,000**	**20,000**	20,000	-	-	-	-	-	-	**20,000**
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	**100,000**	**100,000**	100,000	-	-	-	-	-	-	**100,000**
Critical Care ("CC") Lead (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Resources Matching Referrals (Note 9)	**288,993**	-	125,000	-	-	-	-	-	-	-
French Language Health Services (Note 9)	**106,000**	**106,000**	106,000	-	-	-	-	-	-	**106,000**
French Planning Entities (Note 9)	**568,713**	**568,713**	568,713	-	-	-	-	-	-	**568,713**
Primary Care Lead (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Diabetes Regional Coordination Centre (Note 9)	**1,106,715**	**1,106,715**	1,106,715	-	-	-	-	-	-	**1,106,715**
Pan and Parapan Am Games (Note 9)	-	-	207,249	-	-	-	-	-	-	-
Emergency Mgmt Comm Tool (Note 9)	**200,000**	**200,000**	500,000	-	-	-	-	-	-	**200,000**
Patients First Transition Planning and Implementation (Note 3)	-	**180,000**	-	-	-	-	-	-	-	**180,000**
Amortization of deferred capital contributions (Note 5)	**316,271**	**227,750**	316,271	**896,599**	**855,519**	896,599	**67,614**	-	67,614	**1,083,269**
	4,771,115,688	**4,904,718,986**	4,808,355,899	**6,239,895**	**5,374,253**	5,657,942	**1,402,614**	**2,303,754**	1,524,614	**4,912,396,993**
Funding surplus repayable to the MOHLTC related to operations (Note 4(a))	-	**(1,188)**	(1,900)	-	-	-	-	**(25,129)**	-	**(26,317)**
	4,771,115,688	**4,904,717,798**	4,808,353,999	**6,239,895**	**5,374,253**	5,657,942	**1,402,614**	**2,278,625**	1,524,614	**4,912,370,676**
Expenses										
General and administrative (Note 10)	**5,851,392**	**5,761,683**	5,849,492	-	-	-	-	-	-	**5,761,683**
Common LHIN Services* (Note 11)	-	-	-	**6,239,895**	**5,374,253**	5,657,942	-	-	-	**5,374,253**
LHIN Collaborative** (Note 12)	-	-	-	-	-		**1,402,614**	**2,278,625**	1,524,614	**2,278,625**
Transfer payments to HSPs (Note 8)	**4,762,138,875**	**4,896,026,687**	4,799,105,830	-	-	-	-	-	-	**4,896,026,687**
Enabling Technologies (Note 3)	**510,000**	**423,000**	440,000	-	-	-	-	-	-	**423,000**
Emergency Department ("ED") Leads (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Aboriginal Health Transition Planning (Note 9)	**20,000**	**20,000**	20,000	-	-	-	-	-	-	**20,000**
Emergency Room and Alternate Level of Care (ER/ALC) (Note 9)	**100,000**	**100,000**	100,000	-	-	-	-	-	-	**100,000**
Critical Care ("CC") Lead (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Resources Matching Referrals (Note 9)	**288,993**	-	125,000	-	-	-	-	-	-	-
French Language Health Services (Note 9)	**106,000**	**106,000**	106,000	-	-	-	-	-	-	**106,000**
French Planning Entities (Note 9)	**568,713**	**568,713**	568,713	-	-	-	-	-	-	**568,713**
Primary Care Lead (Note 9)	**75,000**	**75,000**	75,000	-	-	-	-	-	-	**75,000**
Diabetes Regional Coordination Centre (Note 9)	**1,106,715**	**1,106,715**	1,106,715	-	-	-	-	-	-	**1,106,715**
Pan and Parapan Am Games (Note 9)	-	-	207,249	-	-	-	-	-	-	-
Emergency Mgmt Comm Tool (Note 9)	**200,000**	**200,000**	500,000	-	-	-	-	-	-	**200,000**
Patients First Transition Planning and Implementation (Note 9)	-	**180,000**	-	-	-	-	-	-	-	**180,000**
	4,771,115,688	**4,904,717,798**	4,808,353,999	**6,239,895**	**5,374,253**	5,657,942	**1,402,614**	**2,278,625**	1,524,614	**4,912,370,676**
Annual surplus and accumulated surplus, end of year	-	-	-	-	-	-	-	-	-	-

* These amounts will be adjusted by $335,573 for Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 11).
** These amounts will be adjusted by $47,500 for Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 12).
*** 2017 LSSO and LHINC statement of financial operations report eleven months of activities with period ended February 28, 2017.

Endnotes

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