



Transforming Care through *the Patient's Voice*

2014 / 15 Annual Report

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Building a Better Health Care System

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the provincial government through the *Local Health System Integration Act (LHSIA)*, 2006, to plan, coordinate, integrate and fund health services at the local level.

LHINs work with local health service providers and communities to design real-life solutions that improve access to care, better coordinate services and improve people's experience with the system. Together we are building a better health care system by removing obstacles that prevent coordination and providing better value for taxpayer dollars.

We bring together health care providers from sectors such as hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care, and collaborate with primary care providers. Through ongoing engagement and cooperation, we can achieve meaningful system improvements, as we work together to build relationships that help us to understand local health care needs.

LHINs have already brought about significant and positive change through system-wide improvements, improving value for money and access to care, and promoting health equity.



Message from the Chair and CEO

This has been another year of transformational change for the Central Local Health Integration Network (LHIN), our health service providers and other partners. Together, we developed innovative solutions to advance the four Quality-Based System Directions in our Integrated Health Service Plan (2013-2016): Appropriateness, Access, Integration and Person-Centredness.

These health care solutions are improving the health care system for our patients, families and caregivers, because they are ***based on decisions that reflect best practices and what we hear*** – in our engagement sessions and planning meetings, through our advisory groups and in the hundreds of conversations that inform our activities throughout the year.

Better-informed decisions ultimately mean more appropriate care; increased access to services and programs; improved integration across various sectors (when patients are discharged from hospital to the community or home for example); and a deeply embedded commitment to care that is centred on the patient and the family. Only when we truly understand the care experience through the eyes of the patient, can we bring about meaningful and lasting change.

As part of our role to plan, fund and integrate health care, the LHIN is charged with making strategic investments to support the delivery of better care throughout the region – while at the same time responding and adapting to the changing needs of local populations. One of the ways that we do this is through the implementation of priorities that truly ***transform care***. These transformational projects are achieved in partnership with our health service providers and other partners, and are aligned with the priorities of ***Patients First*** - the Ontario government's action plan for health care.

Bold and Breakthrough Initiatives

Here are some of our projects that are ***transforming care***, and helping us to achieve our strategic priorities. These projects are underway and will help us reach key goals.

Increase access to programs and services that promote recovery from mental illness and addictions.

In the past fiscal year, we undertook a comprehensive planning process in partnership with the Region of York that included a bold and innovative Mental Health and Addictions Planning Summit. Over the course of two intense days, we

engaged key stakeholders including people with mental illness and addictions and family members, in the development of a multi-year action plan to enhance the level of support we provide to people who have mental illness, addictions and have housing challenges within York Region. Access to affordable, safe housing – and to services to sustain housing - is a key determinant of good mental and physical health. For example, within Simcoe County including the areas of Bradford and Alliston, we worked with the South Simcoe Link Team to bring affordable housing and health supports to individuals who are homeless or at risk of being homeless, or in fragile housing.

Strengthen palliative care for patients, families and caregivers in our communities, so we can support more people in the location of their choice in their end-of-life journey.

By implementing our Hospice Palliative Care Action Plan, we are striving to create excellent, accessible and efficient hospice palliative care across Central LHIN – one that can sustain us into the future by following best practices and the ‘gold standard’ for care. Initiatives to build the foundation for an enhanced palliative system were planned in 2014/15, for implementation in the upcoming fiscal year. These include a single telephone number that patients and families can call for help with urgent medical palliative care issues; and a central registry (provided through the Central Community Care Access Centre) to connect palliative care patients with vital services when needed..

Create capacity to serve more patients in the community, by introducing new services that forge a stronger link to home and community care.

An innovative example of this priority in action is our ***integrated transportation model***. Through our planning with our partners, the services previously provided through 11 transportation providers – each with differing standards and levels of service – will be consolidated and centralized through two transportation leads (health service providers CHATS and Circle of Care.) The change will assist clients and caregivers to navigate community transportation more effectively, through a standardized and consistent level of care. When the system goes ‘live’ in the summer of 2015, frail seniors and people with disabilities can call one telephone number within their geographic region to arrange for assisted, efficient and equitable transportation to take them

from door-to-door to access medical appointments and programs.

Support our growing population of seniors with the programs and services they need to maintain and enhance their health and well-being.

By providing older adults with vital supports, we can help them to stay at home for as long as possible, reducing reliance on Emergency Department visits and the need for Long-Term Care. For example, we funded a total of 200 Home First spots to support 1,465 clients to safely return home with enhanced at-home care after their hospital stay. And we created 625 new spaces that provided access to assisted living services in their homes, for high risk seniors.

Continued engagement with our patients, families and caregivers helps us to understand where we need to focus our efforts into the future. As well, our performance indicators and targets as defined by the Province of Ontario provide us with valuable information that helps us to monitor our ongoing performance – and to make adjustments and develop strategic solutions that help in areas where we need improvement.

Our Underlying Philosophy

Through the pages of this Annual Report, we demonstrate our underlying philosophy that ***Together, we are better.*** Every single person who works with us in some way becomes part of the team that is essential to our mission of care – whether you are a patient, caregiver or family member; a health service provider, a member of our Board of Directors, a Central LHIN employee, or one of the many partners who help us to be successful.

Together, we are united in our commitment to create a sustainable, seamless and enduring health care system. And ***together,*** we are privileged to ***lead*** and to ***leave*** this life changing legacy for the future.



Warren Jestin

Chair of the
Board of Directors



Kim Baker

Chief Executive Officer

Board of Directors

LHINs operate as not-for-profit Crown agencies governed by an appointed Board of Directors and are bound by a Ministry-LHIN Performance Agreement and Memorandum of Understanding with the Ministry of Health and Long-Term Care. Board members are appointed by an Order-in-Council for a term of one to three years, subject to a maximum of two terms (up to six years).

The role of the LHIN Board of Directors is to oversee, provide advice on and govern the strategic direction and priorities of the LHIN. The Board of Directors is accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds and for its performance results in the local health system.



Warren Jestin – Chair
October 22, 2014 – October 21, 2017
Markham



John Rogers
March 10, 2010 – March 18, 2016
Keswick



Dr. Uzo Anucha
June 2, 2011 – June 1, 2017
Richmond Hill



Brenda Urbanski
April 8, 2011 – April 7, 2017
Barrie



Judy Cameron
June 2, 2011 – June 1, 2016
Keswick



Audrey Wubbenhorst
October 23, 2013 – October 22, 2016
Toronto



Albert Liang
May 17, 2011 – May 16, 2017
Markham



Aldous (Sally) Young
October 23, 2013 – October 22, 2016
Gormley



Stephen E. Quinlan
June 23, 2011 – June 22, 2017
Sharon

More information on the Central LHIN Board of Directors can be found at www.centrallhin.on.ca.

About Central LHIN

All demographic data in this section is drawn from the Integrated Health Service Plan 2013-2016 Environmental Scan, Ministry of Health and Long-Term Care Health Analytics Branch analysis of Census Canada.

Central LHIN's mandate is to plan, coordinate, integrate and fund health services at the local level. In 2014/15, Central LHIN's budget of \$1.9 billion was allocated to 95 Health Service Providers through 109 Service Accountability Agreements. These Health Service Providers provide care and services in the following sectors:

- Seven public and two private hospitals
- 46 long-term care homes
- 36 community support service providers
- 23 mental health and addictions service providers
- One community care access centre (CCAC)
- Two community health centres

Note that some health service providers deliver care and services in multiple sectors.

Population

With a population of over 1.8 million, Central LHIN has the most residents, is among the most diverse and is one of the fastest growing of all LHINs.

The population trends that will have significant impact on planning and delivery of health services in Central LHIN are growth, aging and diversity. A key challenge is to meet the increasing demand for care and services as our population continues to grow and age at a rate above the provincial average.

Growth

Central LHIN's population is growing. Between 2011 and 2016, our population will increase by 10.1 per cent, adding 181,000 residents to the Central LHIN. By 2021, the population will have grown by 20.3 per cent since 2011 – one of the highest projected growth rates among the LHINs (provincial population growth rate projected between 2011 and 2021: 12.7 per cent).

Aging

Central LHIN is experiencing greater-than-average population aging (2011-2021). Currently, 12.5 per cent of residents in the LHIN – or 221,068 people – are seniors aged 65 or higher. This puts Central among the top three LHINs in terms of absolute numbers of seniors. By 2021, seniors will comprise 16.1 per cent of all residents – or 342,538 people. This means that in 2021, Central LHIN will be home to 121,470 more seniors than we have today, and will have the highest number of seniors in all of the LHINs.

Diversity

Central has the largest proportion of immigrants (48 per cent of residents) among the LHINs, and the second highest visible minority population (42 per cent of residents). We also have the highest proportion of residents who report no knowledge of either official language (4.5 per cent). In 2006, just over half of the LHIN's population reported English as their mother tongue (the lowest rate among the LHINs) and only 1.2 per cent included French as their mother tongue (the second lowest percentage in Ontario). Central LHIN is home to 864,000 immigrants (highest in the province) and is one of the most diverse LHINs in Ontario.

Aboriginal and Francophone Communities

Central LHIN has a relatively small Aboriginal population – 0.4 per cent of our population, or about 7,000 people. The majority of the Aboriginal population in Central LHIN are living off-reserve. The Chippewas of Georgina Island, comprised of approximately 200 residents, are Central LHIN's only First Nations and on-reserve community.

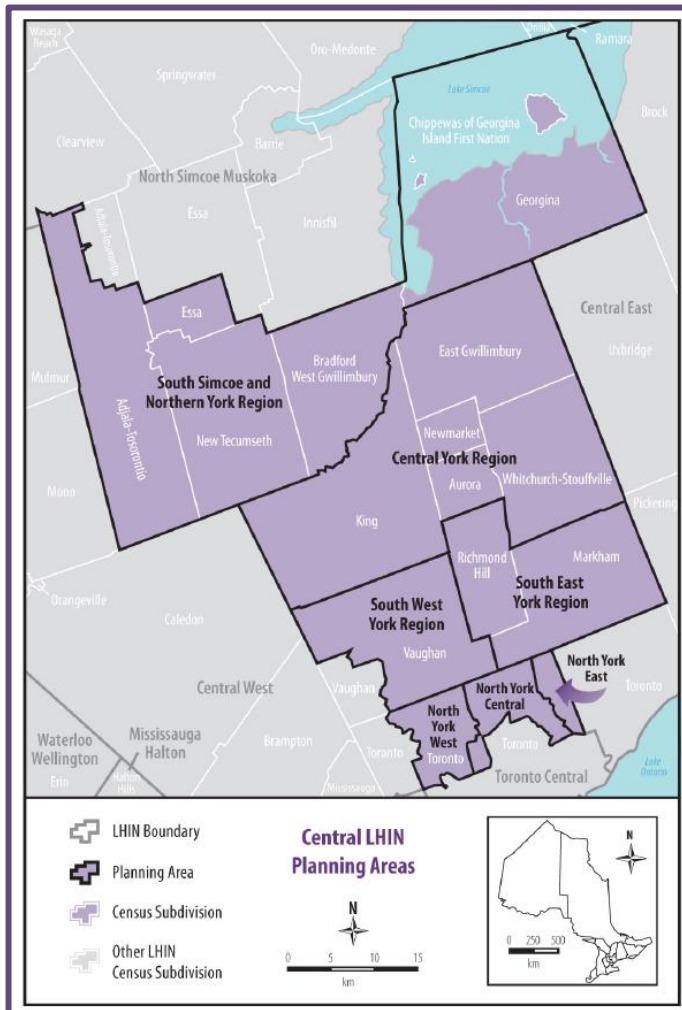
Just over 1.9 per cent of the people who live in the Central LHIN – about 31,725 people – are considered francophone under the provincial definition (adopted in 2009).

Geography

Central LHIN is geographically varied covering an area of 2,730 square kilometres and comprises sections of northern Toronto, a portion of Etobicoke, most of York Region and South Simcoe County. Although Central LHIN is primarily urban, there is a significant rural area in the north, which can present challenges to residents when accessing services close to home in those areas.

Central LHIN's Planning Areas

For planning purposes, Central LHIN is divided into seven geographical planning areas, as illustrated by the map below.



Each planning area has varying populations, age structures, economic conditions, and health and social characteristics. When planning at a system level, targeted approaches are taken to respond to the unique challenges and needs of each planning area.

It's important to note that LHIN boundaries are intended for planning purposes only. Our borders allow us to look at the specific needs of our region but should not impact referral patterns for services. This means that people can receive care from the service provider of their choice, even if that means traveling outside the LHIN.

Health Profile

Analyzing Central LHIN's health profile helps us work towards our goal of reducing health disparities and ensuring equitable access to quality health care in our communities by identifying populations that would benefit from focused initiatives. Generally, our residents have a significantly lower incidence of heart disease, arthritis and multiple chronic conditions than that of Ontario as a whole, and rank among the lowest across the LHINs. Central LHIN residents have the highest life expectancy at birth of 83.6 years and the second highest life expectancy at age 65 in Ontario.

However, social determinants of health such as unemployment, education levels and risk behaviours – such as smoking, obesity and inactivity – have all been shown to affect how healthy people are. Within our planning areas there are variations in health status due to the differences in these characteristics. South Simcoe/Northern York Region and North York West are two planning areas that have been identified as high risk from a population health standpoint. A higher number of residents in these two planning areas face serious chronic diseases and obstacles to accessing primary care, compared to other planning areas in the LHIN.

The growing health needs of our aging population will significantly impact Central LHIN over the next five to 10 years and beyond. The prevalence of multiple chronic conditions increases dramatically with age. Nearly 40 per cent of current Central LHIN residents aged 65-74 and 56 per cent of those aged 75 plus have two or more chronic conditions. These conditions account for six out of 10 deaths, 20 per cent of acute hospital discharges, and 25 per cent of acute hospital days for our residents.

Creating a Sustainable Health Care System: Funding, Accountability and Performance

As a funder, planner and manager of the local health system, Central LHIN's goal is to improve the health care system and make it better for everyone who receives health care in our region. Central LHIN is committed to transparent, responsive and accountable health spending.

Health Service Provider Funding Allocation

In 2014/15, Central LHIN authorized transfer payments of \$ 1,949,997,048 to the following sectors, representing an increase of 3.3 per cent over the previous year:



Sector	2014/15	2013/14
Hospitals	\$1,151,604,778	\$1,128,142,640
Long-Term Care Homes	\$338,701,021	\$330,282,084
Community Care Access Centre	\$282,089,932	\$258,379,710
Community Support Services	\$84,591,275	\$80,252,415
Community Mental Health and Addictions Agencies	\$81,011,874	\$78,343,289
Community Health Centres	\$11,998,168	\$11,588,944
TOTAL	1,949,997,048	1,886,989,082

Health System Accountability

Through the development and execution of Service Accountability Agreements with our health service providers, and through the Ministry-LHIN Performance Agreements with the Ministry of Health and Long-Term Care, LHINs enhance system accountability for public funds. These agreements set out funding and performance deliverables for local services that are aligned with LHIN and Ministry of Health and Long-Term Care priorities.

In 2014/15, Central LHIN had 109 Service Accountability Agreements across all sectors and providers. Ultimately, these agreements support system collaboration to enhance stability and accountability in the health system. They also help us to build a better local health care system – one that emphasizes quality care for people and their families and is delivered within available resources.

Meeting our Performance Goals

Timely access to care is critical, so receiving care in the most appropriate setting allows faster access to care when needed. That is why access to health care services and wait times remain both a provincial and Central LHIN priority.

Over the 2014/15 fiscal year, Central LHIN has taken an integrated approach to making the best use of our local resources and capacity. The Ministry of Health and Long-Term Care, Central LHIN and local health service providers have been working together to continue to improve access and shorten wait times.

The table entitled: *Central LHIN Performance and Targets as Defined by the Province of Ontario*, pg. 12 provides both the 2014/15 annual results and results from the latest quarter. What we are doing to achieve these targets is outlined below:

Access to Health Care Services

Performance Indicators 1-3

Wait times for patients in Emergency Rooms (ER)

Central LHIN did not meet its target of 30.0 hours for 90th percentile ER length of stay for admitted patients. This is partly due to increasing volumes of ER visits along with increasing complexity of admitted patients. In addition, ERs within the Central LHIN experienced an increase in patient surge during the winter months due to seasonal challenges with flu outbreaks and inpatient bed capacity issues in relation to patients designated as Alternate Level of Care (ALC). When patients no longer need acute care

in hospitals, they often remain in acute care beds while waiting to be discharged or transferred. Focused initiatives by Central LHIN hospitals to improve length of stay for admitted patients include patient flow/ALC reduction improvements, increased capital/equipment resources, and process improvement/efficiencies. A Holiday Planning Working Group has also been established by the LHIN to plan and implement mitigation strategies for appropriate, timely and safe access for patients during the holiday/flu season.

Central LHIN continues to perform better than the LHIN target of 7.0 hours for 90th percentile ER length of stay for non-admitted complex patients and also shows improvement from the previous year, as indicated by the quarterly and annual results. Initiatives related to facilitating patient flow in the ER, process improvement for discharging medically complex patients starting at admission, increasing access to diagnostic imaging services and enhancing Physician Initial Assessment remain the main driving forces for improvements.

Likewise, Central LHIN's quarterly and annual performance for 90th percentile ER length of stay for non-admitted minor/uncomplicated patients has been consistently exceeding the LHIN performance target of 4.0 hours and has also shown improvement from the previous year. Initiatives that focus on expediting initial assessment by the physician (e.g. Fast Track Zones, Physician Assistants) and enhancing care coordination in the community (e.g. Health Links, Geriatric Emergency Management nurses, Discharge Planning Nurses) have all assisted in sustaining improvements for this indicator.

Central LHIN continues to closely monitor ER performance, and works collaboratively with hospitals and other key stakeholders across the health care continuum to provide recommendations and opportunities to discuss strategies and learn from each other's expertise.

Performance Indicators 4-10

Percentage of patients who receive their surgical or diagnostic procedure within the Ministry of Health and Long-Term Care's provincial target.

In 2014/15, Central LHIN surpassed its performance targets for cancer, cardiac by-pass, cataract, hip replacement and knee replacement surgeries as well as diagnostic CT scans. These successes were due in part to innovative Central LHIN initiatives such as the two Centres of Excellence for Ophthalmology and the Total Joint Assessment Centre for hip and knee replacements.

Central LHIN also invested funding for additional CT scans and hip and knee replacement surgeries during 2014/15.

The percentage of patients receiving their diagnostic MRI scan within the Ministry of Health and Long-Term Care's provincial target was a challenge for Central LHIN in 2014/15. Increased demand from regional programs caused longer waits for these services. Central LHIN invested funding in additional MRI hours to improve performance which resulted in continuous improvement over the course of 2014/15.

Access to health care services

(2014/15 Annual Results)

The percentage of cases* completed within the provincial target:

- ✓ 100% of Cancer Surgeries
- ✓ 100% of Cataract Surgeries
- ✓ 99% of Cardiac By-Pass Procedures
- ✓ 96% of Hip Replacement Surgeries
- ✓ 95% of Knee Replacement Surgeries
- ✓ 88% of Diagnostic CT Scans

Wait time improvements

(2014/15 Annual Results)

- ✓ Non-admitted minor uncomplicated patients are spending **3.4 hours** in Central LHIN emergency departments – that's the **least amount of time in Ontario**

* Percentage of cases refers to priority IV cases.

Integration and Coordination of Care

Performance Indicator 11

Percentage of Alternate Level of Care (ALC) days to monitor the proportion of patient days used by ALC patients.

In 2014/15, Central LHIN achieved an annual result of 14.4 per cent as compared to the Central LHIN target of 15.0 per cent. Central LHIN's percentage of ALC days in Q1 and Q2 of 2014/15 were 13.8% and 13.7%, respectively. Due to the influenza season and outbreaks in long-term care homes, the flow of patients was impacted in Q3 and hence, the percentage of ALC days increased to 14.5 per cent in the most recent quarter (Q3 2014/15). Nonetheless, the continuous efforts made by our health

service providers across the sectors helped Central LHIN achieve the target for this indicator.

The success in meeting our performance target is a result of the collaboration between Central LHIN, hospitals, Central Community Care Access Centre and community partners; and our continuous focus to invest in initiatives that aim to enhance access to care and deliver care in the most appropriate setting.

Performance Indicator 12

Wait times for Community Care Access Centre (CCAC) in-home services - application from community setting to first CCAC service (excluding case management).

Central LHIN's performance met the overall target for fiscal year 2014/15 despite not meeting the target in the third quarter of the year. This was due primarily to the investment of incremental funding in the third quarter which allowed the CCAC to remove clients with longer wait times from the wait list, thereby affecting the performance of this indicator. It is anticipated that performance will improve in 2015/16 as the wait list is reduced.

Quality and Improved Health Outcomes

Performance Indicator 13

Percentage of repeat unscheduled emergency visits within 30 days for selected Case Mix Groups (CMGs).

In 2014/15, Central LHIN saw a slight increase in the annual result – from 15.04 per cent in 2013/14 to 15.50 per cent. We continue to improve performance in this area with initiatives such as Health Links, the Rapid Response Nursing program, hospital based Telemedicine nurses and the implementation of Quality Based Procedures.

Performance Indicators 14-15

Percentage of repeat unscheduled emergency visits within 30 days for mental health and substance abuse conditions.

In 2015/16, for quarters one-three, Central LHIN did not meet the target in this area at 23.62 per cent, with performance remaining about the same as 2013/14 (23.46 per cent). The figure reflects an increase in unscheduled emergency visits for substance abuse right across the province. Ongoing investments in improving access to mental health and addictions services have been made to address this issue, including the launch of the MOBYSS by the Canadian Mental Health and Addiction Association, York Region and South Simcoe – an innovative mobile bus that delivers primary health care services including mental health and addictions counselling, to youth in the places where they gather. The Central LHIN has also implemented peer navigators in two emergency departments and expanded onsite mobile crisis response services in partnership with Emergency Management Services and police. More details of initiatives targeted at improving performance are described under: *Mental Health and Addictions, pg.14.*

Central LHIN Performance and Targets as Defined by the Province of Ontario 2014/15

PI No.	2014/15 Performance Indicators	Starting Point	Central LHIN Performance Target	Most Recent Quarter	Annual Result
1: Access to healthcare services					
1	90th percentile ER length of stay for admitted patients	32.27	30.00	38.05	32.70
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	7.15	7.00	6.52	6.53
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	3.65	4.00	3.35	3.43
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	100%	90.00%	100.00%	99.75%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	96.50%	90.00%	100.00%	99.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	100%	90.00%	99.68%	99.69%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	96.00%	90.00%	98.86%	96.42%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	95.00%	90.00%	98.21%	95.32%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	48.00%	55.00%	48.09%	38.50%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	84.00%	85.00%	91.11%	88.71%
2: Integration and coordination of care					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	16.27%	15.00%	14.53%	14.40%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	23.00	28.00	31.00	28.00
3: Quality and improved health outcomes					
13	Readmission within 30 Days for Selected CMGs**	15.82%	15.00%	15.36%	15.50%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	17.60%	17.00%	17.31%	17.60%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	20.70%	20.70%	25.95%	23.62%

*FY 2014/15 is based on most recent four quarters of data (Q4 2013/14 - Q3 2014/15) due to availability

**FY 2014/15 is based on most recent four quarters of data (Q3 2013/14 - Q2 2014/15) due to availability

Note: **Green** = indicator met the Central LHIN target; **Yellow** = indicator did not meet the Central LHIN target but has improved from the baseline; **Red** = indicator did not meet the Central LHIN target

Advancing Excellence in Local Health Care, Together



In 2014/15, Central LHIN continued to build on the priorities identified in our Integrated Health Service Plan (IHSP) 2013-2016 launched in February 2013.

The IHSP 2013-2016 is our road map, moving us towards achieving our vision of *Caring Communities – Healthier People*. The IHSP 2013-2016 builds on the achievements of two previous IHSPs (2007-2010 and 2010-2013).

The IHSP 2013-2016 outlines four quality-based system directions that are guiding Central LHIN's activities and investments in the local health system. They are:

- **Appropriateness** – Improve the delivery of safe, effective and timely care in the right setting.
- **Access** – Continue to improve access to hospital, community and primary care.
- **Integration** – Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term care and end of life care.
- **Person-Centredness** – Improve equity in how people experience health care and service delivery.

Working together with our health service providers, we are committed to help our residents receive the right care, at the right time, and in the right place.

Here are a few highlights of the progress and results achieved in the 2014/15 year:

Appropriateness

Improve the delivery of safe, effective and timely care in the right setting.

Improving Emergency Department (ED) Efficiency and Capacity

Improving access to care and delivering care in the most appropriate setting are continued priorities of the province and the Central LHIN. We are committed to reducing the time people spend waiting in a hospital Emergency Department (ED) by strengthening the capacity of our local health care system.

Reducing Emergency Department / Alternate Level of Care Pressures (ALC)

Central LHIN continues to focus on two key areas – reducing the amount of time people spend waiting in the ED and getting people discharged from the hospital faster and into a more appropriate setting of care.



At Central LHIN, there are two active working groups with representation from all Central LHIN hospitals, the Central CCAC and Toronto and York Emergency Medical Services (EMS), along with other key stakeholders. These groups provide collaborative forums to communicate and exchange knowledge and ideas on ED, ALC strategies and system improvements. The following are key initiatives for 2014/15:

- Central LHIN invested in **Home First** to help elderly residents transition from hospital to home and is offered in partnership with Central LHIN hospitals and the Central CCAC. The **Home First** philosophy helps older adults return home with the necessary post hospital supports to safely continue healing when their acute care hospital treatment is complete.

In addition, **Home First** provides adults who may be facing a decision to move to a long-term care home with the time they need to make an informed and thoughtful choice – from the dignity and comfort of their home.

The **Home First philosophy** has served 4,529 clients since its implementation in September 2009 to March 2015. In fiscal year 2014/15, Central LHIN funded a total of 200 Home First spots to support 1,465 clients to safely return home after their hospital stay. 72% of Home First clients remained in the community after receiving enhanced care, thus reducing the need for long-term care.

- Central LHIN facilitated a LHIN-wide **Home First Kaizen Event** in the summer of 2014 with participation from over 30 stakeholders. The outcomes of this Kaizen Event included four key priority projects aimed at improving communications and interactions with patients and families, streamlining the Home First process for patients with existing services from the Central CCAC and developing a process to transition patients into the Home First program directly from the ED.
- Central LHIN funded **103 transitional care beds**, temporary beds that support patients discharged from the hospital, to quickly and safely transition out of an acute care setting and into a more appropriate level of care where they can return to their highest level of independence through specialized, restorative care.
- Central LHIN continued to invest in **Geriatric Emergency Management (GEM) nurses** across Central LHIN hospitals. GEM nurses identify high-risk seniors in the ED, assess the patient, facilitate access to the appropriate community supports and keep people living in the community.
- Central LHIN supported the provincial physiotherapy reform by implementing strategies to **expand physiotherapy services for seniors** in the community, thereby helping seniors to stay healthy, physically active and independent.

- Central LHIN supported the expansion of **Nurse-Led Long-Term Care Outreach Teams (NLOT)** by funding important initiatives to enhance nursing care at long-term care homes, to enable long-term care residents to have better access to timely, high quality care in their homes, and to minimize avoidable transfers to EDs and hospital admissions.
- Central LHIN played a critical role in strengthening linkages between health service providers and community service providers to better serve patients, particularly those with complex needs, through Health Links implementation.
- Central LHIN supported the implementation of the provincial Assisted Living for High Risk Seniors Policy, so that Assisted Living services will be more equitable and accessible by eligible seniors.
- Central LHIN supported the implementation of the provincial **Assess and Restore Guidelines** to enhance rehabilitative and restorative care services to high risk seniors with the goal of intervening and delaying the loss of functional abilities.

Emergency Department Pay for Results (Year 7)

As part of the provincial Emergency Department Wait Times Strategy, the Emergency Department Pay for Results (P4R) program is designed to improve Emergency Room (ER) performance. All designated P4R sites are required to show improvement in the following five provincial ED performance measures:

- 90th Percentile ER Length of Stay for Admitted Patients
- 90th Percentile ER Length of Stay for Non-Admitted, High Acuity Patients
- 90th Percentile ER Length of Stay for Non-Admitted, Low Acuity Patients
- 90th Percentile Time to Physician Initial Assessment
- 90th Percentile Time to an Inpatient Bed

In addition to ED wait times, all designated sites are required to continue to demonstrate improvement on:

- Ambulance Offload Times
- Patient Satisfaction

- Consult Time
- ALC Performance

In 2014/15, Central LHIN was awarded \$12.3 million in one-time funding of the \$99 million provincial investment to support the P4R program. The funding focused on initiatives that were implemented to enhance ER access and capacity, reduce ER length of stay for admitted and non-admitted patients and improve patient satisfaction.

All Central LHIN acute care hospitals – Humber River Hospital (Church and Finch sites), Markham Stouffville Hospital (Markham site), Mackenzie Health, North York General Hospital, Southlake Regional Health Centre and Stevenson Memorial Hospital – participated in the program. Among Central LHIN hospitals, Stevenson Memorial Hospital ranked as the second highest performing site, whereas Southlake Regional Health Centre and North York General Hospital received the highest and second highest funding in the province, respectively.

Nurse-Led Outreach Team Program

The Nurse-Led Outreach Team (NLOT) program was fully implemented in Central LHIN in 2011/12 under Ontario's Emergency Department (ED) and Alternate Level of Care Strategy.

Three Nurse-Led Outreach Teams across the LHIN consist of specialized nurses who build capacity for long-term care homes by working with staff to enhance access to timely and appropriate care in order to reduce avoidable resident transfers to the ED and hospital admissions – which also impact ED wait times. All of the long-term care homes within Central LHIN currently have access to NLOT services.

In 2014/15, two key initiatives were supported by Central LHIN to further enhance performance, better serve long-term care residents and facilitate timely, sustainable repatriation of transferred and admitted residents:

- A pilot project for Central LHIN NLOTs to liaise with Geriatric Emergency Management Nurses, Patient Flow Navigators and discharge staff across Central LHIN hospitals to facilitate timely, sustainable repatriation of transferred and admitted long-term care patients

- Development of an automated notification process to assist in the tracking of patient admissions and discharges, facilitated through the NLOT process

NLOT services have reduced the need for emergency visits. The EMS transport data for Q1 2014/15 shows that ED transfers were averted 89% of the time on average across all the homes*.

* Central LHIN Nurse-Led Outreach Teams Activity Data Summary: Q1 2014/2015 (April 1-June 30, 2014)

Chronic Disease Prevention and Management

The successful provincial transition of diabetes programs to LHINs was completed throughout 2014/15. Central LHIN assumed responsibility for the coordination and planning for five Diabetes Education Programs (DEPs) and two Paediatric Diabetes Programs located in five hospitals and two community health centres. Key accomplishments in 2014/15 included:

- **Common referral:** Central LHIN DEPs have updated and standardized common referral forms. All referral forms (including DEP information and related resources) are available on the Central CCAC's Centralhealthline website: www.centralhealthline.ca.
- **Screening for diabetes:** Central LHIN Diabetes Education Programs have identified partnerships with local pharmacies and Welcome Centres (for new immigrants) to provide diabetes screening and health promotion education to at-risk individuals.
- **Ontario Telemedicine Network (OTN) and accessing specialist care:** Central LHIN enabled all Diabetes Education Programs to have access to telemedicine in 2014/15. The expansion of OTN supports specialist care and group DEP sessions in remote areas and long-term care homes.
- **Community Care Pathways:** Central LHIN's Primary Care Physician Lead completed the development of internet based community clinical pathways for Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

- **Health Links:** Central LHIN DEPs have all been engaged with their local Health Links to support the needs of complex patients.
- **Chronic Disease Management:** COPD clinics were implemented in the two Community Health Centres to support the management of patients in the community. In addition, 20 Breathe Better exercise classes were implemented across the LHIN, specifically for patients at risk of or in early stages of COPD and Chronic Heart Failure (CHF).

Quality Based Procedures

As a key component of Health System Funding Reform (HSFR), Quality Based Procedures (QBP) were introduced in 2012/13 to support the implementation of evidence-based best practices and align patient care with Patient-Based Funding (PBF).

QBPs are clusters of clinically related diagnoses or treatments identified by an evidence-based framework to provide opportunity for process improvements, clinical redesign, improved patient outcomes, enhanced patient experience and potential cost savings.

Previously, Central LHIN worked collaboratively with hospital and community stakeholders to support the implementation of the following QBPs: Unilateral Hip and Knee Replacement, COPD, CHF and Stroke.

In 2014/15, Central LHIN continued to support the implementation of the QBP for Community Acquired Pneumonia. A working group with representatives from Central LHIN's public hospitals and the Central CCAC was formed to lead this work. The group shared tools amongst member organizations, developed a standard clinical pathway for Community Acquired Pneumonia, standardized a list of quality indicators and developed a standard patient guide. The tools developed by the Pneumonia QBP Working Group will be implemented across Central LHIN to help clinicians deliver evidence-based quality care for Pneumonia patients and enhance patients' understanding of their care along the care continuum as they transition from hospital to home.

Expanding Physiotherapy for Seniors and Patients

In 2013, the Ministry of Health and Long-Term Care led reforms to OHIP-funded physiotherapy services in Ontario. These reforms provided an opportunity to expand high-quality physiotherapy services to patients across Central LHIN, including the development of new sources of service.

Physiotherapy reform and expansion has resulted in enhanced access to services in the community and long-term care settings, as well as more equitable access through the development of new services in previously underserved areas of Central LHIN. Access to physiotherapy and regular exercise helps seniors maintain strength and balance reduce falls and stay independent and in their homes.

- ✓ As of March 31, 2015, over 370 group exercise classes and 247 falls prevention classes are available for seniors at over 200 sites across Central LHIN, in both long-term care and community settings
- ✓ In 2014/15, over 10,000 patients accessed OHIP-funded physiotherapy at 25 community physiotherapy clinic sites across Central LHIN
- ✓ In 2014/15, over 15,000 clients received one-to-one in-home physiotherapy services through the Central CCAC
- ✓ All 46 Central LHIN long-term care homes have been funded to provide one-to-one physiotherapy and group exercise classes for their residents



Access

Continue to improve access to hospital, community and primary care.

Young Adults with Medical and Developmental Complexities

In 2013/14, Central LHIN established a Pan GTA LHIN Advisory Group working across multiple Ministries, LHINs and care providers to develop the criteria for a congregate care model that would address the needs of individuals with both medical and developmental complexities who could not direct their own care.

In 2014/15, Central LHIN acted on the recommendations from the Advisory Group and through a collaborative process with the central region of the Ministry of Community and Social Services, are creating nine units – bringing together health care, housing and care coordination– for young adults that fit this profile. Funding for these individuals aligns and flows through two different sectors: developmental services and health.

Assisted Living for High Risk Seniors Policy

Assisted Living services are intended to support seniors with high needs who require services at a greater frequency or intensity than regular home care. Services include a combination of personal support, and homemaking and security checks provided 24/7 on both a scheduled and unscheduled basis. Implementation of the policy has increased access to equitable services for high risk seniors whether they live in the community or in supportive housing units.

Between 2013- 2015, Central LHIN implemented the Assisted Living for High Risk Seniors Policy, including an investment of over \$5 million to serve an additional 625 seniors. In total, Central LHIN increased access to assisted living for high risk seniors by 625 spaces.

Life or Limb Policy

The provincial Life or Limb Policy promotes a philosophy of care for our sickest, most vulnerable and critically ill patients with life or limb threatening conditions. It is intended to improve access to timely medical consultation, and if necessary, support transfer to

a hospital that can provide the clinical services required within a best effort window of four hours.

All Central LHIN hospitals and other key stakeholders worked together to successfully implement the Policy and to have standardized referral, acceptance and repatriation processes in place among all hospitals within the Central LHIN. In addition, Central LHIN worked with other GTA LHINs to develop a collaborative action plan to implement the Life or Limb Policy across GTA LHINs and to have agreed upon referral, acceptance and repatriation processes.

Mental Health and Addictions

Helping people with mental illness and addictions access the supports they need remains a key area of focus for Central LHIN and across Ontario. Central LHIN continues to focus resources where they make the greatest impact for people, so they can manage early symptoms of their health condition, access coordinated services along the continuum of care and obtain the care they need, where and when they need it.

Central LHIN's key goals for enhancing mental health and addictions services are in alignment with the provincial government's Comprehensive Mental Health and Addictions Strategy: Open Minds, Healthy Minds which outlines a 10-year plan to transform mental health and addictions services in Ontario, starting with children and youth services. Key areas of success in 2014/15 included:

- Increasing access to **Mental Health and Substance Abuse Case Management and Counselling** supports in York Region for residents who live in Homes for Special Care (HSCs), domiciliary hostels, shelters or social housing through the Canadian Mental Health Association, York Region and South Simcoe. The program provides case management and support across the continuum with the flexibility to match client needs with the level of support they will receive.
- Expanding existing mental health and addictions mobile crisis services through the implementation of the **Onsite Mobile Crisis Response Model** in York Region. This was developed through the eyes of the patient and consists of a hybrid co-responder model providing mobile crisis support services 24 hours a day, 7 days a week. In this model, the crisis response

worker will meet either the York Regional Police or the York Region Emergency Medical Services on-scene once a 911 call is received and their services are requested.

- Supporting the expansion of the **Mobile York South Simcoe (MOBYSS) mobile clinic**. MOBYSS will expand primary care services for vulnerable youth in the northern portion of Central LHIN, a population that is difficult to reach, and who lack access to physical and sexual health care, and mental health and addictions services. This youth-focused service will be the first of its kind in Ontario where the target population is transitional aged youth from ages 12 to 23 and also includes on-reserve and urban Aboriginal youth, a sub-population that is particularly marginalized by mainstream primary care services. MOBYSS will provide access where youth congregate, including at malls, schools, campuses and skate parks.
- Increasing mental health and addictions supports within housing services through the **South Simcoe Link Team**. This program is in collaboration with the County of Simcoe, bringing both housing and health supports to individuals with mental health and addictions challenges residing in the Simcoe County region of Central LHIN, including Bradford and Alliston. These individuals require supports to maintain their housing, are in fragile housing, and/or are at risk of homelessness or experiencing homelessness.
- Supporting early intervention for mental health challenges through the establishment of the **Mental Health Mood Improvement Program and the Group Psychiatry Model**. Mood disorder programs such as Bounce Back support primary care practitioners by developing a community-based infrastructure to deliver psych-education and guided self-help to patients based on Cognitive Behavioural Therapy (CBT) principles. The Group Psychiatry Model provides group therapy sessions, with psychiatrist oversight to individuals with mild to moderate mood disorders.
- Expanding **Mental Health Peer Support Services** across the LHIN to train individuals to develop their own Wellness Recovery Action Plan (WRAP), and link them to employment and life skills training as well as Cognitive Behavioural Therapy.

- Expanding **Supportive Housing by 12 new units** in Central LHIN. These units include the mental health and addictions supports funded through the LHIN and the rental supplements funded through the Ministry of Health and Long-Term Care. These units will serve residents of York Region living with serious mental health and/or problematic substance abuse issues who are homeless or at risk of becoming homeless. Services include support to residents and their significant others to provide a stable housing environment, assistance with activities of daily living, mental health and addictions supports and crisis avoidance.
- Hosting a **Mental Health and Addictions Housing Supports Planning Summit** in partnership with the Region of York to enable the creation of a multi-year mental health and addictions housing support action plan. Close to 50 people attended, including health service providers; non-funded partners such as York Regional Police and Emergency Medical Services; consumers with lived experience; and housing providers. The work of the summit demonstrates a key planning principle for Central LHIN: to shape our work through what we learn by listening to the voices of our patients. Twenty two consumers of mental health and addiction services were interviewed, with an additional 40 consumers and 12 family members participating in a number of focus groups to inform this project. They were candid in sharing their successes, challenges and recommendations for change. A number of people with lived experiences and involvement in the system attended the event and their participation reminded the group why this work is so important.

Integration

Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care.

Hospice Palliative Care

Central LHIN is working with both our funded and non-funded health service providers to find new ways to strengthen palliative care for patients in our communities and to support more patients through the end of life journey in their preferred locations. Through ongoing collaboration, we are focused on implementing an

equitable, efficient and sustainable model for hospice palliative care. In 2014/15:

- The Regional Hospice Palliative Care Program Council submitted their final service change recommendations based on the Declaration of Partnership and Commitment to Action.
- The Central LHIN developed an action plan to move forward with the implementation of the recommendations over a three year period (2014-17). Implementation started for Phase 1 of the Central LHIN Hospice Palliative Care Action Plan. A co-design process that includes caregivers/families was used for the development of a model for centralized access for palliative and end of life care and a single crisis line for urgent palliative care clinical issues. Investments were also made in education to strengthen knowledge and capacity.
- Central LHIN began the process of establishing a Central LHIN Hospice Palliative Care Coordinating Council to further drive implementation of the action plan.

Health Links

Health Links is a model of care that makes it easier for people who rely on our system the most, such as seniors and people with complex chronic conditions, to access health care in Ontario.

The goal of Health Links is to improve the patient experience. Working together with a patient, providers develop a coordinated care plan with clear goals, ensuring the right services and actions are matched to the patient's needs.

Central LHIN's vision for Health Links is an integrated model of care that extends beyond our funded providers, focused on better coordinating services to deliver person-centred care. The early adopters - South Simcoe Northern York Region Health Link and North York Central Health Link - have been operational since August 2013. Central LHIN's newest Health Link, South West York Region Health Link, began enrolling patients prior to the end of 2014.

Each Health Link is comprised of community, mental health and addictions, primary care and hospital partners, as well as patients, caregivers and other key stakeholders.

As of the end of March 2015, 489 patients with complex needs have been enrolled in Central LHIN Health Links since their implementation.

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"The Southwest York Region Health Link is the third Health Link within the Central Local Health Integration Network. Our health care providers are working together to provide important health care benefits for seniors and patients with complex needs. Through Health Links, our patients can get the right care at the right time and in the right place, while making the most efficient use of our resources and improving the overall care experience."

– Kim Baker, CEO, Central Local Health Integration Network

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Community Transportation

Development of a new community transportation model began in Central LHIN so that patients and clients have more coordinated and equitable access to the health care supports and services they need.

Community transportation provides assisted, non-urgent transportation to qualifying elderly people and adults with disabilities, so they can live independently in the community, while continuing to access medical and other appointments.

The new LHIN wide transportation model will support access to local health care services in communities across the LHIN; will streamline LHIN-funded transportation for Central LHIN residents, so that they can receive the right care, at the right time and in the right place; and will help address challenges that existed in the former model. This new and innovative model for community transportation will:

- ✓ Provide one number for clients to call to access service
- ✓ Improve service consistency, enabling a seamless and consistent client experience, through standardized:

- Policies and procedures including ride prioritization
- Intake, assessment and eligibility criteria
- Fees and subsidies (*where possible*)
- Hours of coverage aligned with client needs (*where possible*)
- ✓ Enhance access to community transportation by improving and expanding service coverage and response times
- ✓ Meet the growing demand for transportation services from Central LHIN residents

Under the new model, two lead health service providers will manage a defined geographic area – CHATS for Central LHIN North (including South Simcoe) and Circle of Care for Central LHIN South.

Central LHIN and the lead agencies began planning for the new model in 2014/15 with implementation occurring over two phases:

- 2015/16: Focus on operational efficiency and effectiveness
- 2016/17: Focus on sustainability, enhanced integration and coordination of services



Centralized Access

Building on a model created in Central LHIN in 2008 for mental health and addiction services, work began on the Centralized Point of Client Access (Centralized Access) project in September 2014 to develop a strategy for

centralized access and service coordination in the community support services sector.

Through standard, efficient and predictable processes, the intent is to rapidly assess and assign individuals to the right service providers upon contact, no matter which health service provider is contacted or what the patient

need. The strategy is centered on the client to improve both the client's experience across the continuum of care and access to services and transitions of care.

Beyond being client-centered, the vision for the new centralized access model incorporates the following:

- Every doorway leads to care – no door is the wrong door
- Clients will provide information only once
- Service delivery will be coordinated at the earliest point possible
- There will be service equity across Central LHIN
- Every client, and/or their caregiver, knows and can relay the agency name and date/time of their appointment

The preliminary phase of this work is complete. Work and implementation will continue once findings from five early adopter LHINs, who are piloting Centralized Access models, are available. These findings will help guide Central LHIN's strategy and implementation.

A Vision for Ophthalmology Services

Central LHIN's local vision care strategy for ophthalmology services was refreshed and endorsed by our Board in May 2014. The local strategy is aligned with the provincial vision strategy recommendations to have an integrated ophthalmology service delivery model that follows best practices, and creates greater efficiencies and better quality.

Central LHIN's vision care strategy focuses on three components:

- Maintaining the current integrated ophthalmology service delivery model of two regional high-volume eye care centers with plans to transfer the remaining small volume of cataract surgeries from Humber River Hospital and Stevenson Memorial Hospital to the high-volume centers
- Exploring the expansion of current levels of specialty eye surgeries such as glaucoma, corneal transplant and strabismus
- Standardizing the process to manage emergency ophthalmology cases including Life or Limb cases

Central LHIN is engaging and working with our Eye Care Committee, leading ophthalmologists, hospitals and ophthalmology service providers to provide high quality, accessible, timely and cost-efficient ophthalmology services for our residents.

Cataract High Volume Centres



Central LHIN has a well-established infrastructure in place through two high functioning, high volume centres to provide low-risk eye surgeries, including all cataract procedures. The Branson Site at North York General Hospital covers the southern part of our LHIN while Southlake Regional Health Centre covers the northern part of our LHIN.

- ✓ In 2014/15, **over 11,000 cataract procedures** were performed by the two Eye Care Centres with each site ranked within the top ten provincial performers for volumes. In 2014/15, North York General Hospital and Southlake Regional Health Centre together performed almost **91% of all the cataracts procedures in our LHIN**.
- ✓ Since implemented in 2010, the two high volume centres have realized significant efficiencies, reduced ophthalmology wait times across Central LHIN and reported excellent patient satisfaction results. As a result of the cataract consolidation at the two high-volume centres, the **wait time for cataract surgery in Central LHIN in 2014/15 was 92 days – that's 69 days less** than the provincial wait time.

Person-Centredness

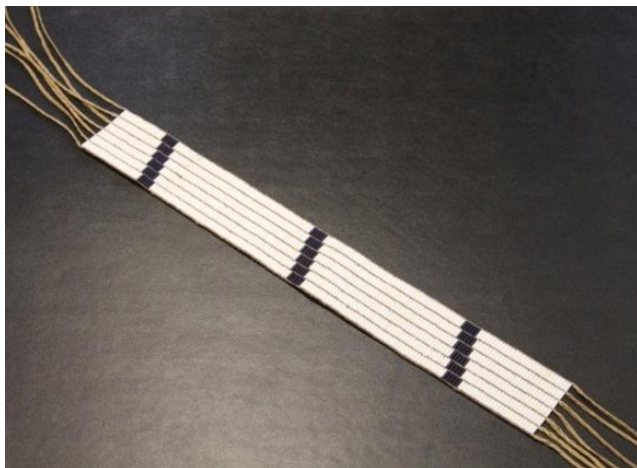
Improve equity in how people experience health care and service delivery.

Enhancing Collaboration with our Aboriginal Community

Central LHIN's Integrated Health Service Plan 2013-2016 re-affirmed the LHIN's commitment to collaborate and engage with its local Aboriginal population. The LHIN's Person-Centredness strategy identifies working with the community, including Aboriginal people, to promote holistic, cross-sectoral strategies to address social determinants of health in at-risk populations.

Central LHIN continues to work with the Ministry of Health and Long-Term Care, health service providers, the Provincial Aboriginal LHIN Network and off-reserve Aboriginal communities – at the local and regional level – to identify and begin to address access barriers to health and healing services, build a trust-based relationship and improve health outcomes for Aboriginals in Central LHIN. Key areas of success in 2014/15 included:

- **Aboriginal Cultural Competency Training for Central LHIN Board and staff.** Delivered by the Ontario Federation of Indian Friendship Centres, the training included a historical overview of Aboriginal people in Ontario, historical markers and a cultural competency framework for addressing different levels of cultural competence. The objectives of the training were to create an empathetic environment; instill better communication; and assist in building trustworthy relationships between Aboriginal populations, health service providers, health system planners and management.
- **Aboriginal Cultural Competency Training for Central LHIN Health Service Providers.** Central



LHIN provided one-time funding to Addiction Services for York Region (ASYR) to coordinate Aboriginal Cultural Competency Training. ASYR worked with the Ontario Federation of Indian Friendship Centres to deliver the training to over 180 health service providers.

Enhancing Collaboration with Our Francophone Community

In 2014/15, Central LHIN continued its collaborative relationship with Entité 4 to address the needs of francophone residents, including determining the capacity of health service providers to deliver services in the French language and development of this service capacity. Some initiatives started or completed during the 2014/15 fiscal year included:

- Collaboration between the Central CCAC, Central LHIN and Entité 4 to enhance the **French language services section of the Central CCAC's Centralhealthline website: centralhealthline.ca**, an online information platform. Users now have the ability to search for and access information relating to health services provided in the French language.
- Continued efforts between Central LHIN and Entité 4 to develop a **mental health and addictions care continuum across the GTA**, with the goal of improving access to mental health and addictions services for francophone adults. Central LHIN also helped to facilitate discussions between Entité 4 and mental health and addictions health service providers to explore how new programs could incorporate a French language component to better serve the francophone population.
- Engagements between Central LHIN, health service providers and the francophone population regarding **French language service availability** for specific initiatives such as access to primary care for the francophone population in the southwest region of the LHIN. In addition, Central LHIN continues to collaborate with Entité 4 to determine the general availability of French language health care services through the annual **Central LHIN French Language Services Survey**.

Citizens Health Advisory Panel

The Citizens Health Advisory Panel (CHAP) began meeting in early 2014 to bring a community perspective to Central LHIN's system planning.



From left: Ron Wadey and Sanjeev Agnihotri, two members of Central LHIN's Citizens Health Advisory Panel (CHAP).

This panel serves as a forum for dialogue among community members with a focus around the LHIN's key initiatives. CHAP provides advice on how to achieve person-centred health care within the local health system to assist the LHIN in designing programs within the local health system context.

Executing the Annual Business Plan

Through our IHSP 2013-2016 and in conjunction with the execution of the 2014/15 Annual Business Plan, we have worked on advancing quality and excellence in the delivery of services and supports to our communities.

The chart below outlines the progress around the implementation of Central LHIN's Annual Business Plan

As illustrated below, 81% of the 2014/15 ABP objectives met their target.

IHSP		Annual Business Plan		Project Management	
System Direction	Action Plan #	Action Plan and Description	Target % to be Complete in 2014/15	% Complete as at Q4	
Appropriateness	1	Align hospital, CCAC and community health centre Quality Improvement Plans (QIPs) to LHIN priorities. Engage family health teams in alignment review.	25%	25%	
	2	Continue to improve and plan for expansion of eReferral and/or resource matching across the health care continuum.	25%	22%	
	3	Advance physiotherapy reform as a key component of the Senior's Strategy to prevent functional decline and reduce falls in seniors.	50%	50%	
	4	Improve system capacity, coordination and care processes to reduce Alternate Level of Care (ALC) pressures within Central LHIN hospitals.	25%	25%	
	5	Implement evidence-based care pathways (Quality Based Procedures) as per MOHLTC schedule (e.g. pneumonia, hip fracture). This work will include the community portion of the pathways for 2013/14 QBPs such as Stroke, CHF and COPD.	25%	25%	

	6	Expand telemedicine capacity LHIN-wide. This includes increasing clinical adoption, expanding telemedicine programs within long-term care, and expanding Central LHIN's telehomecare program	40%	40%
Access	7	Implement medical stability best practices in Central LHIN emergency departments for people with mental health and addiction (MH&A) conditions	25%	25%
	8	Increase use of electronic tools and other electronic methods to share information across providers including primary care. May include electronic hospital reports, coordinated care tools, or centralized repositories of clinical information for access by multiple providers.	25%	20%
	9	Implement the Provincial Life or Limb No Refusal Policy for referral, acceptance and repatriation of clients with a life or limb threatening condition within Central LHIN and GTA hospitals.	100%	100%
	10	Expand access to community supports for people with complex care needs. Includes implementation of a system-wide process for placing clients in assisted living in support of Ontario's Senior's Strategy and may include supports to address caregiver burnout/respite care.	50%	50%
	11	Expand access to services and supports for young adults with medical complexities that may also include developmental disabilities.	25%	25%
	12	Expand access to community mental health and addiction services with a focus on seniors and young adults.	25%	25%
Integration	13	Implement up to five Health Links in Central LHIN as systems of collaborative health care providers working together to improve delivery, integration and coordination of care. Two Health Links underway, third for implementation in 2014-15 and additional two in 2015-16.	75%	75%
	14	Develop a Central LHIN model to optimize LHIN funded community-based transportation services.	75%	65%
	15	Investigate a strategy for centralized access and service integration in the Community Support Services Sector, including Acquired Brain Injury services and Attendant Outreach. Further the development of centralized access and service integration in the mental health and addictions sector.	33%	25%
	16	Reduce High Risk Utilization –Implement eLACE (Length of Stay, Acute Admission, Comorbidities, Emergency Visits), tool for discharge planning that identifies those at high risk of hospitalization across all hospitals. Facilitate utilization of community tool via Health Links to identify those at risk for hospitalization and begin proactive service integration.	25%	25%
	17	Implement Hospice Palliative Care plan to advance high quality and high value palliative care delivery in support of the declaration of partnership between LHINs, the Ministry and the Quality Hospice Palliative Care Coalition of Ontario.	100%	100%
Person-Centredness	18	Establish a Citizens Health Advisory Panel in Central LHIN to inform health system planning and design from the citizen's perspective.	100%	100%
	19	Expand access to primary care and culturally adaptive mental health and substance abuse services, and chronic disease self-management supports for Aboriginal communities which may include the use of telemedicine and/or telehomecare.	10%	10%
	20	Implement evidence-based model to identify and proactively support youth at risk of substance abuse.	75%	75%
	21	Continue engagement with Entité 4 to support additional access to services for the francophone community to improve quality of care and client satisfaction for the Francophone community.	33%	33%
	22	Embed patient experience surveys in Health Links evaluation process.	75%	75%

Community Engagement

Community engagement is fundamental to enabling collaboration with partners across the system to improve access and services for residents in our communities. Throughout the 2014/15 year, Central LHIN continued to engage its diverse communities and stakeholders to support Central LHIN objectives, inform our planning and decision making processes, and maintain alignment with both the Annual Business Plan and the LHIN's Integrated Health Service Plan. Highlights from community engagement activities in Central LHIN for 2014/15 are outlined below:

Aboriginal Engagements

Central LHIN developed an Off-Reserve, Urban Aboriginal Engagement Strategy in 2013/14, intended to build trust and rapport with Aboriginal peoples through a series of engagement sessions with Aboriginal residents and health service providers, both in Central LHIN and in the GTA. To further support the strategy:

- In the spring and summer of 2014, Central LHIN staff met with Anishnawbe Health Toronto and conversed with several LHINs regarding the types of traditional healing programs available – additional engagement with the urban Aboriginal community is required to better understand what traditional healing programs are desired
- In June 2014, Central LHIN staff participated in the annual Nin Os Kom Tin Aboriginal celebration at Fairy Lake in Newmarket
- Central LHIN staff worked with Central CCAC staff to add an Aboriginal section to the Central CCAC's Centralhealthline website: centralhealthline.ca

Mental Health and Addictions Crisis Services Engagement

In July 2014, the Honourable Frank Iacobucci released the report *Police Encounters with People in Crisis* in response to the Toronto Police Services' request for an independent review of the use of lethal force by members of the Toronto Police Service. The report's focus was on encounters between police and people in crisis (those suffering from a mental illness or an individual who is otherwise emotionally disturbed).

The report included 84 recommendations including a section specific on mobile crisis services. Upon release of the report, Central LHIN's York Region Police Model Development Working Group was established in September 2014. The mandate of the working group was to review the current Mental Health Support Team model and identify strengths and opportunities to be leveraged in order to establish a future mobile crisis response model.

The working group met for a total of five meetings over seven weeks between October and November 2014 to review the existing Mobile Crisis Team models, identify the ideal future state and identify and retain elements of the current model that were working well.



The resulting model is co-designed with those who have lived experience including key crisis response services partners including: York Region Police, EMS, Mental Health and Addictions organizations and hospitals and will begin operating in 2015.

Annual Business Plan 2015/16 Engagement Sessions

Over 200 local stakeholders were invited to provide feedback to validate the actions for consideration in the third year (2015/16) of the LHIN's three-year IHSP. Participants viewed and validated the draft action plan and identified gaps, enablers and risks/barriers to successful implementation of the plan. Feedback was used to prioritize the action plans and initiatives outlined in the Annual Business Plan for the 2015/16 year.

Home First Kaizen Event

As part of Central LHIN's continued effort to improve how patients move from one care setting to another and

reduce our Alternative Level of Care (ALC) pressures, the Central LHIN hosted a Kaizen Event from July 22-24, 2014, focused on improving the Home First Process. Over 30 stakeholders from the Central LHIN and our hospitals, CCAC participated in this event including hospital discharge planning teams, CCAC case managers,

patient advisors and administrators. Kaizen Event participants worked together to map out the current state of the Home First process and analyzed key themes around wastes and opportunities through a comprehensive gap analysis.



The Patient Experience

The patient experience has been a strategic focus of Central LHIN as we have been working towards re-framing quality through the eyes of the patient. Our patient experience work was introduced at our quality symposium in March 2014, where we asked participants for input into the elements of a Patient Experience Framework. The framework focuses on seven key areas:

1. Vision: Quality through the eyes of the patient / caregiver
2. Mission: Person-Centred health care
3. Values: Respect, engagement, collaboration and accountability
4. Shared Commitment: Nothing about me without me
5. Aspirations: Don't hurt me. Heal me. Be nice to me
6. Always Events: Aspects of the patient experience that health care providers should always get right. These events should be significant, evidence-based, measurable and affordable
7. Determinants of Health: The framework recognizes that the following determinants play a more significant role in influencing health than the health care system: Income, social support, education, employment, social environment, physical environment, life choices and coping skills, child development, genetics, health services, gender and culture



The framework is a guide for many of our community engagement consultations and conversations and helps to remind us of what is of utmost importance to our patients, caregivers and families.

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"We believe that we can more effectively transform the health care system to better meet the needs of patients, families and caregivers if we understand what's important to them. We want to define success through the eyes of the patient. To do this, we need to understand what they value, so they can help us shape our local health care system so that it's even more patient-centred."

– Kim Baker, CEO, Central LHIN

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Engaging Local Governance

Good governance is fundamental for health service organizations operating in today's complex health care environment. Central LHIN is committed to promoting and supporting our health service provider governors to share best practices and learn from one another. Central LHIN uses Governance Councils (held twice yearly) to bring governors across the sectors together for governance to governance discussions. These sessions are an opportunity to inform health service provider Board Chairs of the initiatives underway in Central LHIN and identify opportunities for collaboration amongst colleagues.

Engaging Local Governments

Central LHIN's Chief Executive Officer and Chair of the Central LHIN Board of Directors met with many of our local MPPs, affording the opportunity to update local

government representatives about our current activities and priorities, foster stronger relationships, and continue our ongoing dialogue on local health issues and our shared commitment to transforming the local health system.

Central LHIN also works closely with local MPPs and our health service providers to announce and celebrate health care progress and investments across our communities.

Integration

In keeping with its legislative mandate, Central LHIN continues to seek out and to support opportunities for the integration of health service delivery. Local health system integrations are informed by the priorities of Central LHIN and its communities and may reach beyond our LHIN boundaries as well. Many Central LHIN health service providers deliver services in neighbouring LHINs, and some of our citizens also cross our Central LHIN planning boundaries to receive some of their health services. Strong partnerships both within and outside of our LHIN are increasingly essential to improve coordinated, accessible and high-quality health care.

The vast majority of Central LHIN initiated integrations that occurred in 2014/15 related to investment in support of the implementation of new and collaborative models of care. These models enable people to receive the right care, at the right time, in the right place and from the right provider.

All LHIN supported service integrations must outline how the integration will improve the care received by Central LHIN citizens in terms of appropriateness, access, person-centredness, quality and efficiency. Integration proposals must also outline how communities and individuals that may be impacted by the integration have been engaged in the planning process and what feedback they have provided. After the integration has occurred, health service providers are required to report regularly to the Central LHIN about the progress made towards the outlined improvements.

eHealth

Central LHIN's Integrated Health Service Plan 2013-2016 identified eHealth as a key enabler for achieving LHIN, Ministry and health service provider priorities.



Steven Del Duca, MPP for Vaughan and CEO Kim Baker of Central LHIN

We believe strategic investments in information technology and information management (IT/IM) will provide secure and integrated access to clinical information and will support the delivery of high quality health care to people in our communities. These include:

Resource Matching and Referral – Continuous Improvement

The LHIN-wide Resource Matching and Referral (RM&R) system is a streamlined, consistent and reliable method of electronically transmitting thousands of patient referrals from acute care to inpatient rehabilitation and the Central CCAC. Referrals are now 34 per cent more complete, and wait times for service have improved which means people are being served faster, smarter and safer.

Central LHIN and the RM&R operational lead continue to work with front line users to improve the RM&R tool. Over the past year, focus has been on integration of the RM&R tool with hospital information systems in order to improve data flow and reduce duplicate data entry by staff, making the referral process faster and more accurate.

Two acute care hospitals – Mackenzie Health and Southlake Regional Health Centre – completed their integration work and both sites have experienced savings of 500 staff hours per year in the amount of time needed to complete electronic referrals.

Additional integration work at Markham Stouffville Hospital and North York General started this year based on the positive results from the first two sites.

Central LHIN has adopted the RM&R reporting and analytics tool which has allowed for improved understanding of roadblocks and barriers to safe, effective patient transfer. It has also allowed for the identification of gaps in services for specific patient groups and led to improved access to rehabilitation services for Central LHIN residents.

Connecting GTA

eHealth Ontario and its partners including LHINs are developing a clinical data repository where patient information and records will be accessible to health service providers in the Central Ontario region.

Connecting GTA (cGTA) is improving the patient and clinician experience by providing clinicians with access to electronic patient information from across the continuum of care, wherever a patient is accessing care.

cGTA enables hospitals and CCACs to upload patient information to the cGTA Clinical Data Repository. Clinicians can then access and view information such as hospital reports, laboratory info, test results, diagnostic imaging, CCAC assessments, etc. through the associated web portal.

The cGTA Clinical Data Repository now contains patient data from 50 per cent of the GTA's hospitals, 93 per cent of CCACs and 75 per cent of provincial laboratories. As a result, over 40 health service providers or 30,000 clinical users currently benefit from the cGTA viewer portal.

Six of the GTA LHINs are involved in cGTA with implementation occurring in stages. Once fully functional, the cGTA CDR will serve as a one-stop-shop for a patient's entire medical record with all health service providers from the six participating LHINs having access to the viewer portal.

For the future, the goal is to increase patient data collection in the GTA's acute care hospitals to 80 per cent including the following Central LHIN hospitals: Stevenson Memorial Hospital, Southlake Regional Health Centre, Mackenzie Health, Markham Stouffville Hospital and Humber River Hospital. Once completed, over 100 health service providers or 40,000 clinical users will benefit from the cGTA viewer portal including the following Central LHIN health service providers: St. Demetrius Supportive Care Services, Ukrainian Canadian Care Centre, LOFT Community Services and York Support Services Network.

Ontario Laboratory Information System

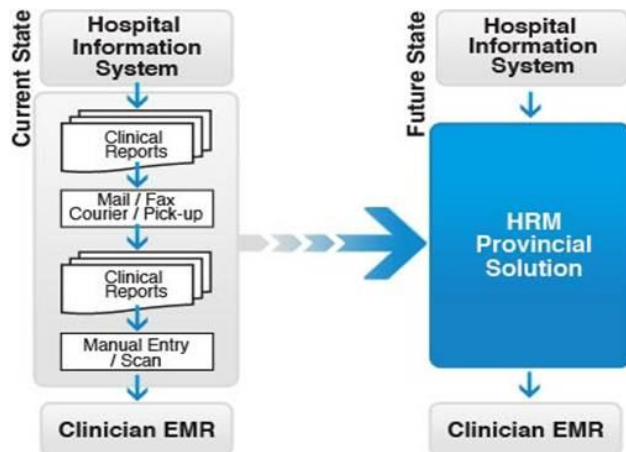
The Ontario Laboratory Information System (OLIS) is a data repository and health information system that facilitates the secure, electronic exchange of laboratory test results amongst Laboratory Information Systems (LIS), Hospital Information Systems (HIS) and Electronic Medical Records (EMRs).

Five of the six Central LHIN public hospitals use OLIS, contributing laboratory test results to the OLIS repository. The remaining public hospital is scheduled to go live in

June 2015. OLIS has been adopted by 692 of Central LHIN's primary care providers, allowing them to receive laboratory test results directly into their EMRs while enabling faster and broader access.

Hospital Report Manager

Hospital Report Manager (HRM) enables clinicians to securely receive patients' hospital discharge summaries and diagnostic imaging reports electronically from participating sending facilities – hospitals and diagnostic imaging clinics – directly into the patient chart in the clinician's electronic medical record, typically within 30 minutes of the report being released. HRM aims to eliminate the paper processes (mail, fax and scanning) that are currently required to receive these reports.



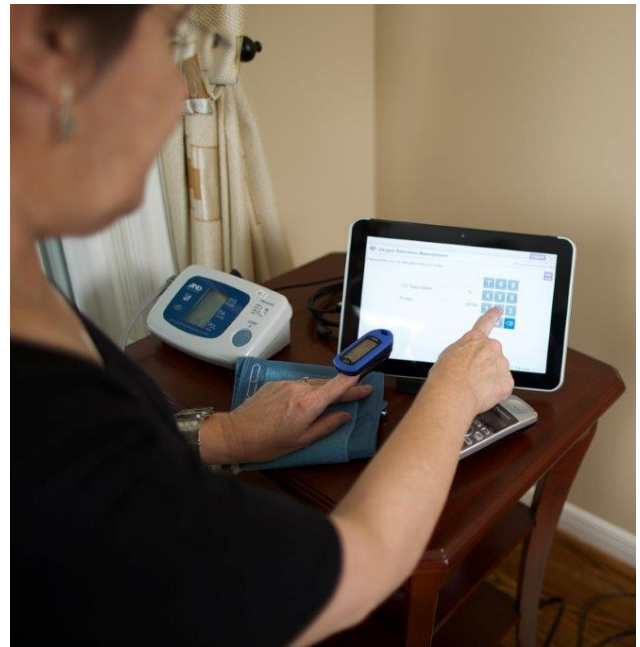
Central LHIN is working with OntarioMD and the cGTA teams to implement HRM across the LHIN. To date, four of six Central LHIN public hospitals are sending reports through HRM with 370 primary care providers benefiting. The remaining two public hospitals are actively implementing HRM and a further 200 primary care providers have signed agreements to move forward with adoption.

Telehomecare

Telehomecare (THC) uses technology to bring chronic disease patients the monitoring they need, right in their home. This technology allows clients, via electronic telemetry monitoring, to input and transmit their vital health information from their home to a remote monitoring care team. The program provides opportunities for proactive client coaching as well as rapid response from the care team to an emerging health crisis, and has demonstrated benefits including:

- Improvements in client's ability to manage their health
- Improved self-reported quality of life and health outcomes
- Decreased hospital readmissions and use of emergency departments and walk-in clinics

As part of Central LHIN's Health Links implementation, THC was identified as a technology solution to support clients who face transportation challenges and/or require daily support to successfully manage their care plan. Two of Central LHIN's THC programs are live, and in 2014/15 Central LHIN continued to work with the Central CCAC to further expand the program into two additional Health Link areas.



Early results from a variety of sources including the Ontario Telemedicine Network and Central LHIN's early adopter program at Southlake Health Centre are promising. Comparing hospital use by patients six months prior to being enrolled in the THC program and six months after discharge, showed a greater than 50 percent decrease in Emergency Department visits. For those patients who did go to hospital, their stay in hospital was much shorter.

Telemedicine Expansion

Using two-way videoconferencing, the Ontario Telemedicine Network (OTN) provides access to care for patients in every hospital and hundreds of other health care locations across the province. In addition to clinical

care, OTN facilitates the delivery of distance education and meetings for health care professionals and patients.

This past year, the focus in the Central LHIN has been on implementing Telemedicine video conferencing units in all 46 Central LHIN long-term care homes to allow for medical consultation and collaboration with existing clinical teams including Nurse Led Outreach Teams, Behavioral Support Mobile Teams and Diabetes Education Programs. Use of these units will result in a reduction in the number of transfers of long-term care home residents to hospital and other care settings, allowing for more care to be provided in the residents' home environment.

Some benefits for long-term care home residents include:

- Timely access to specialists
- Reduction in travel time and expenses
- Delivery of care closer to home

The expansion and continued use of telemedicine equipment will increase access to primary care, mental health, hospital clinics and chronic disease supports while decreasing transportation costs and providing more care for residents in their home environment. This helps patients access the right care, at the right time, in the right place in an efficient manner.

OTN is one of the largest telemedicine networks in the world. It is an independent, not-for-profit organization that is funded by the Government of Ontario.

Emergency Preparedness

Pan Am Games Health System Preparedness

In preparation for the Toronto 2015 Pan Am (July 10-26) and Parapan American (August 7-15) Games hosted in Ontario's Greater Golden Horseshoe area, numerous stakeholders were involved in system-wide plans to coordinate emergency response and preparedness.

While the Ministry of Health and Long-Term Care is responsible for broader health system emergency preparedness, for the Pan Am Games, the Central LHIN has a role in coordinating preparedness from a health system perspective with its hospitals, Public Health, Emergency Medical Services, municipalities and other allied sector partners. Central LHIN has established a Pan Am Games Preparedness Working Group with current activities focusing on health system preparedness, gaps/challenges, collaboration and support of an overall PAN AM communication strategy. In addition, Central LHIN is the lead for planning of the Pan Am North Zone which includes: North Simcoe Muskoka, Central East and Central LHIN.

Together. We're Better.

Financial statements of

**Central Local Health
Integration Network**

March 31, 2015

Central Local Health Integration Network

March 31, 2015

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Independent Auditor's Report

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

We have audited the accompanying financial statements of the Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2015, 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, 2015, and the results of its operations, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in cursive script that reads "Deloitte LLP".

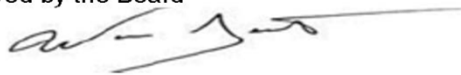
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 26, 2015

Central Local Health Integration Network

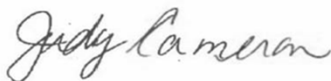
Statement of financial position as at March 31, 2015

	2015	2014
	\$	\$
Financial assets		
Cash	264,873	388,311
Due from Ministry of Health and Long-Term Care ("MOHLTC")	11,373,653	7,308,787
Accounts receivable	94,063	87,215
	11,732,589	7,784,313
Liabilities		
Accounts payable and accrued liabilities	372,232	393,418
Due to Health Service Providers ("HSPs")	11,373,653	7,308,787
Due to Ministry of Health and Long-Term Care ("MOHLTC") (Note 3)	26,548	135,006
Due to Central West LHIN (Note 4)	16,882	1,884
Due to the LHIN Shared Services Office (Note 4)	2,168	1,383
Deferred capital contributions (Note 5)	116,470	154,164
	11,907,953	7,994,642
Net debt	(175,364)	(210,329)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	58,894	56,165
Tangible capital assets (Note 7)	116,470	154,164
	175,364	210,329
Accumulated surplus	-	-

Approved by the Board



Warren Jestin, Chair of the Board of Directors



Judy Cameron, Director and Audit Committee Chair

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

Central Local Health Integration Network

Statement of operations year ended March 31, 2015

	Budget (Note 8)	2015 Actual	2014 Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,886,294,000	1,949,997,048	1,886,989,082
LHIN Operations and Initiatives			
General and administrative	4,189,100	4,177,961	4,188,182
Emergency Room/Alternative Level of Care ("ER - ALC") Funding	-	98,477	100,000
Primary Care Lead	-	72,000	75,000
Aboriginal Initiative	10,000	3,598	10,000
Emergency Department Lead	-	72,000	72,000
French Language Health Services	106,000	91,695	102,769
Critical Care Lead	-	72,000	72,000
Enabling Technologies for Integration			
Project Management Office	-	389,118	392,193
Diabetes Strategy (Note 10)	909,900	904,713	818,228
Amortization of deferred capital contributions (Note 5)	-	52,733	62,007
Total LHIN Operations and Initiatives	5,215,000	5,934,295	5,892,379
	1,891,509,000	1,955,931,343	1,892,881,461
Expenses			
Transfer payments to HSPs (Note 9)	1,886,294,000	1,949,997,048	1,886,989,082
Operations			
General and administrative (Note 11)	4,189,100	4,177,961	4,188,182
ER - ALC funding (Note 10)	-	98,477	100,000
Primary Care Lead (Note 10)	-	72,000	75,000
Aboriginal Initiative (Note 10)	10,000	3,598	10,000
Emergency Department Lead (Note 10)	-	72,000	72,000
French Language Health Services (Note 10)	106,000	91,695	102,769
Critical Care Lead (Note 10)	-	72,000	72,000
Enabling Technologies for Integration			
Project Management Office (Note 10)	-	389,118	392,193
Diabetes Strategy (Note 10)	909,900	904,713	818,228
Amortization of tangible capital assets (Note 9)	-	52,733	62,007
	1,891,509,000	1,955,931,343	1,892,881,461
Annual surplus	-	-	-
Accumulated surplus, beginning of year	-	-	-
Accumulated surplus, end of year	-	-	-

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

Central Local Health Integration Network

Statement of change in net debt year ended March 31, 2015

	2015 Actual	2014 Actual
	\$	\$
Annual surplus	-	-
Acquisition of tangible capital assets	15,039	27,999
Amortization of tangible capital assets	(52,733)	(62,007)
Change in other non-financial assets	2,729	23,157
Decrease in net debt	(34,965)	(10,851)
Net debt, beginning of year	210,329	221,180
Net debt, end of year	175,364	210,329

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

Central Local Health Integration Network

Statement of cash flows year ended March 31, 2015

	2015	2014
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	(52,733)	(62,007)
Amortization of deferred capital contributions (Note 5)	52,733	62,007
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	(4,064,866)	(3,561,984)
(Increase) decrease in accounts receivable	(6,848)	66,954
Decrease in accounts payable and accrued liabilities	(21,186)	(31,624)
Increase in due to Central West LHIN	14,998	1,884
Decrease in due to the MOHLTC	(108,458)	(454,602)
Increase in due to HSPs	4,064,866	3,561,984
Increase in due to the LHIN Shared Services Office	785	1,383
Increase in prepaid expenses	(2,729)	(23,157)
	(123,438)	(439,162)
Capital transaction		
Acquisition of tangible capital assets	(15,039)	(27,999)
Financing transaction		
Deferred capital contributions received (Note 5)	15,039	27,999
Net decrease in cash	(123,438)	(439,162)
Cash, beginning of year	388,311	827,473
Cash, end of year	264,873	388,311

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

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

1. Description of business

The 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 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 mandate of the LHIN is 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 most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with health service providers.

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.

Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers have flowed through the LHIN's financial statements. Throughout the years, funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

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 and expenses in the fiscal year that the events giving rise to the revenues or expenses occur, and the revenues and expenses are earned or incurred and measurable. Through the accrual basis of accounting expenses include non-cash items, such as the amortization of tangible capital assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the Performance Agreement, the LHIN is economically dependent on the MOHLTC.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Performance Agreement.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

2. Significant accounting policies (continued)

Government transfers

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the transfer is authorized and all eligibility criteria have been met.

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.

Deferred capital contributions

Amounts received that are used to fund capital asset purchases are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset. The amount recorded as revenue in the Statement of Operations is consistent with the amortization expense of the related capital asset.

Tangible capital assets

Expenses greater than \$3,000 with a useful life longer than one year will be capitalized as assets and amortized. The value of the asset is determined on an individual basis, for example each software license, not on the total invoice value. Tangible capital assets are recorded at cost. Cost includes the purchase price of the asset and other acquisition costs such as design, construction, and duties. 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.

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

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

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.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Operations and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Revenue has only been recognized to the extent that eligible expenses have been incurred. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

Funding repayable to the MOHLTC is as follows:

			2015		2014
	Funding received	Transferred to deferred capital contribution	Revenue recognized	Repayable	Repayable
	\$	\$	\$	\$	\$
Transfer payments to HSPs	1,949,997,048	-	1,949,997,048	-	-
LHIN operations	4,189,122	10,527	4,177,961	634	285
Special program funding	1,344,908	4,511	1,314,483	25,914	130,912
Other recoveries	-	-	-	-	3,809
	1,955,531,078	15,038	1,955,489,492	26,548	135,006

4. Related party transactions

LHIN Shared Services Offices and LHIN Collaborative

In accordance with the Memorandum of Understanding between the MOHLTC and the LHIN, LHINs are required to centrally source and share services for Legal Services, Audit Services, HR Services, IM & IT Infrastructure Development and Management and Management of Recorded Information. The LHINs accordingly formed the LHIN Shared Services Office ("LSSO") as a division of the Toronto Central LHIN. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LSSO operating under paid by the LHIN at year end is recorded as a payable to the LSSO.

The LHIN Collaborative (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 cost of providing these services is allocated and charged to the LHINs. Any portion of the LHINC operating costs overpaid (or under paid) by the LHINs at year end, are recorded as a receivable (payable) from (to) the LHINC.

During the year, the LHIN made payments to LSSO and LHINC of \$400,872 (2014 - \$436,018).

Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, the LHIN entered into an agreement with Central, Central West, Central East, Toronto Central, Mississauga Halton and North Simcoe Muskoka (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from Central West LHIN of \$389,118 (2014 - \$392,193).

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

5. Deferred capital contributions

	2015	2014
	\$	\$
Balance, beginning of year	154,164	188,172
Capital contributions received during the year	15,039	27,999
Amortization for the year	(52,733)	(62,007)
	116,470	154,164

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	\$	\$	\$
2016	324,076	5,928	330,004
2017	307,960	5,928	313,888
2018	317,327	988	318,315
2019	355,985	-	355,985
2020 and after	27,539	-	27,539

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

7. Tangible capital assets

	2015	2014
	Net book value	Net book value
	\$	\$
Office furniture and fixtures	95,542	131,665
Computer equipment	2,579	-
Leasehold improvements	18,349	22,499
	116,470	154,164

8. Budget figures

Budget amounts have been reported in the Statement of Operations to comply with PSAB reporting requirements and reflect the initial budget at April 1, 2014. The budgets were approved by the Government of Ontario.

	2015	2014
	\$	\$
LHIN total budget	1,891,509,000	1,807,659,100
Less Health Service Provider budget (a)	(1,886,294,000)	(1,802,164,100)
LHIN operating budget (b)	5,215,000	5,495,000

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

8. Budget figures (continued)

a) Health Service Provider budget

	\$
Initial HSP budget	1,886,294,000
Adjustments due to announcements made during the year	63,068,300
	<u>1,949,362,300</u>
The total budget by sector is as follows:	
Hospitals	1,151,284,500
Long Term Care Homes	336,819,300
Community Care Access Centres	282,209,900
Community Support Services	84,875,600
Community Health Centres	12,153,200
Community Mental Health and Addictions	82,019,800
Total budget	<u>1,949,362,300</u>

b) LHIN operating budget

	\$
Initial budget as reported on the statement of operations	5,215,000
Additional funding received in-year	725,000
Funding for capital asset purchased transferred to deferred capital contributions	(15,038)
Closing budget	<u>5,924,962</u>

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of \$1,949,997,048 (2014 - \$1,886,989,082) to the following sectors:

	2015	2014
	\$	\$
Hospitals	1,151,604,778	1,128,142,640
Long Term Care Homes	338,701,021	330,282,084
Community Care Access Centres	282,089,932	258,379,710
Community Support Services	84,591,275	80,252,415
Community Mental Health and Addictions	81,011,874	78,343,289
Community Health Centres	11,998,168	11,588,944
	<u>1,949,997,048</u>	<u>1,886,989,082</u>

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

10. Operations of LHIN - Project Funds

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

	2015	2014
	\$	\$
Salaries and benefits	1,235,052	1,102,269
Professional services	252,000	294,000
Shared services	104,910	112,490
Occupancy	71,193	53,179
Public relations and community engagement	1,800	11,377
Supplies	22,004	10,126
Mail, courier and telecommunications	2,298	1,349
Other	14,344	57,400
	1,703,601	1,642,190

Diabetes strategy operational expenses included in the project fund expenses above are as follows:

	Budget 2015	Actual 2015	Actual 2014
	\$	\$	\$
Salaries and benefits	707,140	736,458	635,702
Others	202,760	168,256	182,526
	909,900	904,714	818,228

11. General and administrative expenses

The Statement of Operations presents the expenses by function. The following table classifies the general and administrative expenses by object:

	2015	2014
	\$	\$
Salaries and benefits	3,197,171	2,940,484
Shared services	295,962	413,218
Occupancy	215,961	230,484
Supplies	118,015	118,140
Board expenses (see below)	64,560	91,180
Public relations and community engagement	56,971	77,933
Professional services	82,913	61,897
Consulting services	-	43,325
Mail, courier and telecommunications	33,968	33,656
Other	112,440	177,865
	4,177,961	4,188,182

Central Local Health Integration Network

Notes to the financial statements

March 31, 2015

11. General and administrative expenses (continued)

Board expenses included in general operating expenses above include per diem costs and other Board expenses as follows:

	Budget 2015	Actual 2015	Actual 2014
	\$	\$	\$
Board Chair per diem expense	42,000	12,100	31,500
Other Board members per diem expense	32,000	25,275	22,700
Governance costs and travel	15,000	27,185	36,980
	89,000	64,560	91,180

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 29 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 2015 was \$345,197 (2014 - \$313,872) for current service costs and is included as an expense in the 2014 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2014. At that time, the plan was fully funded.

13. Guarantees

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

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

14. Comparative figures

Certain comparative numbers have been reclassified to conform to the current year presentation.

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