Central **LHIN**

Leading by Listening – The Power of *the Patient's Voice*

2015/2016 Annual Report

Ontario
Local Health Integration Network

Table of Contents

Together, we're *better!*

The Central Local Health Integration Network (LHIN) is one of 14 LHINs – Crown Agencies 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.

Local health care planning and engagement are important priorities for Ontario's LHINs. The LHINs work together with a wide range of stakeholders – Health Service Providers (HSPs), patients and families, and partners such as municipalities and community residents – to design and implement solutions that can make real improvements 'on the ground' across the local health care system.

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.

The Central LHIN's philosophy is that **Together, we're *better!*** Thanks to the shared purpose and passion that is demonstrated by stakeholders across our geographic region, we're advancing our Vision of ***Caring Communities, Healthier People*** in a measureable and meaningful way.

Message from the Chair and CEO

In 2015/2016, the Central LHIN worked with 96 Health Service Providers and invested over $2 billion to support better health care for 1.8 million residents who live within our geographic region.

The past fiscal year was one of shared leadership, incredible momentum and positive change as we completed *Advancing Excellence in Local Health Care Together* – our Integrated Health Service Plan (IHSP) for 2013-2016. Patients and families, Health Service Providers and partners such as municipalities played a key role in moving our health system forward as we implemented the plan. Together, we advanced the plan's four Quality-Based System Directions: Appropriateness, Access, Integration and Person-Centredness.

We also looked to the future by launching an extensive engagement plan to develop the *Caring Communities, Healthier People* IHSP for 2016-2019. Hundreds of stakeholders were consulted to provide feedback and insights into regional health issues such as our growing and aging population, and to explore unique health considerations in local communities. We also continued to strengthen our connections and working relationships with our three Public Health Units and primary care physicians to better understand local health issues and concerns.

The Central LHIN continues to use evidence-based data and best practices to inform investment decisions that improve access and integration of health care services. We identify population health issues in local communities so we can implement collaborative solutions with the capacity to make an impact now and into the future.

We are committed to ongoing measurement and performance monitoring so that we can confirm that Central LHIN investments are providing system-wide improvements for our population – which is the largest, most diverse and one of the fastest growing in Ontario.

Innovation in Action

Reena clients and staff

The Central LHIN worked with our Health Service Providers and other partners to develop and invest in new initiatives to address health services needs right across our region.

In collaboration with our partners…We responded to data that shows Central LHIN has a high number of young adults with medical and developmental complexity.

In 2015/16, the Central LHIN leveraged the learnings from its unique congregate care model that was first implemented in 2012 at Reena Community Living in Vaughan. The model provides specialized care to improve quality of life for young adults who have medical and developmental complexities. The program supports them to live in an appropriate community setting with access to the essential care they need while enjoying a feeling of independence. This breakthrough was made possible through Central LHIN collaborations with the Ministry of Community and Social Services, two of our Health Service Providers (March of Dimes and the Central Community Care Access Centre), Reena Community Living, and York Region Housing.

In 2015/16, significant progress was made in planning and implementing this new model which integrates a total of nine additional young adults into the model at Reena and the 'Richmond Hill Hub', another innovative housing concept pioneered in York Region.

Working with York Regional Police and Paramedics…We addressed the increase in people who are experiencing mental health and addictions challenges.

New Mental Health Mobile Crisis Teams in York Region bring together York Support Services Network (one of our HSPs), York Regional Police and York Region Paramedic Services to identify and provide crisis intervention to people who have mental health issues and have called 911.

Now, a trained mental health crisis worker accompanies police to 911 calls to provide support and conflict resolution, often successfully diverting Hospital Emergency Department visits and starting to resolve difficult issues.

Working with Physicians and Specialists…We supported the growing number of seniors by providing access to care in safe, supportive settings.

All 46 long-term care homes within the Central LHIN now have the necessary infrastructure and technology support to connect residents remotely through telemedicine technology, with physicians and specialists for endocrinology, internal medicine, fracture follow-ups and psychiatry. This means long-term care home residents in Central LHIN do not need to leave their "home" to receive this care. The consult with the specialist takes place in the safety and comfort of the residents' long-term care home and can reduce unnecessary Emergency Department visits.

We assisted people who want to spend their last days at home – or in another location of their choice.

Although 66 per cent of patients say they would prefer to die at home, the reality is that this occurs only 22 per cent of the time. To address patient preference, we developed and implemented a 24/7 telephone crisis line available at end-of-life to patients and families across the Central LHIN. Patients and families can get end-of-life support from a trained Registered Nurse or are connected to other health care professionals with the necessary expertise, any day of the week and around the clock.

These are just a few examples of health care system investments and improvements that have been achieved during the past fiscal year. The benefits of these initiatives will continue into the future for the residents of our communities.

With the completion of the 2013-2016 Integrated Health Service Plan (IHSP) – *Advancing Excellence in Local Health Care, Together* – we realize that a compelling vision can only be advanced through the efforts and the excellence of thousands of people.

Your contributions move us forward – whether you work or volunteer with one of our Health Service Providers… …participate on a work group or committee…. …raise an issue for consideration…or share an experience or an idea.

We have now launched our new Integrated Health Service Plan for 2016-2019. Entitled *Caring Communities, Healthier People*, this integrated plan builds on our shared accomplishments and learnings so that, working together, we can continue to plan, coordinate, integrate and fund health services that address local needs.

With great thanks for the shared purpose and passion of all of our stakeholders, we're committed to listening and leading together to achieve ***Caring Communities, Healthier People***.

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 Accountability 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).

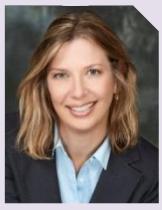
The role of the LHIN Board of Directors is to oversee, provide advice on and govern the strategic direction and priorities of the LHIN. Through the Chair, the Board of Directors is accountable to the Minister of Health and Long-Term Care for the LHIN's use of public funds and for its performance results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

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

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

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

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



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

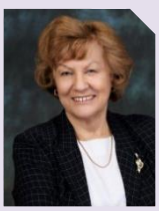
David Lai
March 20, 2016 – March 19, 2019
Richmond Hill

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

John Rogers
March 10, 2010 – March 9, 2016
Keswick

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

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



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

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 2015/16, Central LHIN's budget of $2.048 billion was allocated across a range of health services through 109 Service Accountability Agreements delivered by our Health Service Providers (HSPs), including:

- Six* public and two private hospitals
- 46 long-term care homes
- 33 community support service providers
- 21 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.

* In addition, there is one service accountability agreement with a hospital outside the Central LHIN.

Geography

Central LHIN is geographically varied, covering an area of 2,730 square kilometres and comprising 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.

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 has increased by 10.1 per cent. 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 LHIN 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 LHIN 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.

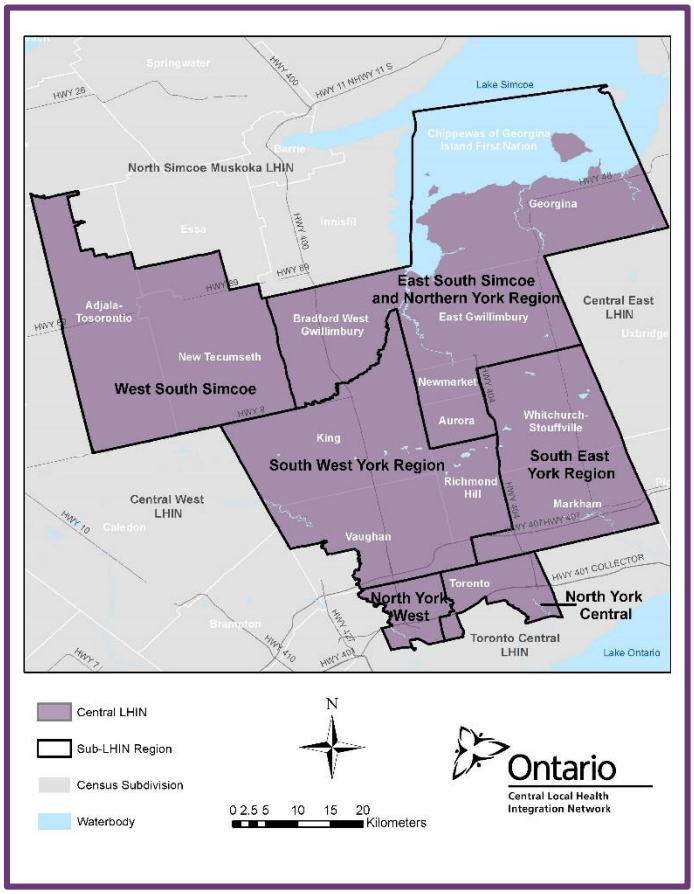
Aboriginal and Francophone Communities

Central LHIN has a relatively small Aboriginal and Métis population – 0.4 per cent of our population, or about 7,000 people. The majority of the Aboriginal population in Central LHIN is living off-reserve. The Chippewas of Georgina Island, comprised of approximately 200 residents, is 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)

Central LHIN's Planning Areas

For 2015/16 planning purposes, six local sub-planning areas were defined within Central LHIN:



Each planning area has unique populations, age structures, economic conditions, 4and 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 are not intended to impact referral patterns for services. This means that residents can receive care from the service provider of their choice, even if that means travelling 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. 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 of 83.6 years and the second highest life expectancy at age 65 in Ontario.

Social determinants of health such as unemployment and education levels, as well as risk factors – such as smoking, obesity and inactivity – all contribute to the health of our residents. Variations in health status exist throughout our planning due to the differences in these characteristics. The three planning areas of West South Simcoe, East South Simcoe and Northern York Region, and North York West have been identified as high needs areas from a population health standpoint. A higher number of residents in these areas face serious chronic diseases and obstacles to accessing services, including 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.

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 that receives health care in our region. Central LHIN is committed to transparent, responsive and accountable health spending.

Health Service Provider Funding Allocation

In 2015/16, Central LHIN authorized transfer payments of $2,043,334,690 to the following sectors, representing an increase of 4.8 per cent over the previous year:

Sector	2015/16	2014/15
Hospitals	$1,218,995,581	$1,151,604,778
Long-Term Care	$342,124,263	$338,701,021
Community Care Access Centre	$297,796,041	$282,089,932
Community Support Services	$86,646,598	$84,591,275
Community Mental Health and Addictions Agencies	$85,446,137	$81,011,874
Community Health Centres	$12,326,070	$11,998,168
TOTAL	**$2,043,334,690**	**$1,949,997,048**

Health System Accountability

Through the development and execution of Service Accountability Agreements with our Health Service Providers, and through the Ministry-LHIN Accountability 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 2015/16, 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 2015/16 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. 13* provides both the 2015/16 annual results and results from the latest quarter. What we are doing to achieve these targets is outlined below:

Home and Community Care

Performance Indicators 1-3

Wait times for patients to receive Community Care Access Centre (CCAC) services for personal support, nursing, and in-home services

Central LHIN did not achieve its targets for these indicators in 2015/16. However, despite increases in the demand for services, Central LHIN performance was maintained when compared to 2014/15, and was at or near provincial performance levels.

This was due to strategic investments from Central LHIN in Nursing and Personal Support Services, and community investments to address demand for CCAC services, including additional Assisted Living services. Targeted performance improvement activities were also implemented by the Central CCAC to improve patient access to services and performance on these indicators. Central LHIN anticipates further improvement for these indicators in fiscal year 2016/17.

System Integration and Access

Performance Indicators 4, 5

Wait times for patients in Emergency Department (ED)

Central LHIN did not meet its target of 8.0 hours for 90th percentile Emergency Department (ED) length of stay for complex patients. However, Central LHIN's 2015/16 performance of 9.80 hours is better than the provincial performance of 9.97; and is an improvement over its 2014/15 performance of 10.28. In 2015/16, all of the Central LHIN's EDs focused on patient flow and improved ED capacity, and more specifically, targeted the length of stay for the complex 'admitted' patient population. In addition, Central LHIN hospitals continued to optimize their EDs by reviewing and redesigning staffing resources to meet the needs of their respective patient populations. For example, a number of initiatives are currently in place: five out of six of Central LHIN's hospitals have Geriatric Emergency Nurses (GEMs) in their EDs and all six hospitals have improved patient access to General Internal Medicine physicians through their respective General Internal Medicine Re-Assessment Clinics and/or Urgent Care Clinics.

The Central LHIN achieved its target of 4.0 hours for the 90th percentile ED length of stay for minor/uncomplicated patients. In 2015/16, the Central LHIN's performance was 3.33 hours, which was better than the provincial performance of 4.07 hours; and an improvement from the 2014/15 performance of 3.43 hours. A number of initiatives are currently in place to sustain this performance, including a focus on patient flow in ED, process improvement for non-complex patients and internal protocols to identify pressures in the ED.

The Central LHIN continues to closely monitor ED 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. The LHIN also supports hospitals by hosting host bi-monthly meetings with the Central LHIN ED working group for the purpose of planning, implementing, and evaluating performance measures to improve the delivery of Emergency Services in the Central LHIN hospitals. Hospitals continue to make their own improvements to improve ED performance.

Performance Indicators 6-9

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

Central LHIN continued to surpass its performance targets for cancer, cardiac by-pass, cataract, hip replacement and knee replacement surgeries. 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.

The percentage of patients receiving their diagnostic CT and MRI scans within the Ministry of Health and Long-Term Care's provincial target was a challenge for Central LHIN. While the LHIN did not meet the provincial target, investments by the LHIN in additional MRI and CT procedures improved access and exceeded provincial performance.

Access to health care services

(2015/16 Annual Results)

The percentage of cases* completed within the provincial target:

- ✓ **99%** of Cardiac By-Pass Surgeries
- ✓ **98%** of Cataract Surgeries
- ✓ **97%** of Hip Replacement Surgeries
- ✓ **96%** of Knee Replacement Surgeries
- ✓ **95%** of Cancer Surgeries

Wait time improvements

(2015/16 Annual Results)

- ✓ Non-admitted minor uncomplicated patients are spending **3.3 hours** in Central LHIN emergency departments – that's the **least amount of time in Ontario**

* Percentage of cases refers to priorities 2, 3, and 4 cases.

Performance Indicators 10, 11

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

In 2015/16, the following revised Alternative Level of Care (ALC) indicators and targets were introduced through the Ministry-LHIN Accountability Agreements (MLAA):

i) Percentage ALC Days: 9.46%
ii) ALC Rate: 12.70%

Central LHIN did not achieve these targets in 2015/16; however, despite high demand for services throughout the healthcare system, performance on these indicators was maintained when compared to 2014/15. This was due to ongoing collaboration and implementation of strategic initiatives among the Central LHIN, the Central CCAC, Community Sector Services and all Central LHIN hospitals. In 2015/16 Central LHIN reported Percentage ALC days (year to date) of 14.26 per cent, and annual ALC rate of 13.87 per cent. Performance on both of these indicators was at or near provincial performance levels.

To improve ALC performance, Central LHIN has established an ALC Collaborative team of hospital, CCAC and LHIN staff to develop a system-wide approach to minimize ALC pressures and to explore and implement hospital and community-based initiatives to enhance patient flow and support transitions between care settings.

Health and Wellness of Ontarians – Mental Health

Performance Indicators 12, 13

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

In 2015/16, Central LHIN saw an increase in repeat ED visits within 30 days for mental health conditions at 19.47 per cent, compared with 18.25 per cent in 2014/15. Central LHIN also saw an increase in repeat ED visits within 30 days for substance abuse conditions – from 27.26 per cent compared to 23.68 per cent in 2014/15. The figure is consistent with an increase in unscheduled ED visits for these conditions right across the province. Ongoing investments have been made to improve access to mental health and addictions services. These include supportive housing, services for transition-aged youth and a mobile support team in partnership with police and Emergency Management Services. Central LHIN has also implemented a Mental Health and Addictions Bed Registry process across all six Central LHIN hospitals. More details of initiatives targeted at improving performance are described under: *Mental Health and Addictions Services across the Central LHIN, pg.17*.

Sustainability and Quality

Performance Indicator 14

Percentage of Readmissions within 30 days for selected HBAM Inpatient Group (HIG) conditions

In 2015/16, Central LHIN saw a slight increase in the annual readmissions result – from 15.50 per cent in 2014/15 to 15.69 per cent. We continue to improve performance in this area with initiatives such as implementation of Ontario Telemedicine Networks (OTN) Telehomecare in all Health Links, implementation of Quality Based Procedures and the adoption of best practice pathways for patients with Chronic Obstructive Pulmonary Disease (COPD); implementation of two COPD clinics in the Community Health Centres (2014), and the implementation of the Integrated Funding Model (IFM) pilot for COPD patients led at North York General Hospital. Also, 380 exercise and 240 falls prevention classes for seniors have been implemented. 20 classes have been designated "Breathe Better", tailored for seniors at risk of COPD and/or CHF.

Central LHIN Performance and Targets as Defined by the Province of Ontario 2015/16

No.	Indicator	ON target	Provincial			Central LHIN		
			2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
1. Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	84.35%	84.92%	84.14%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	94.13%	92.97%	93.72%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	30.00	31.00	27.00	31.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	10.48	9.97	10.28	10.20	9.80
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.28	4.07	3.43	3.47	3.33
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	41.30%	43.31%	40.95%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	87.05%	82.36%	83.96%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	95.63%	98.60%	97.46%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	93.88%	96.62%	96.20%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	14.34%	14.27%	14.26%
11	ALC rate	12.70%	13.70%	14.12%	13.98%	13.23%	14.36%	13.87%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	18.25%	19.46%	19.47%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	23.68%	27.49%	27.26%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	15.90%	15.78%	15.69%

2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	96.01%	95.00%	95.48%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	98.32%	99.00%	99.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	99.71%	97.72%	98.46%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	17.00	19.00	19.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	6.00	10.00	6.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	6.53	1.73	4.67
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	190.85	44.23	133.99
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	53.32%	52.28%	53.74%

*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)

**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)

NA = Not Available

Indicator achieved provincial target

Indicator is within 10% of provincial target

Indicator exceeds 10% of provincial target

Advancing Excellence in Local Health Care, Together

In 2015/16, the Central LHIN completed the final year of our Integrated Health Service Plan (IHSP) for 2013-2016 – *Advancing Excellence in Local Health Care, Together*.

This IHSP was a valuable roadmap to advance our vision of ***Caring Communities, Healthier People*** and outlined four quality-based system directions that guided Central LHIN's activities and investments in the local health system. They were:

- **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.

The following sections outline key progress and results achieved by the Central LHIN, our Health Service Providers and partners in the 2015/16 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 in the most appropriate setting is a critical component of maintaining and improving health care quality and patient safety. Working in collaboration with hospitals, the Central Community Care Access Centre (CCAC) and community partners, the Central LHIN continues to support this goal by reducing the amount of time people spend waiting in the ED, and to safely discharge patients from hospital to an appropriate setting of care.

Emergency Department (ED) Pay for Results

The Central LHIN is committed to work with, and to support Central LHIN hospitals so that patients have timely access to the ED in our region's hospitals. The LHIN continues to host bi-monthly meetings with the Central LHIN ED Working Group for the purpose of planning, implementing, and evaluating performance measures to improve the delivery of Emergency Services in the Central LHIN hospitals. The aim of the Working Group is to identify and facilitate strategies that will improve the Central LHIN's Emergency Care system through the application of best practice evidence, and where appropriate, standardization of care and processes.

As a component of the provincial Wait Times Strategy, the ED Pay for Results (P4R) program is designed to provide incentives for improved performance in the ED. The Ministry of Health and Long-Term Care allocates annual funding to

P4R designated hospitals based on their performance relative to all P4R sites across the province. All of Central LHIN's acute care hospitals currently participate in this program – Humber River Hospital (Wilson site), Markham Stouffville Hospital (Markham site), Mackenzie Health, North York General Hospital, Southlake Regional Health Centre and Stevenson Memorial Hospital.

In 2015/16, Central LHIN received $12.2 million in one-time funding to support the P4R program.

All provincial P4R sites are required to show improvement in the following ED indicators:

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

Beginning in 2016/17, Ambulance Offload Time has been added as a sixth P4R indicator. In addition, P4R sites will be participating in a new ED Return Visit Quality Program, which supports hospitals in investigating return visits to the ED as an indicator of the quality of care provided in the ED.

P4R sites are also required to continue to demonstrate improvement in:

- Patient Satisfaction
- Consult Time
- Alternate Level of Care (ALC) Performance

Among Central LHIN hospitals, in 2015 Stevenson Memorial Hospital ranked as the second highest performing P4R site in the province. At the same time, North York General Hospital, Southlake Regional Health Centre and Humber River Hospital received the first, second and third highest funding allocations in the province, respectively.

Improving Capacity and Reducing Alternate Level of Care (ALC) Pressures

In 2015, the Central LHIN established an ALC Collaborative comprised of staff from hospitals, the Central Community Care Access Centre (CCAC), and the Central LHIN to provide focused, collective resources to enhance the effectiveness of the health system to provide the right level of care to the right patient at the right time. The ALC Collaborative is actively engaging all Central LHIN hospitals, the Central CCAC and other system partners to communicate and exchange knowledge and ideas on ALC strategies and system improvements. The ALC Collaborative has completed an in-depth current state analysis of issues affecting ALC in Central LHIN.

Results from the current state analysis are being used by the ALC Collaborative to identify and prioritize improvement plans for 2016/17, including ALC avoidance, supports for patients with cognitive and/or responsive behaviours, and ways to improve access and reduce wait times to rehabilitative care, while achieving efficiencies in planning for care and improving the patient experience when acute care hospital treatment is complete.

Central LHIN continues to invest in **Home First**, which helps senior 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 6,074 patients since its implementation in September 2009 to March 2016. In fiscal year 2015/16, Central LHIN funded 205 **Home First** spots to support 1,545 patients to safely return home after their hospital stay. Seventy per cent of **Home First** clients remained in the community after receiving enhanced care, thus reducing the need for long-term care.

In 2014/15 the Central LHIN facilitated a LHIN-wide **Home First** Kaizen event and identified four key priority projects to: improve communications and interactions with patients and families; streamline the **Home First** process for patients with existing services from the Central CCAC; and effectively transition patients into the **Home First** program directly from the Emergency Department.

In 2015/16, Central LHIN facilitated the implementation and ongoing evaluation of these projects at all Central LHIN hospitals. To date, 83 per cent of these projects have been implemented in Central LHIN hospitals.

Nurse-Led Outreach Team (NLOT) Program

The Nurse-Led Outreach Team (NLOT) Program was fully implemented in Central LHIN in 2011/12 under Ontario's ED and Alternate Level of Care Strategy. Central LHIN has three teams comprised of Registered Nurses and Nurse Practitioners. The NLOTs build capacity for long-term care homes by working with staff in the long-term care home so that they have access to timely and appropriate care in order to reduce avoidable resident transfers to the ED and hospital admissions. All of the 46 long-term care homes within Central LHIN currently have access to NLOT services.

In 2015/16, the Central LHIN's NLOTs completed the following:

- Approximately 6,400 new consultation requests, of which 2,868 were identified as 'imminent transports';
- An estimated 89% of these imminent transports were averted;
- 10,800 consultation requests; and
- NLOT staff provided 3,564 hours of capacity building services.

Source: Central LHIN Nurse-Led Outreach Teams Activity Data Summary: Q4 2015/2016.

Alignment of Quality Improvement Plans

Since 2010, the Excellent Care for All Act has required that certain types of health service organizations develop and submit an annual Quality Improvement Plan (QIP) to Health Quality Ontario (HQO). The Central LHIN also requests a copy of these QIPs. A Quality Improvement Plan represents a formal commitment that an organization makes to improvement and is also an opportunity for organizations to work together to improve the health care system across different sectors. The impact of QIPs could be greater if Health Service Providers align their priorities for improvement with those of the LHIN. In order to maximize this opportunity, the Central LHIN brought together Health Service Providers and partners including hospitals, the Central CCAC, long-term care homes, community health centres, family health teams and nurse practitioner-led clinics together for a full day Regional Quality Session at the end of November. This day, co-hosted with HQO, focused on developing a shared understanding of the performance of the health care system in Central LHIN. Analysis of the 2015-16 QIPS for Central LHIN showed that our Health Service Providers have made significant progress by aligning their improvement priorities with those of Central LHIN. As well, Health Service Providers from all sectors had the opportunity to work together to identify improvement initiatives to include on their 2016-17 QIPs.

Assess and Restore Implementation

Central LHIN continued to support the implementation of the provincial Assess and Restore Guidelines to enhance rehabilitative care services to high-risk seniors with the goal of intervening and delaying the loss of functional abilities. In 2015/16, the Assess and Restore program in Central LHIN provided standardized rehabilitation services to 251 patients on inpatient medicine units in hospital, and provided enhanced in-home rehabilitation services to 117 patients.

In 2016/17, the focus of the Assess and Restore program will be on:

- Continuation of the program delivered in 2015/16;
- Spread and knowledge translation of the foundational elements of Assess and Restore to all regions of Central LHIN; and
- Early identification of patients for the Assess and Restore program through enhanced community partnerships.

Expansion of Telemedicine Capacity LHIN-wide

By using two-way videoconferencing, the Ontario Telemedicine Network (OTN) provides access to care for patients in every Central LHIN hospital and hundreds of other health care locations across the province. In addition to clinical care, OTN facilitates the delivery of distance meetings and education opportunities for health care professionals and patients.

Central LHIN continued to focus on the expansion and adoption of telemedicine with our Health Service Providers, working towards the vision of a LHIN where telemedicine is embedded into all appropriate models of care to improve the patient experience and enhance health system capacity. The expansion and continued use of telemedicine equipment is

increasing 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. The use of telemedicine continues to grow in Central LHIN. Health Service Providers have increased the number of clinical telemedicine events by 12 per cent in comparison to last year. These events are opportunities to provide timely access to specialists, reduce travel time and expenses, and deliver care closer to home.

Increasing Telehomecare Adoption for Results

Telehomecare (THC) uses technology to bring chronic disease patients the monitoring they need, directly into their homes. 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 a client who may be experiencing an emerging health crisis. Telehomecare has demonstrated benefits, including:

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

As part of the eHealth Strategy for the past year, Central LHIN has been working in partnership with the Ontario Telemedicine Network, Central CCAC and Southlake Regional Health Centre to make our THC program available for all residents who qualify for the service within the Central LHIN. In addition to spreading the program to the full LHIN geography, Central LHIN has also worked to make the program available in different settings where seniors are co-located – for example, within LOFT Community Services Bradford House. This is a supportive housing service for vulnerable and at risk older adults and seniors living with mental health and addiction issues. The Central LHIN and LOFT identified that LOFT residents often visit the ED for concerns related to their chronic conditions and not always for mental health issues. Collaboratively, the Ontario Telemedicine Network (OTN), the Central CCAC, Central LHIN and LOFT launched a version of the THC program at LOFT Bradford House.

"The Telehomecare program has provided the residents of LOFT Bradford House with the opportunity and support to be proactive, focused and in charge of their health and wellbeing. This is significant as many residents have faced challenges with the social determinants of health such as housing, access to food etc., which prevented them from tending to their health. One resident now says about the knowledge and the skills he has gained, 'this is now part of my daily routine' even after finishing the program, and that is what it is all about."

- Debra Walko, Director of Seniors Services, LOFT Community Services * Central LHIN Nurse-Led Outreach Teams Activity Data Summary: Q1 2014/2015 (April 1-June 30, 2014)

Implementing Evidence-Based Pathways for Quality-Based Procedures (QBPs)

As a key component of the Health System Funding Reform (HSFR), Quality Based Procedures (QBPs) were introduced in 2012/13 to support the implementation of evidence-based 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, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Community Acquired Pneumonia and Stroke.

In 2015/16, results from a Pan LHIN QBP implementation assessment survey were used to identify gaps and challenges towards implementation of QBPs in all Central LHIN hospitals, and develop strategies to mitigate these. Specific focus was given to improvement opportunities in the Stroke and Hip Fracture QBPs.

Three key priorities were identified and implemented in 2015 to enhance stroke care in Central LHIN, including:

1) An integrated Stroke Unit has been implemented at SRHC and plans are in place for a dedicated Stroke Unit at MSH by the fall of 2016.

2) Utilization of an electronic communication method (Telestroke) to administer the clot-blocking drug (tPA) at SRHC is scheduled to begin in June 2016.

3) The Central LHIN is actively engaged with partners from the Toronto Central and the Central East LHIN in developing a common model of community rehabilitative care.

In 2016, Central LHIN established a working group with representatives from all Central LHIN hospitals, and the district and regional stroke centres to improve access for stroke patients to screening protocols for swallowing difficulties (Dysphagia).

For patients that have had a Hip Fracture, a working group with representatives from all Central LHIN hospitals and the Central CCAC was formed to enhance care pathways for patients to access necessary services when their acute care hospital treatment is complete.

Access

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

Mental Health and Addictions Services Across the Central LHIN

Helping people with mental illness and addictions to access the supports they need remained a key area of focus for Central LHIN and across the province. Central LHIN continued to focus resources on areas of greatest impact, so residents can manage early symptoms of their health condition and access coordinated services along the continuum of care.

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. Key areas of success for the Central LHIN in 2015/16 included:

- Expansion of **Supportive Housing by 58 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 and the North York West planning area who are: living with serious mental health and/or problematic substance abuse issues; and 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.

- Implementation of a **Central LHIN Mental Health and Addictions Bed Registry.** Since 2013, Central LHIN has been working with our local hospitals and other stakeholders to implement a Bed Registry. On February 2, 2016, a Mental Health and Addictions Bed Registry Protocol was implemented across all six Central LHIN hospitals, providing a process to align with the CritiCall Provincial Adult Mental Health Resource Board, launched in December 2015. While the Resource Board provides up-to-date information about the number of available inpatient mental health and addiction beds in Ontario hospitals with mental health and addiction programs, the Protocol provides a pathway to access the beds. For the first time, the Ministry of Health and Long-Term Care, LHINs and hospitals have access to real-time data on the availability of mental health and addiction beds to improve access, patient flow and bed utilization.

- Expanded access to **Transitional Youth Services** in the North York West planning area. This initiative delivers an integrated recovery-based service model for youth

living with mental illness and/or substance use conditions and a duel diagnosis. It provides a combination of one-to-one mental health and addictions case management and group programming to enable early identification and treatment.

- Establishment in March 2016 of a **Rapid Response Table** by providers in York Region. This critically important Table brings together multiple cross-sector service providers to assist those with mental health and substance abuse challenges to review and address individual situations where a client may be at risk of inflicting harm to him/herself or others. Partners include housing, police, EMS, social services, and health. This collaboration leverages combined strengths and resources to better serve community residents, decrease risk and improve outcomes. Agency partners deploy real-time interventions to ensure that anyone determined to be an 'acutely elevated risk' is connected to appropriate, timely and effective supports.

- Deployment of the **Co-responder Mental Health Mobile Crisis Team** as a partnership between York Support Services Network, York Regional Police and York Region Paramedic Services. The Mental Health Crisis Workers respond to calls that come through 911 from both police and paramedics when someone is experiencing a mental health crisis. They provide support to the first responders, person in crisis and their family/friends who may be at the scene. If it is determined that the person should go to the hospital, they will travel with the person in crisis to hospital. It has been demonstrated that mobile crisis teams at the scene with police results in lower rates of apprehension.

Integrating and Developing Ophthalmology Services

The Central LHIN refreshed its Vision Care Strategy in April 2014, in alignment with the provincial vision care strategy. Central LHIN's vision care strategy includes:

- Maintaining the current integrated ophthalmology service delivery model of two regional high-volume eye care centers (North York General Hospital and Southlake Regional Health Centre);
- Expanding current service levels of specialty eye surgeries within the Central LHIN for procedures; Glaucoma, Corneal Transplant, and Strabismus, to provide access to these surgeries closer to home; and
- Standardizing a process to manage emergency ophthalmology cases, including Life or Limb cases, to provide emergency services in a timely manner.

Maintaining integrated ophthalmology service delivery model

The Central LHIN has completed the transition of remaining cataract surgeries at Humber River Hospital (HRH) to North York General Hospital (NYGH). The complex cataracts and medically necessary bi-lateral cataract procedures will continue to be provided at the Central LHIN's two high volume Eye Care Centres. The Provincial Vision Strategy Task Force is reviewing best practices and funding strategies regarding complex cataracts, bilateral cases, and cataracts performed under general anesthesia and the two regional Eye Care Centres will adopt these best practices as they become available.

Expansion of specialty eye surgeries

Effective January 2015, the Central LHIN has provided one-time funding for two years to the two regional Eye Care Centres in the Central LHIN to expand local access for Glaucoma and Corneal Transplant procedures. The hospitals are reporting a lower 90th percentile wait time for both procedures compared to the province since the expansion of these procedures.

Plans are in progress to expand capacity for Strabismus surgeries for both adults and pediatrics within the Central LHIN to provide access to these surgeries closer to home.

Emergency Ophthalmology Care

In collaboration with the Central LHIN Eye Care Committee, the Central LHIN hospitals have developed a standardized and integrated process across the LHIN to manage emergency ophthalmology cases, including ophthalmology Life or Limb cases, in a consistent and timely manner. A memorandum of understanding has been signed by all Central LHIN hospital CEOs in support of this process. The process will be reviewed by the Central LHIN Eye Care Committee annually.

Expanding Assisted Living Services for Our Growing Population of Seniors

Assisted Living services are intended to support high-needs seniors who require services at a greater frequency or intensity than regular home care. Services include a combination of personal support and homemaking, and safety checks are conducted 24/7 on both a scheduled and unscheduled basis.

Central LHIN also funded additional Assisted Living services to Lumacare for 110 new Assisted Living clients for high-risk seniors in the North York West planning area.

Supporting Young Adults with Medical and Developmental Complexities

In 2013/14, the Central LHIN established a Pan LHIN GTA Advisory Group that worked 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 March 2016, Central LHIN acted on the recommendations from the Advisory Group and funded nine units to integrate individuals with these complex needs into the community through a collaborative process with the Central Region of the Ministry of Community and Social Services. Young adults living in these units benefit from care coordination and 24/7 integrated health and developmental services within a community-based housing setting. This initiative is a joint project between the Central LHIN and the Ministry of Community and Social Services (MCSS), with funding flowing from both sectors to provide the services.

To date, five young adults have been placed into units at the Reena site program location – a community living facility providing support to people with developmental disabilities. The remaining four young adults will be placed into the Region of York's "Richmond Hill Hub" location and full occupancy is anticipated by summer 2016.

Life or Limb

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.

In 2015/16,

- 1,050 cases were declared Life or Limb by Central LHIN hospitals; and
- 92.8% of patients transferred were transferred to an appropriate facility for higher level of care within 4 hours.

One Number-to-Call

On December 9, 2015, CritiCall Ontario launched a One-Number-to-Call (ONTC) initiative to provide timely and coordinated access to specialty consultation and transportation for confirmed Life or Limb patients. The goal of ONTC is to help patients receive access to care at the closest, most appropriate hospital and via the most appropriate method of transport. All transport interactions will be coordinated by Criticall Ontario which will reduce the time spent by Emergency Department staff making transport arrangements, and will reduce duplications while enhancing integration and standardizing the process across the province.

Integration

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

Implementing the Palliative Care Action Plan

A key priority for the Ontario government and for the Central LHIN is strengthening palliative care for patients in our communities, and providing initiatives that will support more patients through the end-of-life journey in their preferred locations. Both funded and non-funded Health Service Providers have provided important input into advancing the Palliative Care Action Plan for the Central LHIN.

These significant milestones were achieved in 2015/16:

- The Central CCAC became the lead organization for the Patient Registry, Bed Registry and Centralized Resource Registry which went live during the past fiscal year. This registry provides centralized access to palliative

care services and residential hospice beds for patients and their families.

- Implementation of the 1-844-HERE4ME Palliative Care Crisis Line – a single telephone number answered by trained Registered Nurses, with the capacity to 'warm transfer' calls to other expert specialists if needed. The telephone line assists patients at end-of-life and their caregivers with emotional or physical changes; physical pain or symptoms; and issues with medical equipment or supply concerns.

- The Central LHIN funded the Hospice Palliative Care Team at Southlake Regional Health Centre to establish a standardized education program across Central LHIN for all palliative care providers, volunteers and families/caregivers that is based on best practice. In 2015/16, over 900 individuals completed the palliative care education program.

- The Long-Term Care Home Working Group was established to develop a plan by March 2017 to increase palliative care capacity in the Central LHIN's long-term homes, through education and supports.

- An online directory of palliative care and end-of-life resources is now available on the CCAC website at www.centralhealthline.ca.

- A model was developed to provide palliative specialist support to primary care practitioners for pain and symptom management, medical management and interventions, and care coordination and navigation with plans for implementation in 2016/17.

The Central LHIN established the Palliative Care Coordination Council in alignment with the recommendations of the Ontario Palliative Care Network. The Council will provide guidance to the continued implementation of the Central LHIN Action Plan and identified provincial initiatives.

Expanding Health Links

Health Links is a planned system of collaborative health care providers, designed to improve delivery and coordination of care for high-needs patients, including seniors and others with complex conditions. In the first phase of the provincial implementation, the North York Central Health Link in the southern part of the LHIN and the South Simcoe Northern York Region Health Link in the northern part of the LHIN were launched. This year saw the development of the second phase with the launch of the South West York Region Health Link for a total of three Health Links in the Central LHIN. The Central LHIN also worked with the South East York Region and North York West Health Links to achieve approval by the MOHLTC this fiscal year.

Also of note is the Health Links Evaluation currently underway with the Health System Performance Research Network, in partnership with the Central LHIN and the three early adopter Health Links. The review aims to develop a better understanding of the impact of Health Links processes on patient health service utilization.

Bringing Standardized Community Transportation to Central LHIN

Development of a new community transportation model began in Central LHIN in 2014/15, and in July 2015 the new service, called iRIDE^{Plus}, was launched with the goal of improving and expanding response times across the region. The iRIDE^{Plus} program responds to the growing demand for transportation services from Central LHIN residents who represent the frail elderly and adults with disabilities. By providing the iRIDE^{Plus} service, these Central LHIN residents can live independently in the community, knowing they are able to get a safe, accessible and affordable ride to medical appointments and community programs such as Adult Day Programs.

At the official iRIDE^{Plus} launch.
Left to right: Graham Constantine, Chair of Board of Directors, CHATS; Christina Bisanz, CEO, CHATS; Kim Baker, CEO, Central LHIN; Michael Scheinert, President (retired in 2016), Circle of Care

The two lead agencies for iRIDE^{Plus} are CHATS as the Central LHIN North lead (including South Simcoe) and Circle of Care for Central LHIN South. The new model creates consistency, convenience and client comfort by:

- Standardizing operating procedures and driver training;
- Centralizing bookings through the new 1-844-iRIDE01 phone number;
- Optimizing ride scheduling through a centralized software system including the use of GPS technology in vehicles. This allows the drivers to better navigate traffic and reduce delays, and therefore maintain an efficient route for clients who need to get to medical and other appointments on time; and
- Standardizing client fees in both regions covered by the lead agencies is nearing completion.

In 2015/16, over 7,000 clients benefited from iRIDE^{Plus} and the focus for the future is on sustainability, operational excellence and expansion.

eHealth

A key enabler for achieving the LHIN, Ministry and Health Service Provider priorities in our Integrated Health Service Plan is eHealth.

Outlined below are summaries of how strategic investments in information technology and information management (IT/IM) are providing secure, integrated access to clinical information and supporting the delivery of high quality health care to people in our communities.

Resource Matching and Referral (RM&R)

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 more complete, and wait times for service have improved which means people are being served faster, smarter and safer.

The past 2015-16 fiscal year focused on completing integration of RM&R with all hospital clinical systems. This has assisted in reducing duplication of data and increase accurate completion of referrals. The time gained through this initiative can be used for additional patient care and services instead of administrative activity. In addition, Central LHIN funded the integration between Southlake Regional Health Centre's Cancer Centre clinical system and RM&R so that referrals sent from the Cancer Centre are now completed faster and with improve accuracy in information.

ConnectingGTA

eHealth Ontario and its partners including LHINs are developing and implementing a Clinical Data Repository (CDR) where patient information and records will be accessible to Health Service Providers in the Central Ontario region. ConnectingGTA (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 six GTA LHINs are involved in a staged implementation of cGTA. Once fully functional, the cGTA clinical data repository will serve as a one-stop-shop for patient medical records with all Health Service Providers from the six participating LHINs having access to the viewer portal. The cGTA CDR now contains patient data from 11 GTA

hospitals, all six GTA CCACs and most of the GTA provincial laboratories. As a result, over 41,000 clinical users and their patients currently benefit from the cGTA viewer portal. The following Central LHIN organizations are contributing to cGTA: North York General Hospital, Humber River Hospital and the Central CCAC.

For 2016/17, the goal is to increase patient data collection in the GTA's acute care hospitals including the four remaining Central LHIN public hospitals: Stevenson Memorial Hospital, Southlake Regional Health Centre, Mackenzie Health, and Markham Stouffville Hospital. By the end of 2016/17, over 100 Health Service Providers and their patients will benefit from the cGTA viewer portal including some Central LHIN community agencies.

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 among Laboratory Information Systems (LIS), Hospital Information Systems (HIS) and Electronic Medical Records (EMRs).

As of August 5, 2015, all Central LHIN public hospitals and community laboratories are live with OLIS, contributing laboratory test results to the OLIS repository. OLIS has been adopted by almost 1,000 of Central LHIN's primary care providers, allowing them to receive laboratory test results directly into their EMRs and enabling faster and broader access.

Hospital Report Manager

Hospital Report Manager (HRM) enables clinicians to securely receive patients' hospital medical and diagnostic imaging reports electronically from participating sending facilities and insert directly into their patient's electronic medical record. This transfer typically occurs within 30 minutes of the report being released. HRM aims to eliminate the paper processes (mail, fax and scanning) that are currently in use to exchange these reports.

Central LHIN worked with OntarioMD and the cGTA teams to implement HRM in the two remaining Central LHIN public hospitals.

As of November 5, 2015, all the Central LHIN public hospitals are live with Hospital Report Manager (HRM) – sending reports through HRM, with 861Central LHIN primary care providers and their patients benefiting.

e-Consult

An eConsult occurs when a requesting clinician (family physician or nurse practitioner) electronically sends a question to a specialist. This can be a simple question (e.g., about a drug dosage) or a more complex question following an initial assessment by the requesting clinician (e.g. asking for a virtual dermatology assessment and providing images of the patient). eConsults may avoid the need to physically send a patient to a specialist for diagnosis or treatment reducing the amount of time a patient has to wait.

Starting in October 2015, Central LHIN's North York General Hospital participated in an eConsult pilot program with the Toronto Central LHIN's F.A.S.T. (Find a Specialist Today) partners: Sunnybrook Health Sciences Centre and Toronto East General Hospital along with four other LHINs and the Ontario Telemedicine Network (OTN). In the Central LHIN, 169 eConsults were sent to specialists by 38 clinicians with an average response time of five days, the shortest being 12 minutes. The pilot program will continue until September 2016 to be followed by a phased provincial deployment.

Integrated Assessment Record (IAR) Adoption

The Integrated Assessment Record (IAR) is an application that allows authorized users to view a consented client's assessment information to effectively plan and deliver services to that client. Used primarily in the Community Sector, IAR adoption is a priority in the Central LHIN eHealth Strategy as it:

- Reduces the number of times clients have to repeat information;

- Facilitates collaboration between community sector providers which is becoming increasingly important as more care is shifted to home and community and more complex clients with multiple needs are being seen in the community sector; and

- Reduces duplication and allows for access to assessment data to help identify client needs and put services in place to meet those needs.

Over a period of several years, Central LHIN Health Service Providers (HSPs) participated in both Common Assessment and IAR implementations. Although the majority of HSPs completed their implementations of the common assessment tools and the IAR, it was suspected that sustainability and adoption of the tools had started to slowly decrease. To support adoption and use, Central LHIN is working collaboratively with both the Community Support Services (CSS) and Mental Health and Addictions (MH&A) Networks to support common assessment and IAR adoption.

The focus of the past year was in the CSS sector, with several accomplishments. In early May 2015, the LHIN supported the purchase of an on-line training and competency testing tool that is being used by our CSS Agencies to support building assessment capability in the sector. In early 2016, a new role – Common Assessment and IAR Trainer – was staffed at Community and Home Assistance for Seniors (CHATS) to support sustainability and adoption efforts. Several training sessions for CSS agency staff were held in March 2016. All sessions received positive feedback from the agencies that attended. In the CSS sector, we also saw a 20 per cent increase in the number of agencies that are now using the IAR through the uploading of client's assessments. Work with both the CSS and MH&A sectors will continue in the next fiscal year.

Person-Centredness

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

Enhancing Collaboration with our Aboriginal Community

The Central LHIN's commitment to continue to work with its local Aboriginal population was confirmed in the 2013-2016 Integrated Health Service Plan. The 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 both the local and regional level. Through ongoing collaboration, the Central LHIN is identifying and addressing access barriers to health and healing services, building trust-based relationships and improving health outcomes for Aboriginals in Central LHIN. In 2015/16, the key areas of success included the following:

Continued Funding of Indigenous Cultural Competency Training (ICC) Workshops

In collaboration with the Ontario Federation of Indian Friendship Centres (OFIFC), the Central LHIN has funded a number of training sessions over the past two years for Central LHIN staff, new Board members and Health Service Providers (through Addictions Services York Region). Training objectives are to: enhance cultural competency; create an understanding environment; foster better communications; and assist in building trustworthy relationships between Aboriginal populations, Health Service Providers, health system planners and management. By March 2016, 360 staff of Central LHIN Health Service Providers had completed ICC training.

Aboriginal Navigators Funded in Black Creek Community Centre

In October 2015, Central LHIN funded two part-time Aboriginal Navigators through our one of our Health Service Providers, Black Creek Community Health Centre. Black Creek serves the North York West and South Simcoe and Northern York Region planning areas of the Central LHIN. These areas are designated as priority communities within the Central LHIN. The Navigators worked with Central LHIN's Aboriginal community (youth and adult, off-reserve and on-reserve), who would benefit from culturally sensitive navigation and case management support. Specific areas of focus were to improve access to all health care services including access to primary care, chronic disease management and mental health and addictions supports.

Enhancing Collaboration with our Francophone Community

In 2015/16, Central LHIN continued its collaborative relationship with Entité 4 to meet the needs of the Francophone adult population. Key achievements for the 2015/16 year included the following:

Addressed the needs of the Mental Health and Addictions sector for the Francophone population

The Central, Toronto Central and Central East LHINs worked to optimize existing centralized access systems and processes to better support Francophone clients with mental health and addictions issues across the three LHINs. A working group of the mental health and addictions Health Service Providers within the three LHINs established a series of deliverables which were introduced with a focus on outreach, capacity-building and data collection.

French Language Services Navigator Pilot

In October 2015, the Central LHIN funded a Black Creek Community Health Centre to develop and pilot a French Language Services navigator model to serve the North York West community. The Francophone population in this area received navigation and case management support to improve access to physical health care services; mental health and addictions services and supports; and chronic disease prevention and management services.

Developed a Francophone table in the Region of York in partnership with Entité 4.

This table of Francophone stakeholders within the Region of York was a forum where the Central LHIN engaged Francophone community members and organizations to better understand the health needs of Central LHIN French speaking residents.

Executing the Annual Business Plan

Through our IHSP 2013-2016 and in conjunction with the execution of the 2015/16 Annual Business Plan, we have continued to advance quality and excellence in the delivery of health care services and supports to our community. As well, we continue to make measureable progress towards our Vision of ***Caring Communities, Healthier People.***

The chart below outlines the progress around the implementation of Central LHIN's Annual Business Plan for 2015/16.

IHSP	Annual Business Plan		Project Management	
System Direction	**Action Plan #**	**Action Plan and Description**	**Target % to be Complete in 15/16**	**% Complete as at Q4**
Appropriateness	1	Strengthen the alignment between Hospital, CCAC, LTCH, and Community Health Centre Quality Improvement Plans (QIPs) and LHIN priorities. Engage Family Health Teams and Nurse Practitioner-Led Clinics in alignment review.	100%	**100%**
	2	Expand telemedicine capacity LHIN-wide. This includes increasing adoption of telemedicine in clinical practice (i.e. Diabetes, COPD and Stroke clinics, LTCH and Hospitals) and expanding Central LHIN's telehomecare program into additional Health Links.	20%	**17%**
	3	Improve system capacity, coordination and care processes to reduce ALC pressures and wait times for complex clients within Central LHIN hospitals and the community	33%	**33%**
	4	Implement evidence-based care pathways (Quality Based Procedures) as per the MOHLTC schedule (e.g. hip fracture). This work may include the community portion of the pathway	33%	**20%**
Access	5	Complete implementation of medical stability best practices in Central LHIN emergency departments for people with mental health and addiction (MH&A) conditions	100%	**75%**
	6	Implement an integrated ophthalmology service delivery model that focuses on excellent patient outcomes, ease of access, and maximum patient satisfaction.	50%	**20%**
	7	Implement the Provincial Life or Limb No Refusal Policy for referral, Expand access and integration for community mental health and addiction services, including expansion of mobile crisis teams in collaboration with police services and Emergency Medical Services; and development of a MHA supports within housing strategy in collaboration with Ministry of Municipal Affairs and Housing and the municipalities.	33%	**33%**
Integration	8	Increase use of provincial electronic tools to share information across providers. May include electronic hospital reports, consult solutions, Referral and Resource matching solutions, coordinated care tools and centralized repositories of clinical information for access by multiple providers.	25%	**20%**
	9	Complete implementation of planned Health Links in Central LHIN	90%	**90%**
	10	Further to the recommendations of the Regional Hospice Palliative Care Program Council, implement relevant phases of the Hospice Palliative Care Action Plan	33%	**30%**

	11	Complete the implementation of the regional model for LHIN-funded community-based transportation services	50%	**50%**
	12	Implement the strategy for centralized access in the community support services sector	50%	**0%**
Person-Centredness	13	Expand Indigenous Cultural Competency training to increase access to culturally adaptive mental health and substance abuse services; and continue to expand chronic disease self-management supports for Aboriginal communities.	25%	**25%**
	14	Collaborate with Entite4 to develop a process to increase access to MHA supports for francophone residents in Central LHIN.	50%	**50%**
	15	Implement a Patient Experience Survey to capture the patient's voice and how patients experience the system; and strengthen patient, family and caregiver engagement in LHIN planning initiatives.	50%	**50%**
	16	Develop a strategy to create and manage bed capacity within long-term care homes within the Central LHIN.	75%	**75%**

Community Engagement

Listening to the voices of our patients and caregivers, and continued engagement with our diverse communities and stakeholders is a powerful tool in local health care planning. In 2015/16, the Central LHIN engaged key stakeholders to support our objectives, advance our planning (including the development of our Integrated Health Service Plan for 2016-2019) and inform our decision-making processes. Highlights from our engagement activities of the past year are included below.

Engagement for the Integrated Health Service Plan (IHSP) 2016-2019

In accordance with the provisions of the Local Health System Integration Act, 2006, a community engagement process was developed and implemented to consult a wide range of stakeholders regarding the development of Central LHIN's Integrated Health Service Plan (IHSP) 2016-2019 and concurrently, the 2016-17 Annual Business Plan.

Through this engagement process, consultations were held with hundreds of representatives of local health and community service providers, through face-to-face opportunities for dialogue and web-based formats. Some Health Service Providers also submitted formal feedback reports. Through this process, feedback was received from over 375 Central LHIN residents and stakeholder representatives.

Specific engagement activities included:

- Consultation with existing LHIN work groups and advisory structures as well as existing non-LHIN community-based advisory structures;
- Community engagement forums that included representatives of targeted population segments in our LHIN such as seniors, consumer-survivors, visible minorities, marginalized populations and diverse languages/cultures;
- Consultation with providers in other sectors such as municipalities, children and youth providers, housing providers, and police;
- Consultation with content experts through targeted engagement with system leaders, representatives of Health Service Providers and other stakeholders on the draft content of the IHSP;
- Utilization of public surveys through web-based tools disseminated to both the community and Health Service Providers, who were encouraged to share the survey with their clients/patients;
- Leveraged Central LHIN website as a mechanism for feedback by posting materials and inviting feedback; and
- Ongoing engagement of directional strategy with the Central LHIN Board of Directors.

The following groups were also consulted:

- Citizens' Health Advisory Panel (CHAP)
- Health Service Providers - Governance Councils
- Health Professional Advisory Committee (HPAC)
- Health Links System Planning Committee
- Hospital/CCAC CEO Leadership Forum
- Primary Care Council
- Citizens' Health Advisory Panel (CHAP)
- Patient & Family Advisors Council (PFAC) – Stevenson Memorial Hospital
- PFAC – Southlake Regional Health Centre
- PFAC – Mackenzie Health
- Patient Advisory Council – North York General Hospital
- Community Support Services sector
- Clinical Services Vice Presidents

- Hospital Mental Health and Addictions (MH&A) Chiefs and Directors
- Palliative Care sector
- Long-Term Care Home sector
- Critical Care Network
- Municipal Engagements
- Consumer Survivor Initiative
- Mental Health and Addictions sector
- Entité 4, French Language school boards
- eHealth Advisory Council
- Regional Diabetes Advisory Committee
- Hospital and CCAC Chief Financial Officers
- North York West stakeholders
- Stroke Planning Committee
- Georgina Island
- Nin Os Kom Tin
- Emergency Department Working Group
- IHSP4 Summative Engagement (and Annual Business Plan 2016-2017 Engagement)

A thorough engagement feedback and evaluation process was developed and implemented to document the input received through these engagement activities and to incorporate the feedback into the content of the IHSP. The draft IHSP continually evolved throughout the consultation engagement process as feedback was incorporated and re-engaged in subsequent consultation.

Aboriginal Community Engagements

Aboriginal people represent 0.4 per cent of the LHIN's population. While a portion of this population lives on Georgina Island, the majority live off-reserve in Central LHIN. Central LHIN developed an Aboriginal Engagement and Cultural Competency Strategy in 2015-16. The plan supported the foundation to build trust and rapport with the Aboriginal community through engagements with both the Aboriginal community and Health Service Providers in the LHIN. The goal is to establish the LHIN as a partner to assist the Aboriginal community in building capacity where health needs are identified.

Engagement activities included LHIN participation in local off-reserve events, facilitation of meetings between Georgina Island and the Central CCAC and Integrated Health Service Plan engagement.

The purpose of facilitating meetings between Georgina Island and the Central CCAC was to identify gaps in service to Georgina Island residents, understand the role of the CCAC and eligibility for CCAC services.

Francophone Community Engagements

During the fiscal year 2015-16, the Central LHIN conducted three formal community engagement sessions with Francophones. These sessions presented key information and updates, followed by an interactive discussion. These were important opportunities to engage different Francophone stakeholders in the Central LHIN catchment area such as:

- Entité 4 (the French Language Health Planning Entity)
- Association of Francophone in the Region of York (AFRY)
- The Francophone Catholique school board
- The Francophone public school board (Conseil Viamonde)
- Other organizations with Francophone representation such as the Children's Aid Society of York

As a result of the meetings, Francophones were able to provide their feedback on the Central LHIN Integrated Health Service Plan for 2016-2019. They were able to express their health needs as well as articulate the gaps and potential strategies to improve access to health care services as outlined in the LHIN priorities.

Mental Health and Addictions Engagement

To enable the creation of a multi-year Mental Health and Addictions Supports within Housing Action Plan, the Central LHIN co-hosted a two-day planning

Summit with the Region of York. The objective of the Summit was to establish shared goals and levers for change that would inform the development of the Action Plan. The engagement used a co-design process with 50 key stakeholders, including persons with lived experience, their families, housing providers, Health Service Providers (including acute care hospitals), emergency service providers and police.

Twenty-three levers for change were identified under four shared goals. These levers for change were used to inform the development of the Central LHIN multi-year Mental Health and Addictions Supports within Housing Action Plan for York Region.

As well, the Central LHIN and Region of York co-hosted a follow-up meeting with participants from the Summit, to review and gain feedback on the Action Plan developed with the input from the event. Twenty-three Summit attendees participated in the follow-up meeting. The feedback received from participants was supportive of the resulting Action Plan and included suggestions to: evaluate the effectiveness of the Service Coordination Council in implementing the Action Plan and to continue to leverage system strength, existing work and informal networks through ongoing engagement.

Citizens' Health Advisory Panel (CHAP)

The mandate of the Central LHIN CHAP is to:

- Provide system level, experience-based advice and guidance to the Central LHIN in support of the successful implementation of the Central LHIN Integrated Health Service Plan (IHSP);
- Provide experience-based advice on Central LHIN and Ministry strategic initiatives as they relate to priority areas; and
- As required, act as a resource to and/or work in collaboration with other Central LHIN planning groups/committees.

The nine-member Panel met four times throughout 2015-16 and provided advice to the LHIN on a variety of issues, including the vision care strategy, PanAm Games planning, IHSP development, hospice palliative care strategy and branding, the Seniors' and eHealth strategies and the Ministry of Health and Long-Term Care's *Patients First* discussion paper.

As well, the CHAP participated in an evaluation to determine how well the group functions. The evaluation feedback indicated that the committee process works well and members gain a great deal from the varied perspectives of the panel and staff. Specifically the members commented that they can see the CHAP's work reflected in results such at the IHSP and hospice palliative care branding. Members expressed that the collective voice of the Panel is very well captured. CHAP members felt that they had been educated on topics enough to be able to provide helpful feedback and advice and suggested that more communication updates would further enhance their experience.

Health Professions Advisory Council (HPAC)

The HPAC is the only LHIN committee required by legislation (Local Health System Integration Act, 2006) or Ontario Regulation 267/07 LHSIA). HPAC membership composition is directed by legislation and is constituted with representatives of a variety of health professional groups.

The primary mandate of the HPAC is to "provide advice to the LHIN on how to achieve patient-centred health care within the local health system for the purpose of assisting the LHIN in carrying out its activities." In carrying out its responsibilities, HPAC considers all matters before it in the context of the LHIN's strategic priorities (Integrated Health Services Plan) and articulated Annual Business Plan. Upon referral of a matter from the LHIN, HPAC provides system-level advice with respect to that matter, which may include:

- Identification of success factors, enablers, potentials risks and barriers, with respect to strategies, proposals, or projects submitted by the LHIN for consideration; and

- Advice regarding strategic initiatives sponsored by the LHIN or the MOHLTC.

The committee met five times in the 2015-16 fiscal year. HPAC has provided feedback to the LHIN on the Integrated Health Service Plan for 2016-2019; palliative care; mental health and addictions; seniors' care; North York West planning; long-term care redevelopment and primary care reform.

In addition, HPAC provided feedback on the holiday surge capacity plan, the *Patients First* discussion paper, the palliative care action plan including the Regional team's model and the seniors' strategy.

Health Service Provider (HSP) Governance

Good governance is a fundamental and powerful tool for overseeing the advancement of strategic priorities and is essential for health care organizations as they operate within a complex and changing environment.

Thus, connecting with the Boards of nearly 100 Health Service Providers in Central LHIN is an important priority for our Board. In addition to one-to-one meetings throughout the year, the Central LHIN hosts Governance Councils to bring HSP Board Chairs together at a governance level, discuss health system issues and implications, share solutions, and advance Central LHIN's IHSP.

The Central LHIN Board is committed to ongoing education. In 2015/16, the Board focused on patient stories, caregiver strategies, and effective integration, management and accountability of health services through special Board education and development sessions. HSPs and stakeholders are fundamental contributors to educating the LHIN on system-wide challenges and the co-creation of patient-centred care strategies.

We are committed to facilitating the sharing of best practices and to learn from the experiences of the patients, families and Health Service Providers within the Central LHIN. Annually, our Board recognizes exceptional performance by sponsoring the Innovation through Collaboration Awards for Health Service Providers who have demonstrated exemplary health care leadership and collaboration.

In fiscal year 2015/16, the Innovation through Collaboration Award was presented to the Canadian Mental Health Association, York Region and South Simcoe for the launch of the Mobile Walk-in Health Care for Youth (Mobile York South Simcoe – MOBYSS) initiative. This bright, graffiti-clad bus travels to youth-populated spaces, including malls, recreational facilities, schools and youth shelters, to connect young people with health care services, with an emphasis on mental health and addiction services.

Another Innovation through Collaboration Award was presented to CHATS and Circle of Care for their role as the lead agencies in implementing the iRIDE^{Plus} community transportation model across the Central LHIN that helps bring patients to health services.

The Canadian Mental Health Association, York Region and South Simcoe, was presented with the Innovation through Collaboration Award for the Mobile Walk-in Health Care for Youth (Mobile York South Simcoe – MOBYSS) initiative.

Government

Central LHIN's Chair/Vice Chair of the Board of Directors and Chief Executive Officer meet with local government representatives at all levels, with a focus on Members of Provincial Parliament who have constituents in the Central LHIN. This ongoing dialogue is a valuable opportunity to update government representatives about our current activities and priorities, while also hearing from

government officials about health care issues and services comments from their constituents.

Central LHIN also works closely with local MPPs and Health Service Providers to announce and celebrate health care progress and investments across our communities, and to use these opportunities to foster greater awareness on how to navigate the health care system.

Integration

When the Central LHIN Board of Directors issues a decision with respect to the integration of services between Health Service Providers in accordance with the Local Health System Integration Act (2006), the LHIN monitors the impact or results of the integration over time and reports back to the Board regularly. Health Service Providers are required to provide reports on a regular basis, usually for a period of two years following an integration.

In this past year, the Central LHIN has continued to monitor and report on several integrations, including Circle of Care and Mount Sinai Hospital, PACE Independent Living Inc. and abiPossibilities; and St. John's Rehabilitation Centre and Sunnybrook Health Sciences Centre.

Emergency Preparedness

In preparation for the Toronto 2015 Pan Am (July 10-26) and Parapan Am (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 had a role in coordinating preparedness from a health system perspective. Working in partnership with its hospitals, Public Health Units, Emergency Medical Services, municipalities and other allied sector partners. Central LHIN established a Pan Am Games preparedness Working Group that focused on health system preparedness and communication. In addition, Central LHIN acted as the lead for planning for the Pan Am North Zone that included: North Simcoe Muskoka, Central East and Central LHINs.

Emergency Management

Central LHIN is participating in a Pan LHIN Emergency Management Implementation working group to develop an Emergency Response Template to standardize and strengthen emergency response processes and plans. Central LHIN will also work with its Health Service Providers in 2016 to enhance utilization of the Emergency Management Communication Tool (EMCT) to provide a centralized location for alerts, information, and responses to emergency situations.

Central LHIN
Together, we're better!

RLISS du Centre
Ensemble, nous sommes meilleurs!

Financial statements of

Central Local Health Integration Network

March 31, 2016

Central Local Health Integration Network

March 31, 2016

Table of contents

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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, 2016, 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, 2016, and the results of its operations, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Chartered Professional Accountants
Licensed Public Accountants
May 31, 2016

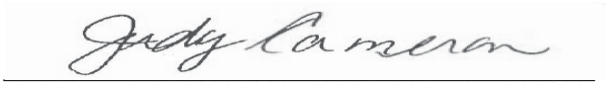
Central Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	$	$
Financial assets		
Cash	**380,753**	264,873
Due from Ministry of Health and Long-Term Care (“MOHLTC”)	**8,526,855**	11,373,653
Accounts receivable	**81,147**	94,063
	8,988,755	11,732,589
Liabilities		
Accounts payable and accrued liabilities	**470,241**	372,232
Due to Health Service Providers (“HSPs”)	**8,526,855**	11,373,653
Due to Ministry of Health and Long-Term Care (“MOHLTC”) (Note 3)	**36,158**	26,548
Due to Central West LHIN (Note 4)	**-**	16,882
Due to the LHIN Shared Services Office (Note 4)	**5,856**	2,168
Deferred capital contributions (Note 5)	**81,579**	116,470
	9,120,689	11,907,953
Net debt	**(131,934)**	(175,364)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**50,355**	58,894
Tangible capital assets (Note 7)	**81,579**	116,470
	131,934	175,364
Accumulated surplus	**-**	-

Approved by the Board

Warren Jestin, Chairman 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, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,928,276,400**	**2,043,334,690**	1,949,997,048
LHIN Operations and Initiatives			
General and administrative	**4,189,100**	**4,252,574**	4,177,961
Emergency Room/Alternative Level of Care ("ER - ALC") Funding	**100,000**	**100,000**	98,477
Primary Care Lead	**-**	**72,000**	72,000
Aboriginal Initiative	**10,000**	**10,000**	3,598
Emergency Department Lead	**-**	**72,000**	72,000
French Language Health Services	**106,000**	**106,000**	91,695
Critical Care Lead	**-**	**72,000**	72,000
Enabling Technologies for Integration Project Management Office	**-**	**406,000**	389,118
Diabetes Strategy (Note 10)	**909,900**	**891,710**	904,713
Amortization of deferred capital contributions (Note 5)	**-**	**55,829**	52,733
Total LHIN Operations and Initiatives	**5,315,000**	**6,038,113**	5,934,295
	1,933,591,400	**2,049,372,803**	1,955,931,343
Expenses			
Transfer payments to HSPs (Note 9)	**1,928,276,400**	**2,043,334,690**	1,949,997,048
Operations			
General and administrative (Note 11)	**4,189,100**	**4,252,574**	4,177,961
ER - ALC funding (Note 10)	**100,000**	**100,000**	98,477
Primary Care Lead (Note 10)	**-**	**72,000**	72,000
Aboriginal Initiative (Note 10)	**10,000**	**10,000**	3,598
Emergency Department Lead (Note 10)	**-**	**72,000**	72,000
French Language Health Services (Note 10)	**106,000**	**106,000**	91,695
Critical Care Lead (Note 10)	**-**	**72,000**	72,000
Enabling Technologies for Integration Project Management Office (Note 10)	**-**	**406,000**	389,118
Diabetes Strategy (Note 10)	**909,900**	**891,710**	904,713
Amortization of tangible capital assets (Note 5)	**-**	**55,829**	52,733
	1,933,591,400	**2,049,372,803**	1,955,931,343
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, 2016

	2016 Actual	2015 Actual
	$	$
Annual surplus	**-**	-
Acquisition of tangible capital assets	**20,938**	15,039
Amortization of tangible capital assets	**(55,829)**	(52,733)
Change in other non-financial assets	**(8,539)**	2,729
Decrease in net debt	**(43,430)**	(34,965)
Net debt, beginning of year	**175,364**	210,329
Net debt, end of year	**131,934**	175,364

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, 2016

	2016	2015
	$	$
Operating transactions		
Annual surplus	**-**	-
Less items not affecting cash		
Amortization of capital assets	**(55,829)**	(52,733)
Amortization of deferred capital contributions (Note 5)	**55,829**	52,733
	-	-
Changes in non-cash operating items		
Due from MOHLTC	**2,846,798**	(4,064,866)
Accounts receivable	**12,916**	(6,848)
Accounts payable and accrued liabilities	**98,009**	(21,186)
Due to Central West LHIN	**(16,882)**	14,998
Due to the MOHLTC	**9,610**	(108,458)
Due to HSPs	**(2,846,798)**	4,064,866
Due to the LHIN Shared Services Office	**3,688**	785
Prepaid expenses	**8,539**	(2,729)
	115,880	(123,438)
Capital transaction		
Acquisition of tangible capital assets	**(20,938)**	(15,039)
Financing transaction		
Deferred capital contributions received (Note 5)	**20,938**	15,039
Net decrease in cash	**115,880**	(123,438)
Cash, beginning of year	**264,873**	388,311
Cash, end of year	**380,753**	264,873

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

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 Accountability Agreement ("MLAA"), 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 Accountability 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 Accountability Agreement.

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.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, 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:

				2016	2015
	Funding received	**Transferred to deferred capital contribution**	**Revenue recognized**	**Repayable**	Repayable
	$	**$**	**$**	**$**	$
Balance, beginning of year	**-**	**-**	**-**	**26,548**	-
Transfer payments to HSPs	**2,043,334,690**	**-**	**2,043,334,690**	**-**	-
Operations	**4,274,122**	**20,938**	**4,252,574**	**610**	634
Initiatives	**1,332,710**	**-**	**1,323,710**	**9,000**	
Deferred capital contributions	**-**	**-**	**55,829**	**-**	25,914
Enabling Technologies (Note 4)	**406,000**	**-**	**406,000**	**-**	-
	2,049,347,522	**20,938**	**2,049,372,803**	**36,158**	26,548

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 Legal, Audit, and Human Resources services. Each LHIN must also use the same Information Management & Information Technology infrastructure, standards, practices and policies as all other LHINs. 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 costs 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 over paid by the LHINs at year end, are recorded as a receivable from the LHINC.

During the year, the LHIN made payments to LSSO and LHINC of $429,164 (2015 - $400,872).

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 $406,000 (2015 - $389,118).

5. Deferred capital contributions

	2016	2015
	$	$
Balance, beginning of year	**116,470**	154,164
Capital contributions received during the year	**20,938**	15,039
Amortization for the year	**(55,829)**	(52,733)
	81,579	116,470

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	$	$	$
2017	328,738	5,928	334,666
2018	349,865	988	350,853
2019	360,078	-	360,078
2020 and after	30,077	-	30,077

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

			2016	2015
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office furniture and fixtures	**477,980**	**401,308**	**76,672**	95,542
Computer equipment	**23,126**	**21,579**	**1,547**	2,579
Leasehold improvements	**70,753**	**67,393**	**3,360**	18,349
	571,859	**490,280**	**81,579**	116,470

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, 2015. The budgets were approved by the Government of Ontario.

	2016	2015
	$	$
LHIN total budget	**1,933,591,400**	1,891,509,000
Less Health Service Provider budget (a)	**(1,928,276,400)**	(1,886,294,000)
LHIN operating budget (b)	**5,315,000**	5,215,000

8. Budget figures (continued)

a) Health Service Provider budget

	$
Initial HSP budget	**1,928,276,400**
Adjustments due to announcements made during the year	**119,426,100**
	2,047,702,500
The total budget by sector is as follows:	
Hospitals	**1,220,256,700**
Long Term Care Homes	**343,442,600**
Community Care Access Centres	**297,782,100**
Community Support Services	**86,742,900**
Community Health Centres	**12,381,000**
Community Mental Health and Addictions	**86,394,200**
Initiatives	**703,000**
Total budget	**2,047,702,500**

b) LHIN operating budget

	$
Initial budget as reported on the statement of operations	**5,315,000**
Additional funding received in-year	**697,832**
Funding for capital asset purchased transferred to deferred capital contributions	**(20,938)**
Closing budget	**5,991,894**

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of $2,043,334,690 (2015 - $1,949,997,048) to the following sectors:

	2016	2015
	$	$
Hospitals	**1,218,995,581**	1,151,604,778
Long Term Care Homes	**342,124,263**	338,701,021
Community Care Access Centres	**297,796,041**	282,089,932
Community Support Services	**86,646,598**	84,591,275
Community Mental Health and Addictions	**85,446,137**	81,011,874
Community Health Centres	**12,326,070**	11,998,168
	2,043,334,690	1,949,997,048

10. Initiatives

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

	2016	2015
	$	$
Salaries and benefits	**1,224,287**	1,235,052
Professional services	**256,924**	252,000
Shared services	**102,572**	104,910
Occupancy	**94,615**	71,193
Public relations and community engagement	**12,143**	1,800
Supplies	**22,560**	22,004
Mail, courier and telecommunications	**11,300**	2,298
Other	**5,309**	14,344
	1,729,710	1,703,601

Diabetes strategy expenses included in the above table are as follows:

	2016	2015
	$	$
Salaries and benefits	**697,928**	736,458
Others	**193,782**	168,256
	891,710	904,714

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:

	2016	2015
	$	$
Salaries and benefits	**3,330,211**	3,197,171
Shared services	**326,592**	295,962
Occupancy	**240,414**	215,961
Supplies	**109,591**	118,015
Board expenses (see below)	**82,216**	64,560
Community engagement	**38,912**	56,971
Professional services	**25,123**	82,913
Mail, courier and telecommunications	**13,892**	33,968
Other	**85,623**	112,440
	4,252,574	4,177,961

11. General and administrative expenses (continued)

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

	2016	2015
	$	$
Board Chair per diem expense	**15,925**	12,100
Other Board members per diem expense	**30,725**	25,275
Governance costs and travel	**35,566**	27,185
	82,216	64,560

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 34 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 2016 was $374,241 (2015 - $345,197) for current service costs and is included as an expense in the 2015 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2015. 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*.

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