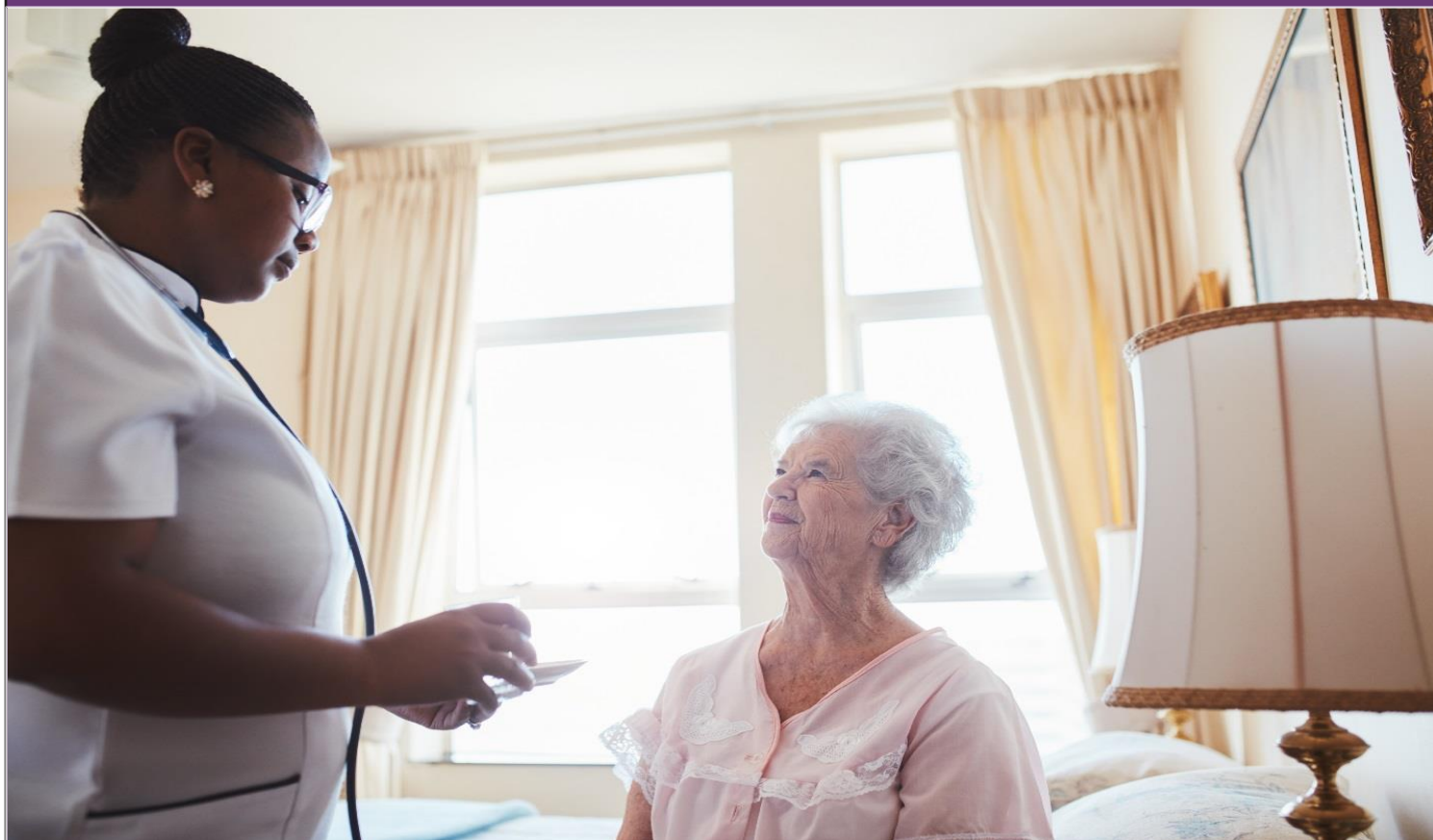




Annual Report 2016-2017

Strengthening our Local Health Care
System through Collaboration

CENTRAL LHIN

At Central LHIN, we know that every day of the year and through every night, people are being cared for, lives are being born and saved, and caregivers are giving excellent and compassionate care to their patients in hospitals, at home, at their schools and in their communities.

Here are some of the touchstones that drive the Central LHIN's commitment to strengthen our local health care system:

Vision

Caring Communities, Healthier People

Mission

Enabling people in our diverse communities to receive the right care, at the right time, in the right place, through a high-quality, person-centred, sustainable, integrated system of care from prevention through to end of life.

Strategic Priorities

- Better Seniors' Care
- Better Palliative Care
- Better Care for Kids and Youth
- Better Community Care
- Better Care for Underserved Communities
- Better Mental Health

Goals

- Access
- Connect
- Inform
- Protect

Levers

- Health Human Resources
- Health System Funding Reform
- Performance Management
- Quality Improvement Plans
- Information Technology/Management
- Capital Infrastructure

Values

- Listen to the patient voice
- Openness and transparency
- Collaboration/Partnership
- System responsiveness
- Efficient and evidence-driven
- People/community-focused

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Alternative Level of Care Collaborative
Central LHIN Eye Care Committee
Chronic Disease Prevention and Management Service Coordination Committee
Clinical Services Planning Group
Community Sector Working Group
Critical Care Network
eHealth Advisory Council
Emergency Department Working Group
Health Links Systems Planning Committee
Integrated Care Advisory Council
Long-Term Care Sector Working Group
Mental Health and Addictions Service Coordination Council
Mental Health Hub Committee-York Region
Quality Based Procedures Steering Committee
Regional Palliative Care Network
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Local Health Care Planning

The Central Local Health Integration Network (LHIN) is one of 14 LHINs – Crown Agencies established by the provincial government through Bill 36, *the Local Health System Integration Act, 2006*.

Each LHIN is accountable “to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks” (2006, s1. [1])

The Central LHIN comprises sections of northern Toronto, a portion of Etobicoke, most of York Region and South Simcoe County.

Annually, the Central LHIN works together with approximately 100 Health Service Providers (HSPs), along with patients and families, and partners such as municipalities and community residents, to plan, design and implement solutions to manage and improve our local health care system which serves nearly 1.9 million people.

In 2016-2017, the Central LHIN was responsible for planning, coordinating, integrating and funding for seven public hospitals, 46 long-term care homes and 53 other Health Service Providers (community care access centre, community health centres, community support services, and mental health and addictions providers).

In December 2016, the provincial government passed Bill 41, *the Patients First Act, 2016*, which expands the LHIN’s mandate in the areas of home care, linkages with public health, and further responsibilities in planning, health equity and engagement with patients and families, primary care physicians, Indigenous communities and French language health care partners.



Message from the Chair and CEO

On behalf of the Board, staff, our Health Service Providers, patients, caregivers and families, and our many other stakeholders, we are pleased to present the Central LHIN's 2016-2017 Annual Report.

This report will provide highlights of our ongoing work to advance our local health care system as accessible, equitable, and integrated, responsive and sustainable to meet the health care needs of our local community.

Strategic Priorities

The Central LHIN's successes in 2016-2017 are reflective of the strategic priorities and directions articulated in our **2016-2019 Integrated Health Service Plan** entitled *Caring Communities, Healthier People*, along with the more specific in-year actions plans that we outlined in our **2016-2017 Annual Business Plan** aligned with our six key strategic priorities.

- Better Seniors' Care
- Better Palliative Care
- Better Care for Kids and Youth
- Better Community Care
- Better Care for Underserved Communities
- Better Mental Health

As well, this past year has advanced critical work for consultation and engagement on the *Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario* (December 2015), followed by readiness for implementation of the LHINs expanded mandate outlined in the *Patients First Act, 2016* (December 2016).

The *Patients First Act, 2016* outlines key requirements to put the patient at the centre of the health care system, to create a more local and integrated health care system, and to improve the patient experience and deliver higher quality of care.

Sub-Region Planning

To achieve more integrated and local planning, the Central LHIN received approval from the Ministry of Health and Long-Term Care to plan at a sub-regional level. This means the Central LHIN will plan and monitor the health care

needs across the entire Central LHIN geography – which spans 2,730 square kilometres and nearly 1.9 million residents across from northern Toronto, part of Etobicoke, most of York Region, and South Simcoe County – and also look at care patterns through a smaller, more local lens – namely, six sub-regions within the LHIN.

Community Engagement

As part of defining our six sub-regions, the Central LHIN held local engagements with patients, providers and community members, and assessed patient referral and navigation patterns. With the six sub-regions confirmed in December, the Central LHIN undertook further consultations with patients and providers in March and April 2017 to advance sub-region planning and integration.

Our six sub-regions are:

- South Simcoe
- Northern York Region
- Western York Region
- Eastern York Region
- North York West
- North York Central

Sub-region planning supports the LHIN's goal to plan care through the eyes of the patient and provide a better patient experience that is closer to home. This invaluable work is ongoing.

Patients First

Another key priority for 2016-2017 was preparing for the Central LHIN to assume responsibility in 2017 for the management and delivery of home and community care, either directly or through contracts with service providers, including new direct placement responsibilities for long-term care.

At the same time, the Central LHIN strengthened broader outreach and engagement with additional stakeholders – including Public Health Departments, Primary Care Providers, Family Health Teams and the new Patient Ombudsman's Office which became active on July 4, 2016. Inclusive of this work was increased focus in considering the impact of social determinants in health.

Accessibility

Necessary to the Central LHIN's work, extensive and ongoing collaboration and consultation was undertaken throughout 2016-2017. This included focused conversations regarding the needs of our local Francophone and Indigenous communities, who often experience challenges accessing and navigating the health care system.

Last year also saw ongoing and broader consultation with our patient and family committee – which is currently known as Citizens' Health Advisory Panel (CHAP).

We also engaged all of our Health Service Provider Board Chairs in Governance Council and all of our Health Service Providers, along with patients and other stakeholders, in our broadcast communications, webinar and in-person community conversation sessions.

Working Together

We wish to thank the Central LHIN Board and staff – and all our many stakeholders – for contributing to another year of strengthening our local health care system and working together to put *Patients First*.



Warren Jestin

A handwritten signature in black ink, appearing to read 'W. Jestin'.

Chair, Board of Directors



Kim Baker

A handwritten signature in black ink, appearing to read 'Kim Baker'.

Chief Executive Officer

Board of Directors

The Central LHIN is a not-for-profit Crown Agency of the Province of Ontario. It is governed by a Board of Directors, who are appointed by Order-in-Council for a term of one to three years, subject to a maximum of two terms (up to six years).

The role of the LHIN Board of Directors is to oversee, provide advice on and govern the strategic direction and priorities of the LHIN. The Board is accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds and for its performance results in the local health system. Further information about the Central LHIN Board of Directors may be found online at www.centrallhin.on.ca and www.pas.gov.on.ca.

The following individuals served on the Central LHIN Board of Directors during the reporting period of this Annual Report (April 1, 2016 to March 31, 2017).



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



Tanya Goldberg
June 30, 2016 – June 29, 2019
Toronto



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



Michael MacEachern
February 2, 2017 – February 1, 2020
Alliston



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



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



Audrey Wubbenhorst
October 23, 2013 – October 22, 2018
Toronto



Aldous (Sally) Young
October 23, 2013 – October 22, 2018
Toronto

About the Central LHIN

The Central LHIN's mandate for 2016-2017 was to plan, coordinate, integrate and fund health services at the local level. Our budget of \$2.1 billion for this fiscal year – April 1, 2016 to March 31, 2017 – was allocated across 95 Health Service Providers and 102 Service Accountability Agreements which span hospitals, long-term care homes, community support service providers, mental health and addictions service providers, a community care access centre, and two community health centres. Some of our Health Service Providers deliver care and services in multiple sectors. We have one service accountability agreement with a hospital outside the Central LHIN.

Geography

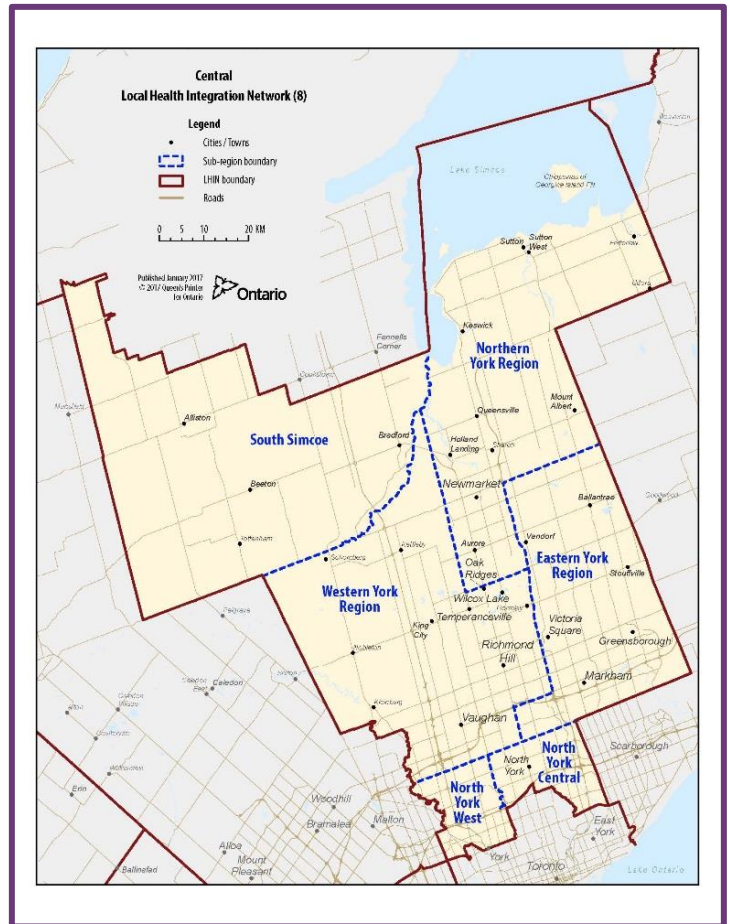
Central LHIN is geographically varied, covering an area of 2,730 square kilometres and comprising sections of northern Toronto, a portion of Etobicoke, most of York Region and South Simcoe County. Although Central LHIN is primarily urban, there is a significant rural area in the north, which can present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

Planning Areas

The Central LHIN has a strong track record of developing targeted solutions that respond to local health care needs. We are able to undertake this work by assessing the entire Central LHIN's health care needs – which includes nearly 1.9 million people across many very distinct communities spread across 2,730 square kilometres.

In December 2016, the Central LHIN received approval to formalize our system planning at a sub-region level. We have begun further analysis and planning of our six sub-regions, listed below, to deliver an improved patient experience.

1. South Simcoe
2. Northern York Region
3. Western York Region
4. Eastern York Region
5. North York West
6. North York Central



By looking at care patterns through this smaller lens, the Central LHIN will be able to achieve a more local approach so local health care services reflect the unique needs of patients and their families within those specific communities. This includes the needs of Francophone Ontarians, Indigenous communities, newcomers and other individuals and groups whose health care needs are unique or who experience challenges accessing and navigating the health care system.

The Central LHIN's sub-regions were established based on existing care patterns and insights gleaned from patients, Health Service Providers and other stakeholders. Moving forward, physicians, nurses and other clinicians as well as patients, caregivers and their families will play a role in planning, priority setting and implementing the improvement activities at the Central LHIN sub-region level to ensure the needs of patients and communities are being met.

Population Profile

With a total population of nearly 1.9 million, the Central LHIN has the most residents, is among the most diverse and is one of the fastest growing of all LHINs. Within our six sub-regions, the average local population size is approximately 310,000 residents.

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

Between 2010 and 2015, the Central LHIN's population increased by 8.4 per cent, the second highest growth rate among all LHINs. Ontario's population grew by 5.1 per cent over the same period. Population growth is expected to remain high relative to the province over the next five to 10 years, with Central LHIN's population projected to increase by a further 8.3 per cent between 2015 and 2020, and 17.1 per cent between 2015 and 2025.

Diversity

In 2011, 51.7 per cent of Central LHIN residents reported English as their mother tongue (lowest in the province) and 1.3 per cent of Central LHIN residents reported French as their mother tongue (second lowest in the province). Central LHIN had the highest proportion of residents with no knowledge of either official language (4.9 per cent) in the province in 2011.

Among all LHINs, Central LHIN reported the highest proportion of residents who were newcomers (48.6 per cent). Of this group of newcomers, 6.9 per cent were recent newcomers, having arrived in Canada between 2006 and 2011 – the second highest proportion in the province. Among all LHINs, Central LHIN reported the second highest proportion of residents who are visible minorities (46.9 per cent).

Indigenous Communities

Central LHIN has a relatively small Indigenous and Métis population – approximately 7,000 people, or 0.4 per cent of our population. The majority of the Indigenous population in Central LHIN lives off-reserve. The Chippewas of Georgina Island, comprised of approximately 200 residents, is Central LHIN's only First Nations and on-reserve community. (*Data source: National Household Survey, 2011*)

Francophone Communities

Approximately 1.3 per cent of the people who live in the Central LHIN – about 31,725 people – are considered Francophone under the provincial definition, which was adopted in 2009 (*Data source: 2011 Census, according to the Inclusive Definition of Francophones (2014), Office of Francophone Affairs*).

Aging

In 2015, seniors aged 65 and over accounted for 14.3 per cent of the LHIN's population, or 268,794, the highest number of seniors among the 14 LHINs (*Data source: 2015 Population Projections, IntelliHealth, MoHLTC*).

In 2021, seniors aged 65 and over will comprise 16.9 per cent of all residents or 348,549 people (*Data source: 2021 Population Projections, IntelliHealth, MoHLTC*). This means that in 2021, Central LHIN will be home to 79,755 more seniors than we have today.



Unless specified otherwise, demographic data in this section is sourced from the Integrated Health Service Plan 2016-2019 Environmental Scan, Ministry of Health and Long-Term Care Health Analytics Branch analysis of Statistics Canada and Ministry of Finance estimates and projections.

Health Profile

Taking a Population Health Approach to Planning

An important part of effective and patient-centred health system planning is understanding the overall health profile of the people who live in the Central region. Taking this population health approach enables the Central LHIN to address the needs of our entire population and at the same time plan in a way that improves health equity and the experience of people who access health services in our communities.

In 2013, 32 per cent of Central LHIN residents over the age of 12 had a chronic condition and 9 per cent had multiple conditions. These rates were the lowest among all LHINs and were significantly lower than the provincial rates. The prevalence of multiple chronic conditions among Central LHIN residents has declined since 2009-2010.

The prevalence of arthritis and asthma was also significantly lower in Central LHIN compared to the province. Among all LHINs, Central LHIN residents had among the lowest prevalence rate of arthritis, chronic obstructive pulmonary disease (or COPD), and diabetes. The prevalence rates of arthritis, asthma, diabetes and heart disease have declined since 2009-2010, while the rates of high blood pressure increased.

The selected chronic conditions accounted for 58 per cent of deaths, 26 per cent of total acute days and 20 per cent of hospital discharges for Central LHIN residents. Compared with Ontario, Central LHIN had comparable or lower mortality, hospital discharge rates, and total acute day rates for all selected chronic conditions.

Over time, Central LHIN residents' mortality rates for diabetes, heart disease and stroke have decreased while the COPD and hypertension rates increased.

Using population health data that is further validated by our Health Service Providers, the Central LHIN is also able to better understand the distinct characteristics and attributes of local populations as well as existing care patterns. This enables us to more accurately identify and respond to needs at a neighbourhood level.



Health profile highlights for the Central LHIN's six sub-region planning areas, each with their own unique demographics, includes:

- South Simcoe** – With just over 75,000 residents, South Simcoe is the smallest of Central LHIN's sub-regions. It has the highest proportion of people living in rural areas and the lowest proportion of residents living in low-income. This area has a higher rate of chronic obstructive pulmonary disease and asthma compared to the rest of the LHIN. It also has high rates for mental health-related physician visits for adults, but the lowest percentage of repeat emergency department visits for mental health.
- Northern York Region** – 219,786 people live in this sub-region. It has the lowest percentage of seniors over the age of 65 (13.6 per cent) and the second lowest percentage of residents living in low income (8.5 per cent). Combined with South Simcoe, Northern York has the highest rates for mental health physician visits for persons over the age of 20 but, in a variance from South Simcoe, this sub-region has the highest percentage of repeat emergency department visits.
- Western York Region** – With 511,646 residents, this is the most populous Central LHIN sub-region. It has the lowest unemployment rate (4.3 per cent) and the lowest percentage of lone-parent families (12.6 per cent). All five prevention and screening indicators in this sub-region are better than the provincial rates. While this area has the lowest percentage of seniors (13.6 per cent), it has the second highest prevalence of mental health physician visits for persons age 65 and over.

- **Eastern York Region** – 376,839 people live in this sub-region. It has the highest proportion of visible minorities – 67.1 per cent, versus the LHIN average of 46.9 per cent, and the provincial average of 25.9 per cent. Other than English, Chinese, Tamil and Persian Farsi are the most common languages spoken at home. All five prevention and screening indicators in this area are better than provincial rates. There is a higher rate for diabetes here compared to LHIN and provincial averages, but low rates for asthma and COPD. Eastern York Region has the lowest rate of emergency department visits per 1,000 people.
- **North York West** – A full 100 per cent of the 284,763 residents here live within a large urban setting. This area has the lowest percentage of adults who have completed post-secondary education (52 per cent), the highest unemployment rate (5.9 per cent), and the highest percentage of lone-parent families. At 21.8 per cent, this area has more people living in low income than anywhere else in the LHIN, well exceeding the provincial rate of 13.8 per cent. North York West has higher disease prevalence compared to the LHIN average in all four indicators (asthma, diabetes, high blood pressure and chronic obstructive pulmonary disease). Diabetes in this sub-region is particularly higher than the provincial average.
- **North York Central** – With 395,339 residents – this is the second largest sub-region by population – and all of these people live within a large urban centre. Many residents are new to the area: in fact, it has the highest percentage of newcomers (58.6 per cent) and recent newcomers (12.5 per cent) across the LHIN's planning areas. This area also has the highest percentage of seniors. While 79.4 per cent of adult residents have completed post-secondary education, 20.2 per cent are living in low-income, the second highest in the LHIN after North York West. North York Central has lower or comparable rates to the LHIN and provincial rates in all four disease prevalence indicators: asthma, diabetes, high blood pressure and chronic obstructive pulmonary disease.



Creating a Sustainable Health Care System

Accountability

The purpose of the *Local Health System Integration Act* is “to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks”.

Priorities for health care in the Central LHIN are outlined in the Ministry-LHIN Accountability Agreement, the Central LHIN’s 2016-2019 Integrated Health Service Plan (IHSP), and the Central LHIN’s 2016-2017 Annual Business Plan, all available on our website: www.centrallhin.on.ca.

Service Accountability Agreements are a key mechanism used in the oversight of the health system. All Central LHIN funded Health Service Providers enter into an agreement with the LHIN which details the funding the LHIN provides, the services to be provided, performance indicators, reporting requirements and the terms and conditions of the funding. In 2016-2017, the Central LHIN entered into 102 Service Accountability Agreements with 95 Health Service Providers (HSPs).

Central LHIN monitors each HSP’s performance results, and using a risk-based approach, provides advice and support to support system performance and resolve and report on areas of concern or underperformance.

2016-2017 Service Accountability Agreements

- 9 Hospital Agreements with:
 - 7 Public Hospitals
 - 2 Private Hospitals
- 40 Long-Term Care Agreements with:
 - 46 Long-Term Care Homes
- 53 multi-sector agreements with:
 - 29 Community Support Services
 - 21 Mental Health and Addiction Service Providers
 - 2 Community Health Centres
 - 1 Community Care Access Centre

Note: Long-Term Care Home operators with more than one location may be covered by a single agreement, while those who provide services in multi-sector may have more than one agreement. Hospital agreements include West Park for ventilator beds.



Funding Allocation

In 2016-2017, and through the 102 Service Accountability Agreements, the Central LHIN authorized transfer payments of just over \$2.1 billion to 95 providers in the following sectors, representing an increase of 3.44 per cent over 2015-2016.

Sector	2016-2017	2015-2016
Hospitals	\$1,259,701,164	\$1,218,995,581
Long-Term Care	\$347,927,561	\$342,124,263
Community Care Access Centre	\$318,610,800	\$297,796,041
Community Support Services	\$92,076,075	\$86,646,598
Community Mental Health and Addictions Agencies	\$82,431,488	\$85,446,137
Community Health Centres	\$12,891,912	\$12,326,070
TOTAL	\$2,113,639,000	\$2,043,334,690

Overall, the hospital sector increased by 3.3 per cent in 2016-2017. This was largely due to an \$18.1 million increase to Humber River Hospital and \$9.3 million increase to Markham Stouffville Hospital to expand services in their new buildings. All hospitals received additional funds through the small hospital, general hospital service delivery, or high growth funding, which assisted our hospitals in addressing operational and service pressures in our growing LHIN.

Long-Term Care Homes received sustainability increases as well as investments in Behavioural Support Services to assist with the provision of quality care for residents with responsive behaviours.

Central LHIN received \$16 million in 2016-2017 to expand home care services, including respite services for caregivers in greatest need.

The LHIN also received \$4.2 million in funding to expand community services. In order to support our community providers, the LHIN provided \$2.5 million in one-time funds to the community sector to meet legislative obligations, equipment upgrades, staff training, and to help offset other one-time pressures. This \$2.5 million was allocated through a proposal process across 111 projects.

Performance and Targets

The Central LHIN enters into an accountability agreement with the Ministry of Health and Long-Term Care, called the Ministry-LHIN Accountability Agreement, or MLAA, which outlines the obligations and responsibilities of both organizations with respect to planning, coordinating, funding and integrating local health care services.

The MLAA includes measures to assess the LHIN performance. These measures may be updated from time to time. For fiscal 2016-2017, there were 14 performance indicators and eight monitoring indicators

- **Performance Indicators:** The provincial targets for the 14 performance measures are based on best practice and clinical evidence where possible.
- **Monitoring Indicators:** The eight monitoring measures can provide supplemental or explanatory information about the performance measures.

The table on page 15 outlines each MLAA Indicator along with the provincial target and the Central LHIN's 2016-2017 results. The Central LHIN reports to the Ministry on these targets quarterly and annually. This section provides specific commentary on each of the 14 performance indicators.

Central LHIN Performance and Targets as Defined by the Province of Ontario 2016-2017

No.	Indicator	ON Target	Provincial			Central LHIN		
			2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 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%	85.36%	82.10%	85.58%	83.68%	87.21%	86.03%
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%	94.00%	93.83%	94.53%	94.23%	95.32%	95.54%
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	31.00	33.00	27.00	37.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.97	11.03	10.38	9.80	10.83	10.20
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.07	4.23	4.15	3.33	3.48	3.50
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	38.43%	40.76%	40.17%	40.95%	37.41%	44.75%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	74.66%	78.31%	75.89%	83.96%	71.47%	74.54%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	79.97%	77.89%	78.47%	97.46%	98.54%	97.90%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.14%	74.50%	75.02%	96.20%	96.32%	96.41%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.50%	15.85%	15.16%	14.36%	16.88%	15.33%
11	ALC Rate	12.70%	13.98%	15.27%	15.19%	13.87%	15.98%	15.72%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	20.19%	20.39%	19.81%	18.99%	18.58%	18.32%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	33.01%	31.15%	31.40%	26.02%	21.60%	23.75%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.65%	16.66%	16.51%	15.92%	15.91%	15.79%

No.	Indicator	ON target	Provincial			Central LHIN		
			2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	88.03%	86.82%	87.23%	95.48%	95.10%	95.05%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	95.00%	93.00%	93.00%	99.00%	100.00%	98.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	88.09%	85.32%	85.01%	98.46%	97.65%	96.69%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	22.00	21.00	22.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	8.00	8.00	6.00	4.00	5.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	18.47	4.58	12.28	6.87	1.75	4.65
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.13	81.88	241.40	177.72	45.25	138.96
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.61%	47.46%	47.81%	54.31%	53.82%	54.63%

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)

**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

NA = Not Available

	Indicator achieved provincial target
	Indicator is within 10% of provincial target
	Indicator exceeds 10% of provincial target (unfavourable)

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 has met and/or improved in two of the three indicators in 2016-2017 while experiencing increases in the demand for services.

Central LHIN continues to target investments in Nursing and Personal Support Services (PSS), and community investments to address demand for CCAC services, including enhanced Assisted Living and PSS in the community support services sector. An eighth CCAC nursing clinic was opened in October 2016, providing increased capacity for nursing services.

Performance improvement activities were also implemented by Central CCAC to improve patient access to services and performance on these indicators. Some of the activities includes the review of clinical pathways for Physiotherapy services and improved communications between CCAC and contracted service providers.



System Integration and Access

Performance Indicators 4-5

Wait times for patients in Emergency Department (ED).

While Central LHIN did not meet its target of 8.0 hours for 90th percentile ED length of stay for complex patients, 2016-2017 performance of 10.20 hours is better than the provincial performance of 10.38 hours.

Performance was impacted by a challenging seasonal influenza outbreak that began in late November 2016. The Central LHIN established the Holiday Planning Working Group to develop and implement strategies to ensure a systemic approach to mitigate the overcrowding and surge conditions in hospitals during the winter holiday period. The working group included Central LHIN hospitals, Central Community Care Access Centre, York Region Public Health and other community partners.

The Central LHIN has met and maintained its better than target performance of 4.0 hours for the 90th percentile ED length of stay for minor/uncomplicated patients for the past 3 fiscal years. In 2016-2017, the Central LHIN's performance was 3.50 hours, which was better than the provincial performance of 4.15 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 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.

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 maintain its strong wait time performance for hip replacement and knee replacement surgeries. These successes were due in part to innovative Central LHIN initiatives such as the Total Joint Assessment Centre for hip and knee replacements.

The percentage of patients completing their CT and MRI scans within the Ministry of Health and Long-Term Care's provincial target remains a challenge for Central LHIN and the rest of the province. Hospitals continue to experience a significant increase in demand which has impacted wait times. Hospitals are operating efficiently based on number of scans per hour. The LHIN continues to allocate additional funding for both MRI and CT hours to improve performance. All Central LHIN hospitals participate in Choosing Wisely, a provincial initiative to address demand and have completed LEAN initiatives.

Access to health care services

(2016/17 Annual Results)

The percentage of cases* completed within the provincial target:

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

Wait time improvements

(2016/17 Annual Results)

- ✓ Non-admitted minor uncomplicated patients are spending **3.5 hours** in Central LHIN emergency departments – that's the **least amount of time in Ontario**

* Percentage of cases refers to priority II, III, and IV 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.

The following Alternative Level of Care indicators and targets were introduced in 2015-2016 through the MLAA.

- i) Percentage ALC Days: 9.46 per cent
- ii) ALC Rate: 12.70 per cent

Central LHIN did not achieve these targets in 2016-2017, and reported Percentage ALC Days of 15.33 per cent, and ALC Rate of 15.72 per cent. Performance on both of these indicators was at or near provincial performance levels.

The majority of Central LHIN patients designated ALC are awaiting placement in a Long-Term Care (LTC) Home. At present, Central LHIN has the second lowest provincial rate of LTC beds per capita, and has the highest population of seniors in the province. Consequently, Central LHIN LTC Homes are at near maximum capacity (approximately 99 per cent occupancy) with over 5,000 patients awaiting placement and growing. Additional factors contributing to long waits for LTC beds include patient choice for homes with long wait lists and increasing crisis placements from the community.

To improve ALC Performance, the Central LHIN established an ALC Collaborative team of hospital, CCAC and LHIN staff to develop a system-wide approach to minimize ALC pressures. The ALC Collaborative completed current state and gap analyses of ALC issues in Central LHIN, and engaged with system partners and stakeholders to identify, prioritize, and support implementation of strategic initiatives to enhance patient flow and support transitions between care settings.

Additional details of initiatives targeted at improving performance are described under: *Improving Capacity and Reducing Alternate Level of Care Pressures*, page 26.

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.

While Central LHIN did not meet its targets in 2016-2017 for Repeat Unscheduled Emergency Visits within 30 Days for Mental Health and Substance Abuse Conditions (at 18.32 per cent and 23.75 per cent respectively), performance for these indicators were better than the LHIN's 2015-2016 and provincial performances.

Ongoing investments to improve access to mental health and addictions services have been made to address this issue, including supportive housing, services for transitional aged youth, a mobile support team in partnership with police, and a Mental Health and Addictions Bed Registry process across all six Central LHIN hospitals.

In addition, the LHIN is closely monitoring several hospital-led pilot programs at Southlake Regional Health Centre, North York General Hospital and Mackenzie Health aimed at improving access to mental health and addiction services.

More details of initiatives targeted at improving performance are described under: *Mental Health and Addictions*, page 34.

Sustainability and Quality

Performance Indicator 14

Percentage of Readmissions within 30 days for selected Health Based Allocation Model (HBAM) Inpatient Grouper (HIG) conditions.

In 2016-2017, Central LHIN performance (15.79 per cent) is within 10 per cent of the target and is better than the previous year and provincial performance at 15.91per cent and 16.51per cent respectively.

Central LHIN continues to monitor and support various improvement initiatives such as the LHIN-funded Telehomecare program, which support clients with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) by providing coaching and education as well as rapid response from the care team so the clients can manage their own health at home. In 2016-2017, the Central LHIN Telehomecare program enrolled 715 clients making it the largest program in the province.

Additionally, Central LHIN continues to support the Integrated Funding Model pilot: The North York Central Collaborative for COPD and CHF Patients.



Quality Based Procedures

Quality-Based Procedures (QBP) are specific groups of services that offer opportunities for best practice sharing across health care providers in an effort to achieve process improvements, clinical redesign, improved patient outcomes, enhanced patient experience and potential cost savings.

All Central LHIN hospitals, along with the Central LHIN and Central CCAC, have worked collaboratively to implement QBPs for:

- Unilateral Hip and Knee Replacement
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Community Acquired Pneumonia
- Stroke

To develop QBPs, expert advisory panels – including clinicians and patients, and partners such as Health Quality Ontario, Cancer Care Ontario and Cardiac Care Network – develop evidence-based frameworks and best practice recommendations for patient care along with indicators to monitor for ongoing quality improvement.

QBPs support the implementation of evidence-based Patient-Based Funding (PBF). This means that once a procedure has been established as a QBP, funding for that specific diagnosis or treatment is provided on a "price times volume" basis, and health care providers are funded using a standard rate (or price) adjusted for the types of patients they serve.

As well, QBPs promote provincial standardization of patient care, aligned with the *Patients First: Action Plan for Health Care* to support health care system transformation.

In another element of Health System Funding Reform, several local health providers have partnered in an Integrated Funding Model (IFM). Applying the principles of IFM, the LHIN works with a group of health care providers to champion the delivery of quality, evidence-based care with integrated funding over a patient's episode of care, regardless of who is providing the care, or in what care setting.

Initiated in 2015-2016, the Central LHIN continued to support two IFM pilots in 2016-2017:

- One Client, One Team: Central and Toronto Central LHIN Integrated Stroke Care

- Integrating Specialized and Primary Care: The North York Central Collaborative for COPD and CHF Patients

This pilot has demonstrated improved clinical outcomes for patients enrolled in both projects, including reduced length of stay in hospital, reduced emergency department visits, and a decrease in hospital readmissions.

Quality Improvement

The Central LHIN continues to focus on quality – supporting quality improvement initiatives across the health care system.

The Central LHIN recognizes the importance of Health Quality Ontario's (HQP) Common Quality Agenda indicators as an important process in grounding our quality work. In sharing the same values as HQO, the Central LHIN creates an overarching means of connecting efforts across the system and leverages key stakeholders in broader provincial quality improvement initiatives.

As part of the system transformation and sub-region planning, the Central LHIN is prioritizing quality as a foundational area of focus for regional and local plans and the safe delivery of care for our residents. Through the establishment of regional quality tables, HQO and LHINs are collaborating across the province to advance clinical quality in a coordinated and impactful manner to drive improvement in ways that have a meaningful impact on patients.

Specific areas of focus include:

- Wait times reporting
- Surgical quality improvement
- Health Links
- Patient engagement
- Patient relations measurement and reporting

Embedding the voice of the patient in all of our improvement initiatives is a priority for the Central LHIN. We will continue to foster a patient engagement community of practice to support effective patient engagement efforts.



Strategic Priorities

The Central LHIN's six strategic priorities, as articulated in our Integrated Health Service Plan (IHSP) 2016-2019, are shaped by these inputs:

- Priorities and directions from the Ministry of Health and Long-Term Care on health care system quality, equity, accessibility, integration, innovation and sustainability through our Ministry-LHIN Accountability Agreement, Memorandum of Understanding, the Local Health System Integration Act, the Patients First Act, and other ongoing action plans and developments.
- Our collaboratively developed IHSP 2016-2019, a shared planning framework that outlines key elements to advance our vision of Caring Communities, Healthier People.
- The voice of patients and caregivers, and their shared experiences.
- Engagements and input from our Health Service Providers including hospitals, community health centres, home and community care providers, community support service providers, long-term care homes, mental health and addictions service providers, public health and other contributors.
- Views, insights and data from other system partners, contributors and key stakeholders including public health and primary care providers (physicians, nurse practitioners, and clinical advisors).
- Environmental scans and public health data at LHIN-wide and sub-regional level.



Better Seniors' Care

According to the Canadian Institute for Health Information (CIHI), while Canadians age 65 and older represent about 16 per cent of the Canadian population, they account for close to 46 percent of the country's public-sector health care dollars. CIHI's data reported that total health spending per person was \$6,045 per person in 2014. For senior citizens, this increased to \$6,424 for those age 65 to 69, \$8,379 for those 70 to 74, \$11,488 for those 75 to 79, and \$21,150 for those 80 and older (*Data source: Canadian Institute for Health Information. National Health Expenditure Trends, 1975 to 2016. Ottawa, ON: CIHI; 2016*).

The Central LHIN's 2016-2019 IHSP Priority for *Better Seniors' Care* is to develop specialized strategies and support systems to help older adults stay healthy and independent at home for as long as possible. This includes reducing reliance on acute care by exploring and implementing other options that are senior-friendly and cost-effective.

In our 2016-2017 Annual Business Plan, we identified the following as priority action areas:

1. Continue to implement, evaluate, and spread **assess/restore** pilot projects to enhance rehabilitative and restorative care services to prevent further functional decline for frail elderly patients.
2. Complete a **Long-Term Care Capacity** Assessment to develop and implement alternatives to institutional care for seniors.
3. Develop and implement focused and sustainable improvement strategies to enhance system capacity across the continuum to address **Alternative Level of Care** patients in Central LHIN hospitals.
4. Develop and begin implementing a phasing and risk management plan for the Ministry's 10-year **Long-Term Care Homes redevelopment** initiative for the 21 LTCH's identified for redevelopment, including capacity planning, licensing and decanting.
5. Align **specialized geriatric services** to LTCHs with the LHIN planning areas.

Over the course of the year, progress updates for these five action areas included:

1. Assess and Restore Implementation

The Central LHIN continued to support the implementation of the Assess and Restore (A&R) Program to enhance rehabilitative care services for seniors. A&R interventions provide short-term rehabilitative and restorative care treatments to help seniors, and others, who have experienced a reversible loss of functional ability and are at-risk of losing their independence. In 2016-2017, the A&R program helped over 500 patients who received standardized rehabilitation services within the hospital, and another 180 patients to receive standardized in-home rehabilitation services.

The A&R program, which was evaluated in partnership with York University, has shown an increase in the quality of life score, readmission and emergency department visit avoidance. As well, anecdotally, patients and caregivers alike have shared positive feedback on A&R supporting them to regain their independence.

To support knowledge sharing across Central LHIN hospitals, a series of education sessions were conducted and an 'Assess and Restore Toolkit' was developed and disseminated to all participants.

In 2017-2018, the focus will be to spread the foundational elements of the A&R program across all Central LHIN hospitals to improve patient experience in maintaining patient mobility and preventing functional decline.

2. Long-Term Care Capacity & Alternatives to Institutional Care

The Central LHIN developed a Long-Term Care Capacity Plan to provide seniors with alternatives to "bricks and mortar" Long-Term Care Homes. This plan is intended to inform future community investment opportunities.

A key part of the plan is expanding and enhancing both Assisted Living and Adult Day Programs. Progress made in 2016-2017 of this multi-year plan included:

- Funding an Enhanced Assisted Living model of care for an additional 133 high-risk seniors. This expansion reduced the CCAC waitlist for personal support services and enabled more seniors to live independently in their homes. In addition to monitoring client satisfaction and ED visits, the LHIN is monitoring Long-Term Care Home admissions to assess whether this model of care is delaying or preventing admissions, and thus

functioning as an alternative to institutional long-term care.

- Expansion of four Adult Day Programs and enhancing the programs by providing funded foot care services resulting in more comprehensive care.
- Establishing an Enhanced Adult Day Program Working Group to provide recommendations on Adult Day Programs expansion and enhancement. A Central LHIN Adult Day Program current state analysis was completed to provide the foundation for recommendations.

Additionally, a shared care model with the North York General Hospital Geriatric Outreach Team and the Central CCAC was implemented to provide joint in-home visits with a family physician certified in the Care of the Elderly and a Care Coordinator for frail elderly home-bound patients.

3. Improving Capacity and Reducing Alternative Level of Care (ALC) Pressures

In December 2015, the Central LHIN established an ALC Collaborative comprised of hospital, Central CCAC, and Central LHIN staff to provide focused, collective resources to enhance the effectiveness of the health system and provide the right level of care to the right patient at the right time.

The ALC Collaborative has engaged in regular and ongoing collaboration with all system partners and stakeholders to complete an in-depth current state analysis of issues affecting ALC and to identify, prioritize, and support implementation of the following strategic initiatives to improve patient flow and access within Central LHIN hospitals:

- Outpatient Stroke/Neurological Rehabilitation clinic, operated by Southlake Regional Health Centre, provides Allied Health services in the community to Central LHIN patients recovering from a mild to moderate stroke, thereby supporting patient transition from hospital, creating capacity and improving access to inpatient rehabilitation for patients with more disabling strokes.
- Behavioural Support Transition Resource (BSTR), operated by LOFT Community Services is implemented to support all Central LHIN hospitals for early identification and stabilization of patients with cognitive/responsive behaviours to support safe and effective transitions to home and community settings,

and avoid unnecessary and extended lengths of stay in hospital.

- A standardized Discharge Planning pathway is being implemented across all Central LHIN hospitals to facilitate proactive and patient-centred discharge planning.
- A web-based Discharge Planning Dashboard, developed and hosted by Humber River Hospital, is being implemented across all Central LHIN hospitals to enable efficient discharge planning process.
- A standardized Rehabilitation Referral pathway is implemented across all Central LHIN hospitals to minimize delays in transitions from acute care to rehabilitation, and avoid ALC days.
- The Rehabilitative Care Alliance Definitions Framework (Bedded Level) was implemented across all Central LHIN hospitals. The definitions framework provides clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs, and creates the foundation for local capacity planning.
- Also related to ALC pressures, the Central LHIN continues to invest in *Home First* to help older adults return home with the necessary post-hospital supports to safely continue healing when their acute care hospital treatment is complete. *Home First* also 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 7,459 patients from September 2009 to March 2017. In 2016-2017, Central LHIN funded 237 *Home First* spots to support 1,840 patients to return home safely after their hospital stay. A significant majority of *Home First* patients – 72 per cent – remained in the community after receiving enhanced care, thus reducing the need for long-term care.



4. Long-Term Care Home Redevelopment Initiative

In October 2014, the Ministry of Health and Long-Term Care announced the Enhanced Long-Term Care Home Renewal Strategy with the aim of supporting the modernization of more than 30,000 long-term care beds in over 300 long-term care homes across the province by 2025. As a result, all long-term care homes will be brought up to the current design standards to better accommodate residents with increasingly complex care needs and ensure the continued safety and quality of care for residents. In Central LHIN, there are 21 long-term care homes and over 2,800 beds that are eligible for redevelopment. This represents almost 40% of the LHIN's total long-term care bed capacity. During 2016-2017, one Central LHIN long-term care home completed the application process and received Ministry approval to begin construction. The majority of eligible long-term care home operators have shown strong interest in redevelopment.

Central LHIN will continue to focus on engaging and working with the Ministry of Health and Long-Term Care, long-term care home operators, and neighbouring LHINs to support the redevelopment of older long-term care homes to maintain the long-term care bed capacity and regional access to services.

5. Align Specialized Geriatric Services to Long-Term Care Homes

Beginning in 2016, the Central LHIN led a comprehensive review of Specialized Geriatric Services (SGS) with providers and subject matter experts to improve equitable access to specialized care in long-term care homes.

The engagement sessions included representatives from 11 SGS outreach teams, the Central Community Care Access Centre, Emergency Management Services, over 30 long-term care homes, and Central LHIN physicians. In total, over 100 stakeholders actively participated in 13 sessions and resulted in the identification of opportunities for service improvements, and key elements for a future service delivery model.

The new delivery model is being developed in alignment with sub-region planning to create better linkages with specialized geriatric teams to minimize avoidable transfers to hospitals. This new delivery model will be implemented in 2017-2018.

Better Palliative Care

In Central LHIN, 60 per cent of deaths are from chronic progressive diseases. While 66 per cent of patients in Central LHIN say that they would prefer to die at home, the reality is that only 22 per cent achieve this goal. Meantime, on a national level, it is estimated that less than one-third of Canadians have access to palliative care and supports that are appropriate to their needs.

To address these gaps, the Central LHIN's 2016-2019 IHSP priority for *Better Palliative Care* aims to provide holistic, proactive and continuous care and support for patients with progressive, life-limiting illness – and to support families through the entire spectrum of care before and after death – by helping patients to live as they choose, and to die in their preferred location of choice with quality of life, comfort dignity and security.

Our 2016-2017 Annual Business Plan identified that we would work on the following four actions:

1. Strengthen capacity of specialists and generalists through education and standardization of tools
2. Implement palliative care medical services to provide a common basket of services
3. Increase palliative care capacity in Long-Term Care Homes
4. Implement one new residential hospice (Margaret Bahen Hospice for York Region – Southlake)

The Central LHIN has made advancements in each of these four action areas:

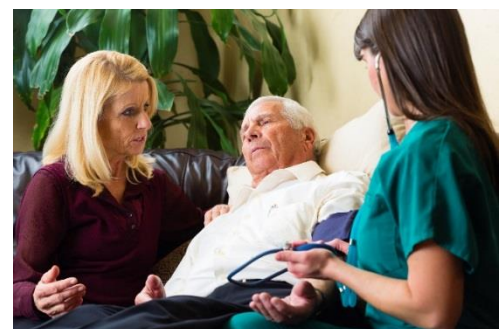
1. Strengthened capacity of specialists and generalists through education and standardization of tools

- The Central LHIN's Hospice Palliative Care Teams at Southlake Regional Health Centre received funding to establish standardized palliative education across our region for physicians, health care professionals, palliative care providers and volunteers based on best practice. In 2016-2017, 1,953 Health Service Providers received training, advancing the collective total to 5,422 Health Service Providers who have received training since 2015. (Source: HPC Teams)
- Early Identification & Prognostic Indicator Guide was disseminated to the Central LHIN palliative Primary Care providers.

- The Central LHIN participated in the Ontario Medical Association's End of Life Planning and Care seminar in September 2016.
- Central LHIN palliative care providers attended Hospice Palliative Care Ontario's Health Care Consent & Advance Care Planning Community of Practice webinar series.
- In partnership with the Ontario Palliative Care Network, the Central LHIN hosted a Palliative Care Summit entitled "*Embracing Palliative Care: Compassion, Comfort & Choice*" in March 2017, which engaged 142 participants.
- The Central LHIN provided \$1.8 million in annualized funding for home care services to enhance personal support levels and provide respite care for patients nearing the end of their lives, when their preferred place of death is home.

2. Implemented palliative care medical services to provide a common basket of services

- Central LHIN Regional Palliative Care Team model was developed. A working group was established to plan the implementation of the teams.
- The Regional Palliative Care Network was established in alignment with the recommendations of the Ontario Palliative Care Network. The Network will provide guidance to build on the Central LHIN Hospice Palliative Care Action Plan and develop a comprehensive strategy that is aligned with identified provincial initiatives.
- LHIN staff worked with Better Living Health and Community Services and provided funding for them to upgrade their clinical information system and implement that system at six visiting hospices in the LHIN. This will enable better electronic patient documentation and integration with provincial eHealth solutions including ConnectingOntario and the Integrated Assessment Record (IAR) for better patient care.



3. Increased palliative care capacity in Long-Term Care Homes

- Central LHIN began development of a plan to enhance capacity in long-term care homes through education and training.
- Implementation of the plan along with dissemination of best practices for palliative care in long-term care homes will begin in 2017.

4. Implemented a new residential hospice

- In 2016-2017, the Central LHIN funded four hospice beds at Mathews House Residential Hospice, and confirmed Ministry approval for an additional six beds to be operationalized in 2018.
- Better Living Health and Community Services will be the lead operator for the new Margaret Bahen Hospice for York Region and will be fully integrated with PalCare Network for York Region. This new 10-bed residential hospice is scheduled to open in November 2017.
- The LHIN also received confirmation for 10 new beds for the opening of the Vaughan Residential Hospice in 2019.



Better Care for Kids and Youth

The Central LHIN's 2016-2019 IHSP priority for *Better Care for Kids and Youth* aims to develop new partnerships and innovative models to bring specialized care closer to home for children and youth.

Cross-Sector Complex Care Model

The Central LHIN has now established an innovative partnership care model in collaboration with the Ministry of Community and Social Services (MCSS) and several of our Health Service Providers.

In partnership with MCSS, as well as the REENA, the March of Dimes, Central CCAC, York Region (Housing) and Community Living York South, the Central LHIN developed a model of care for young adults with developmental and medical complexity who are unable to direct their own care. This model was operationalized in 2015-2016.

In 2016-2017, this Cross-Sector Complex Care Model for Young Adults with Medical and Developmental Complexities supported nine individuals and their families. An evaluation of this model was initiated in February 2017 and focused on quality of life as well as return on investment. The final evaluation will be available in the first quarter of 2017-2018.

To advance learnings from this program, the Central LHIN/MCSS implementation group presented the model at the MCSS *Team Days* in April 2016 and the Ontario Community Support Services Association Conference in October 2016. In December 2016, MCSS announced support for a provincial community consortium to develop an inclusive, community-based housing strategy for adults with developmental disabilities, with contributors to the Central LHIN model to support the provincial consortium.

Acute Paediatric Care

In 2016-2017, paediatric care was a source of dialogue between the Central LHIN and local hospitals. Moving forward, the Central LHIN will support and encourage the adoption and sharing of consistent practices for acute paediatric care across all Central LHIN hospitals.

Better Community Care

The Central LHIN's 2016-2019 IHSP priority for *Better Community Care* is to create stronger links to integrated community services and to primary care, to help patients recover and receive more of their health care at home, with safety and independence.

In 2016-2017, the Central LHIN funded 29 Community Support Services, two Community Health Centres and the Central Community Care and Access Centre (CCAC), and our Annual Business Plan strategies included:

1. Continue to create closer linkages between the Central LHIN and local **Public Health** Units to enhance planning.
2. Engage **Primary Care** to develop an integrated regional model and implementation plan for Primary Care service delivery that aligns with the planning areas in Central LHIN.
3. Implementing the **home and community-based care** coordination and Personal Support Services Policy Guidelines to coordinate and optimize home and community care for older adults.

In 2016-2017, the Central LHIN undertook the following initiatives to advance *Better Community Care*.

1. Building closer linkages with Public Health

Of the 36 public health units in Ontario, three have areas of responsibility within the Central LHIN. The Central LHIN's six sub-regions are aligned to the boundaries of the three local Public Health Units:

SUB-REGION	PUBLIC HEALTH UNIT
South Simcoe	Simcoe Muskoka District Health Unit
Northern York Region Western York Region Eastern York Region	York Region Public Health
North York West North York Central	Toronto Public Health

Health units are active in health promotion and education, disease prevention programs, communicable disease control, immunization, and selected screening services, along with food premises inspection.

The LHIN has been engaged with all three Public Health Units, and have started to identify areas for collaboration on

joint priorities at neighbourhood, sub-region and regional levels. This includes engaging Public Health Unit experts and staff as key partners and stakeholders at various health planning tables throughout 2016-2017.

2. Engagements with Primary Care

With over 1,790 family physicians in the Central region, the Central LHIN commenced primary care engagements to varying degrees in 2016-2017. During this timeframe, Central CCAC staff engaged with the vast majority of primary care providers on Health Links (see Health Links information below). To support early planning, primary care discussion tables were formed in four Central LHIN sub-regions, namely: North York West, North York Central, Eastern York Region and Western York Region, while preliminary discussions have been initiated in South Simcoe and Northern York Region. With the passage of the *Patients First Act* in December 2016, the provincial government enhanced the LHIN's mandate to engage with primary care and fund primary care models (not physicians). The Central LHIN is eager to advance primary care engagements in 2017-2018.

3. Expanded Home & Community Care Services

The expansion of home care and community services, including respite care, was a focus for 2016-2017. In addition to the funds targeted for Home First and palliative programs, an additional \$7.1 million in annualized funding was provided to the Central CCAC to enhance the basket of services for complex patients who are at risk for a long-term care admission or being hospitalized. A further \$1.6 million in annualized funding was provided to enhance personal support levels and provide respite care for patients waiting in the community for crisis placement.

In the Fall of 2016, Central LHIN approved funding for the development of a three-year Acquired Brain Injury and Attendance Outreach strategy to address patient needs. Central LHIN also made an additional investment into Mobile Attendant Outreach Services (a leading provincial best practice) designed to provide at-home services to support an additional seven individuals in their own home. Central LHIN funded the expansion of Acquired Brain Injury services that included personal support, independence training, adult day program and psychology. This program – which will provide community support for an additional 67 clients – will improve quality of life for clients and their families, improve system capacity and decrease inappropriate living situations.

In January 2017, the Central LHIN implemented the policy guideline related to the delivery of personal support services

by community support services agencies. Subsequently, the Ministry of Health and Long-Term Care approved Community & Home Assistance to Seniors (CHATS) and Better Living to provide personal support services to low needs single service patients. As a result, 50 new clients previously on a CCAC wait-list began receiving personal support services.

Additional measures that supported stronger links between patients, primary care and other community services to help patients safely recover at home include:

4. Community Paramedicine

In 2014-2015, the province invested in 30 community paramedicine programs across Ontario as an innovative way to help seniors and other patients live independently in their homes, while reducing 911 calls, emergency room visits, hospital admissions, and long-term care placements.

York Region Paramedic Services partnered in the “Expanding Paramedicine in the Community” (EPIC) pilot project, which connected patients of family health teams with paramedics who, in turn, made scheduled and unscheduled home visits to help high-needs, high-risk patients manage their chronic disease and medication requirements.

In 2016-2017, LHINs were asked to provide a status update on the local community paramedicine programs. The EPIC Program in York Region helped 119 residents with chronic health conditions receive non-emergency care from a paramedic, often in their own home. As a result of this work, the Central LHIN will provide funding to York Emergency Paramedic Services to further community paramedicine services in 2017-2018.

5. Health Links

Five per cent of patients account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. (Source: Ministry of Health and Long-Term Care, www.health.gov.on.ca/en/pro/programs/transformation/community.aspx)

The Health Links care model was established in 2015 to help coordinate complex patients with multiple conditions who require the care of multiple service providers.

Central LHIN has five operational Health Links that closely, but not identically, mirror our six sub-regions.

The Health Links are led by the following HSPs:

South Simcoe & Northern York Region: Southlake Regional Health Centre

South West York Region: Mackenzie Health

South East York Region: Markham Stouffville Hospital

North York West: Black Creek Community Health Centre

North York Central: North York General Hospital

In 2016-2017, our five Health Links teams completed new Coordinated Care Plans for 1,511 complex patients, and 2,644 complex patients since 2013.

Key enablers and successes this past year included the development of standardized Central LHIN communication tools, and the development and implementation of the Integrated Coordinated Care Process Model through the Care Coordination Tool (CCT) pilot. To date, over 100 end users were trained on the CCT in the South Simcoe and Northern York Region Health Link. As well, Central CCAC’s primary care engagement strategy, a critical component to knowledge sharing on the Health Links approach, connected with over 1,600 primary care providers in the Central LHIN.

As part of a pan-LHIN Health Links Maturity Assessment conducted in October 2016, it is estimated that 13 per cent of all provincial Health Link areas will achieve the minimum of Functional Excellence (third out of five stages) by the 2016-2017 fiscal year-end. The North York Central Health Link successfully reached this stage in 2016-2017.

Right Care, Right Time, Right Place

Getting the right level of care in the place at the right time is an important tenet of health care. As important as our focus was in working with our community-based stakeholders in 2016-2017, the Central LHIN also worked with our local hospitals so emergency and acute care services were available for those most in need of it.

Two acute care initiatives in 2016-2017 included:

1. Improving Emergency Department (ED) Efficiency and Capacity

Working in collaboration with all local hospitals, the Central CCAC and other community partners, the Central LHIN continued to monitor and support ED efficiency and capacity with a goal to reduce the amount of time people spend waiting in the ED, and to safely discharge patients from hospital to an appropriate setting of care.

2. Emergency Department (ED) Pay for Results

In 2016-2017, the Central LHIN provided \$12.1 million in one-time funding to support the ED Pay for Results (P4R) program. All provincial P4R sites are required to show improvement in the following six ED indicators:

- 90th Percentile ED Length of Stay for Admitted Patients
- 90th Percentile ED Length of Stay for Non-Admitted, 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
- 90th Percentile Ambulance Offload Time

Central LHIN hospitals were among the top performers relative to the 73 P4R sites for ‘Non-Admitted, Low Acuity Patients’, and Central LHIN was ranked #1 in the province for this indicator. Southlake Regional Health Centre was ranked #1 for ‘Time to Physician Initial Assessment’, Stevenson Memorial Hospital was ranked #2 for ‘Non-Admitted, Low Acuity Patients’, and Markham Stouffville Hospital was ranked #9 for ‘Non-Admitted, High Acuity Patients’.

In 2016-2017, Central LHIN hospitals experienced an increase in ED volumes and significant challenges related to in-patient capacity, and consequently did not meet the Ministry-Led Accountability Agreement target for ‘90th Percentile ED Length of Stay for Complex Patients’.

In the year ahead, Central LHIN hospitals will focus on improving their respective ED length of stay for admitted patients.

Better Care for Underserved Communities

Equitable access to health care is a priority for the Central LHIN.

In our 2016-2019 IHSP, the *Better Care for Underserved Communities* priority outlines our intent to create organized, integrated systems of care to improve early intervention and treatment of disease in neighbourhoods or populations (Indigenous or Francophone) where there are recurring patterns of chronic and acute or episodic health conditions.

Also, as part of our commitment to health equity, the Central LHIN recognizes the challenges that newcomers face and continues to provide timely access to culturally appropriate care. Our IHSP priority states that we will develop

partnerships that will improve the long-term health by addressing the key factors that determine healthy outcomes.

Our 2016-2017 Annual Business Plan outlined that the following action plans would be undertaken to support *Better Care for Underserved Communities* included:

1. Improve access to services for the **Indigenous** population in the Central LHIN, including Georgina Island
2. In collaboration with Entité 4 and two surrounding LHINs (Central East and Toronto Central), leverage current resources to establish and implement the Mental Health & Addictions access pathway for **Francophone** services and leverage the Francophone navigator work to increase access to Primary Care services in French in the North Work West area
3. Complete development of **North York West** multi-year action plan and implement early initiatives (includes both Mental Health & Addictions and physical health)
4. Develop and implement a regional model for the delivery of **Chronic Disease Prevention and Management** programs that leverages the Diabetes Education Programs delivery model and aligns with Primary Care

The following initiatives and actions were undertaken in 2016-2017:

1. Services for Indigenous Communities

Central LHIN is home to approximately 7,000 Indigenous people, representing 0.4 per cent of the population. The Chippewas of Georgina Island, comprised of approximately 200 residents, is Central LHIN’s only First Nations on-reserve community. While a portion of Central LHIN’s Indigenous population lives on Georgina Island, the majority are living off-reserve, primarily in semi-rural and smaller communities in northern York Region and south Simcoe County (*Source: National Household Survey, 2011*).

Central LHIN recognizes that Indigenous people have a greater burden of illness than the general population that is exacerbated by barriers to equitable access to health services.

Annually, the Central LHIN develops an Indigenous Engagement and Cultural Competency Training Plan that identifies various Indigenous stakeholders in our local community. Our 2016-2017 engagements have included face-to-face meetings with Georgina Island and NinOsKomTin (a local urban Indigenous group) in addition to other Indigenous and non-Indigenous stakeholders.

In February 2016, the Central LHIN commenced funding for two Indigenous Navigators to support the local community in navigating health care services, in particular access to primary care, mental health and addictions and chronic disease management. Indigenous stakeholders were engaged in the development of this proposal and the program that was piloted.

Central LHIN is exploring innovative and improved sustainable funding mechanisms to support Indigenous people living on and off-reserve, and is engaging local Indigenous leaders to determine the needs of their community and how best to meet those needs. Central LHIN will continue to partner with Indigenous communities to further understand how to support and co-design culturally appropriate, and safe services for improved health outcomes.

The Central LHIN also continued to invest in Indigenous Cultural Competency and Safety Training in 2016-2017 to support Health Service Providers in better understanding the importance of adopting culturally safe practices. This was done in conjunction with the Ontario Federation of Indigenous Friendship Centres. In 2016-2017, 489 Health Service Provider staff from Mental Health and Addictions agencies, the Community Care Access Centre, and diabetes education programs participated in the Indigenous Cultural Competency and Safety Training.

As well, Central LHIN provided funding for a two-day Wellbriety Gathering hosted on Georgina Island, which brought 24 community members together to celebrate their wellness journey and share traditional teachings.

2. Services for the Francophone Population

The Central LHIN is home to approximately 31,725 Francophones, or about 1.3 per cent of our total population. Among French speaking residents in Central LHIN, a significant portion are newcomers who have settled in the North York West planning area.

In collaboration with Entité 4 and Black Creek Community Health Centre (CHC), the Central LHIN developed the French Language Services Advisory Committee for North York West. The purpose of this Committee is to promote health services in French and support health prevention. The Committee uses existing partnerships and networks (community organizations, school boards and Health Service Providers) to sensitize and mobilize the Francophone communities on various health issues.

As a result of this community engagement and feedback, two priorities were identified:

- To reduce stigma associated with mental illness and addictions and promote culturally appropriate access to mental health and addiction services through outreach
- To develop access hubs that help identify clients that need or prefer health care services to be provided in French

The Central LHIN will continue to work collaboratively with the French Language Services Advisory Committee for North York West to develop and implement strategies to address the priorities identified.

Further actions to support access and availability to Francophone health services can be found in the next section – North York West Multi-Year Action Plan.

3. North York West Multi-Year Action Plan

The Central LHIN data suggests that residents in North York West planning area have been identified as being at a higher risk for sub-optimal health outcomes, including serious health challenges related to chronic disease, mental illness and substance abuse issues, while also facing higher obstacles to accessing primary care compared to other Central LHIN sub-regions.

As such, the Central LHIN is working with partners to gather information from community residents and stakeholders to inform the development of a sub-region plan.

In 2016-2017, the Central LHIN provided community funding to Black Creek Community Health Centre to develop a French Language Service Navigator program to provide case management support to local Francophone residents. The goals of the program were to improve access to physical health care services, mental health and addictions supports, and chronic disease prevention and management programs.

Black Creek Community Health Centre is now successfully engaging the Francophone community by offering workshops in French for numerous programs such as mental health and addictions, chronic disease self-management, including diabetes. The Navigator also refers patients to primary care services in French.

Also in 2016-2017, the Central LHIN implemented a Mental Health and Addictions Outreach pilot program provided by Toronto North Support Services. The goals for this pilot and work plan included:

- Training for Health Service Provider staff and Mental Health First Aid to be offered to other providers and the public in French
- Informing the community of available community mental health and substance use services for Francophones
- Building capacity to enable early identification and reduce stigma of mental health/substance use issues in the community
- Collaborate with the French Language Service Navigator at Black Creek Community Health Centre to identify and coordinate outreach activities in North York West

The Central LHIN will use learnings from our March-April 2017 sub-region engagement conversations and actively engage new and existing partners to further explore opportunities to foster community-based solutions at the local level and strengthen opportunities for changes as we embark on system transformation in the North York West sub-region.

4. Chronic Disease Prevention and Management

Chronic diseases – which includes cardiovascular disease, diabetes, respiratory disease and cancer – are the leading cause of death and disability in Ontario.

In addressing chronic diseases and their risk factors, consideration is given to health equity and socio-ecological factors as major contributors to chronic disease including tobacco use, unhealthy eating and lack of physical activity. (Source: Public Health Ontario www.publichealthontario.ca)

The Chronic Disease Prevention and Management (CDPM) Service Coordination Committee was established to oversee the development of an integrated regional/sub-region model to achieve equitable access to CDPM programs across the region. This objective aligned with the strategic priority aimed at improving early intervention and treatment of disease in neighbourhoods or populations with recurring patterns of chronic and acute or episodic health conditions.

This committee consists of key leaders and stakeholders from chronic disease programs, Public Health, primary care, mental health, long-term care, the Francophone community as well as two patient advisors/persons with lived experience.

In 2016-2017, the committee conducted an initial environmental scan of all CDPM programming across the LHIN and identified gaps in awareness and information on available programs. Moving forward, the LHIN will apply a population health based approach in planning CDPM programs and services.

Better Mental Health

Based on an analysis completed by the Ministry's Health Analytics Branch (January 2015), the Central LHIN region has the highest population with mental health and addictions challenges in the province.

Our 2016-2019 IHSP priority for *Better Mental Health* is to integrate a supportive system of programs and services to enhance the wellness of people with mental illness and addictions, and to promote and sustain recovery.

To help achieve this priority, the Central LHIN established accountability agreements with 23 Mental Health and Addictions Service Providers in 2016-2017, and our 2016-2017 Annual Business Plan identified the following priorities:

1. **Evaluate** the mobile crisis co-responder models to determine best practice and implement a more consistent model
2. Evaluate impact of key initiatives of the Mental Health and Addictions Action Plan and Service Coordination Council for **York Region**
3. Continue to expand access to **supportive housing**

Over the course of 2016-2017, the Central LHIN undertook the following actions aligned to our Annual Business Plan:

1. Evaluation of mobile crisis co-responder models

An external evaluation of Mental Health and Addictions initiatives in the Central LHIN is currently being conducted by the Centre for Excellence in Economic Analysis and Research (CLEAR). Central LHIN, in partnership with the Canadian Mental Health Association–York Region and South Simcoe branch, has been overseeing this work, culminating in an interim research report on March 31, 2017. The interim report contains preliminary findings on the following programs:

- Mental Health and Addictions crisis services
- Peer Navigator Program
- Flexible Supports Program
- Service Coordination Council (Qualitative Measures)

Submission of the final report is expected in December 2017. The results of this analysis will enable Central LHIN to ensure programs are cost effective, potentially decrease duplication of services, and assist with evidence-based planning and decision making to further strengthen Mental Health and Addictions services.

2. York Region Mental Health Hub Being Explored

In July 2016, the Central LHIN was invited to participate in discussions to collaboratively address emergency department (ED) utilization for people with Mental Health and Addictions issues in York Region. A committee was created with membership including federal and provincial elected officials in York Region along with leadership from Southlake Regional Health Centre, Mackenzie Health and Markham Stouffville Hospital, Canadian Mental Health Association –York Region, York Regional Police and Emergency Medical Services.

Data from hospital, community, and municipal partners demonstrated an increased demand in service utilization, including:

- 7.7 per cent average year-over-year growth in mental health and addictions visits to ED (fiscal year 2013-2014 to 2015-2016)
- 13.1 per cent growth in mental health and addictions repeat visits to ED (fiscal year 2013-2014 to 2015-2016)
- 23 per cent increase in mental health and addictions calls to York Regional Police (2011 to 2015)
- 30 per cent of all York Region Emergency Medical Services volume is comprised of mental health and addictions

As a result of a literature review, current data analysis, and discussions with Health Service Providers, Central LHIN presented potential attributes that could be included in the design of a new Mental Health and Addictions Hub to the committee in February 2017. The key attributes of a hub focused on access to services that address mental health and addiction conditions, walk-in and primary care support, crisis stabilization beds, psychiatry (possibly virtual) and mobile crisis teams. The Central LHIN continues to be involved in this initiative with partners.

3. Expanded Access to Supportive Housing

The shortage of affordable housing (lowest in Ontario), coupled with the highest population and the fourth lowest per capita funding for Mental Health and Addictions services in Ontario, poses significant challenges in York Region.

The expansion of supportive housing in Central LHIN will help address the need for affordable housing and supports, promoting and sustaining recovery of those with serious and persistent Mental Health and Addictions issues.

On March 29, 2017, Central LHIN received a letter from the Ministry of Health and Long Term Care confirming base funding to provide support services in co-ordination with 23 new supportive housing rent supplement units for people with serious mental health issues and/or problematic substance use who are homeless or at risk of being homeless.

Two Health Service Providers, Canadian Mental Health Association-York Region and LOFT Community Services, will receive funding to support the expansion of supportive housing in the Central LHIN. The Central LHIN will allocate funds for this initiative to the designated Health Service Providers in the first quarter of 2017-2018.



Additional Priorities on Working Together

eHealth

Central LHIN's Integrated Health Service Plan 2016-2019 identified eHealth as a key enabling health system transformation.

Key initiatives and focus areas in 2016-2017 included:

Connecting Ontario (formerly Connecting GTA)

The program revolves around three major regional partners in the Greater Toronto Area, South West, and Northern and Eastern regions, as well as vendors and stakeholders, all working together to deliver electronic health records for every patient in Ontario.

ConnectingOntario (cOntario) will enable province-wide information sharing by building and linking systems, so that clinicians, whether in a doctor's office, community clinic or hospital can access to patients' personal health information anywhere, anytime. Having rapid access to complete, up-to-date and accurate information puts clinicians in a better position to provide the best possible care.

cOntario enables hospitals and CCACs to upload patient information to the cOntario Clinical Data Repository (CDR). 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.

Once fully functional, the cOntario CDR will serve as a one-stop-shop for a patient's medical record with all Health Service Providers having access to the viewer portal. The GTA portion of the cOntario CDR now contains patient data from 24 hospitals, seven CCACs and most of the provincial laboratories. As a result, over 42,000 clinical users and their patients currently benefit from the cOntario viewer portal in the GTA. The following Central LHIN organizations are contributing to cOntario: North York General Hospital, Humber River Hospital and the Central CCAC. The following Central LHIN organizations are viewing cOntario: Humber River Hospital, Markham Stouffville hospital, North York General Hospital, Southlake Regional Health Centre,

Better Living, Carefree Lodge, Cummer Lodge, and Ukrainian Canadian Care Centre.

A goal for 2017-2018 is to increase patient data collection including the four remaining Central LHIN public hospitals: Stevenson Memorial Hospital, Southlake Regional Health Centre, Mackenzie Health, and Markham Stouffville Hospital.

Ontario Laboratory Information System

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

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 over 1,000 of Central LHIN's primary care providers, allowing them to receive laboratory test results directly into their EMRs, enabling faster and broader access.

Hospital Report Manager & eNotification

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

All the Central LHIN public hospitals are live with HRM sending reports through HRM with over 900 Central LHIN primary care providers and their patients benefiting.

eNotification will notify the CCAC and Primary Care (through HRM) when patients/clients: present to the hospital emergency department (ED), are discharged from the ED, are admitted to a hospital inpatient unit, and are discharged from the hospital inpatient unit. Markham Stouffville hospital is live with eNotification. NYGH and Humber River have been identified as the next Central LHIN hospitals to go live with eNotification. The project kick-off meetings were held with a planned go-live for fiscal year 2017-2018 which is later than originally anticipated due to OntarioMD schedule.

eConsult

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.

Central LHIN's North York General Hospital participated in an eConsult pilot program, starting in October 2015, with their 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).

Including the 2016-2017 provincial expansion, 2,843 eConsults were sent to specialists province-wide. Of these, 335 were sent to specialists by 286 Central LHIN clinicians with an average response time of two days, the shortest being five minutes. Central LHIN specialists answered a total of 559 eConsults.

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. RM&R speeds up the referral and matching process by replacing a paper based system and improves the completeness of patient referrals.

For 2016-2017, the focus was spreading the solution into some of the hospitals' in-patient and outpatient clinics which will allow for more patients to access their services in a timely manner.

Telehomecare

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

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

As part of 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 promote our THC program to all residents of the Central LHIN. Work continued this year to make the program available in various congregate living settings for seniors in the community.

Telemedicine

Telemedicine equipment is used by Health Service Providers to deliver care to patients via two-way videoconferencing. Our goal is to imbed telemedicine into models of care, where appropriate, to improve the patient experience and enhance health system capacity. Overall, telemedicine events increased by 33 per cent in 2016-2017 compared to the same period last year.

Growth in telemedicine events can largely be attributed to the increased use of Personal Computer Video Conferencing (PCVC) by CLHIN Health Service Providers. Telemedicine use (PCVC) continues to grow in LHIN priority programs. For example, Central CCAC Mental Health and Addictions Nurses who provide support to students with mental health or addiction issues now connect with students via PCVC.

The Central LHIN Teleophthamology program planning continued throughout 2016-2017. The program is now ready to go live in April 2017, which is later than anticipated due to Ontario Telemedicine Network technology procurement timeline changes.



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 allow for access to assessment data to help identify client needs and put services in place to meet those needs.

Central LHIN continues to support the adoption and use of both Common Assessments and the IAR by working collaboratively with the both the Community Support Services (CSS) and Mental Health and Addictions (MH&A) Networks. The CSS sector continues to move forward with education, training and competency testing to improve the quality of the common assessment and IAR use. Work with Community Mental Health has brought the number of HSPs completing assessments and uploading to the IAR to close to 100 per cent.



Client Information & Management System – Palliative Agencies

This initiative is part of the Community IM/IT (Information Management / Information Technology) strategy to increase the capacity of the community sector to use technology to modernize care delivery.

As the health care system moves to digital practice, it will be important to ensure that community providers have the necessary tools to support the electronic patient record. Some organizations providing palliative care use paper health records, or systems that do not have the capability to interface with other systems. A client information and management system allows for the electronic documentation of clinical information, enabling connection with the provincial electronic health record as well as other client information systems in the health care system.

Central LHIN worked with Better Living Home & Community Services to understand the current state of clinical systems used in visiting hospices. The LHIN funded Better Living to upgrade their clinical information system (CIS) and implement the CIS for six visiting hospices (Hospice Georgina, Hospice Vaughan, Doane House Hospice, Evergreen Hospice, Hospice King-Aurora and Better Living Hospice Services).

This initiative will allow hospices to be better positioned for integration with various provincial electronic tools that support the sharing of health records, enhancing the overall patient experience.

Integration

A key priority for each LHIN is to plan, fund and manage an integrated health system that improves the health of Ontarians through equitable access to coordinated, integrated, high-quality services.

To help achieve an integrated system, the *Local Health Integration Network Act, 2006* articulates LHIN and Health Service Provider (HSP) obligations to support an effective and transparent integration process, including:

- Voluntary integrations where HSPs proactively plan to integrate services funded by the LHIN;
- Integrations through funding where the LHIN uses its funding authority to promote integration of services;
- Facilitated and negotiated integrations where the LHIN and/or HSPs explore and plan integration of services;
- Required integrations where the LHIN orders HSPs to integrate services;

The Central LHIN Board of Directors may, on occasion and given the above circumstances, approve a motion for integration of services between Health Service Providers in accordance with the *Local Health System Integration Act, 2006* for more efficient, timely and seamless care coordination across the system. In the event of a potential integration or recommended integration, the LHIN will monitor the system level impact of the integration and provide progress reports to the Board. The involved Health Service Providers may be required to provide status updates on a results basis for a multi-year period after integration.

In 2016-2017, the following integration was carried out:

Integrated Palliative Care Services

Following the issuance of an Expression of Interest for an organization to deliver an integrated basket of hospice and palliative care services to York Region, including governance and operation of the Margaret Bahen Residential Hospice, the Central LHIN received a proposal from Better Living Health and Community Services and Palliative Care Network for York Region.

Together, Better Living Health and Community Services and Palliative Care Network for York Region submitted a proposal for full merger and integration of the latter into Better Living Health and Community Services to enable provision of integrated hospice palliative care services.

This integrated organization is now creating a new integrated model of hospice palliative care which will provide more accessible, equitable, and quality-focused hospice palliative care in York Region. There will be enhanced support and choice for patients through the entire spectrum of care, including greater choice to live and die in their preferred location, and increased services for the patient's family including bereavement support.



Executing the Annual Business Plan

Through action plans outlined in our 2016-2017 Annual Business Plan, and in alignment with our IHSP 2016-2019, the Central LHIN has continued to advance quality and excellence in local health care services in support of the needs of the Central LHIN population.

The following chart outlines progress on a project management percentage basis for the action plans outlined in the Central LHIN's 2016-2017 Annual Business Plan outlined to our six strategic priorities.

- Better Seniors Care
- Better Palliative Care
- Better Care for Kids and Youth
- Better Community Care
- Better Care for Underserved Communities
- Better Mental Health

These initiatives and projects are also important contributors to the Central LHIN achieving measureable progress toward our vision of *Caring Communities, Healthier People*. With the passage of the *Patients First Act, 2016*, certain additional action items that were undertaken this year are not captured in this chart, while other action items required a change in focus over the period April 1, 2016 to March 31, 2017.

IHSP4		Annual Business Plan		Project Management	
Strategic Priority	Action Plan #	Action Plan and Description	Target % to complete in 2016-2017	% Complete as at Q4	
Better Seniors Care	1	Complete a LTC capacity assessment to develop and implement alternatives to institutionalized care for Seniors.	50%	50%	
	2	Develop and implement focused and sustainable improvement strategies to enhance system capacity across the continuum to address Alternate Level of Care (ALC) patients in Central LHIN hospitals.	50%	60%	
	3	Continue to implement, evaluate and spread assess/restore pilot projects to enhance rehabilitative and restorative care services to prevent functional decline for frail elderly patients.	100%	100%	
	4	Align Specialized Geriatric Services to Long-Term Care Homes with the LHIN planning areas.	100%	100%	
	5	Develop and begin implementing a phasing and risk management plan for the Ministry 10-year LTCH redevelopment initiative in the Central LHIN for the 21 LTCHs identified for redevelopment, including capacity planning, licensing and decanting.	10%	10%	

Better Palliative Care	6	Continue to strengthen capacity of specialists and generalists through education and standardization of tools.	50%	50%
	7	Implement palliative care medical services to provide a common basket of services and supports in alignment with the LHIN planning areas.	100%	90%
	8	Implement the plan to increase palliative care capacity in Long-Term Care Homes through education and supports.	50%	50%
	9	Implement one new residential hospice.	10%	10%
Better Care for Kids & Youth		Complete a current state analysis to identify gaps.	0%	N/A
		Implement best practices and enhance standardization for acute paediatric care in all hospitals across the Central LHIN.	0%	N/A
Better Community Care	10	Implement the Home and Community-based Care Coordination and the PSS Policy Guidelines to coordinate and optimize home and community care for older adults.	100%	100%
	11	Engage Primary Care to develop an integrated regional model and implementation plan for Primary Care service delivery that aligns with the planning areas in Central LHIN.	33%	20%
	12	Continue to create closer linkages between Central LHIN and the three Public Health Units to enhance planning in the Central LHIN planning regions.	100%	100%
Better Care for Underserved Communities	13	Complete development of North York West multi-year action plan and implement early initiatives (includes both MHA and physical health)	50%	25%
	14	Develop and implement a regional model for delivery of Chronic Disease Prevention and Management (CDPM) programs that leverages the Diabetes Education Programs delivery model and aligns with Primary Care.	25%	10%
	15	Improve access to services for the Aboriginal population in Central LHIN, including Georgina Island.	100%	100%
	16	In collaboration with Entité 4, CE LHIN and TC LHIN, leverage current resources to establish and implement the MHA access pathway for Francophone services and leverage the Francophone navigator to work to increase access to Primary Care services in French in the North York West area.	50%	50%
Better Mental Health	17	Evaluate the mobile crisis co-responder models to determine best practice and implement standardized model; evaluate impact of key initiatives of the MHA Action Plan and Service Coordination Council for York Region.	75%	75%
	18	Continue to expand access to supportive housing.	100%	100%

Community Engagement

Community engagement is at the core of Central LHIN's health system planning initiatives. Including the voice of our patients and caregivers, and our Health Service Providers, is fundamental to putting patient needs at the centre of our local health care system.

As we undertake community engagement with our diverse communities and stakeholders, our goal is to inform, involve and collaborate to work together with stakeholders for health care system improvement. Community engagement is a dynamic process and many tools, techniques and methodologies are employed to effectively collaborate through engagement with our patients and stakeholders.

Since the inception of LHINs, Central LHIN Board members and staff have been committed to local community engagement with residents, Health Service Providers, local government leaders and many other organizations to work together on enhancing the health care system.

Highlights from the Central LHIN's community engagement activities and consultation and input structures in 2016-2017, which embraced a focus on identification of services for underserved communities including our Aboriginal and Francophone populations, included the following:

- **Indigenous Community Engagement** – The Central LHIN is home to approximately 7,000 Indigenous people, representing 0.4 per cent of the population. Please refer to action items in Strategic Priority “Better Care for Underserved Communities” for actions taken in 2016-2017 to support better health outcomes for the Indigenous population in Central LHIN. In 2016-2017, the Central LHIN engaged in in-person meetings with the Health Services office for the Chippewas of Georgina Island along with elders and members of the community, including from NinOskKomTin, an urban Indigenous community group. Our purpose in these engagements is to co-design a plan along with services and supports that aligns with the needs of the community and improves access to culturally appropriate services. Our meetings
- took place throughout the year. The Central LHIN will continue to engage with local Indigenous leaders to explore further innovative options to support Indigenous people with culturally appropriate services for improved health outcomes.
- **Francophone Community Engagement** – The Central LHIN is home to approximately 31,725 Francophones, or about 1.3 per cent of our population. To help respond to this community, a large concentration of whom reside in the North York West sub-region, the Central LHIN collaborated with Entité 4 and Black Creek Community Health Centre, which is based in the North York West sub-region, to develop the French Language Services Advisory Committee for North York West. The purpose of this committee is to promote health services in French and support health prevention. The committee utilizes existing partnerships and networks (community organizations, school boards and Health Service Providers) to sensitize and mobilize the Francophone communities on various health issues. The Central LHIN will continue to work collaboratively with the French Language Services Advisory Committee for North York West to develop and implement strategies to address the priorities identified.
- **Citizens' Health Advisory Panel (CHAP)** – The Central LHIN established CHAP in 2013-2014 to add patient and family voices from our local communities into the Central LHIN's system planning initiatives. This panel serves as a forum for dialogue with community members as they advise the LHIN on how to achieve person-centred health care in designing programs within the local health system context. In 2016-2017, with some members completing a three-year term, the Central LHIN issued a community call for new members for CHAP. The committee welcomed several new members in 2016 and also maintained some current members for continuity, and they continue to meet on a regular basis to share patient experience stories and provide suggestions and feedback. In 2016, we engaged

a CHAP representative in our Board Development Day. As well, we begin every Board Meeting with a Patient Experience story as a learning opportunity.

- **Sub-region Planning and Community Conversation Sessions**

Aligned with the *Patients First Act*, and the Ministry's approval of Central LHIN's six sub-regions, Central LHIN staff are advancing consultations on our sub-region planning strategy, which involves working with our patients and Health Service Providers to co-design a more integrated care delivery model to strengthen the patient experience.

Initially to define the sub-regions, the Central LHIN conducted community engagement in the summer and fall of 2016, followed by a webinar in March 2017, and then a series of sub-region and system transformation community engagement sessions, held in March and April 2017. A session was held locally in each sub-region.

The Central LHIN's sub-region strategy is grounded in the Collective Impact methodology, providing a platform for stakeholders to work together towards a specific common goal to solve complex challenges. The Collective Impact approach will support stakeholders to:

- Transform the patient experience
- Drive innovation and sustainable service delivery
- Build and foster interdependent networks of care
- Tackle health inequities by focusing on population health

During our sub-region community conversation sessions, over 300 patients and Health Service Providers, including community, hospital, municipalities, public health and primary care providers, participated to bring context to system-level data and set the stage for the future of stronger patient care in the Central LHIN. The conversations were thoughtful, robust and grounded in the patient experience. We heard both patient and provider perspectives on

navigating the local healthcare system. Collectively, we achieved foundational dialogue to build momentum for our call to action to co-design local solutions that respond to health care needs at the local level. The Central LHIN is preparing a summary report on the key themes that emerged from these community conversations, which included access to care, access to data, health literacy, social isolation, caregivers and solutions.

As well, the Central LHIN will continue engagement on sub-region planning and generate sustainable solutions for care gaps at the sub-region level. Supporting our sub-region co-design work is the Integrated Care Advisory Council (ICAC), defined below. As a critical next step, the Central LHIN is committed to achieving a shared common agenda by September 2017 through a co-design approach to achieving consistent, quality-based outcomes that improve and strengthen patient care transitions between health services and providers.

- **Health Service Provider Engagement**

In addition to Central LHIN staff working with HSP staff on their individual Service Accountability Agreement and ongoing performance and program dialogues, the Central LHIN Board of Directors, led by the Chair and supported by other Board Directors and the Chief Executive Officer, conducted two Governance Council Meetings in 2016-2017. The meetings took place in May and November 2016. All Board Chairs, or their delegate, of the 95 Health Service Providers who receive funding from the Central LHIN were invited to come together for governance updates and dialogues. In addition to bi-annual in-person meetings, the Central LHIN provided periodic email updates to all Central LHIN's funded HSP Chairs. As well, the Central LHIN Chair and CEO and occasionally other Board Directors attended HSP board meetings, annual general meetings, funding events, and individual briefing and update sessions. In turn, public notice is provided for all Central LHIN Board Meetings should HSP representatives or other members of the public wish to attend.

- **IHSP 2016-2019**

The Central LHIN's 2016-2019 Integrated Health Service Plan (IHSP) is our fourth IHSP. In preparing this strategic plan, the LHIN undertook numerous engagement sessions and heard from patients, caregivers and Health Service Providers, which was also combined with continuous engagement with Indigenous and Francophone stakeholders, face to face stakeholder meetings, and other consultations. Dialogue was shared on barriers and challenges in delivering coordinated care to patients and accessing high quality and comprehensive services. This valuable engagement and input helped inform our 2016-2019 IHSP which in turn contributed to our 2016-2017 Annual Business Plan to support the LHIN's priorities and plans to enhance the local health care system.

- **Local Government**

The Central LHIN Board of Directors, led by the Chair and supported by other Board Members and the Chief Executive Officer, lead outreach activities with local government representatives who have constituents in the Central LHIN. In 2016-2017, we shared written updates on strategic priorities and coordinated in-person meetings to have dialogue and share our current strategic priorities while hearing about health care challenges from their local constituents. We also provided an update on the Public Appointment Secretariat process for the Central LHIN Board of Directors.

- **Board Meetings**

All members of the public are welcome to attend Central LHIN Board of Directors open meetings and education sessions. Following the open portion of these meetings, time is allocated for Health Service Providers, stakeholders and members of the public to meet with members of the Board for informal dialogue. Additionally, the Board welcomes public deputations at Board Meetings. To enable a consistent and transparent approach on public deputations, the Public Delegations at Central LHIN Board Meetings Policy is posted on our website.

Sector Networks and Engagement

- **Alternate Level of Care (ALC) Collaborative**

– The ALC Collaborative is a dedicated team comprised of hospital, Central CCAC and Central LHIN staff aimed at providing focused and collective resources to enhance the flow, efficiency, effectiveness and system capacity across the continuum for the benefit of Central LHIN patients. The ALC Collaborative has actively engaged with all Central LHIN Hospitals, the Central CCAC, and other system partners as appropriate throughout its two year funding period (December 2015 to December 2017). Through this work, several actions have been implemented; additional recommendations are pending further assessment.

- **Central LHIN Eye Care Committee (ECC) –**

The Central LHIN ECC is an advisory body comprised of Central LHIN staff and administrative/medical leads from each Central LHIN hospital. The committee meets quarterly to provide advice on best practices for the overall service provision, coordination, delivery, evaluation and evolution of the eye care service models in Central LHIN hospitals. The committee also provides advice on the implementation of the Central LHIN vision care strategy, human resource planning, clinical utilization, and management of quality of care pertaining to eye care services across the Central LHIN.



- **Chronic Disease Prevention and Management Service Coordination Committee** – Established in 2016, this committee benefits from membership of people with lived experience, primary care, Health Service Providers and York Region Public Health. The purpose of this group is to provide advice to the Central LHIN on the coordination and integration of service delivery at the local level and to achieve equitable access to chronic disease prevention and management programs across the LHIN planning areas. The Committee advises the LHIN by engaging local stakeholders regarding the local health system's needs and applies a population-based approach, including specific focus on high needs and at-risk populations.
- **Clinical Services Vice President Planning Group** – The Clinical Services Vice President Planning Group consists of clinically-focused senior leaders from Central LHIN hospitals and the Central CCAC to provide specific support to maintain major clinical program /service plans and to ensure patient access to new innovations and expertise. This group makes recommendations using a system-wide planning approach and explores opportunities to scale and spread better practices that can be supported through evidence and data.
- **Community Sector Working Group** – The mandate of the Community Sector Working Group is to support the Central LHIN's 2016-2019 IHSP priorities as well as improve Central LHIN's Ministry-LHIN Accountability Agreement performance. It advises on ways to advance the local health system to achieve desired outcomes and provides enhanced understanding and insights into sector specific issues within the Central LHIN. Meeting minutes and a communique are published to the entire community sector so that all community HSPs are apprised of the meeting discussions.
- **Critical Care Network** – This working group includes administrative and clinical leads from each Central LHIN hospital, CritiCall Ontario and Central LHIN staff. It is co-chaired by the Central LHIN Critical Care Physician Lead and the Central LHIN Director of Health System Planning. The group meets bi-monthly and holds additional meetings as required for the purpose of planning, implementing, and evaluating performance measures to improve the delivery of Critical Care Services in Central LHIN hospitals.
- **eHealth Advisory Council** – Central LHIN's Integrated Health Service Plan 2016-2019 identifies eHealth as a key enabler for achieving the Ministry's priorities and those of the LHIN and its partners. The Council is composed of Information Technology leadership from various sectors in the continuum of care. Its main objectives are to support the development and implementation of the Central LHIN eHealth Strategic Plan for each year as indicated in the Ministry-LHIN Accountability Agreement and provide guidance and advice on eHealth implementations.
- **Emergency Department Working Group** – This working group, mandated by the Ministry of Health and Long-Term Care Emergency Department Network, is represented by Emergency Department Directors and Physician Chiefs at all Central LHIN hospitals, Central CCAC and Emergency Services. Meeting bi-monthly, this group's mandate is to plan, implement, and evaluate performance measures to improve the delivery of emergency services in Central LHIN hospitals, and to collaborate and exchange best practices.
- **Health Links System Planning Committee** – This committee was originally established in 2013 to oversee and coordinate the implementation of the five Health Links in the Central LHIN and monitor performance as it relates to patient and system outcomes.
- **Integrated Care Advisory Council (ICAC)** – The ICAC's inaugural meeting took place in January 2017, and has since met on a bi-monthly basis. The ICAC is an advisory group comprised of engaged thought leaders with varying perspectives tasked with challenging system planning and activities to bring about system transformation and strengthened continuity of

care during transitions at the sub-region level to achieve consistent, quality-based outcomes.

- **Long-Term Care Sector Working Group** – The mandate of the long-term care sector working group is to support the Central LHIN 2016-2019 IHSP priorities and improve Central LHIN's Ministry-LHIN Accountability Agreement performance. It also advises on ways to advance the local health system to achieve desired outcomes and provides enhanced understanding and insights into the long-term care sector specific issues and support knowledge building and exchange.
- **Mental Health and Addictions Service Coordination Council** – Working closely with the Central LHIN, the Canadian Mental Health Association-York Region is responsible for the implementation of the Central LHIN Mental Health and Addictions Supports within Housing Action Plan for York Region. To guide this implementation, the Canadian Mental Health Association-York Region is required to establish and support the Mental Health and Addictions Service Coordination Council. The mandate of the Council is to collaborate and provide guidance on how to continue moving forward with coordinated mental health and addiction services in the Central LHIN.
- **Mental Health Hub Committee-York Region** – This committee was established in 2016 to address the need for high quality crisis services being available at the right place and right time, including pressures being faced by first responders and hospital emergency departments. This robust committee has representation from federal and provincial elected officials, regional police and emergency medical services, local hospitals, Mental Health and Addictions providers, and other experts within the health care sector.

- **Quality Based Procedures (QBP) Steering Committee** – Implementation of QBPs is an integral component of the Health System Funding Reform, aimed to incentivize health care providers to adopt best practices that result in improved patient outcomes in a cost-effective manner. With representatives from Central LHIN, all Central LHIN hospitals and the Central CCAC, the QBP Steering Committee provides guidance, identifies support needs and monitors QBP implementation across Central LHIN.
- **Regional Palliative Care Network** – The Central LHIN established the Central LHIN Regional Palliative Care Network to advise the LHIN and provide leadership and structure to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care. This Network also oversees the implementation of the Central LHIN Palliative Care Action Plan through a regional approach to address priorities and needs in the Central LHIN area.
- **Stroke Planning and Care Council** – The Central LHIN Stroke Planning and Care Council is a forum to bring stakeholders together for collaborative planning, input and advice on service integration opportunities and performance gaps and supports achievement of targeted performance metrics. Working in alignment with the Ontario Stroke Network's vision and mission, the Stroke Planning and Care Council provides guidance to the Central LHIN and other stakeholders in stroke care, supporting them to achieve current best practices for stroke care.

The **LHIN Community Engagement Guidelines**, updated in June 2016, are available on our website at www.centrallhin.on.ca/communityengagement.



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