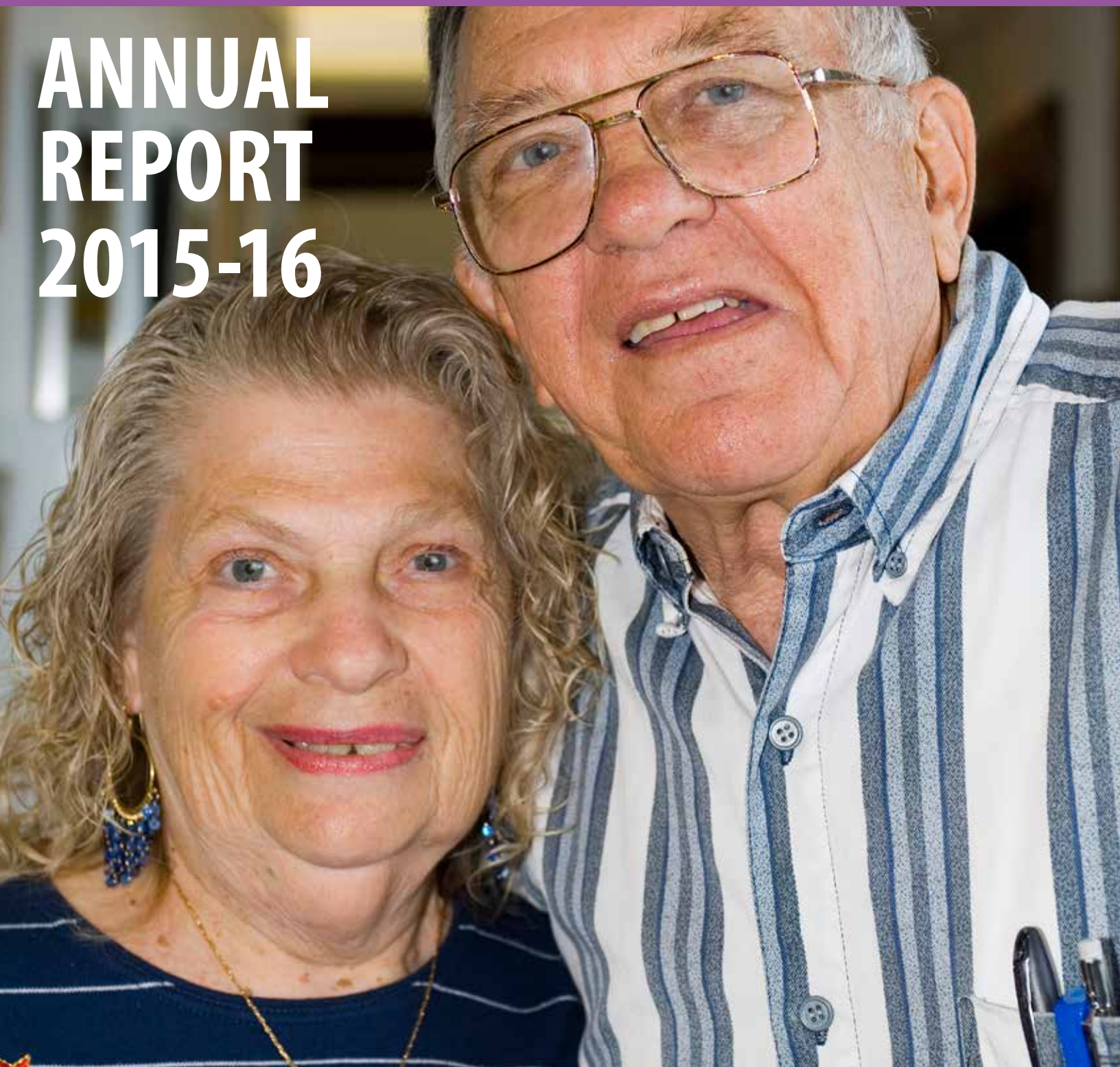


ANNUAL REPORT 2015-16





OUR MISSION IS: To lead a high-quality integrated health system for our residents.

OUR VISION IS: Better Health – Better Futures.

OUR CORE VALUE IS: Acting in the best interest of our residents' health and well-being.

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“When we look at the magnitude of our collective accomplishments, one theme stands out: Innovation.”



LETTER FROM CEO/CHAIR

The past year marked the completion of the 2013-16 Integrated Health Service Plan (IHSP), an ambitious three-year plan for local health care that resulted in significant changes to how services are organized and delivered.

Three years ago most of our health programs in hospitals operated independently of one another, today they are led by integrated clinical program councils to ensure the same high-quality care is provided as efficiently as possible from Southgate to North Dumfries. As a result, we have the most improved stroke program in the province. More residents are surviving and thriving after a heart attack. People in Waterloo Wellington are the least likely in all of Ontario to need to be readmitted to hospital for care following a hospital stay and spent almost 40,000 fewer days in hospital waiting for care in a more appropriate place.

Waterloo Wellington is also home to several first-in-Ontario programs such as HERE 24/7, Mobile Crisis Teams and Connectivity tables. These programs bring together resources from across public service and health agencies to support the well-being of residents beyond just health care to better address the social determinants of health.

When we look at the magnitude of our collective accomplishments, one theme stands out: Innovation.

Waterloo Wellington is a hub of innovation. While known for its “Silicon Valley of the North” technology sector, innovation in our local community is so much more. It’s innovation through leadership – community leaders in health, justice, business, social services, municipalities, etc., stepping up to advocate for the advancement of our community. Innovation through collaboration – organizations coming together and reaching outside of traditional roles. Innovation

through research – capitalizing on world-class educational institutions to apply best-practices to direct patient care. And of course innovation through technology – utilizing enabling technologies to better connect community needs with community services.

While we have continued to invest significantly in local health care, \$300 million more today than almost 10 years ago, the most significant improvements in care have been made through innovation.

This Annual Report shares highlights of the major innovations this year across the health system - through collaboration and partnership with our local health service providers, governors and community leaders – to deliver a high-quality, integrated health system for local residents.

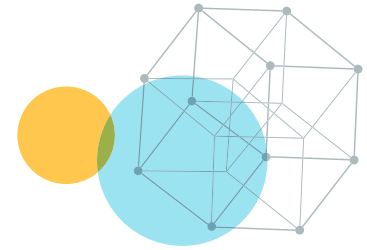
We would like to thank all of our local health professionals for their tremendous work each day to provide the best possible care for our residents. We look forward to sharing more stories and updates with you throughout the year as we continue to innovate to improve the health and well-being of each and every resident across Waterloo Wellington.



Joan Fisk,
Chair, Board of Directors



Bruce Lauckner,
CEO



BOARD OF DIRECTORS 2015-16

Waterloo Wellington Local Health Integration Network Governance Structure

The Waterloo Wellington Local Health Integration Network is governed by a Board of Directors who are selected by the Lieutenant Governor in Council and appointed through Order in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Board is skills-based, drawing on local individuals with a variety of experiences and expertise. Waterloo Wellington LHIN Board meetings are open to the public. There are three standing committees of the Board: Finance and Audit, Governance and Nominations.

Transitions in Board Membership

After serving as a Board member since November 2009, the Board wishes to thank Dale Small for his commitment to the health and well-being of Waterloo Wellington residents. The Board also wishes to thank and acknowledge the late William Dinwoody for his service on the Board since December 2009.

In April 2015, the Waterloo Wellington Board of Directors welcomed Michael Delisle, while Board Member Jeff Nesbitt was appointed as Vice-Chair of the Board of Directors in December 2015.



Joan S. Fisk, Chair

Jun. 2, 2011 – Jun. 1, 2014

Reappointed: Jun. 2, 2014 – Jun. 1, 2017



Dale Small, Vice-Chair

Nov. 18, 2009 – Nov. 17, 2012

Reappointed: Nov. 18, 2012 – Nov. 17, 2015



Manjit Basi

Oct. 6, 2010 – Oct. 5, 2013

Reappointed: Oct. 6, 2013 – Oct. 5, 2016



Murray O'Brien

Jun. 2, 2011 – Jun. 1, 2014

Reappointed: Jun. 2, 2014 – Jun. 1, 2017



William (Bill) Dinwoody

Dec. 2, 2009 – Dec. 1, 2012

Reappointed: Dec. 2, 2012 – Dec 1, 2015



Jeff Nesbitt, Vice-Chair

Nov. 19, 2013 – Nov. 18, 2016



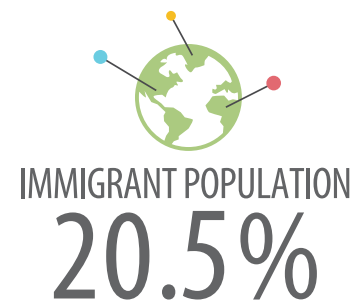
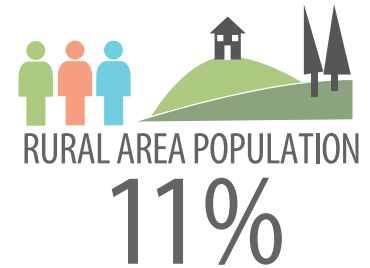
Bryan Larkin

Feb. 11, 2015 – Feb. 10, 2018



Michael Delisle

Apr. 15, 2015 to Apr.15, 2018



POPULATION PROFILE

With a population of almost 780,000, the Waterloo Wellington LHIN is a growing community of diverse residents. Our population is projected to grow to more than 860,000 residents by 2025. Seniors 65 and over make up more than 14% of the Waterloo Wellington LHIN population, with those 75 and over accounting for more than 6%.

No one knows better what is needed for our community than the residents who live here, work here and receive health care here. We interact regularly with our residents through various engagements to seek input and feedback on what is working well in the health system and where we can improve. That is the benefit of being local: knowing the needs, understanding the health system and where pieces need to be better connected and leading locally driven solutions to improve the health of the entire population.

Our geography includes four community planning areas that we have identified: Wellington, Guelph, Cambridge and North Dumfries and KW4 (Kitchener, Waterloo, Wellesley, Woolwich and Wilmot). Understanding the health care experience of residents in these four areas helps us to plan care for our residents close to home.

In our LHIN, 20.5% of the population is made up of immigrants. The Waterloo Wellington LHIN is one of the key landing sites for refugees in Ontario. Nearly 14% of our residents are visible minorities. 10,000 of our residents self-identify as Aboriginal. Just over 12,000 residents are part of the Francophone community and more than 20% of residents report a mother tongue other than English or French.



HEALTH PROFILE

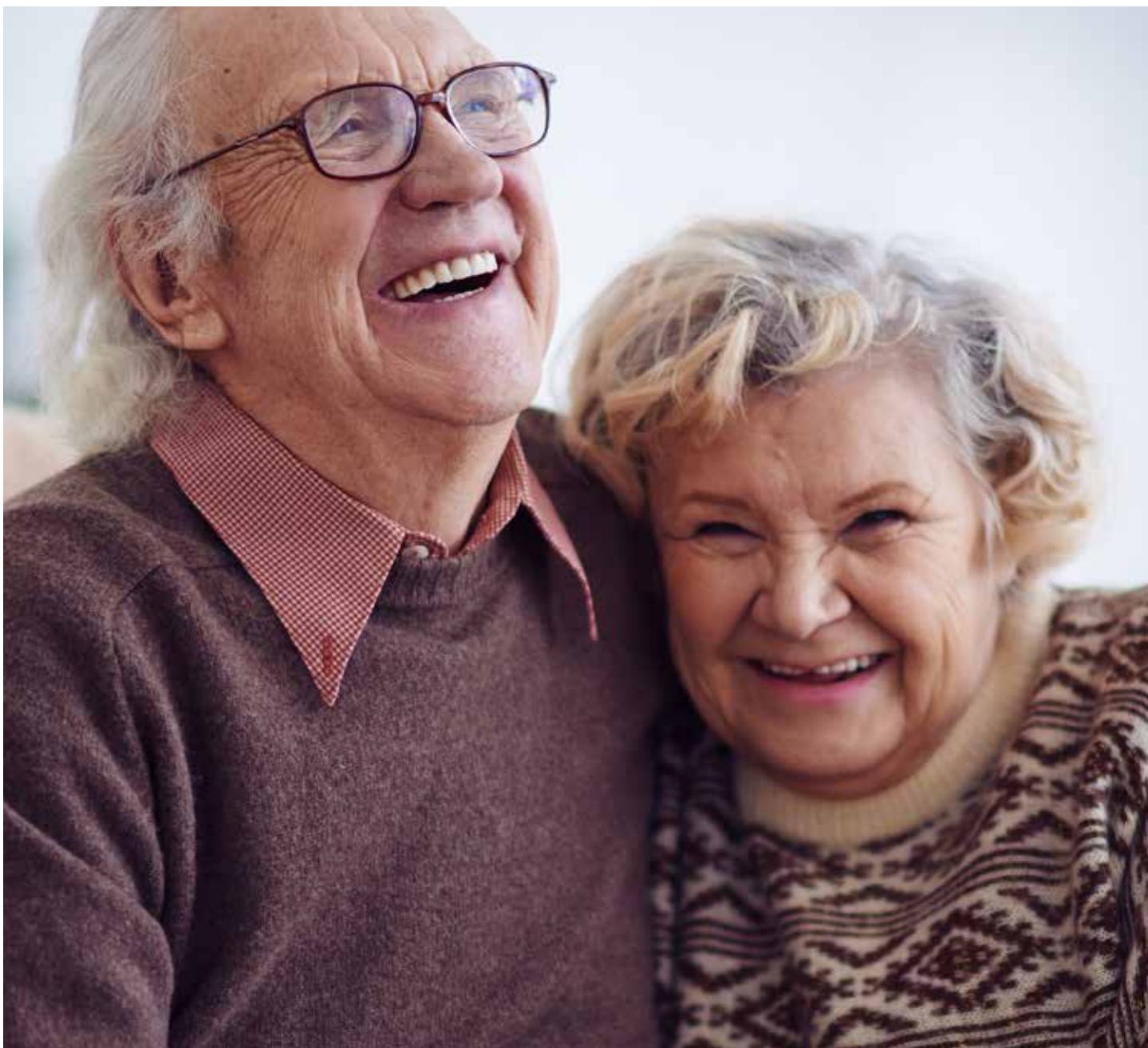
The health of residents in Waterloo Wellington is partly measured by a number of different health indicators. These indicators are compared to provincial averages to determine how healthy residents are compared to the rest of the province.

Life expectancy among males and females in Waterloo Wellington is similar to the average life expectancy for Ontario. The percentage of newborns classified as “small for gestational age” was less than the provincial average, while the percentage classified as “large for gestational age” was slightly higher. This is important because low birth weight is a determinant of infant health.

Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures. Waterloo Wellington residents are more likely than other Ontarians to rate their overall health as “Excellent” or “Good”.

Poor health practices are related to increased risk of chronic conditions, mortality and disability. Examples of poor health practices are smoking (18.9 per cent of residents smoke), not eating well (60.6 per cent report consuming less than 5 servings of fruits and vegetables a day) and not exercising (42.5 per cent report being physically inactive). More than 50 per cent of residents report that they are overweight or obese. The chronic conditions with the highest mortality rates in Waterloo Wellington are cancer, ischemic heart disease and stroke.





A ROADMAP FOR IMPROVING LOCAL HEALTH

Every three years, we engage with local residents, health service providers and other community leaders to create a strategic plan that outlines what health services matter most to local residents. That plan, the Integrated Health Service Plan (IHSP), is the roadmap for improving the local health system over the following three years.

The following pages provide an overview of the key initiatives undertaken this year in the priority areas of:

- Enhancing Access to Primary Care;
- Creating a More Seamless and Coordinated Health Care Experience; and
- Leading a Quality Health Care System Using Evidence Based Practice.

This report also includes stories from residents to tell you how local health system improvements have positively affected their health and well-being. We are fortunate to interact with residents each and every day and believe that the true impact of our work is best seen through their stories.



ENHANCING ACCESS TO PRIMARY CARE



Your primary care provider is probably the first health care professional you will turn to for care. Primary care professionals are often family doctors but they may also be nurse practitioners or other health care professionals who support your day-to-day care and are responsible for coordinating any services that you may need from other providers or specialists.

For primary care providers across the Waterloo Wellington LHIN to deliver the best care possible, it is important that they are well informed, connected with

other health service providers and have access to technology that will assist them in providing the best care.

This year, we put great focus on enhancing access to primary care for our most vulnerable residents – those with complex medical needs and those from populations that are marginalized or at risk for poor health outcomes.

IN 2015-16...

2nd

among Ontario LHINS for the lowest overall hospital readmission rates for patients with chronic conditions (a measure of high quality care).

62%

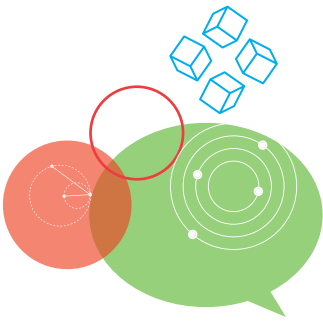
of residents report that their primary care provider always discusses care options and includes them in medical decisions, an increase of 9%.

170

residents received wrap-around social supports through Connectivity Tables; an international award winning partnership that better supports residents at risk.

34,000

virtual care visits provided in Waterloo Wellington in 2015-16, bringing care close to home through video conferencing for many residents who have difficulty traveling to see their doctor.



“It was so well organized; all of the health care providers were amazing and worked very well together, even though they were all from different places. They went beyond their job to help people feel comfortable.”

- Doha Shahin, an Arabic interpreter with the KW Multicultural Centre.



FROM DESPAIR TO HOPE: CONNECTING REFUGEES TO PRIMARY CARE

As part of Canada’s commitment to resettle 25,000 Syrian refugees, the Waterloo Wellington LHIN led the local health care response to ensure families arriving in Waterloo Wellington from Syria would have access to the vital health services they need. Working in partnership with public health, primary care, education, hospitals, community organizations and local municipalities, a number of innovative initiatives were launched collaboratively to welcome these new families and help them navigate local services.

“Overall, the health of Syrian newcomers was generally good but many had not had regular health and dental care or immunizations for years due to the Syrian civil war and the difficulties that come with living in refugee camps,” explained Lisa Bitonti-Bengert, Senior Manager, Health System Integration. “Additionally, many were impacted by emotional trauma as a result of experiencing the violent conflict that comes with war.”

Primary Care Registered Nurses from Sanctuary Refugee Health Centre were deployed to the Refugee Assistance Program Centre in Kitchener to triage reported health concerns and provide health teaching to prevent unnecessary visits to the Emergency Department (ED). Public health held on-site immunization clinics. Service Ontario provided on-site OHIP card registrations. As new residents began to arrive quickly, it was evident that the need for faster access

INNOVATION THROUGH COLLABORATION

More than 1,200 Syrian refugees have settled in Waterloo Region since late 2015. Over the next five years, we anticipate the arrival of up to 3,500 more refugees from Syria and other countries to settle in Waterloo Wellington.



to primary care was vital but in an organized way that would support their transportation, housing, translation and cultural realities to ensure the care provided was thoughtful and effective.

“Together we came up with the idea of clinic days where newcomer families could receive their initial health assessments, necessary medications, any referrals to other services they might need and be connected to a more permanent primary care provider all in one visit,” said Lisa.

Many partners came to the table to organize the clinic, including: the Mount Forest Family Health Team, the Centre for Family Medicine Family Health Team, the Woolwich Community Health Centre, the KW Multicultural Centre, LifeLabs, and Waterloo Region and Wellington Dufferin Guelph Public Health. Grand River Transit also provided free transportation for refugees and their families to and from the clinic.

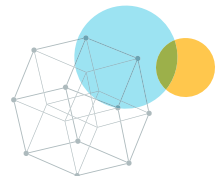
“So many organizations partnered to make this happen,” explains Lisa. “Several family and emergency room doctors, nursing staff, volunteers, a pharmacist, and interpreters from all over participated to support this work. In all, there were three weekend clinic days that cared for 198 people. It was a tremendous success that connected an extremely vulnerable population to the care they needed quickly, and reduced the need for them to seek care in emergency departments and urgent care clinics.”

“It was so well organized; all of the health care providers were amazing and worked very well together, even though they were all from different places. They went beyond their job to help people feel comfortable. Some learned some greeting words in Arabic so that they could say hello, goodbye, and great job. We, as interpreters, thought it would be chaotic due to the large numbers of clients, but it really wasn’t. We were all impressed! Although the new clients had seen a lot of sadness, there were some happy stories in these clinics. One woman, for example, had two sons, the youngest 11 and has been trying for nine years to have another baby. She was tested at the clinic and it turned out that she had gotten pregnant during her first month in Canada. She was thrilled – over the moon to have a Canadian baby!”

- Doha Shahin, an Arabic interpreter with the KW Multicultural Centre.

“We’ve recognized that when people come to live in a new country where the culture and language are different, using public transit can be intimidating. So, we provide travel training and can arrange tours for newcomers to show them the bus routes, community resources, how to use tickets and transfers and hopefully, make it a more pleasant experience to foster independence. Helping new residents get to the clinic seemed like a great way to support them. One of the drivers involved told me afterwards that it was a really positive experience.”

- Dave Steffler, training specialist, Grand River Transit





“First, we opened access to all of our wellness classes and groups to patients of family doctors who didn’t have these additional supports.” - Ross Kirkconnell, Executive Director, Guelph FHT



• Provider and patient in a Guelph FHT office.

INNOVATION THROUGH LEADERSHIP

2,200 residents who have complex medical and social needs have a care plan outlining their health and wellness goals that is shared with their primary care provider and care team.

THEN (2012)

64% of residents had a primary care provider

NOW (2016)

97% of residents have a primary care provider

IMPROVED ACCESS TO COMPREHENSIVE PRIMARY CARE FOR GUELPH RESIDENTS

Close to 15,000 more Guelph residents are now able to access health and wellness supports they didn't have before thanks to a decision made in early 2016 by the Board of the Guelph Family Health Team (FHT).

"When the Guelph FHT started, we had 33 family doctors and about 40,000 patients," explains Ross Kirkconnell, the Family Health Team's Executive Director. "We would repeatedly hear from patients whose doctors were not in our team that they wanted access to the supports we have. It was evident that we needed to look at ways to provide – as much as possible – equitable access to available health services for all residents to really improve the health of our population."

There are many different models of primary care in Ontario. Some family doctors work on their own to provide care while some work in groups. Family Health Teams, like the Guelph FHT, use teams with a variety of health professionals that include family doctors in addition to other support services including dietitians, mental health counsellors and social workers. But while the Guelph FHT's 40,000 patients were able to access these vital health and wellness services, many other Guelph residents could not.

Over the years, the Guelph FHT expanded to 115,000 patients, 80 family physicians and more than 200 staff in 25 locations in Guelph. Between the Guelph FHT and the Guelph Community Health Centre, about 90 per cent of Guelph residents had access to comprehensive team-based care. The Guelph FHT Board saw the need and opportunity to be even more

inclusive. So they researched models of care that exist outside of Ontario that allow for the integration and collaboration of health services across care providers to better support the health needs of an entire population.

With the guiding principle that all patients who have complex needs can benefit from this type of care, whether their primary care providers are part of the family health team or not, this comprehensive care was made available to anyone in need in the community.

"First, we opened access to all of our wellness classes and groups to patients of family doctors who didn't have these additional supports," explains Ross.

"We are now meeting with these doctors to better understand the needs of their patients and ensure that we can support their work through access to our interdisciplinary team services."

Staff at the Guelph FHT are continuing to work with area family doctors, practice by practice, to embed additional supports for their patients.

"So far feedback is very positive," says Ross. "I have heard stories of couples where one spouse belonged to the Family Health Team while the other did not. The spouse who was not with the team often felt like they weren't getting the same support. And feedback from physicians has repeatedly indicated that sharing these services creates an equitable outcome for everyone with a real focus on helping their patients, especially those with complex situations and chronic diseases."



To achieve our objective of enhancing access to primary care, the following initiatives were undertaken with health professionals across Waterloo Wellington:

ESTABLISH FAMILY HEALTH CARE AS THE HUB OF THE HEALTH CARE SYSTEM TO IMPROVE YOUR ACCESS TO SERVICES AND POSITIVE HEALTH OUTCOMES.

**HEALTH LINKS
INITIATIVE**

- Build on the four Waterloo Wellington Health Links to improve coordinated access to care for residents with complex health needs.
- Ensure residents with complex health needs have access to primary care.

ACCOMPLISHMENT

- 2,200 residents with complex medical and social needs have a care plan outlining their health and wellness goals that is shared with their primary care provider and care team.
- A pilot project to make these care plans available online was completed so that residents, their family and their care team can see the care plan and update it.
- 100% of residents who have complex medical needs have a primary care provider

**SOCIAL DETERMINANTS & COLLABORATION OUTSIDE OF HEALTH CARE
INITIATIVE**

- Continue to grow partnerships amongst and between health, housing, social services, education, justice, and other community partners to improve population health.
- Identify more effective support for those at risk in our community through efforts such as Connectivity/Situation Tables.

ACCOMPLISHMENT

- 1,250 Syrian Refugees were welcomed and connected to medical care, housing, education, social services, public health, and local transit.
- Four connectivity tables are now in place so all residents in Waterloo Wellington LHIN have access to this wrap around multi-sector support. Two of these four tables were newly developed this year.
- 170 resident situations were supported by Connectivity Tables preventing crime, suicide, school drop outs and homelessness. An evaluation showed a 74% reduction in calls for police services within 90 days of resolution.

"Practicing for over a decade, I am aware that is difficult for health care providers and patients to "navigate the system". Central intake has allowed us to get the RIGHT care at the RIGHT time for the RIGHT patient at the RIGHT location. Central Intake has been effective, efficient and easy for ALL to use!!" - Endocrinologist, Waterloo

IMPROVE TIMELY ACCESS TO PRIMARY CARE.

ACCESS TO CARE CLOSE TO HOME/ENABLING TECHNOLOGIES

INITIATIVE

- Review and optimize use of telemedicine and tele-homecare.

ACCOMPLISHMENT

- More than half of long-term care homes are ready to access virtual (secure video conference) primary and specialist care.
- 27,000 virtual care visits were provided to residents so they did not need to travel outside of their home town to see a specialist. 75% of these visits were for supports related to mental health and addiction needs.
- 6,700 virtual care visits of the 27,000 were done using mobile devices (hand-held or laptop) as opposed to stationary units in organizations.
- 3,000 virtual education events were held for residents and Health Care providers. Events included support groups, self-care education sessions. Virtual care visits and education sessions are now being delivered through mobile devices.
- 337 residents received innovative end-of-life care in their homes through a tele-homecare program called "e-shift". A nurse monitors patients 24 hrs a day/7 days a week virtually and care is provided by specially trained Personal Support Workers so residents and families are well supported.

DEVELOP AND IMPLEMENT A MODEL FOR COMMUNITY-BASED CHRONIC DISEASE PREVENTION AND MANAGEMENT.

CHRONIC DISEASE PREVENTION & MANAGEMENT & DIABETES

INITIATIVE

- Improve access and best practice guidelines for diabetes care and chronic disease prevention and management focused on congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

ACCOMPLISHMENT

- Residents in Waterloo Wellington are among the least likely in Ontario to be readmitted to hospital after discharge for a chronic condition (e.g. diabetes, chronic obstructive pulmonary disease (COPD)).
- Diabetes adult education programs worked with 11,285 patients with diabetes in 2015-16 providing nearly 38,000 clinical interactions for these patients.
- The average wait time for access to diabetes care was as long as 16 weeks only a few years ago. In 2015-16, patients with an urgent referral were seen on average in 2 days, semi-urgent in 8.6 days and non-urgent in 16.8 days – all within the provincial targets.
- Stroke/TIA (warning stroke) patients treated on a specialized stroke unit at any time during their inpatient stay improved from 62.8% to 75.9% - best in Ontario.
- The Waterloo Wellington LHIN achieved the highest proportion of patients in the province admitted to inpatient rehabilitation with severe strokes, increasing from 42.1% to 54.7%.
- 978 residents were supported through the Integrated Comprehensive Care discharge model from St. Mary's General Hospital contributing to significant reductions in emergency visits and hospital readmissions for patients with COPD and CHF (Chronic Heart Failure). This innovative program is the 2nd of its kind in Ontario.



There are 147 additional practicing family doctors and specialists in Waterloo Wellington since 2010.

IMPROVE TIMELY INFORMATION SHARING BETWEEN PRIMARY CARE AND OTHER PROVIDERS.

SYSTEM COORDINATED ACCESS/ENABLING TECHNOLOGIES

INITIATIVE

- Build and enhance a technology solution to provide coordinated access to health services including Community Support Services, Rehabilitative Care, Palliative/End of Life Care, Mental Health and Addictions services and Diabetes Education through the System Coordinated Access project.
- Support primary care through technology to ensure coordinated, equitable, informed access to specialist care and explore options for shared care planning.

ACCOMPLISHMENT

- We have innovated a one-of-a-kind referral system that helps connect residents to services more quickly and efficiently through their primary care provider and care team. Successes to date:
 - 6,231 residents with diabetes were referred for diabetes care through central intake, an 11% increase from the previous year, including 302 self-referrals which increased 27% from 2014-15.
 - 1,269 resident referrals were made to diabetic specialists through central intake.
 - 4,886 residents were referred to a number of programs and services, including meals on wheels, transportation, housekeeping, Adult Day Programs and more.

IMPROVE ACCESS TO APPROPRIATE CARDIAC CARE.

INITIATIVE

Improve access to appropriate levels of congestive heart failure care (CHF) in community, primary and acute care settings.

ACCOMPLISHMENT

- New Vision Family Health Team implemented a new program for residents who suffer from congestive heart failure (CHF). This primary care based model allows patients to receive care closer to home.



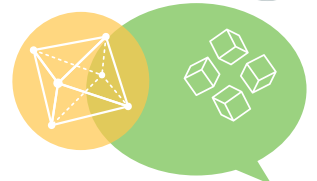
Residents can now self-refer online to access more than 285+ programs to help them prevent and manage chronic diseases at www.selfmanagement.ca. A coordinated online referral has also been developed for primary care so they can quickly help their patients get connected to these supports.



• The Bosch Foundation Tour Guests at Woolwich CHC.

“What you have here is what we have been dreaming about in Germany.”

- Pediatrician, guest of The Bosch Foundation touring Waterloo Wellington to learn about best practice primary care in Canada





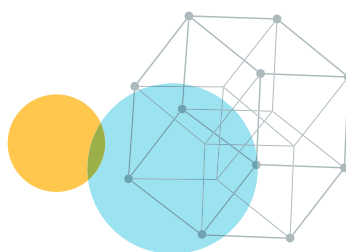
SYSTEM COORDINATED ACCESS

A lot of work is happening in Waterloo Wellington to embed enabling technology solutions within the local health system to support better, timely and more equitable care for residents. Enabling technologies are information and clinical technologies that are used to improve health care.

It means we're working to develop innovative technology solutions that will support care providers and improve patient care by reducing errors, better connecting care providers with each other and patients, improving communication and allowing patients to play a more significant role in their own health.

In late 2015, the Waterloo Wellington LHIN Board of Directors approved an investment of up to \$250,000 in funding for the development and implementation of a System Coordinated Access tool for primary care providers to refer their patients to area specialists, starting with orthopaedic surgeons (hip and knee surgery). This will allow primary care providers to locate area surgeons, view their wait times and share information to support the care of patients together, all securely on-line. This will also allow patients to choose the surgeon and location that works best for them.

From electronic medical records, used by nearly 90% of local primary care providers, to hospital report manager, a system that allows hospitals to seamlessly update the electronic medical records of patients they share with local primary care providers, enabling technologies are changing the way that health care is accessed and delivered in Waterloo Wellington.



CONNECTING CARE, PATIENTS AND THEIR LOVED ONES THROUGH HEALTH CARE TECHNOLOGY

As Cancer Care Coordinator with the Mount Forest Family Health Team, Carol's role often involves meeting with patients and their families to provide support and help them navigate on their journey through the health system.

"My day-to-day tasks change a lot depending on the needs of the patient and family," explains Carol.

"Sometimes I provide more support for the family than the patient. Recently I supported a family, Kevin who had been diagnosed with late-stage cancer and his wife Linda. I started by visiting them in their home to provide emotional support and practical help but it wasn't long before Kevin had to be admitted to the hospital for more intense round-the-clock care."

Kevin was transferred to hospital and then to long-term care at St. Joseph's Health Centre in Guelph to receive end-of-life care. The transition from hospital to long-term care was difficult for both Kevin and his family; St. Joseph's Health Centre was the right place for him to be but was far from his home.

Kevin and Linda lived in North Wellington, just over an hour away from Guelph by car. His transition from hospital to palliative care happened during winter which meant poorer driving conditions for his wife, Linda. Transportation services, used to support patients, were not available to family members.

Linda was by his side as often as she could be but wanted to be there more. Both Carol and Linda knew about video technology that was often used to connect patients with care providers, education and specialists and thought; why not for families?

"When you're advocating for rural residents, it's about bringing care and services close to home," says Carol. "This technology brought her to his bedside and – as

INNOVATION THROUGH TECHNOLOGY

As of 2016, 20 long-term care homes have been equipped to access video conferencing through the Ontario Telemedicine Network (OTN) to support the health of local residents.



far as I know – it's one of the first times we've used it for a family meeting."

Carol worked with the members of Kevin's care team at St. Joseph's Health Centre and with the help of a telemedicine nurse, they helped to arrange video visits with his family, through a computer unit that was brought to his room.

"It was really good," says Linda. "There was one day during the winter that I could just not get down to Guelph. Carol said; why don't we use the video system and his care team couldn't think of a reason why they

couldn't. Everybody was so excited about it. We got to visit for as long as we liked and it really was just like I was in the room with him, sitting beside him."

Sadly, Kevin passed away that winter.

"We're fortunate to have telemedicine here," says Carol. "This was a real team effort to keep this family connected during a very unfortunate life circumstance. I don't know what they would have done without it."

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE



A key aspect of providing a quality health system is ensuring residents get the right care, at the right place, at the right time. Easily navigating the health system is particularly important for those with the most complex health care needs.

Seamless care occurs when residents can easily transition from one area of care to another. A well-coordinated system means you don't have to repeat your story and you will know where to go to find the help you need.

IN 2015-16...

525

residents were assessed using a new tool that helps to identify seniors at risk of decline. These residents were referred to local community supports that will help keep them healthy and out of the hospital.

1,700+

seniors benefitted from expanded adult day programs last year.

#1

for the shortest wait time in Ontario for access to home and community care services (application from community setting - 13 days).

\$17.1M

reinvested in hospital care through a reduction in the number of days residents spend in hospital waiting for care in a more appropriate place (ALC).

INNOVATION THROUGH EQUITY

Two Indigenous Wellness Conferences were attended by more than 200 residents, with additional opportunities for local First Nations, Métis and Inuit community members to attend a one hour, one-on-one session with a Traditional Healer.

INCREASING QUALITY OF LIFE FOR MORE WATERLOO WELLINGTON SENIORS THROUGH COMMUNITY SUPPORT CONNECTIONS

93-year-old Helen and her 92-year-old husband, Fred, have been attending Community Support Connections' free gentle exercise classes at their retirement home for the past two years. "We exercise as often as we can," says Helen. Married for 71 years, Helen and Fred hope to make it to their 75th wedding anniversary. One of the ways they intend to get there is by leading a healthy lifestyle.

The couple began attending SMART™ (Seniors Maintaining Active Roles Together) exercise classes shortly after they moved into their residence because Fred was told it would help prevent falls.

"It's pleasant to exercise with people you know in a group like that. The instructors have been very good. They are conscious of how everyone is doing and they watch for changes to make sure everyone is okay. I'm impressed with them!" said Helen.

The classes have also inspired Helen and Fred to stay active throughout other parts of the day, including walking to the grocery store - a journey that can take up to a half an hour each way. Fred uses a walker to help him along and the couple stop and rest when they need to. But most importantly, they keep moving.

"If you don't use it, you lose it," says Helen. "It is keeping us in shape and it's something to look forward to every day."

The Waterloo Wellington LHIN began funding exercise and falls prevention classes at Community Support Connections – Meals on Wheels and More (CSC) in late 2013. The program has been a great success and is very popular with local seniors.

In 2015, as part of the health system's ongoing commitment to ensure equitable access to health services, an opportunity was identified to support local French speaking seniors by providing exercise classes in French. In partnership with the Centre communautaire francophone de Cambridge, CSC collaborated with the

Centre in securing bilingual gentle exercise facilitators and were able to commence French language gentle exercise classes in February of 2016.

"CSC was delighted to partner with the Centre communautaire francophone de Cambridge to provide this service. It aligns with our strategic priorities of community engagement, responsiveness and exceptional client experience."

- Jenn McDonald, Exercise and Falls Prevention Coordinator



Electronic medical records (EMR) are tools that support collaborative, integrated patient care by connecting health care providers. Amy's family doctor was able to follow her care in hospital through information updated in the EMR system and better support her care and recovery after her surgery.



Amy and her husband •

PUTTING PATIENTS FIRST: EXPERIENCING SEAMLESS CARE ACROSS PROVIDERS

It was a few days before Christmas when Amy first started feeling ill. Sick to her stomach and experiencing pain on one side, her husband convinced her to call her family doctor for help.

"It just didn't get better," says Amy. "I felt worse and worse. I didn't know if anyone at my doctor's office would be able to fit me in so close to Christmas but they did. They got me in that afternoon."

Amy arrived at the Guelph Family Health Team that day to see the nurse practitioner (NP). When a routine examination could not confirm what was wrong, her

NP decided to order an ultrasound to help identify the source of Amy's pain.

"It was four days before Christmas and many offices were closed," Amy explains. "I don't know how many phone calls they made but I know they called a lot of different places to get me that ultrasound. When I mentioned that I lived in Erin, they thought they could try the Fergus hospital which is close to me."

Less than two days later, Amy's ultrasound at Groves Memorial Hospital in Fergus showed that she had gallstones and needed surgery, results that were

INNOVATION THROUGH INTEGRATION

More than 95% of residents needing home care following a hospital stay receive their first service within 5 days.

shared electronically with her family doctor. A referral to a Guelph area surgeon was made that same day which provided both relief and disappointment for Amy and her husband.

“My doctor’s office called me right away to let me know. I was so glad to truly know what was happening to me – it meant that I didn’t have to spend my Christmas holidays worrying about what it could be,” says Amy. “But at the same time, it meant that we were probably going to have to cancel our trip to Florida. A physician at my family doctor’s office took the time to meet with us to discuss the risks, and we decided together that travel outside of the country would be too risky for my health.”

Amy’s surgery was booked for March 30th but it actually happened on February 12th. As a retiree with a flexible schedule, Amy was able to take an earlier appointment, available after another patient cancelled. Having surgery as soon as possible was a priority for Amy.

“I had the surgery and everything went very well,” says Amy. “Everyone was so accommodating and reassuring. I remember when gallbladder surgery was a very huge procedure, but I was home in my own bed by 6:30 pm that evening. It was a very easy recovery.”

Amy credits an integrated health system with her positive experience.

“My experience is a great example of when the system works well. In my case, it all worked together really smoothly. My doctor’s office called me right away with results of my ultrasound and everyone worked together to get me the care I needed. Look at how many different practitioners were involved and how smoothly it went. In Ontario, we’re very fortunate to have the quality of health care that we have. It’s pretty amazing.”

THEN (2013)

72% of primary care doctors were using Electronic Medical Records.

NOW (2015)

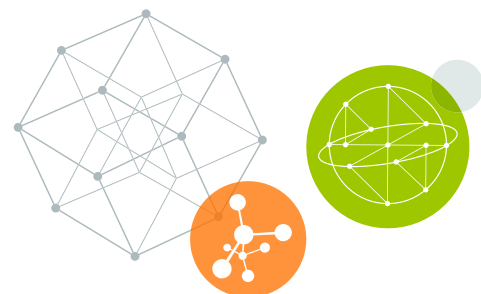
Nearly 90% of primary care doctors are now using an Electronic Medical Record

MINTO RURAL HEALTH CENTRE OPENS TO PROVIDE RURAL RESIDENTS WITH COORDINATED CARE



After five years of planning, the Minto Rural Health Centre opened its doors to residents in spring 2016 to provide increased access to integrated and coordinated care. Residents can now go to one central location to receive primary care, mental health and addictions support, wound care and support through the Community Care Access Centre. “This is a great example of how integrated health models can support better health outcomes for rural residents,” says Waterloo Wellington LHIN Board Chair Joan Fisk. “Residents will benefit from a number of health services all located centrally, and working in partnership to support the continuum of care. This is the type of collaboration that will build a strong foundation for improved health and wellness for years to come.”

The Waterloo Wellington LHIN has equipped the new centre with video-conferencing technology that will help care providers and residents connect with other centres and care providers for education, consultation, assessments and follow up care, close to home.



To achieve our objective of creating a more seamless and coordinated health care experience, the following initiatives were undertaken with health professionals across Waterloo Wellington:

INTEGRATING SERVICES TO IMPROVE EXPERIENCE AND HEALTH OUTCOMES BY STREAMLINING ACCESS TO SIMILAR TYPES OF CARE AND SERVICES (HORIZONTAL INTEGRATION); COORDINATING ACCESS ACROSS ORGANIZATIONS INVOLVED IN THE HEALTH CARE JOURNEY

**COMMUNITY CARE
INITIATIVE**

- Establish efficient and integrated personal support service delivery for residents in the community.
- Improve health outcomes and experience for residents by increasing timely access to equitable and integrated community services.

ACCOMPLISHMENT

- The second year of a three-year investment to increase personal support worker pay for community providers was implemented. This provincial initiative aims to ensure community PSWs are paid at minimum \$16.50 per hour.

**SENIORS CARE
INITIATIVE**

- Continue to improve care for seniors through effective assess and restore services, dementia and Alzheimer strategies, and by improving access to specialized geriatric services.

ACCOMPLISHMENT

Waterloo Wellington is home to world class aging innovation hubs:

- The Research Institute for Aging (RIA) in Waterloo Region opened in 2015 and aims to be one of the top five innovation institutes for aging in the world. The Institute is a partnership between Schlegel Villages, University of Waterloo and Conestoga College.
- The RIA is associated with the Schlegel Centre for Learning, Research and Innovation in Long-Term

Care (CLRI) which has real-life classrooms with simulations to provide health care providers with research-informed practice change and care innovations.

- Waterloo Wellington is home to innovative memory clinics – developed locally and being implemented internationally:
 - There have been 1,715 memory assessments completed through the Centre for Family Medicine (CFFM) Memory Clinic since inception in 2006, serving 614 residents with memory loss.
- A new exercise program was established for French speaking seniors through Community Support Connections – Meals on Wheels and More. French speaking residents can access these community services that keep them fit and help to prevent injuries from falls.
- Since 2013, 7,573 residents have been referred for specialized geriatric services. Wait times for these services have been reduced from approximately five months to 4-6 weeks thanks to collaboration, integration, investments in geriatric nurse practitioners, memory clinics, and a clinical intake service that has increased efficiency and improved the patient experience.
- Local hospital emergency departments are now using short one-page assessments for seniors to identify residents who would benefit from additional help in their home.

**PATIENT TRANSITIONS
INITIATIVE**

- Improve patient experience and flow for patients through integrated discharge and patient transition practices.

ACCOMPLISHMENT

- All hospitals have implemented an improved discharge planning experience for residents.



- More than 93% of residents needing home care following a hospital stay receive their first service within five days.
- Through collaboration across health service providers, strategies and communications tools have been put in place that improve the discharge process from hospital to long-term care.
- Residents in Waterloo Wellington have some of the shortest wait times for long-term care in Ontario (2nd shortest from hospital and 5th shortest from home).
- A Patient Transitions Dashboard that tracks any upcoming patient transitions for providers has been created and shared across the system. As a result, care providers are better able to share best practices and strategies for successful patient transfers.



ALTERNATE LEVEL OF CARE

INITIATIVE

- Remove barriers for people waiting for care in another area of the health system (alternate level of care or ALC).

ACCOMPLISHMENT

- The number of days residents spend in hospital waiting for care in a more appropriate place has been cut by more than 50% since 2009 (25.9% ALC Days in 2009 to 12.19%).
- In 2015-16, 1,969 hospital ALC days were saved through a reduction in the ALC rate.
- Since the implementation of Home First in 2011, 38,183 hospital ALC days have been saved resulting in \$17.1M being re-invested into hospital care.

As a result of the Integrated Stroke Program, the Ontario Stroke Network has recognized Waterloo Wellington as having the most improved stroke program in the province.

“Sarah’s situation was critical. By the time she got to Community Care Concepts, she had exhausted all other options.”

- Karla, Community Outreach Coordinator with Community Care Concepts (CCC)

CULTURALLY APPROPRIATE CARE MAKING A DIFFERENCE

Sarah’s situation was critical. By the time she got to Community Care Concepts, she had exhausted all other options. Previous contact with community and government supports resulted in Sarah’s children being removed from her home which left her distrustful of others.

“Sarah has very severe obsessive compulsive disorder,” explains Karla, Community Outreach Coordinator with Community Care Concepts (CCC). “She was referred to us through a Community of Practice meeting. This is where a number of different health practitioners and community workers from different organizations meet to discuss cases that are not progressing. We’re careful to protect patient privacy but it does give us a great opportunity to collaborate and share new ideas that may help each other’s clients.”

Obsessive compulsive disorder is a mental illness that causes unwanted and repetitive thoughts, urges or images that don’t go away (obsessions) and actions that are meant to reduce the anxiety brought on by the obsessions (compulsions). Some people have obsessions, some have just compulsions and some like Sarah, have both.

As a member of the Mennonite community, many aspects of Sarah’s life, including her health, are intertwined with wider cultural and religious beliefs. Mental illnesses are sometimes not recognized as a health issue. These cultural and religious considerations can make traditional health care methods less effective and the family’s attempts to support Sarah were not achieving a lot of success.

It seemed there was no other way to help her. But when her case was presented, other possible solutions were identified. Members agreed that Sarah’s home environment needed support and that CCC’s programs might have success by incorporating an approach that centred more around Sarah’s culture and family connections.

“It took time to build trust between us,” explains Karla. “The Mennonite culture is not very trusting of “outside” people, professional or not. Once we had an entire meeting through an open window on the front porch in the middle of winter, she inside and me outside. But we try to meet people where they are at, and Sarah has been making progress.”

Karla also met with Sarah’s family to advocate for her and help to build practical strategies that worked for everyone, grounded within their strong Mennonite culture. This has also helped her family to better understand her illness.

“I think that if this work has taught me anything, it’s that we can all find ways to be flexible and creative to help our clients reach their goals,” says Karla. “Culture, religion and personal preferences and experiences are huge a part of who we are and they can be part of our solutions too.”



LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE BASED PRACTICE



Having access to quality care means that your care is safe, effective, accessible, equitable, efficient, integrated and focused on prevention as much as treating illness.

The best way to ensure our services meet those standards is to base our care off of proven methods and ensure those methods are used consistently across the system.

IN 2015-16...

2,800+

residents have received advance care planning resources through Advance Care Planning Waterloo Wellington.

99%

of residents receive timely access to cardiac bypass surgery (within target).

54%

more long-term care beds in the City of Waterloo through the opening of The Village at University Gates.

978,360

fewer hours spent in Waterloo Wellington Emergency Departments (ED) with patient flow improvements since April 2008 (when ED wait times were first measured).



EXTRAORDINARY NEEDS PROGRAM FINDS PHILIP A PLACE TO BELONG

If it weren't for the Extraordinary Needs Program (ENP), Philip might still be in the hospital today. By the time he got to the ENP, he had already spent a total of 424 days as an inpatient in hospital, and a significant amount of time in other facilities to help him cope with a dual diagnosis, disrupted sleep patterns, limited attention span, and difficulty managing activities of daily living on his own. A dual diagnosis usually means that a person has a mental disability at the same time as they are managing a mental illness.

He attended day programs at the hospital each week

but was unable to find the intensive one-on-one care and support that he needed to experience the quality of life that he was capable and deserving of. Philip's family was worried he would never have a place that he truly belonged.

Then staff from the Extraordinary Needs Program (ENP) entered his life. The ENP provides dedicated individualized supports to individuals with complex mental health and other needs to live in a community setting. The program helps many residents that are

INNOVATION THROUGH APPLIED RESEARCH

Residents seeking emergency mental health or addictions care in Guelph Wellington are benefiting from care improvements as a result of a full review and recommendations to improve these services. Last year residents needing emergency mental health and addictions care spent a total of 5,252 less hours in the emergency department.

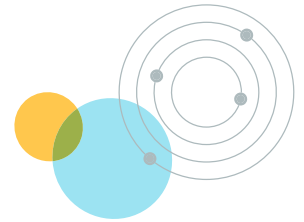
considered Alternate Level of Care; patients who no longer need care in hospital but still need support to live in the community or care at another facility. In Philip's case, he could not be safely discharged from the hospital without having additional community supports.

The ENP staff worked with Philip to create a plan that would see him connected to one-on-one support and helped him transition to community-based living in a group home.

"When Philip arrived, he was withdrawn," explains his worker. "It took him a while to get used to it. He was skeptical of staff and very wary of the intentions of the other housemates. But now, he's completely different. He's been decorating his bedroom and has three bulletin boards full of pictures of his family, roommates, and of many of the outings he's enjoyed."

As Philip has improved, his need for one-on-one support has decreased. He enjoys scheduling and completing daily tasks and has developed trust in the staff that care for him.

Without the ENP, Philip might still be spending his days in a hospital. While his journey is just beginning, Philip has found friends, a quality of life and a place where he belongs – he has finally come home.



SECURE ACCESS TO PATIENT'S DIGITAL HEALTH INFORMATION SUPPORTS TIMELY CARE

To provide high quality and timely care, the health care professionals at the Village of Winston Park in Kitchener need to frequently access their residents' medical information. Traditionally, this meant making endless calls and submitting formal requests for information to understand the 'big picture' of their residents' care needs. This has all changed since they gained access to the cSWO Regional Clinical Viewer, ClinicalConnect™, a secure, web-based portal that enables doctors and clinicians to talk to one another and share patient information electronically.

Barb Sutcliffe is a registered nurse and the Memory Clinic Team Lead at Winston Park. She noted that they can now source the relevant details and medical documents relating to the residents' health history easily and seamlessly.

"We were preparing in Memory Clinic for one of our clients and realized the CAT scan results we requested had not been forwarded by the family doctor. We were able to pull up the results on ClinicalConnect, which aided in our discussion to determine a diagnosis for our client, and this saved him having to book another appointment while we waited for his results. This is a win-win for us and the client."

The connecting South West Ontario (cSWO) Program is part of eHealth Ontario's Connecting Ontario initiative, which is enabling systems to talk to each other in order to get secure, accurate and comprehensive patient information into the hands of health care providers as quickly as possible. In Waterloo Wellington, the cSWO Program delivery partner at the Centre for Family Medicine Family Health Team eHealth Centre of Excellence, which deployed ClinicalConnect at Winston Park, works with physicians and health care professionals at hospitals, long-term care homes, the CCAC, physician offices and other health care organizations to deploy ehealth solutions.

Local health care providers are now able to securely access their patient's electronic health information from all acute care hospital sites, Community Care Access Centres (CCACs) and Oncology Centres in south west Ontario, plus two provincial data repositories for lab and diagnostic imaging tests and results.



To achieve our objective of leading a quality health care system using evidence based practice, the following initiatives were undertaken with health professionals across Waterloo Wellington:

IMPLEMENT EVIDENCE-BASED PRACTICES TO ENSURE THE SAME HIGH-QUALITY STANDARD OF CARE IS PROVIDED ACROSS ALL SITES FOR SIMILAR SERVICES.

QUALITY IMPROVEMENT INITIATIVE

- Accelerate best practice care through the system-wide adoption of electronic clinical order sets for Quality Based Procedures.
- Enhance quality and ensure delivery of best practice through current integrated programs and new integrated programs.

ACCOMPLISHMENT

- All residents who have been to local hospitals can expect their hospital information will now be electronically forwarded to their primary care provider. 400 of our local 600 primary care providers, are set up to receive hospital patient information electronically.
- Electronic Clinical Order Sets were launched in the first quarter of the year. These ensure that all patients with similar health needs receive the same, high-quality, best practice care at all area hospitals.

EXPAND AND ENHANCE INTEGRATED PROGRAMS THAT ENSURE QUALITY AND DELIVER BEST PRACTICE CARE ACROSS THE CONTINUUM OF CARE. KEY IMPROVEMENTS WILL INCLUDE:

PALLIATIVE CARE INITIATIVE

- Improve the end-of-life experience for palliative residents and their families by ensuring there are options for people to die in the place of their choice.
- Support advanced care planning processes across the continuum of care and throughout the community.

ACCOMPLISHMENT

- More than 2,800 people were engaged in a regional Advance Care Planning initiative aimed at improving end-of-life care for local residents. Today, 85.7% of palliative patients in Waterloo Wellington are able to pass away in the place of their choice – an increase of 8% since December of 2014.
- Residents in long-term care are benefiting from increased staff education in managing pain and end-of life symptoms. Local long-term care homes manage pain more effectively than the provincial and national averages.

LONG TERM CARE (LTC)

INITIATIVE

- Improve the quality and safety of care in LTC Homes.

ACCOMPLISHMENT

- Residents in Waterloo Wellington receive higher quality care in LTC than the provincial and national averages, related to potentially unnecessary antipsychotic drug use, restraint use, and pain management.
- Two Nurse Practitioners were funded to work out of four Wellington County LTC homes to provide more efficient and coordinated care to residents.
- Waterloo Wellington long-term care homes have the lowest number of residents needing emergency department care in Ontario (5.6%).

EMERGENCY DEPARTMENT (ED)

INITIATIVE

- Continue implementation of best-practices in ED care.
- Improve care and experience for mental health and addictions patients

ACCOMPLISHMENT

- Residents have waited 978,360 fewer hours in the ED with patient flow improvements since April 2008 (when ED wait times were first measured).
- Residents with complex needs in local emergency departments were seen and sent home or admitted to a hospital bed within 8 hours. The Waterloo Wellington LHIN met the provincial target, sharing the top result in the province.
- Residents in Waterloo Wellington who visited an ED and required admission to hospital spent the least amount of time in the ED in the province. The length of stay for admitted patients is 18.2 hours compared to 28.1 hours provincially.

MENTAL HEALTH AND ADDICTIONS

INITIATIVE

- Ensure all residents have access to complex capable services at the right time, in the right place.

- Improve access to intensive mental health services including optimizing Assertive Community Treatment Teams and support coordination.
- Expand availability of mental health and addiction supports in housing.

ACCOMPLISHMENT

- 56 new complex capable supportive housing beds were created in Waterloo Wellington. This means that residents with both mental health and addictions concerns can be better supported.
- Residents needing emergency mental health care are waiting 83% less time for care as a result of a full review of emergency mental health services in Guelph and Wellington completed in early 2016. The review resulted in a series of recommendations - many have been implemented and others will be implemented throughout 2016.

PHARMACY

INITIATIVE

- Implement protocols for anti-microbial stewardship.

ACCOMPLISHMENT

- An anti-microbial stewardship committee was launched early in the year to ensure safe practices around, and prevent the overuse of antibiotics across the region.
- 5 Waterloo Wellington pharmacists were trained by the Harvard School of Medicine in anti-microbial stewardship and an educational event was held for pharmacists, physicians and hospital staff.

DIAGNOSTIC IMAGING

INITIATIVE

- Reduce duplicate diagnostic imaging procedures.
- Reduce wait times for diagnostic imaging procedures by optimizing service delivery models.

ACCOMPLISHMENT

- Provincially, the Waterloo Wellington LHIN has the highest demand per operating hour in MRI and is the most efficient in serving the highest number of

We have some of the most effective hospitals in Ontario. Our rate of readmissions to hospital is the lowest in the province for residents requiring major surgery or who have had a heart attack (a measure of high quality care).

residents per funded operating hour. 38,767 adults received MRIs in Waterloo Wellington last year, an increase of 7.5%.

- 82.7% of residents receive their CT scan within the provincial access targets, compared with 74.6% provincially. 33,953 adults in Waterloo Wellington received CT scans last year.

CRITICAL CARE

INITIATIVE

- Implement standardized clinical protocols and intensive care unit best-practice design.
- Develop and implement long-term ventilation program standards.

ACCOMPLISHMENT

- Residents are receiving more consistent care across providers as a result of the ICU high performing checklist being implemented in all Intensive Care Units to ensure best practice across Waterloo Wellington.

SURGERY

INITIATIVE

- Improve access to specialized vision (eye) care and promote a seamless eye care experience by strengthening the relationships between primary care, ophthalmology, and optometry.

ACCOMPLISHMENT

- In the spring of 2014, University of Waterloo launched a Vision Centre of Excellence. This local planning group, including hospitals, schools, specialists, and the Waterloo Wellington LHIN will identify gaps and barriers to better care, improve collaboration, and develop recommendations for improving access to care.



SHORTER WAIT TIMES

IMPROVED BY*

Emergency department stay for admitted patients: Down 47.9%

13.9 HRS

Non-urgent MRIs:
Down: 66.1%

148 DAYS

Non-urgent CT scans:
Down: 76.5%

101 DAYS

Hip replacements:
Down: 47.1%

197 DAYS

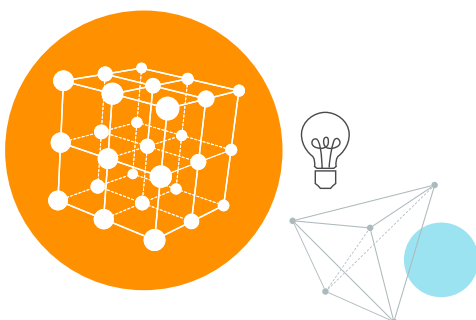
Knee replacements:
Down: 43.8%

216 DAYS

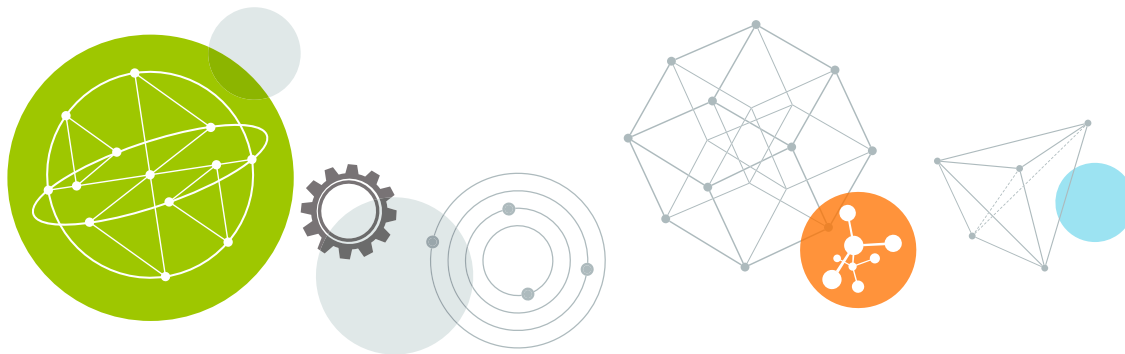
Cardiac by-pass surgery:
Down 82.2%

120 DAYS

*This reflects improvements from the system starting point, i.e. when measurement started.







WATERLOO WELLINGTON LHIN PERFORMANCE SUMMARY

Over the past year, residents in Waterloo Wellington benefited from increased access to higher quality, and better integrated local health services.

Through collaboration with local health service providers, the Waterloo Wellington LHIN met the provincial targets for: wait times for home care in a community setting, the emergency department (ED) length of stay for complex patients, the rate of patients waiting in hospital for care in a more appropriate place (ALC), readmission rates for select conditions, and wait times for cancer and cardiac by-pass surgery. In addition, the WWLHIN is the provincial leader in two of these areas.

Performance improved over last year in the areas of: wait times for patients with complex needs receiving home care; wait times for CT scans, the percentage of days residents spend in hospital waiting for care in a more appropriate place; repeat emergency visits for substance abuse; wait times for long-term care from community and hospital; the hospitalization rate for ambulatory care sensitive conditions; and the rate of emergency visits for conditions best treated elsewhere in the health system.

Work continues to improve: access to home care services for residents being discharged from hospital;

wait times for hip and knee replacements; cataract surgery and MRIs; length of stay in EDs for patients with minor treatment needs; the percentage of patients that receive a follow-up visit with their primary care provider within seven days of a hospital visit; and the number of emergency visits for mental health conditions. In many of these areas, the implementation of centralized access will improve efficiency and reduce wait times. Through the implementation of Here 24/7, the Waterloo Wellington LHIN has a clear picture of the mental health needs of the community and is working with mental health providers to increase access to supports outside of the ED. The Waterloo Wellington LHIN is also working with primary care providers on advanced access to reduce avoidable ED visits to ensure physician follow-up within seven days of a hospital visit.

The Waterloo Wellington LHIN is also working with local providers to ensure they are maximizing their resources through Health System Funding Reform (HSFR) to provide the best possible care for local residents.

For specific information about initiatives undertaken, the stories and achievements on the prior pages provide an overview of the health system's collective work to improve care for local residents.

Performance Data

No.	Indicator	Provincial Target	Provincial			Lhin		
			2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (Year-To-Date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (Year-To-Date)
Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	84.50%	88.97%	86.44%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	94.77%	93.23%	93.97%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	30.00	12.00	13.00	13.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	10.48	9.97	7.62	8.42	7.73
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.28	4.07	4.23	4.88	4.42
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	42.02%	40.51%	35.29%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	78.81%	76.53%	82.76%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	84.88%	62.33%	63.44%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	81.80%	57.09%	61.75%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	13.20%	11.82%	12.19%
11	ALC rate	12.70%	13.70%	14.12%	13.98%	9.96%	9.27%	9.33%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	15.20%	18.14%	17.21%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	24.36%	24.55%	23.98%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	15.84%	15.54%	15.06%
2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	93.46%	91.65%	91.50%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	99.66%	100.00%	99.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	95.13%	71.01%	73.77%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	12.00	10.50	10.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	6.00	5.00	5.50
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	13.24	2.95	8.62
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	299.64	73.98	217.00
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	44.14%	42.60%	43.89%

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

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



ENGAGING OUR COMMUNITY

COMMUNITY ENGAGEMENT

Community engagement is critical to understanding the unique needs of our local residents. Throughout the past year, staff at the Waterloo Wellington LHIN formally and informally engaged thousands of residents, health care workers, community groups, patients and families.

Throughout the development of our Integrated Health Service Plan for 2016-2019, the annual business plan, the community report, community and health events, network and council meetings, Board of Directors meetings, community surveys, outreach and more, the Waterloo Wellington LHIN Board of Directors and staff were regularly engaging, meeting with and talking to stakeholders.

We focused our engagement efforts on the following key stakeholders:

LOCAL RESIDENTS

Our residents and families are at the heart of our strategy to improve access, service and quality and in building a local system of care that is integrated and sustainable. Residents were engaged through focus groups, surveys, community events, one-on-one meetings, through health service providers and more to guide planning, decision-making and provide feedback. The perspectives of local residents are central to every decision made by the Waterloo Wellington LHIN Board of Directors and staff.

FRONT-LINE CARE PROVIDERS

Those on the front-lines of local health care are the eyes and ears of the Waterloo Wellington LHIN on the ground when it comes to improving care for local residents. We rely on the expertise of these professionals, including nurses, personal support workers, doctors, dietitians, physiotherapists, and more to provide vital input into the planning and decision making at the Waterloo Wellington LHIN. We engage directly with the front-line through surveys, focus groups, meetings, and through their leaders to ensure their perspective is reflected.

LOCAL HEALTH SERVICE PROVIDERS

Health service providers are the foundation of our health system. They provide essential services and are dedicated to improving the health and well-being of our residents. Together their work helps to shape health system improvements through priorities identified in our Integrated Health Services Plan (IHSP). Specific events and initiatives are outlined next in the report. Many board-to-board meetings and governor engagement sessions took place to advance health system integration by encouraging governance collaboration.

LOCAL ORGANIZATIONS

There isn't one sector or organization that can improve the health and quality of life for our communities alone. So many of our health and social problems have shared core issues. This is why engaging different organizations across health, community, municipal and other sectors is so vital. Working together we can address big problems that we just haven't been able to solve yet individually.

Social determinants of health are the socio-economic, cultural, and environmental conditions of our lives that impact overall health. This year, we focused on engaging the broader public sector and community organizations to better support vulnerable residents through Health Links and by working with our health service partners to address inequities that create gaps in care within the local health system. As a result of these efforts, organizations are now wrapping health and social services around residents most in need – looking beyond the scope of their own service to

ensure residents receive the right supports across the spectrum of care. We are also working with multiple partners to develop solutions to address social concerns that directly impact health and quality of life, including shared strategies to support residents in completing high school. Waterloo Wellington is quickly becoming a provincial leader in these areas.

ADVISORY GROUPS, NETWORKS, COMMITTEES, AND INTEGRATED PROGRAM COUNCILS

Advisory Groups, Networks, Committees, and Integrated Clinical Program Councils are some of the unique ways the Waterloo Wellington LHIN brings health service providers together to work towards a common goal – improving the health and well-being of residents. This past year, the Waterloo Wellington LHIN worked with these groups on the integration of various programs and services, including: rehabilitation and stroke, chronic disease prevention and management, diagnostic services, addictions and mental health, and more.

FRANCOPHONE AND ABORIGINAL RESIDENT ENGAGEMENT

As part of its commitment to equity, and as a legislative accountability, the Waterloo Wellington LHIN regularly engages with the local Francophone and Aboriginal populations to determine their needs and increase access to culturally appropriate health services. Health service planning for these specific populations is outlined further in the report. In 2015-16, the Waterloo Wellington LHIN engaged with 51 French speaking residents and 405 Aboriginal residents. This is in addition to surveys and other events where these stakeholders were active participants.





Patient Experience Event •

SPECIFIC EVENTS AND INITIATIVES

IHSP ENGAGEMENT

Engagement with our community regarding the priorities for the 2016-19 IHSP was one of our largest engagement projects in 2015-16.

Key engagement activities included

- Have Your Say - Phone and Online Survey
755 participants
- Mapping the Future of Our Local Health System - Online Survey
1,100 responses
- Focus Groups
19 group conversations

PATIENT EXPERIENCE EVENT

On May 26, 2015, the Waterloo Wellington LHIN, in partnership with The Change Foundation, hosted an event focused on developing tools and strategies for increasing the use of meaningful patient and family engagement to improve the experience our residents have in the health system and ultimately achieve better health in our community.

The event was attended by almost 200 of our stakeholders and received overwhelmingly positive feedback.

HQO EVENT

On February 1, 2016, the Waterloo Wellington LHIN hosted an interactive workshop, in partnership with Health Quality Ontario (HQO), with the aim of working together, in community planning areas, to identify common, data driven areas of focus for quality improvement across health service providers and to develop common areas of focus within organizational quality improvement plans to create better coordinated care for patients with complex care needs.

The event was attended by 175 local health care professionals and was well received as great starting point for local planning discussions.

PATIENT'S FIRST DISCUSSION PAPER

Throughout January and February of 2016, the Waterloo Wellington LHIN worked in partnership with local MPP offices, health service providers and councils/networks to conduct a series of engagement sessions regarding the Ministry's Patients First: A Proposal to Strengthen Patient Centered Health Care in Ontario.

The objective of the events was to engage local stakeholders regarding the proposed structural changes outlined in the paper and gather their questions, comments and feedback. These events were to complement feedback being provided to government from the numerous other stakeholders locally and across the province that represent patients, caregivers, health service professionals, and others. The feedback also complemented the information we received from thousands of local residents as part of our Integrated

Health Service Plan and ongoing community engagement activities.

The engagement campaign included 12 events and included 193 participants.

CRITICAL CONVERSATIONS EVENT

On January 13, 2016, the Waterloo Wellington LHIN hosted a Critical Conversations event focused on facilitating important discussions between primary care providers and palliative care, orthopedic and neurology specialists. The purpose of the event was to provide an opportunity for primary care providers to connect with specialists to discuss common barriers to health services and learn about evidence informed practices to establish best practices for ensuring the most efficient, high-quality care for patients.

60 local primary care providers and specialists attended the event and were appreciative of the opportunity to learn from each other.



GENERAL ENGAGEMENT ACTIVITIES

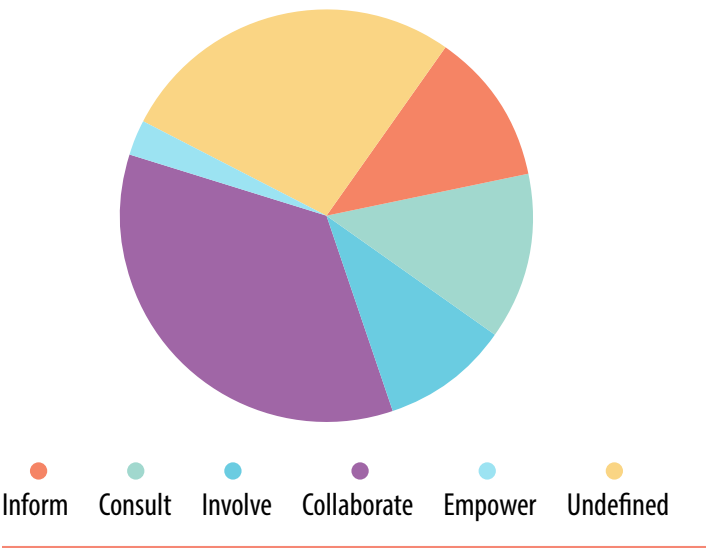
The Waterloo Wellington LHIN’s Community Engagement Database* captures strategic interactions with local stakeholders as the Waterloo Wellington LHIN: builds relationships, engages residents and providers in decision-making about their health system, and captures patient experiences to improve the care local residents receive.

Summary

Overall staff attended 849 unique engagement events and engaged 12,092 stakeholders

Level of Engagement

Based on the International Association for Public Participation Spectrum of Engagement (IAP2)



*As this can include a large number of interactions, the purpose of the interaction determines whether or not it is tracked (i.e. day-to-day ex. requesting a document/report/etc. vs. strategic input/relationship building). Staff can have hundreds of day-to-day interactions each month that will not be depicted in the report. Activities that are tracked via other methods, such as surveys, social media campaigns and focus groups are also not included in this report.



ABORIGINAL SERVICE PLAN

We work closely with our local First Nations, Métis and Inuit (FNMI) communities to identify and address gaps in health services. Improvements are advanced through the work of our Aboriginal Health and Wellness Promoter, who is funded to help FNMI residents navigate health services in Waterloo Wellington.

Over the last year we have initiated a mental health, addictions and homelessness solution table that includes representation from FNMI communities, health service providers and social service stakeholders. This cross-sector collaboration was intended to identify innovative ways to address the interplay of mental health, addictions and homelessness in the FNMI communities.

Waterloo Wellington LHIN staff received FNMI cultural awareness training to increase understanding of the unique and diverse culture of our FNMI residents. This training helps to ensure all health service planning at the LHIN is undertaken with specific consideration given to our FNMI residents.

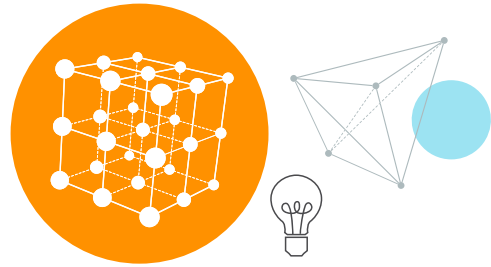
Cultural safety training was delivered to health service providers working in mental health and addictions. This means they now have the knowledge and tools they need to provide culturally safer services for FNMI residents. FNMI people have their own ways of knowing, being, doing and seeing. They have a holistic worldview about life and living, with each Nation having cultural ways of taking care of their health and well-being. With this in mind, the Aboriginal Health and Wellness Promoter, in support of the Waterloo Wellington LHIN, provided two Indigenous Wellness Conferences with additional opportunities for local FNMI community members to attend one hour, one-on-one sessions with a Traditional Healer. These events promote health and wellness from a holistic perspective while building a stronger and healthier cultural identity.

FRENCH LANGUAGE SERVICE PLAN

Francophone residents face unique challenges in navigating the health system. The Waterloo Wellington LHIN continues to work in partnership with the French Language Health Planning Entity (Entity2) to understand and support the health needs of Francophone residents.

Our focus is on enhancing health equity for Francophone residents and improving access to services. Francophone seniors in the community experience difficulties in accessing programs that meet their needs. Over the last year we have improved access to care for Francophone seniors by developing a French component of the SMART exercise program in partnership with our health service providers. This means our Francophone seniors are now able to access exercise programs in the community tailored to their health and language needs.

Without appropriate mental health and addictions services provided in French, Francophone residents are more vulnerable to mental health and addictions issues. A mental health café now provides regular monthly support to Francophone residents experiencing mental health and addictions issues. Mental health support for Francophone residents has been further expanded in the past year through counselling delivered over secure video conferencing. This supplements existing access to French speaking psychiatrists in the region. With these improvements, more Francophone residents are able to access the care they need, when they need it.



OPERATIONS SUMMARY

Total revenue for 2015-16 includes funding for Waterloo Wellington LHIN operations and initiatives, and funding for health service providers in accordance with public sector reporting guidelines.

In 2015-16, the Waterloo Wellington LHIN operational and initiatives budget was \$1.030M, with health service provider funding totaling \$1.024B. In total, approximately 0.4 per cent of our total funding is used for Waterloo Wellington LHIN operations to support the important roles of health system oversight, performance management, funding, planning, coordinating, integrating and improving our local health system.

The Waterloo Wellington LHIN ended the fiscal year with an operational surplus of \$2,540. The Waterloo Wellington LHIN had a staff compliment of 31 full-time equivalent (FTE) positions focused on improving quality outcomes, access to care and value for taxpayer dollars. Our full-time and contracted staff have diverse skill sets and backgrounds and include nurses, allied health professionals, former executives from large health service providers, our Primary Care Physician Lead, Emergency Department Physician Lead, Critical Care Physician Lead, Diabetes/Chronic Disease Prevention and Management Physician Lead and Enabling Technologies Physician Lead.





LOOKING FORWARD

As we reflect on the progress we have made over the past three years, we are also looking forward to the work that still needs to be done.

In February of 2016, we released our next Integrated Health Service Plan (IHSP). The 2016-19 IHSP directly reflects the needs of local residents, health service providers and other community leaders through extensive engagement. The objectives outlined in the plan align with the provincial direction for health care but also reflect the unique health care needs of our local population. You told us what health services were important to you and your family and we listened.

Each year, we will develop an Annual Business Plan that outlines specific actions that will be taken across the health system to achieve the objectives set in the IHSP. We heard you say that increased access to primary care, improving home and community care and a continued focus on health quality are important to you. In the coming year, those areas will be a significant focus of our work. To our partners, thank you for your ongoing commitment to improving the health and well-being of our families, friends and neighbours.

The 2016-19 IHSP focuses our work on four priority areas that will result in better health outcomes for residents and a stronger health system:



ACCESS - Provide faster access to the right care.

CONNECT - Deliver better coordinated and integrated care in the community, closer to home.

INFORM - Support people and patients – providing the education, information and transparency Ontarians need to make the right decisions about their health.

PROTECT - Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.



APPENDIX A: FINANCIAL STATEMENTS

Financial statements of

**Waterloo Wellington Local
Health Integration Network**

March 31, 2016

Waterloo Wellington Local Health Integration Network

March 31, 2016

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Independent Auditor's Report

To the Members of the Board of Directors of the
Waterloo Wellington Local Health Integration Network

We have audited the accompanying financial statements of Waterloo Wellington Local Health Integration Network, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Waterloo Wellington Local Health Integration Network as at March 31, 2016 and the results of its operations, change in its net debt, and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in black ink that reads "Deloitte LLP". The signature is written in a cursive, flowing style.

Chartered Professional Accountants
Licensed Public Accountants
June 22, 2016

Waterloo Wellington Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	\$	\$
Financial assets		
Cash	539,555	421,932
Due from Ministry of Health and Long-Term Care (Note 9)	11,436,200	5,546,146
Other receivables	32,924	306,375
	12,008,679	6,274,453
Liabilities		
Accounts payable and accrued liabilities	391,921	542,072
Due to Ministry of Health and Long-Term Care (Note 3b)	194,990	248,355
Due to Health Service Providers ("HSPs") (Note 9)	11,436,200	5,546,146
Due to the Local Health Integration Networks Shared Services Office (Note 4)	16,535	4,308
Deferred capital contributions (Note 5)	199,505	249,620
	12,239,151	6,590,501
Net debt	(230,472)	(316,048)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	30,967	66,428
Tangible capital assets (Note 7)	199,505	249,620
	230,472	316,048
Accumulated surplus	-	-

Approved by the Board

_____ Board Chair

_____ Finance and Audit Committee Chair

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

Waterloo Wellington Local Health Integration Network

Statement of operations
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	\$	\$	\$
Revenue			
Ministry of Health and Long-Term Care funding			
Health Service Providers transfer payments (Note 9)	1,024,202,400	1,054,673,430	1,035,139,980
Local Health Integration Network operations - general and administrative	4,198,719	4,238,720	4,107,343
Project Initiatives			
Diabetes Regional Coordination	1,036,138	1,036,138	1,057,284
Enabling Technologies ETI PMO	510,000	510,000	510,000
Emergency Department Lead	75,000	75,000	75,000
Emergency Department/Alternative Levels of Care Lead	100,000	100,000	100,000
Aboriginal Planning	5,000	5,000	5,000
French Language Services	106,000	106,000	106,000
Critical Care Lead	75,000	75,000	75,000
Primary Care Lead	75,000	75,000	75,000
Amortization of deferred capital contributions (Note 5)	-	50,115	94,245
	1,030,383,257	1,060,944,403	1,041,344,852
Funding repayable to Ministry of Health and Long-Term Care (Note 3b)	-	(2,540)	(248,355)
	1,030,383,257	1,060,941,863	1,041,096,497
Expenses			
Transfer payments to Health Service Providers (Note 9)	1,024,202,400	1,054,673,430	1,035,139,980
Local Health Integration Network operations - general and administrative (Note 11)	4,198,719	4,286,295	4,085,542
Project Initiatives (Note 10)			
Diabetes Regional Coordination	1,036,138	1,036,138	985,524
Enabling Technologies ETI PMO	510,000	510,000	454,095
Emergency Department Lead	75,000	75,000	75,000
Emergency Department/Alternative Levels	100,000	100,000	100,000
Aboriginal Planning	5,000	5,000	924
French Language Services	106,000	106,000	105,432
Critical Care Lead	75,000	75,000	75,000
Primary Care Lead	75,000	75,000	75,000
	1,030,383,257	1,060,941,863	1,041,096,497
Annual surplus and accumulated surplus, end of year	-	-	-

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

Waterloo Wellington Local Health Integration Network

Statement of change in net debt
year ended March 31, 2016

	Budget (Note 8)	2016	2015
	\$	\$	\$
Annual surplus	-	-	-
Change in prepaid expenses, net	-	35,461	(33,202)
Acquisition of tangible capital assets	-	-	(91,377)
Amortization of tangible capital assets	50,115	50,115	94,245
Decrease (increase) in net debt	50,115	85,576	(30,334)
Net debt, beginning of year	(316,048)	(316,048)	(285,714)
Net debt, end of year	(265,933)	(230,472)	(316,048)

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

Waterloo Wellington Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	\$	\$
Operating activities		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of tangible capital assets	50,115	94,245
Amortization of deferred capital contributions (Note 5)	(50,115)	(94,245)
	-	-
Changes in non-cash operating items		
Due from Ministry of Health and Long-Term Care	(5,890,054)	(3,167,674)
Decrease in other receivables	273,451	(182,285)
Decrease in accounts payable and accrued liabilities	(150,151)	(125,591)
Due to Ministry of Health and Long-Term Care	(53,365)	(86,151)
Due to Health Service Providers ("HSPs")	5,890,054	3,167,674
Due to Local Health Integration Networks		
Shared Services Office	3,458	4,219
Champlain LHIN	8,769	-
Prepaid expenses	35,461	(33,202)
	117,623	(423,010)
Acquisition of tangible capital assets	-	(91,377)
Financing activity		
Capital contributions received (Note 5)	-	91,377
Net decrease in cash	117,623	(423,010)
Cash, beginning of year	421,932	844,942
Cash, end of year	539,555	421,932

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

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2016

1. Description of business

The Waterloo Wellington Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Waterloo Wellington Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers all of the County of Wellington, the Region of Waterloo, and the City of Guelph. The LHIN also contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs. The LHIN enters into service accountability agreements with health service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSPs' Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

Commencing April 1, 2007, all funding payments to LHIN managed HSPs in a LHIN geographic area, have flowed through each LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in each LHIN's financial statements for the year ended March 31, 2016.

The LHIN statements do not include any Ministry managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items such as the amortization of tangible capital assets.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2016

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

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

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

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

Segment disclosures

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

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2016

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

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

			2016	2015
	Funding received	Eligible expenses	Funding excess	Funding excess
	\$	\$	\$	\$
Transfer payments to HSPs	1,054,673,430	1,054,673,430	-	-
LHIN operations	4,288,835	4,286,295	2,540	116,046
Diabetes Regional Coordination Centre	1,036,138	1,036,138	-	71,760
Enabling Technologies	510,000	510,000	-	55,905
Critical Care Lead	75,000	75,000	-	-
Emergency Department Lead	75,000	75,000	-	-
Emergency Department/Alternative Levels of Care Lead	100,000	100,000	-	-
Aboriginal Planning	5,000	5,000	-	4,076
French Language Services	106,000	106,000	-	568
Primary Care Lead	75,000	75,000	-	-
	1,060,944,403	1,060,941,863	2,540	248,355

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

	2016	2015
	\$	\$
Due to MOHLTC, beginning of year	248,355	334,506
Paid to MOHLTC during year	-	(334,506)
Paid to South West LHIN for eHealth Surplus (Prior Year)	(55,905)	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	2,540	248,355
Due to MOHLTC, end of year	194,990	248,355

4. Related party transactions

LHIN Shared Services Office, Local Health Integration Network Collaborative

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all the LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2016

4. Related party transactions (continued)

The LHINC was formed in fiscal 2011 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- Fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- Their role as system manager;
- Where appropriate, the consistent implementation of provincial strategy and initiatives;
- The identification and dissemination of best practices.

LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

Enabling Technologies for Integrated Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and South West (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The MOHLTC provided the South West LHIN with \$2,040,000 (2015 - \$2,040,000) related to Enabling Technologies initiatives. The South West LHIN flowed \$510,000 (2015 - \$510,000) of the funding to the Waterloo Wellington LHIN.

5. Deferred capital contributions

	2016	2015
	\$	\$
Balance, beginning of year	249,620	252,488
Capital contributions received during the year	-	91,377
Amortization for the year	(50,115)	(94,245)
	199,505	249,620

6. Commitments

The LHIN has commitments under various operating leases and maintenance contracts related to building, software and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	\$
2017	311,380
2018	311,380
2019	311,380
2020	77,845
2021	-
Thereafter	-

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

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Notes to the financial statements

March 31, 2016

7. Tangible capital assets

			2016	2015
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office equipment, furniture and fixtures	362,261	352,024	10,237	14,965
Computer equipment	85,467	84,350	1,117	2,234
Leasehold improvements	358,651	170,500	188,151	232,421
	806,379	606,874	199,505	249,620

8. Budget figures

The budget figures reported in the statement of operations reflect the initial budget at April 1, 2015 as approved by the LHIN Board. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of \$1,054,673,430 is derived as follows:

	\$
Initial budget	1,024,202,400
Additional funding received during the year	30,471,030
Final budget	1,054,673,430

The final LHIN general and administrative and specific initiatives budget of \$ 6,321,088 is derived as follows:

	\$
Initial budget	6,180,857
Additional funding received during the year	140,231
Amount treated as capital contributions made during the year	
Final budget	6,321,088

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9. Transfer payments to HSPs

During the year, the LHIN was authorized to allocate funding of \$1,054,673,430 (2015 - \$1,035,139,980) to the various HSPs in its geographic area. Actual transfer payments to the various sectors in fiscal 2016 as follows:

	2016	2015
	\$	\$
Operations of hospitals	582,067,918	591,089,080
Grants to compensate for municipal taxation - public hospitals	159,225	159,225
Long-term care homes	188,499,088	178,940,392
Community care access centre	143,693,475	130,112,449
Community support services	28,302,607	27,176,605
Assisted living services in supportive housing	6,471,004	6,013,278
Community health centres	21,353,059	21,393,493
Community mental health programs	42,203,639	38,641,303
Specialty psychiatric hospitals	30,642,050	30,642,050
Addictions programs	11,281,365	10,972,105
Health infrastructure renewal fund		-
	1,054,673,430	1,035,139,980

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2016, an amount of \$11,436,200 (2015 - \$5,546,146) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

10. Project Initiatives

Separate funding amounts were received by the LHIN from MOHLTC for specific project initiatives. These revenues and the associated expenses are classified by initiative in the Statement of operations. The following table classifies the initiative expenses by object:

	2016	2015
	\$	\$
Salaries, benefits, and consulting services	1,703,878	1,664,776
Occupancy	90,503	74,338
Shared services	126,049	120,008
Public relations	19,793	1,410
Mail, courier, and telecommunications	11,465	5,042
Other	30,450	5,401
	1,982,138	1,870,975

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Notes to the financial statements

March 31, 2016

10. Project Initiatives (continued)

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

	2016	2015
	\$	\$
Salaries and benefits	855,773	857,288
Other expenses	180,365	128,236
One-time expense	-	-
	1,036,138	985,524

11. LHIN operations - general and administrative expenses

The statement of operations presents expenses by function. The following classifies general and administrative expenses by object:

	2016	2015
	\$	\$
Salaries and benefits	3,150,000	2,579,361
Occupancy	201,790	215,822
Amortization	50,115	94,245
Shared Services	255,615	283,655
LHIN Collaborative	47,500	47,500
Public relations	47,660	129,647
Consulting services	129,368	271,347
Supplies	34,366	67,888
Board Chair per diems	68,950	65,975
All other board members' per diems	34,033	26,550
Other governance costs	63,072	53,023
Mail, courier and telecommunications	33,057	44,148
Other	170,769	206,381
	4,286,295	4,085,542

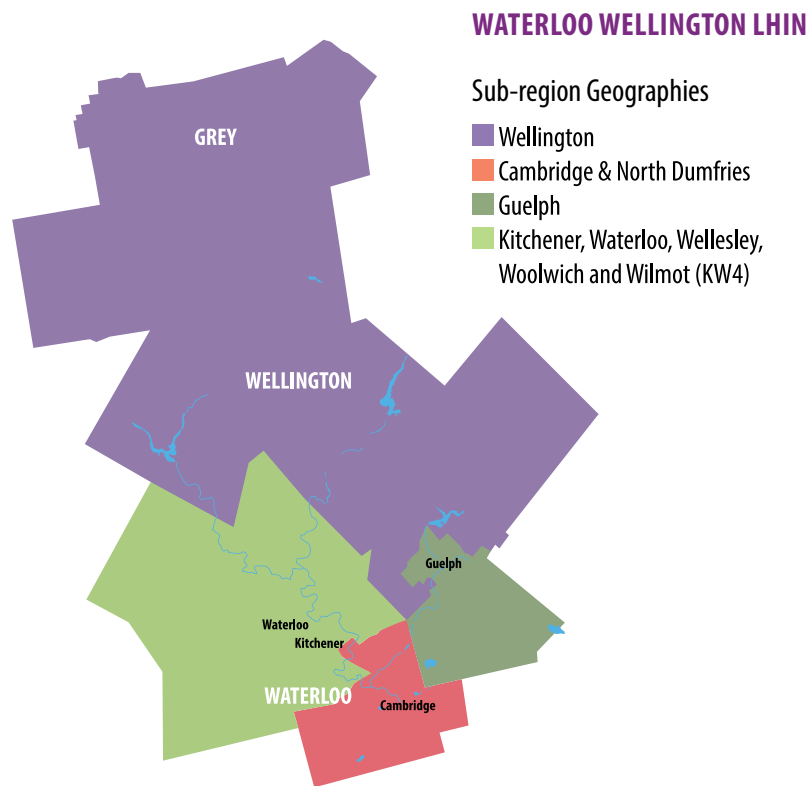
12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2016 was \$352,614 (2015 - \$299,130) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan on December 31, 2015. At that time, the plan was fully funded.

13. Guarantees

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

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



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