Annual Report

2017-2018

Ontario

Toronto Central Local Health Integration Network

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Message from the Board Chair and the CEO

Dr. Vivek Goel
Board ChairCEO

Susan Fitzpatrick

On behalf of everyone at the Toronto Central Local Health Integration Network (LHIN), we are pleased to present our 2017-18 Annual Report. This past year was one of important and positive change at Toronto Central LHIN. On June 7, 2017, the Toronto Central Community Care Access Centre joined the Toronto Central LHIN to create one organization. Through robust planning, careful execution and active staff engagement, we made the transition with no disruption to patient care.

The new Toronto Central LHIN has a clear purpose—to plan, fund, integrate and deliver health care services to the growing and diverse population of the City of Toronto. It is a simple statement but a complex task, one that must be supported by a robust Strategic Plan with strong and action-oriented priorities. The Toronto Central LHIN's 2015-18 Strategic Plan, now in its final year, provided the solid platform we needed for the integration of the two organizations and for what we have achieved for the people we serve; including the work we have done in primary care, home and community care and integration. Looking ahead, as we develop our first new Strategic Plan as the new Toronto Central LHIN, service provision across the health system will remain a key priority, and we will continue to evolve the model of care and improve quality outcomes for our clients and citizens.

An organization is only as good as its people, and we would like to take this opportunity to thank the hundreds of skilled and dedicated employees who embraced the new organization and every day contribute to our achievements truly operating as "One Team."

We are also grateful to the many health system partners who work with us to improve the quality of care we are collectively able to provide to the citizens we serve. In addition, of course, we are grateful to the remarkable citizens of this equally remarkable city who have willingly offered us their valuable insights and precious time as we deliver care today and plan for how care will be delivered tomorrow. They have played, and will continue to play, a critical role in what we do at the Toronto Central LHIN - as patients, providers, partners and planners work together for better health care, aligning our efforts to build a stronger health care system.

Toronto Central LHIN has set a high bar for our organization and our partners -one that makes us strive to not just deliver service seamlessly, but to constantly improve and innovate. With everything we have achieved this year there is still much more to do, and we looking forward to partnering with you as we continue to fulfill our vital mandate.

Toronto Central LHIN Profile

Uniquely Urban

Toronto Central LHIN represents a diverse population of 1.2 million people, as per the 2016 Census.[1] Toronto has become North America's fourth largest city and the population continues to grow.[2] The 2016 Census revealed some key characteristics of the Toronto Central LHIN that impact how we plan and deliver services, outlined below:

- With the second highest population and smallest land area, Toronto Central LHIN has a considerably higher population density (6,412.6 persons per square kilometre) than all of the other LHINs[3]
- The fastest-growing age group in the LHIN is seniors aged 65 and older; this age group is expected to make up 21% of Toronto Central LHIN's population by 2041[1,4]
- Some of the richest and poorest neighbourhoods in Canada can be found in Toronto Central LHIN. 19.0% of Toronto Central LHIN's population living in private households are living below the low-income measure[3]
- Toronto Central LHIN has the highest percentages of children aged 18 and younger (21.9%) and seniors aged 65 and over (18.7%) living in low income households[3]
- Toronto Central LHIN remains a multicultural hub, with over a third of the population being immigrants (36.4%), the fourth highest percentage of all of the LHINs[5]
- Toronto Central LHIN has the fourth highest percentage (5.5%) of new immigrants, receiving immigration status between 2011 and 2016[5]
- A large variety of languages and dialects are spoken in Toronto Central LHIN, with the top three non-English and non-French languages spoken at home being Portuguese, Mandarin, and Cantonese[1]
- Toronto Central LHIN includes 34,905 Francophones (2.9% of the population); a large lesbian, gay, bisexual and transgender community; and a rapidly growing urban Aboriginal population, many with unique and complex health needs[5]
- More than half (60.5%) of Toronto Central LHIN residents described their health as excellent or very good, the second highest percentage compared to all other LHINs, while another 26.8% reported having good health during October 2016 - September 2017[6]
- Toronto Central LHIN residents reported the highest health care satisfaction, with 91.6% being satisfied with care in their community, which is almost five percent higher than the provincial average[6]
- Between 2008 and 2015, Toronto Central LHIN experienced the greatest decline in premature mortality rates compared to the other LHINs, having a 35.5% decrease in rate for males and 32.6% in females[7]

The LHIN also experiences a large amount of population inflow: people who do not reside within the Toronto Central LHIN geography who work, attend school, or use services within it. These people also need to be considered when planning for service delivery within the LHIN.

What is also unique about Toronto is that it is home to a high concentration of world-class physicians, academic hospitals, and health research institutes, also known as academic health science centres. These assets and strengths help to improve the health of the population the LHIN serves. Our strong community and specialty hospitals partnering with our academic health science centres all contribute to a world-class hospital sector.

High Growth in the Toronto Central LHIN

Since 2006, the Toronto Central LHIN population has grown by 13.0%; 5.1% between 2006 and 2011 and 7.6% between 2011 and 2016, showing that the population continues to grow at an increasing rate.[1] Within this large urban centre, the Toronto Central LHIN includes 73 neighbourhoods, across which there is much diversity.

Some of Toronto Central LHIN's neighbourhoods had large population growth in the last five years (from 2011 to 2016):

- Waterfront Communities-The Island (52%), Niagara (48%), Bay Street Corridor (33%), Little Portugal (29%), Mimico (28%), and Moss Park (26%)[1]

- Within the next 10-15 years (beginning in 2016), it is estimated that the following neighbourhoods will continue to experience high growth: Waterfront Communities -The Island (125%), Regent Park (117%), Church-Yonge Corridor (106%), Mount Pleasant West (90%), Bay Street Corridor (74%), and Moss Park (71%)[8]

The impact of this population surge has been felt by hospitals and other health service providers, which is why, in 2017-18, the Toronto Central LHIN continued to look at innovative, more efficient ways of delivering services to the people we serve.

Capacity Challenges

Property values in downtown Toronto have led to fiscal challenges for facilities in the long-term care and broader community sector that need to be replaced or expanded. Resourcing in the face of the cost of land within the Toronto Central LHIN continues to be a challenge and poses the risk of having insufficient infrastructure to support this vital resource as the population continues to grow. That is why the Toronto Central LHIN continues to work closely with the other four LHINs in the Greater Toronto Area, as well as with the City of Toronto, in order to ensure that addressing health concerns is at the forefront of future development in the region. Basing future infrastructure investments on data-driven planning will help ensure that the unique challenges faced in delivering health care to the city's core are taken into account. This will also enable the LHIN to deliver on its commitment to support specialized care to patients across the province.

OUR PEOPLE: A DIVERSE POPULATION

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

Seniors

Within the Toronto Central LHIN boundaries, those aged 65 years and older accounted for 14%of the population in 2016.

- In 2016, the Toronto Central LHIN had more than a third (34%) of seniors aged 65 and older in private households living alone, the highest percentage compared to other LHINs.[1] Of those seniors living alone, 29.6% of them always experience difficulties with activities of daily living[1]
- Of those aged 75 and older living in private households in Toronto Central LHIN, 38.4% lived alone with 34.3% of them always experiencing difficulties with activities of daily living[1]

There was a large difference in the percentage of seniors aged 65 and older living alone in private households across Toronto Central LHIN's 73 neighbourhoods.

- The highest percentages of seniors living alone were in Mount Pleasant West (55.1%), Church-Yonge Corridor (53.2%), and North St. Jamestown (51.3%)
- The lowest percentages were in Little Portugal (15.6%), Bridle Path-Sunnybrook-York Mills (15.8%), and Corso Italia-Davenport (16.1%)[1]

Of Toronto Central LHIN's five sub-regions, the highest percentage of seniors living alone was in Mid-East Toronto (43.9%), while the smallest percentage was in Mid-West Toronto (28.8%)[1]

Health care use rises as people age and most costs are incurred during people's final years of life. With the large cohort of aging baby boomers reaching their senior years, health care costs will inevitably continue to grow. The LHIN has been working to manage the rate at which those costs grow by improving the quality and efficiency of care and investing in services that add value.

Caregiver Distress

As the population ages and health care needs rise, informal caregivers are increasingly relied upon. Providing care to a loved one can be incredibly difficult, particularly when they have high care needs, multiple co-morbidities, or are experiencing rapid decline in health. Often, caregivers experience declines in their own health. As caregiving becomes progressively difficult, caregivers can find themselves increasingly in distress and require additional support.

In 2016-17, Community Support Services provided a total of 55,080 hours of caregiver support to 7,044 unique individuals in Toronto Central LHIN.[9] Within the same timeframe, 66,150 total hours of respite care were provided to 1,173 people .[9]

Indigenous Peoples

Indigenous communities have significant health disparities when compared to non-Indigenous populations, and have been historically marginalized within the mainstream health system. In addition, there is limited information about the health status and health care use of Indigenous peoples for a variety of reasons. For example, census data often does not include Indigenous people as this population group is highly mobile and has high housing instability and homelessness.

According to Our Health Counts Toronto, the population of the Indigenous community in the city is 34,000 to 69,000, with key considerations below[10]:

- The burden of poverty, adverse living conditions, and racism have been linked to the high prevalence of health conditions in Indigenous adults[11,12]
- In Toronto, the prevalence of many health conditions in Indigenous adults were at least double, if not morethe prevalence rates of the general population, including asthma, high blood pressure, respiratory illnesses, and diabetes[10]
- Almost a fifth (18%) of Indigenous adults in Toronto used prescription opiates without a prescription or out of keeping with how they were prescribed[10]
- Indigenous adults in Toronto have a higher prevalence of mental health conditions than the overall adult population (aged 15+ years) in Ontario. Only 31% of Indigenous adults in Toronto reported very good or excellent mental health, which is 2 times lower than that reported by the general Canadian population[10]

Francophones

Toronto's Francophone population is rich in diversity and is dispersed across the city. Likewise, French language health services are dispersed across the LHIN, which contributes to challenges navigating the health care system for this particular population. Toronto Central LHIN's population included 34,905 Francophones (2.9% of the population) in 2016.[5] Within Toronto Central LHIN, the highest percentage of Francophones resided in Mid-East Toronto (3.8%) while the lowest percentage was in East Toronto (2.6%).[5]

According to Statistics Canada (2011), many Francophones are recent immigrants or visible minorities. Almost half were born outside of Canada and may not be familiar with the Ontario health care system, making it more difficult to access timely and appropriate care.

People Affected by Mental Health and Addictions

Mental Health and Addictions (MHA) affects a considerable proportion of Toronto Central LHIN's population who require ongoing treatment and supports, with the prevalence of MHA conditions much higher among the top high-cost users of the system:

- In 2015-16, Toronto Central LHIN had the second highest age standardized rate of mental health disorders compared to all of the LHINs (143.8 per 1,000 population)[1]
- During the same timeframe, Toronto Central LHIN had the highest age standardized rate of psychotic disorders (16.8 per 1,000 population) compared to the other LHINs.[1] However, these figures drastically underestimate the prevalence of mental health issues as they do not include non-Ontario Health Insurance Plan (OHIP) claims or people who do not seek treatment for their conditions
- In 2015-16 and 2016-17, Toronto Central LHIN had the third highest rate of emergency department visits

for mental health and addiction conditions of all the LHINs[1]

- Toronto Central LHIN also has the highest percentage, 28.06% from April 1, 2017 to December 31, 2017, of repeat emergency department visits within 30 days for mental health among all the LHINs[13]
- Toronto Central LHIN has also been heavily impacted by the opioid crisis. During the same timeframe, Toronto Central LHIN had the second highest percentage, 38.56%, for repeat emergency department visits within 30 days for substance abuse conditions compared to the other LHINs[13]

Homeless

The Toronto Central LHIN has a large number of homeless individuals who have high health care needs. According to the 2013 Streets Needs Assessment (the latest survey available), there were an estimated 5,300 homeless individuals in Toronto.[14]

There has been an increasing demand for shelter spaces within the City of Toronto. According to City of Toronto projections, by November 2018 refugee claimants will represent nearly 54% of the City's shelter population. As of May 2018, the City of Toronto had 76 Emergency and Transitional shelter locations, and 8 Motel Programs, with the majority of the shelters are in Toronto Central LHIN.[14]

The 2013 Street Needs Assessment reported high use of health related services among homeless people surveyed:

- 45% had used health clinics in the past 6 months and 48% had used hospital services[14]
- 14% had used detox centres and 16% harm reduction services, and 25% had used ambulances[14]

Many homeless individuals reported that improved access to health care services would help them find housing. The most frequently mentioned services were:

- general health care - 44%
- mental health care - 33%
- alcohol and drug treatment - 22%
- harm reduction supports - 18%
- detox treatment - 16%

Newcomers and Refugees

Newcomers often encounter barriers to care, particularly if they do not speak English. Evidence shows that people with limited proficiency in English tend to stay longer in hospital, as do those who are unable to communicate with care providers in their first language. In Toronto Central LHIN, 3.5% of residents had no knowledge of either English or French, the third highest of all of the LHINs.[5] In 2016, over a third (36.4%) of the Toronto Central LHIN population were immigrants and 5.5% were new immigrants who received immigration status between 2011 and 2016.[5]

Refugees are a vulnerable group in need of quick and sustained access to health care, as well as resources and services related to mental health. Of those who reside in Toronto Central LHIN who immigrated between 1980 and 2016, 16.8% were admitted as refugees.[5] Within Toronto Central LHIN's sub-region during the same timeframe, 23.2% of immigrants were admitted as refugees in West Toronto, while 10.1% of immigrants were admitted as refugees in North Toronto.[5]

Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ)

The Toronto Central LHIN is home to the largest LGBTQ community in Canada. LGBTQ communities have some unique health concerns and may be at increased risk for certain health problems, such as higher rates of depression, mental health and substance abuse, and high-risk behaviours such as smoking. Although some supports are in place, many gaps in care remain for this community. For example, the accumulated impact of stigma, discrimination and isolation affects the mental health of LGBTQ people, leading to higher rates of depression, anxiety and suicide than the general population and may also lead to delay or avoidance in seeking health care. Substance use such as alcohol and drugs is also higher among LGBTQ populations.

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

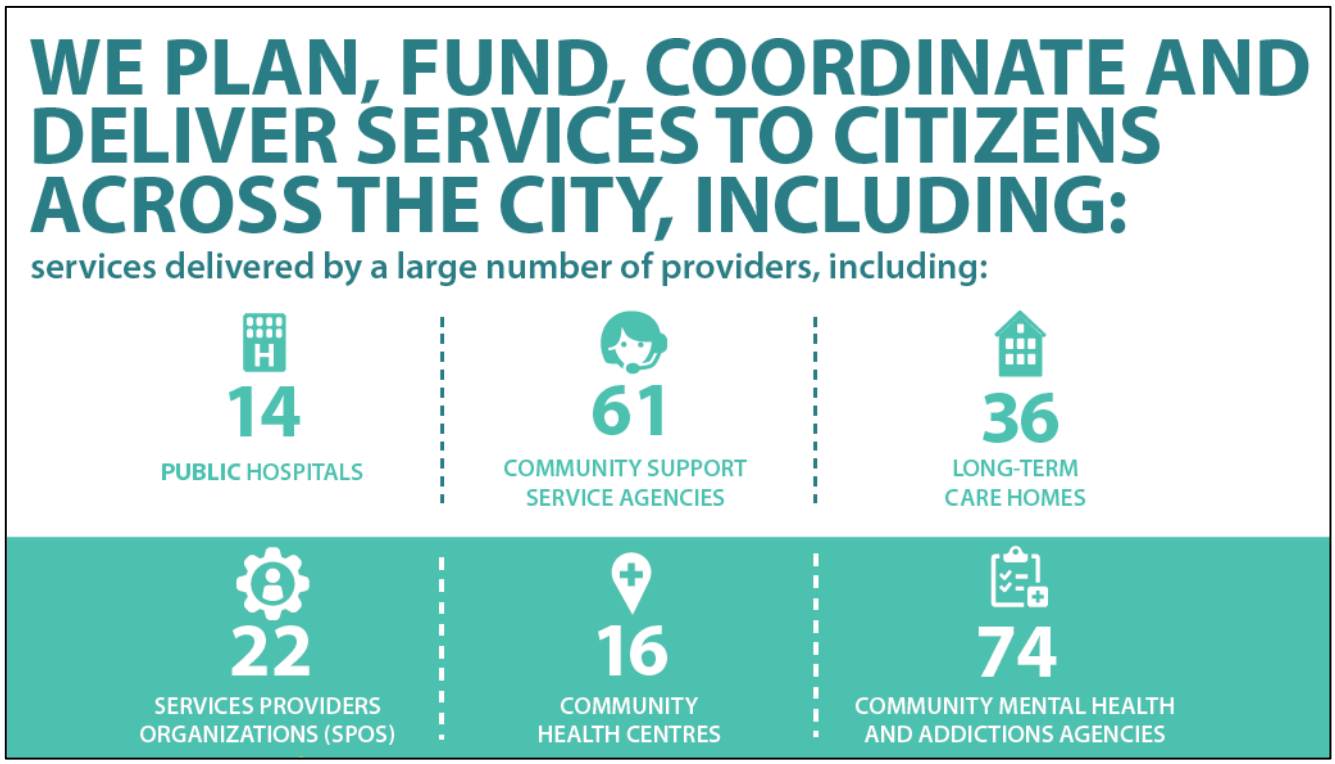
Uninsured

Uninsured individuals are ineligible to access publicly funded health services and experience major barriers obtaining health care, which often results in poor health outcomes. Due to barriers in accessing care, they often delay or forego seeking health care and prenatal care, which may lead to serious health consequences such higher rates of complications in pregnancy and delivery. They are usually denied care and are ineligible for services such as home care and long-term care, which may lead to long stays in hospital when other forms of care would be more appropriate.

Limited data exists on the number of uninsured population in Toronto Central LHIN. However, there is increasing evidence of rising use of health services by the uninsured population. A 2016 study estimated there were about 200,000 to 500,000 uninsured people in Canada with the majority living in Greater Toronto Area.. They are a heterogeneous group with diverse backgrounds that includes people in the three month OHIP wait period, temporary visa holders (e.g., students, visitors), refugees, and undocumented residents who have lost their identification.

Community Health Centres serve a considerable proportion of uninsured clients and they have dedicated funding for non-insured patients. In 2016-17, 13 out the 16 CHCs surveyed had approximately 7,600 uninsured clients, representing 17% of total clients served. These clients had a total of nearly 45,000 visits, with the majority of clients having incomes below $15,000 per year.

OUR HEALTH SERVICE PROVIDERS



Toronto Central LHIN has the highest concentration of health services in Canada, with 177 unique health service providers offering 206 unique programs and services. The following breakdown of services is based on the 2017-2018 fiscal year:

- **14** public hospitals with a total estimated **2,201,477** inpatient days
- **Two** private hospitals
- **16** community health centres providing service to an estimated **81,065** individuals
- **61** agencies providing community support services totaling an estimated **1,130,826** community visits and 973,742 resident days;
- **74** agencies that provide community mental health and addictions and problem gambling services totaling an estimated **1,221,132** visits and **1,560,142** resident days;
- **36** long-term care homes accounting for almost **5,879** approved long-term care beds (equivalent to)
- **2,479,173** bed days available for admission).

In 2017-18, Toronto Central LHIN's total budget transferred to health service providers was $4.84 billion. Hospitals accounted for 83 percent of Toronto Central LHIN funding, followed by long-term care homes at six percent, the community mental health addictions program at three percent, and other community agencies at eight percent.

STRATEGIC PLAN FOR 2015-2018

Since 2015, the priorities for the Toronto Central LHIN as articulated in the Strategic Plan have been as follows:

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

The strategic priorities that guided our investments and activities to drive the reforms needed to achieve our goals have been:

I. Designing Health Care for the Future
II. Taking a Population Health Approach
III. Transforming Primary Health and Community Care
IV. Achieving Excellence in Operations
V. Leading and Supporting Our People*

The Strategic Plan was updated following the merger of the Toronto Central LHIN and the Toronto Central Community Care Access Centre in June 2017 to include the fifth Strategic Priority: "Leading and Supporting Our People." This pillar reflects the essential role of the LHIN's workforce to successfully meet our legislative, mandated and business objectives.

The graphic below illustrates the strategic direction that we have been operationalizing since 2015, with the new addition of "Leading and Supporting Our People" in 2017.

Strategic Updates: Designing Health Care for the Future

Our 2015-18 Strategic Plan has created a solid foundation for us to accelerate transformation. Beginning in the Fall 2017, we began the engagement process to develop our new Strategic Plan for 2018-22. Over the past eight months, we have focused heavily on engagement with our health system and non-health system partners, our staff, and - most importantly - our clients, patients and communities to understand what is most important to them.

Some highlights of our engagements include: completing an internal engagement with more than 200 staff, from frontline to the senior management team; hosting sessions focusing specifically on health equity (such as Indigenous leaders and Francophone communities); community engagements to connect with the diverse population we serve (seniors, LGTBQ, residents from marginalized/vulnerable neighbourhoods, etc); and regular monthly engagements with our Citizens' Panel and with our Home and Community Care Patient and Family Committee.

This extensive engagement has provided us with significant themes that have served as key inputs into our new Strategic Plan.

For example, the people from which we heard told us the following were most important to them:

- coordinated community and primary care close to home
- excellence in specialized care and continuous improvement
- population health and equity
- integrated health care, meaning a connected system of care that is seamless for the patient

We are committed to delivering on what matters to people, and these commitments, along with our new vision and mission, will be launched with our new Strategic Plan in 2018.

Reintegration Care Model

RCM HEALTH SERVICE PROVIDERS:

1. UHN / Hillcrest Reactivation Centre
2. UHN / St. Hilda's
3. Woodgreen Community Services
4. The Rekai Centres
5. Bellwood Centres for community Living
6. Etobicoke Services for Seniors
7. LOFT Community Services
8. Reconnect Community Services
9. The Neighbourhood Group
10. West Neighbourhood House
11. Providence Healthcare
12. West Toronto Services for Seniors
13. Storefront Humber
14. Sunnybrook/LOFT/SPRINT

In October 2017, Toronto Central LHIN submitted a proposal to the Ministry of Health and Long-Term Care for funding to support the testing of a range of short-term transitional care models. These were intended to safely address the needs of patients designated or at risk of Alternate Level of Care (ALC) in settings outside of hospitals, while ensuring that the solutions comply with current regulations, legislation, and ministry policies.

The successful proposal resulted in the opening of more than 203 funded "spaces" as part of the Reintegration Care Model initiative, which involved the testing of a series of Reintegration Care Models (RCMs) designed to support the transition of patients designated as ALC or at risk of becoming ALC from Toronto Central LHIN hospitals.

The LHIN worked with thirteen community agencies in the pilot project that tested reintegration care units (as well as a range of services focused on supporting caregivers known as Caregiver ReCharge Services (i.e., in- home respite; overnight respite away from home; and Adult Day Program)

Between November 15, 2017 (the official start date of the RCM pilots) and March 31, 2018, the total number of patients admitted to RCMs (clinical and personal care units including UHN St. Hilda's) was **323**. As of March 31, 2018, **223** of these patients had been discharged.

Development of a centralized referral process helped to streamline processes improving the ease of referrals by hospitals and helping RCM providers consider how to then reallocate some of their resources to support patients/families.

It is believed that RCMs have contributed to reducing the ALC rate in Toronto Central LHIN:

- From October 31, 2017 to February 28, 2018, the number of patients designated ALC decreased by 80
- Many of the 323 patients admitted to the RCM programs were designated ALC upon arrival
- A portion of the programutilization of 13,185 days can be directly translated to ALC days saved

The RCMs also supported successful discharge from the RCM back to the community. The majority of patients transitioning from RCMs were discharged to a community setting:

- Only 18% of patients admitted to clinical care RCM programs
- 5% of patients admitted to personal care RCM programs were discharged to an acute care setting

Funding for fiscal 2018-19 has been confirmed, so looking ahead we will be focusing on refining the reintegration care models by reviewing the impact of each model, determining which patients are not currently being served, and understanding which models of care are having the most success.

Mental Health and Addiction Services

In 2017-18, the Toronto Central LHIN developed a mental health and addictions action plan in consultation with providers, partners, and clients to align work streams across the LHIN and include a focus on problematic substance use.

5 new hospital-based Rapid Access to Addiction Medicine (RAAM) clinics where patients can access medication-assisted treatment five days a week

The action plan was informed through open-invitation consultations with citizens, consumers/survivors, health service providers, and municipal and Ministry of Health and Long-Term Care partners and focused on the following key goals:

- Expand access to structured psychotherapy and supportive housing
- Establish referral networks with primary care providers
- Make access to community mental health services a priority for local planning, in collaboration with community and social service providers and partners
- Support the provincial opioid strategy, and provide support to connect patients with high quality addictions treatment

Key Accomplishments:

- Implementation of five new hospital-based Rapid Access to Addiction Medicine (RAAM) clinics where patients can access medication-assisted treatment five days a week
- Allocated funding for 140 Mental Health and Addiction Supportive Housing units to be implemented in 2017-18 and 2018-19 (rent supplements/supportive services)

- Additional project underway include:
  - Expand primary care-based non-pharmacological pain management programs facilitated by physiotherapists integrated into community health centres
  - Increase front-line harm reduction services for overdose prevention and response work
  - Increase provision of peer support/case management outreach services aligned with LGBTQ youth population (aged 16-29) using substances in the Toronto Central LHIN
  - Increase medical services (NP/RN) within the Withdrawal Management Service setting to meet the needs of those with complex medical and problematic substance use conditions
  - Expand trauma and bereavement supports for service providers on the frontline of the opioid crisis
  - Support overdose prevention and response training, as well as policy/protocol development

for service agencies

- Support the development of an Indigenous-specific overdose strategy for the City of Toronto, in partnership with Toronto Public Health that promotes a culturally safe, comprehensive, and evidence-based plan, in accordance with the operating principles of the Toronto Indigenous Health Strategy

Withdrawal Management and Addiction Medicine (WMAM) Program

The Toronto Central LHIN funded a new Withdrawal Management and Addiction Medicine (WMAM) Program through Anishnawbe Health Toronto (AHT) beginning in April of 2018. The program enables AHT to expand and enhance its current mental health and addictions services, with a new evidence-based delivery model, in partnership with Women's College Hospital's (WCH). This collaborative program will assist in the response to the current widespread opiate dependency crisis.

There are three components to this program:

1. Rapid Access Addiction Medicine Service: immediate crisis-oriented counseling and when indicated, prescription medication for opiate dependency or anti-craving medication for alcohol dependency

2. Medical Detoxification: clients with mild to moderate withdrawal will be treated on site at AHT. Clients with severe symptoms will be transferred to Women's College Hospital's Acute Ambulatory Care Unit

3. Training and Capacity Building: WCH will provide training and capacity building for AHT staff on short and long term prescribing of withdrawal and anti-craving medications. AHT will provide training and capacity building for WCH staff related to cultural sensitivity

Mental Health and Addictions Nursing Program

Toronto Central LHIN also works with Ministries of Health and Long-Term Care, Education, and Children and Youth Services on the Mental Health and Addictions Nursing Program. The primary focus of the program is to help students thrive in school, remain in school or successfully transition back to school. The goal of the program is to provide mental health and addictions supports and services in an inter-disciplinary team with mental health leaders, mental health workers and District School Board staff to children and youth in Ontario's 72 publicly funded District School Boards.

16% increase in overalls tudents referral to the Mental Health and Addictions Nursing Program

The program, available in English and French, supports the Toronto District School Board; the Toronto Catholic District School Board; the French Public School Board (conseil scolaire Viamonde); and the French Catholic School Board - conseil scolaire de district catholique Centre-Sud (MonAvenir).

Program nurses have an average caseload of 20-25 students. They provide support through a wide range of activities including: early identification and intervention for students with mental health and addiction issues; help for students to return to the classroom or community, e.g., from hospital, psychiatric treatment facility or the justice system; and assisting staff and families in understanding medication effects and the possible impact on behaviours and needs in the classroom.

Key Accomplishments:

- Last year, overall 671 students were referred from all school boards, which is a 16% increase from last year
  - 24% increase for Toronto District School Board, and
  - 14% increase for Toronto Catholic District School Board
- All admitted students had an InterRAI Child and Youth Mental Health assessment completed
- Pilot Provincial Mental Health and Addiction Nursing Client Experience Survey
- Forged new partnerships with new stakeholders; for example, Center for Addiction and Mental Health, the Hospital for Sick Children, St. Joseph's Hospital and a community pharmacist specializing in psychiatric medications

Long Term Care Capacity Planning

The Toronto Central LHIN plays a role both in planning for long-term care capacity and in supporting access to long-term care through our placement team who, in fiscal year 2017-18, helped 5,998 people find long-term care beds.

Our Long-Term Care Capacity Plan is intended to help ensure we continue to help people find the long-term care they need. Building on the work started in 2016-17, in 2017-18 we completed Phases 1 and 2 of our plan:

- Phase 1: understanding current resident and client profiles to ensure changing needs are reflected in the recommendations on the size and type of services necessary to meet current and future LTC resident needs.
- Phase 2: developing a mitigation plan to address LTC bed capacity challenges to maintain current LTC bed capacity through redevelopment solutions and identify where current needs could be met through investments in other suitable places of care for seniors.

In addition, Toronto Central LHIN responded to the Ministry of Health and Long-Term Care's call for applications from interested parties for new long-term care bed capacity across Ontario in February 2018.

Toronto Central LHIN participated in the evaluation of applications, which were reviewed and prioritized by a cross-LHIN evaluation team using the provincial evaluation template and local evaluation criteria.

Six applications from Toronto Central LHIN are moving forward to the next stage in the ministry process – representing a potential 975 new long-term care beds. These applications are from new and existing operators, and include new Indigenous and culturally specific long-term care capacity.

Engaging Citizens in Program Delivery and Design

Toronto Central LHIN strives to improve the patient, client, and caregiver experience for those who live, and receive care, within our catchment area. Through initiatives targeted at ensuring the patient voice and citizen needs are captured in our planning and delivery of health services, we endeavour to design and support the implementation of a care system that is informed by patients/clients and caregivers.

In 2017-18 we strengthened how we ensure we are listening to patients and families by:

- Refreshing the existing Citizens' Panel by recruiting six new members
- Having citizens as co- chairs, increasing frequency of engagements, and strengthening LHIN accountability to the panel by reporting back on how citizen feedback is being used
- Creating a new Home and Community Care Patient and Family Advisory Committee (PFAC) to help the LHIN improve how it delivers home and community care services

- Engaging the Citizens' Panel in a variety of important projects in 2017- 18, including: the development of the 2018-22 Toronto Central LHIN Strategic Plan; review of the LHIN's maturity model of an Integrated Health Service Delivery Network from a patient perspective; discussion of the ideal state for patient experience; and other key priorities/projects such as secure digital messaging within primary care
- Expanding our pool of citizen advisors, who are people who reside within the Toronto Central LHIN and have indicated interest in contributing to the work of the LHIN by joining working groups, focus groups, or providing individual feedback on projects

The City-LHIN Partnership Agreement

The Toronto Central LHIN and the City of Toronto have collaborated in the past, but in 2017-18 we formalized our partnership with a System Leadership Table, co-chaired by our CEO, Susan Fitzpatrick, and the City Manager.

The System Leadership Table brings together an important cross-section of city leaders (e.g., academic hospitals, University of Toronto, Wellesley Institute). This partnership aims to improve health equity for Toronto's vulnerable and marginalized populations and improve health outcomes. By working together, this table will share data and decision-making, driving system improvement through changes to policy, programs/services, partnerships, research/training/education, and funding.

The City Partnership Agreement included identification of five projects:

- Develop primary care capacity plan

- Create City's Seniors Housing and Services Entity to define an integrated service model at seniors-designated Toronto Community Housing buildings
- Develop seniors vulnerability map to identify opportunities for neighbourhood investments along continuum of seniors care and service supports
- Develop an approach to integrate primary care, mental health and addictions, and social services
- Explore options for a new child and family hub, co-locating pediatric primary care with children's services

Accomplishments in 2017-18 included:

- Inaugural meeting of the System Table in November, which included identification of five projects to improve outcomes for populations identified as priorities: Seniors; Homeless/Under-housed; and Children & Families. In addition, the development of a detailed primary care capacity plan was identified as a priority project for all populations
- More than 150 interviews were conducted with key stakeholders across the City to identify challenges and opportunities related to a City-LHIN Partnership
- Development of the Partnership Agreement, including grounding principles, a shared vision and objectives, and priority action areas

Regional Quality Table

The Regional Quality Table is a partnership between the Toronto Central LHIN and Health Quality Ontario (HQO), with a mandate to: develop and implement an integrated regional quality plan; engage providers in a culture of quality care; improve partnerships; foster innovation; build capacity; and enhance reciprocal communication and knowledge exchange. It is chaired by a Clinical Quality Lead, and has cross-sectoral representation of clinical and quality specialists from all LHIN sectors, patient and caregiver advisors as well as other stakeholders such as Toronto Public Health.

The Table developed a Toronto Central LHIN Quality Improvement Framework to guide its work. The overall goal is improving patient outcomes through new and innovative approaches to quality improvement within our LHIN.

Key Accomplishments:

- Introduced a model to track quality improvement measurement
- In collaboration with the Local Collaboratives and the Improving & Driving Excellence Across Sectors (IDEAS) program, delivered the inaugural Regional Quality Forum in June 2017, which was attended by more than 100 participants, including health service providers

Integration

Integration is a fundamental part of our work at the Toronto Central LHIN. From the beginning Toronto Central LHIN has supported and encouraged integration activity with the goal to produce better outcomes for patients and clients. We believe that advancing the integration of health care services around patients and clients is key to achieving a healthier Toronto.

The four key components of our updated integration strategy are:

- Partnering and sharing accountability for meeting local needs
- Building shared capacity across health service providers
- Setting standards for services, ensuring positive client/patient experiences and outcomes
- Harmonizing funding for services (equitable funding and strengthening accountability)

In 2017-18, there were two full integrations:

- Providence Healthcare, St. Joseph's Healthcare, St. Michael's Hospital
- West Toronto Support Services and Humber Community Seniors' Services

There was also one program/funding transfer:

- Canadian Red Cross transfer of Assisted Living and Attendant Outreach Services to Bellwoods Centres for Community Living

In addition, there were five structured collaborations along the integration continuum.

2017/18 Integrations Summary		
Health Service Providers	**Integration Objectives**	**Integration Date**
Providence Healthcare, St. Joseph's Healthcare, St. Michael's Hospital	Improving care for patients, residents, clients and their families through shared expertise: • Enable consultative approaches within the network to focus bi-directionally through primary care, acute, post-acute, residential and community care • Be able to leverage full spectrum of care to advance alternate level of care (ALC) avoidance and ensure that care is delivered to our patients at the right place, at the right time and by the right providers Harmonizing best practices and services to support care throughout the network: • Enable high quality and safe care • Sustain and reinvest in services to better align care particularly for complex patients and those experiencing disadvantage • Improved access to tertiary and other specialty services • Leverage a comprehensive network of consultation services	August 1, 2017

2017/18 Integrations Summary		
Health Service Providers	**Integration Objectives**	**Integration Date**
	• A common information technology platform that will serve as an enabler of common care pathways, seamless transitions and access to the full continuum of care Improving population health through an increased focus on community partnerships: • Proactive in improving the health of our communities, in order to reduce the burden of illness both in our network and in our neighbourhoods • Better able to follow our patients and caregivers beyond the walls of the hospitals so as to monitor, measure and reconnect, if required • Develop common strategies to engage independent or small group physicians and improve access for patients to resources • Build on existing community partnerships and leverage role as a system player will allow us to improve health and the social determinants of health for the populations we serve to a greater extent	
West Toronto Support Services and Humber Community Seniors' Services	To better serve seniors and adults with disabilities with unmet needs in West Toronto: • Address health equity and reduce gaps by expanding services for underserved populations including Mount Dennis and Rockcliffe-Smythe • Expand services and reduce fees to low-income seniors and adults with disabilities in West Toronto Expand the basket of community services for current clients of both agencies: • Clients can receive more of the services they need through one organization, sooner, without delays and disruptions • A more comprehensive approach to care for seniors and adults with disabilities with a range of needs requiring community and in-home supports Become a more sustainable and efficient organization: • Back office functions will be fully integrated, enhancing operational efficiency, creating economies of scale, and enabling resources to be redirected to service delivery Have greater capacity to innovate and pursue new programs/services, play system leadership roles, and pursue partnerships: • The new agency will offer more professional development and educational opportunities to staff • Working in multidisciplinary teams will help staff meet clients' needs, while enhancing professional satisfaction. Staff will have more resources to draw on for problem solving and client care	January 1, 2018

2017/18 Integrations Summary		
Health Service Providers	**Integration Objectives**	**Integration Date**
Canadian Red Cross and Bellwoods Centres for Community Living	To better serve adults with disabilities • Building capacity and sustainability through like services coming together • Bringing complementary client focused services from both organizations to create the highest level of quality • Create new models of care and innovative partnerships with the broader continuum of care providers Harmonizing best practices and services • Bringing together best practices from two organizations to build a stronger, more consistent service Become a more sustainable organization • Transfer of services will establish a larger footprint of services delivered by Bellwood • Support sustainability of the program and build greater influence on policy related to services for the physically disabled	January 15, 2018

Governance-to-Governance Sessions

Throughout October and November 2017, the Toronto Central LHIN held five Governance-to-Governance sessions across the LHIN. These sessions were an opportunity for boards of health service providers and home care service provider organizations to come together, and meet with Dr. Vivek Goel, the Toronto Central LHIN Board Chair, members of our Board of Directors, and CEO Susan Fitzpatrick.

The meetings provided an opportunity for the LHIN to share our vision for developing integrated service delivery networks and discuss the benefits and realities of a spectrum of integration, as a means to achieve improved outcomes and experiences for clients/patients and communities.

The sessions opened a dialogue on how integration benefits patients and communities. They also included discussion of critical success factors for moving integration forward. Participants were asked to bring the topic of “integration” to their respective boards as a follow up to the meeting. Feedback was overwhelmingly positive, with the majority of participants reporting that they are very likely to engage another agency to discuss the spectrum of integration and that they would benefit from attending another Governance-to-Governance session.

Strategic Updates: Taking a Population Health Approach

Planning across the health care system has generally been focused on meeting the needs of those actively receiving health care. Evidence suggests that adopting a population health approach and proactively planning for the health needs of all people will benefit both patients and the system. Taking an approach where we work to understand our communities enables us to ensure that they have equitable access to health care services. With this approach we are reorienting the work of Toronto Central LHIN towards activities that aim to improve the health status of the population as a whole, as well as its many sub-populations.

Health care is personal and requires tailored approaches to be most effective. Dividing populations into sub-populations assists us in understanding the unique needs and challenges faced by people within those groups and providing targeted care that is required in order to address their unique needs.

The following sections offer a snapshot into the accomplishments of fiscal year 2017-18.

Access to High Quality Palliative Care

Palliative care is the broad approach to providing comfort and dignity for patients and famil

ies who are living with, or at risk of developing life- threatening illness. The Toronto Central LHIN is committed to improving access to the provision of equitable and sustainable palliative care services in Toronto Central. We are uniquely positioned to do this through direct service provision, and also by bringing together service providers that provide palliative care to collectively plan for, and drive palliative care system improvements. Our strategic partnerships and targeted funding are key to enabling palliative improvements.

Providing Palliative Care in the Community

As a service provider organization, the LHIN plays an important role in delivering palliative care to clients in the community. Our Integrated Palliative Care program provides integrated, interdisciplinary team-based care to clients with palliative needs in the community. There is a shared Electronic Medical Record amongst team members, and integration of home visits from physicians, nurses and other members of the team, available 24/7.

INTEGRATED PALLIATIVE CARE TEAMS INCLUDE:

- LHIN care coordinators and nurse practitioners
- Homecare physicians from Temmy Latner Centre as well as Dorothy Ley Hospice
- Palliative nurses and personal support workers from three service providers, St. Elizabeth Health Care, Spectrum Health Care, and SRT Med-Staff
- Volunteers from three hospices and additional homecare specialists (such as pharmacists or occupational therapists) as needed.

Key accomplishments:

- Provided high quality palliative care to 2,672 clients this year, a 5% increase from the previous year
- 89% of clients of the palliative program to die in their place of choice - one of the highest rates of any jurisdiction in the world

Additional Accomplishments:

- 36 LTC homes received specialized palliative care training, quality improvement training, in-home clinical and quality improvement coaching and peer support
- Partnered with eight hospital-based palliative care units and residential hospice to review current bed use, access and improve efficiency for more than 200 hospice beds
- Partnered with Toronto Paramedic Services to enable a call to the palliative home care physician to determine if the client's needs can be met in the home by the team, possibly avoiding a transfer to the Emergency Department.
- The LHIN worked collaboratively with the Toronto Regional Cancer program to bring together a Network of local health service providers and stakeholders to collectively work towards developing a comprehensive, integrated and coordinated system of palliative care

Residential Hospice

In 2016, Toronto Central LHIN was awarded funding for 19 new hospice beds. Development of the new beds began in 2017-18, with four of the 19 opening this year at Journey Home Hospice.

In late 2017-18, Saint Elizabeth Foundation, Inner City Health Associates and Hospice Toronto partnered to open the Journey Home Hospice to improve equitable access to hospice palliative care for Toronto's homeless community in a socially innovative way. Journey Home Hospice provides clients with high quality health care services and a safe, welcoming and caring environment for their end-of-life journey. When fully operational, Journey Home Hospice is expecting to serve approximately 100 individuals annually, plus a much larger network of family, friends and caregivers. Looking ahead, we expect that the remaining 15 new beds will be complete by March 31, 2019.

Creation of innovative **4** bed homeless hospice that will serve **100** people annually.

Right Place of Care

To ensure clients receive the right care at the right time in the right place, the Toronto Central LHIN has been working collaboratively with our partners in the Community Support Sector to match people requiring home care services with the agency best suited to meeting their needs.

The Toronto Central LHIN is now serving more people with higher care needs in the community. Until very recently, many of the people we now support at home would have been receiving care in hospitals or long-term

care homes. In 2017-18 the Toronto Central LHIN has been transitioning the care of clients with lower care needs to community support service agencies to enable the LHIN to focus its resource on those with complex home care support needs.

The services offered through community support service agencies are designed to help clients remain independent and connected to their community. The community support service agencies adhere to the same quality of home care services as the Toronto Central LHIN.

In 2017-18 we collaborated with more than 13 community support sector agencies to smoothly transition over 260 clients to the right place of care. Our partners included: Woodgreen Community Services, The Neighborhood Group, SPRINT, West Neighborhood House, Store Front Humber, Etobicoke Services for Seniors, West Toronto Services for Seniors, Reconnect: West Toronto Support Services, LOFT, Bellwoods: and PACE.

Neighbourhood Data Profiles

The Toronto Central LHIN created neighbourhood profiles based on demographic, living circumstances, disease prevalence, screening, and health care utilization data.

The profiles present a comprehensive description of Toronto Central LHIN's 73 neighbourhoods to inform planning within the LHIN and by LHIN partners. The profiles also enable us to target deeper dives within the neighbourhoods to support the identification of priority areas. The profiles were published publicly on the Toronto Central LHIN website, allowing the data to be easily used by a wide range of audiences (health system providers, community providers, health organizations, other government) for their own purposes.

Toronto Public Health (TPH) and Toronto Central LHIN also established a population health assessment partnership, considering shared priorities and identifying indicators that could be used to measure the health and health related needs of the population. Looking ahead, planned initiatives for the partnership include: developing a needs-based health assessment and analysis as a component of the population health strategy; focused data analysis to support local planning; and the data sharing or knowledge transfer of any analyses, frameworks, inventories or tools developed or finalized during the partnership.

Integrated Health Service Delivery

We are partnering with East Toronto sub-region leaders to provide direction as a living lab for improving integration in the Toronto Central LHIN. The East Toronto Integrated Health Service Delivery Network involves health system leaders, citizens, and researchers from the Dalla Lana School of Public Health (University of Toronto) to explore how local health services could be better coordinated to improve health outcomes, patient experience, and value.

Progress in East Toronto will inform future implementation across the rest of the LHIN. To ensure progress is manageable, we are phasing our improvement approach in three parts:

- Creating a network accountable for implementation
- Partnering with social care
- Aligning services across LHINs

To move network building forward, we have launched advisory tables to establish priorities for integration, and we have launched a focused leadership table in East Toronto to establish shared accountability and governance.

Initial leadership includes Michael Garron Hospital, Providence, Woodgreen Community Services, Flemingdon Health Centre, Toronto Public Health, Citizen members, Health Quality Ontario, and VHA home care.

Indigenous Population

The Toronto Central LHIN is committed to ensuring engagement with Indigenous leaders, providers and patients to guide investments and initiatives. Our main vehicle to achieve this goal is through our continued partnership with the Toronto Indigenous Health Advisory Circle through Anishnawbe Health Toronto and Toronto Public Health (TPH). The Toronto Indigenous Health Advisory Circle (TIHAC) is a group of dedicated Indigenous community leaders in Toronto who provide recommendations to the Toronto Central LHIN, as well as Toronto Public Health, on improving health outcomes for Indigenous people in Toronto.

In 2017-18, the Circle continued to move a number of initiatives forward from the 5-year Indigenous Health Strategy. In addition to regular meetings, the TIHAC came together for a strategic planning session in October and hosted a community update in March. The TIHAC youth collective also hosted their first ever Toronto Indigenous Youth Conference to increase the capacity of youth leadership and to promote wellness amongst urban Indigenous Youth. This conference took place in March 2018 through funding from the Toronto Central LHIN and Toronto Public Health.

The Toronto Central LHIN advanced a number of recommendations from the Toronto Indigenous Health Strategy in 2017-18. These include:

- Ongoing completion of the Indigenous Cultural Safety training by health service providers throughout the Toronto Central LHIN
- A specific Indigenous Opioid strategy to complement the Toronto Opioid Strategy
- Funding a palliative care harmonization strategy and pilot project

Indigenous Palliative Care:

The Toronto Central LHIN provided funding for an Indigenous traditional healer and a patient navigator as part of a new Indigenous Palliative Care Model, which harmonizes Indigenous and western/mainstream palliative care delivery. Anishnawbe Heath Toronto (AHT) designed the project with the help of a Palliative Care Committee. The program is was co-designed with patients, families and caregivers in the community to ensure the provision of traditional healing practices and treatments while continuing access to mainstream palliative care services and is part of the recommendations of the Toronto Indigenous Health Advisory Circle through the Toronto Indigenous Health Strategy.

Two-Spirit/Trans Community Program

In 2016, a need for Indigenous-led supports in the Two-Spirit community was identified through engagement with our LHIN Citizen advisors. Following consultation with the Toronto Indigenous Health Advisory Circle and aligned with the Toronto Indigneous Health Strategy 2016-2021, Toronto Central LHIN engaged Anishnawbe Health Services, community members and partners to identify gaps and co-design a program that would support improved health outcomes. In 2017, the Toronto Central LHIN provided funding for a Two-Spirit support counselor as well as a Two-Spirit safe healer/ elder position. These new positions provide new counseling and peer support services to address the lack of appropriate and culturally safe health services for Two-Spirit individuals.

The Indigenous population has a high proportion of LGBTQ who may be further marginalized – 23% identified themselves as Two-Spirit and 9% identified their sexual orientation as bisexual, Gay or Lesbian.[10] Youth are another vulnerable group – it is estimated that 21% of youth in Toronto shelters identify as Lesbian, Gay, Bisexual, Transgender, Queer, Two- Spirit (LGBTQ2S) and many do not feel safe due to discrimination and violence in shelters.[12] Toronto Central LHIN has co-designed and funded the Two-Spirit/Trans community program.

Training in Active Offer of French Language Health Services

In 2017-18, Toronto Central LHIN supported the delivery of further training opportunities about *Active Offer of French Language Health Services* to the Francophone community and its relevance in supporting the delivery of culturally competent care within Toronto Central LHIN.

Partners Reflet Salvéo, Les Centres d'Accueil Héritage (CAH), Health Nexus, and Collège Boréal teamed up in offering a cost-free, three-day workshop to provide health service providers and managerial staff with practical tools and strategies to adopt a systemic approach to the offer of French Language Health Services. The project delivered the in class module to 36 participants.

Francophone Cultural Competency Training

The Francophone population living or receiving care in the Toronto Central LHIN has specific cultural and linguistic characteristics and challenges. To better serve this population, health service providers across all sectors need to better understand the distinctive cultural and linguistic characteristics and gain competence to deal with patients from that community. The LHIN partnered with *La Passerelle IDÉ*, a leading Francophone agency with a track record on cultural competency training, to develop this important initiative.

Toronto Central LHIN rolled out the fourth installment of learning opportunities for health service providers and Service Provider Organizations serving the Francophone population. All health service providers were required to encourage staff to enroll and attend cultural competency training to ensure they deliver culturally and linguistically sensitive care to French-speaking patients. In total, 161 participants have been trained.

Respite, Recovery and Transitional Beds for Francophone Seniors

Les Centres d'Accueil Héritage (CAH) requested the LHIN's support to dedicate one of its affordable housing units specifically to respite, recovery and transitional services.

The purpose is to be able to offer respite to the caregivers of our francophone clients across the community, as well as to be able to look after those clients who are transitioning from the hospital back home, and those who are waiting to be admitted to long-term care and are unable to remain safely in their homes.

In 2017-18, Toronto Central LHIN funded the proposed model that will operate by building specific partnerships with acute care facilities and partner agencies and bring together primary care, community support services and home and community care.

Looking ahead, the new respite unit is launching in 2018-19 and once we are able to evaluate utilization, Toronto Central LHIN and CAH will look into spreading and scaling the newly created service for Francophones and integrate it within the broader Toronto Central LHIN Respite Care Model network.

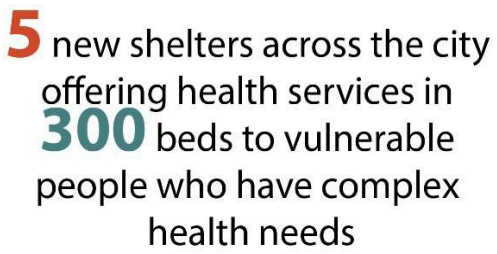
Homelessness

As of May 2018, the City of Toronto had 76 emergency and transitional shelter locations, and eight motel programs. The majority of the shelters are in Toronto Central LHIN. Overall, the Toronto Central LHIN has 81% of the total capacity of spaces in the City of Toronto (i.e., 3,601 of 4,428 available shelter spaces). Of the 64 shelters located in the LHIN, 40 of these are designated as emergency shelters (885 spaces), and the remaining 24 shelters (2,716 spaces) are transitional. Nearly half of all shelter spaces in the Toronto Central LHIN are designated for men (49%), 17% are for women, 13% are for families, 11% for youth, and 9% are for mixed adult.

There has been an increasing demand for shelter spaces within the City of Toronto. According to the City of Toronto projections, by November 2018 refugee claimants will represent nearly 54% of the City's shelter population. Given this higher demand, the city will keep emergency spaces open to accommodate the population.

Improving Access to Health Services for the Homeless Population

In January 2018, a new collaborative approach to improving access to essential health services for the homeless was announced by Ontario and the City of Toronto. Beginning in five new shelters across the city, this new approach provides more than 300 beds to vulnerable people who often have complex health needs and offers improved access to primary care and mental health supports for people who are homeless or using shelters in the City of Toronto.



Alex Zsager, co-chair of the Toronto Central LHIN's Citizens' Panel, spoke to his lived experience in homelessness as part of the announcement.

In addition, a new advisory committee of shelter operators, shelter users and health service providers has been created to provide ongoing advice on improving access to health services for shelter users.

Strategic Updates: Transforming Primary Health and Community Care

The LHINs are now a single access point to all publicly-funded home and community care services in Ontario. LHIN Home and Community Care staff work in a range of care sites including homes, clinics, emergency departments, hospitals, schools, long-term care, and family health teams. LHINs now deliver a broad range of care to support people to transition home after a hospital stay, live safely at home, attend school with health care supports, move to long-term care when needed, and to die in their place of choice with supportive end-of-life care.

The number and complexity of people receiving home and community care services is increasing. In fiscal year 2017-18, Toronto Central LHIN care coordinators assessed a total of 100,892 clients, a 2% increase over 2016-17.

The in-home clients are older and more complex. 48% of clients received short stay services (Acute and Rehab services), 47% received long stay services (Maintenance and Long Term Supportive care) and 5% received end-of-life care. Furthermore, there was a 7% increase in the number of home care complex clients with a Resident Assessment Instrument (RAI) score of high or very from 5,464 (April 2017) to 5,840 (April 2018). There is also need to support caregivers of home care clients; as of May 29, 2018, over one-third (34%) of clients who had a RAI assessment reported caregiver distress.

Toronto Central LHIN will continue to implement our Integrated Community Care strategy. Leveraging the work that began in late 2016 bringing together primary care providers, mental health and addiction, and community support and home care services, in partnership with clients and families to co- design a system of care that is easier to access and navigate.

Musculoskeletal (MSK) Models of Care

Musculoskeletal (MSK) Models of Care has been identified as a top strategic priority in an effort to transform MSK care in Ontario. To accomplish this, all the LHINs across the province had to scale, spread and integrate proven service delivery models such as Rapid Access Clinics (RAC) for Hip and Knee Arthritis.

In 2017-18, the Toronto Central LHIN planned for the expansion of the MSK Rapid Assessment Clinics for hip and knee arthritis to three hospitals – University Health Network, Michael Garron Hospital and St. Joseph's. Looking ahead, full implementation of the model at these three hospitals will occur in 2018-19.

As well, the Toronto Central LHIN worked on the development of patient pathways for the conservative management of knee and hip osteoarthritis, and secured $2.9 million in funding to develop and implement a Conservative Management of Hip and Knee Osteoarthritis pilot project across three LHINs (Toronto Central, Champlain, and North West) to allow for planning at both the provincial and local level.

Key Accomplishments:

In Q3 the Toronto Central LHIN exceeded our target of 90% of priority 2, 3, and 4 hip replacement and knee replacement cases being completed within access targets:

- 91.8% of priority 2, 3, and 4 hip replacement cases were completed within access targets
- 91.51% of priority 2, 3, and 4 knee replacement cases were completed within access targets

Met the 2017-18 Accountability Requirements for Hip and Knee Replacement Surgical Volumes being registered in Central Intake.

Home and Community Care

The Toronto Central LHIN provides home and community care services through directly funded staff (care coordinators and some nurses) and contracted services through 22 Service Provider Organizations (SPOs). We provide care coordination services in the community and during transitions from one part of health care system to another, assisting clients and their families while navigating the health care system and helping with information and referral to other resources in the community. We want the people we serve to be able to remain in their homes safely, and a range of specific programs and services (outlined below) are in place to support that goal.

Nursing Clinics

The Toronto Central LHIN has three ambulatory clinics across its geography to provide quick and easy access to specialized nursing services such as Intravenous (IV) therapy (including chemotherapy disconnect), wound consultation and treatment, ostomy consultation and skin care and Foley catheter changes. These nursing clinics, which operate seven days a week, 365 days per year, provide intervention and education and are an efficient method of providing cost-effective nursing care to clients who are able to access the clinic sites. Looking ahead, a fourth clinic is under development for 2018-19.

3 nursing clinics, which operate seven days a week, 365 days per year.

For many clients, clinics are the most appropriate option, so in August of 2017 we began promoting a Clinic First philosophy, which resulted in clinic utilization increasing over the course of the year. In August, 6.6% of Toronto Central LHIN's monthly nursing visits occurred in the clinics; by March 2018 that number had grown to 9%.

Looking ahead, as part of our ongoing efforts to increase client accessibility to clinics, we are expanding clinic locations and activities to support referral practice to the clinics. This work will be done collaboration with GTA-LHIN Nursing Clinics, health service providers and Community Support Service Agencies.

Wound Care

An extensive wound management program for clients was launched in 2015 with the aim to ensure that best practice guidelines for wound care would be implemented. This work has continued into 2017-18, including audits, new reporting requirements and bundled care pathways to improve treatment outcomes. This past year we continued to focus on reducing the overall length of stay and utilization of wound care clients to increase best practice and fiscal accountability. Our initial wound care clientele had an average length of stay of 44 weeks and this was reduced to 22 weeks. We continue to work towards further improvement. Through collaboration and partnership with our service providers, we have worked together to increase the use of standardized guidelines for wound care.

We have also increased the number of consultations to enterostomal nurses and wound specialists. This

collaboration improved best practice for Toronto Central LHIN clients and promoted a more integrated approach to wound care. This past year also reflected a greater emphasis on documentation with notable improvements in wound care electronic reporting to ensure improved data integrity.

This project also aims to establish an electronic measurement and reporting system on the clinical outcomes and variances for clients with chronic wounds.

Toronto Seniors Helpline

In 2017-18, Woodgreen Community Services and the Toronto Central LHIN successfully integrated a number of existing services to create the new Toronto Seniors Helpline, a phone line that streamlines access to community, homecare and crisis services for seniors, their caregivers and their health care providers through one single number.

Staffed by certified professionals, Toronto Seniors Helpline offers free assistance navigating the health care system, and provides warm transfers to partners as well as standardized assessments.

During 2017-18, there were 16,992 incoming calls with 13,286 answered immediately (an average of 1,107/month) and others returning the voicemail within 24 hours. We increased the number of calls answered live by an average of 184/month.

These calls generated a total of 1,349 crisis assessments, 7,893 non-crisis assessments and 1,064 electronic assessments for community support services, for a total of 10,306 assessments.

Integrated Community Care

The Integrated Community Care (ICC) Strategy is a Toronto Central LHIN initiative to transform home and community-based care to operate as one integrated system of care.

The project is led by the Toronto Central LHIN through the Integrated Community Care Council (the ICC Council), which comprises community leaders selected through an expression of interest process. The ICC Council provides system and implementation leadership of the strategy. The work is informed by the input of more than 200 clients and family members, care providers, community partners, and health leaders who participated in a summit in 2016 to explore ideas to enhance our system of care. They identified core areas of focus that included improvements to client experience and ways to increase system efficiency. The Identified areas of focus were then turned into action focused areas: Simple and Coordinated Access, Capacity Management and Flow, and Common Screening, Referral and Assessment.

Work was based around a set of high use/high-resource core services and was implemented with an eye to cross-sector integration.

Key accomplishments:

- Development of a single integrated service-needs screener that will ensure individuals can be consistently referred to other services they may need
- Improvements in access to mental health (Intensive Case Management and Assertive Community Treatment Teams) and seniors services (Meals on Wheels and Adult Day Program services) within the Toronto Central LHIN. Health service providers committed to access targets for 2018/19 to increase access for these services
- Sharing of best practices on practical approaches to improve system capacity and flow across different provider agencies
- The connection of 83% of addiction providers to an existing coordinated access point that will improve how individuals with addictions issues are connected to supports
- Development of a directory of immediately available and low-threshold addiction services for individuals contemplating seeking service and/or waiting for services

In the second year of operation, the ICC Council is focusing on standardizing care to ensure positive patient experiences and equitable access to care. With standards in place, we will be better able to align services at the community level.

Complex Care

In November 2016, the Toronto Central LHIN fully aligned the Health Link approach to the Primary Care Strategy and integrated historical Health Links under the leadership of local Primary Care Clinical Leads. For 2017-18, the planning for Health Links activities was fully incorporated into the Primary Care work plans for each sub-region.

A key component of our work in complex care is the creation of Coordinated Care Plans. The LHIN has Transitional Care Coordinators to support the creation of these detailed care plans, which are also a living document that require regular review and updates driven by changes to the patient's status. These plans serve to streamline coordinated, collaborative approaches to meeting the patient's goals and support holistic care across programs, organizations, and sectors. In 2017-18, we completed over 1,000 Coordinated Care Plans.

Primary Care

Toronto Central LHIN has established a core network for engaging primary care providers in planning and designing a health system that incorporates and integrates primary care. Within each of our five regions, a primary care provider has been identified as the LHIN's Primary Care Clinical Lead (PCCL) and they chair local Primary Care and Community Care Committees. These committees consist of primary care providers who practice across different models of primary care and provide services to a diverse population, coupled with representatives of the mental health, home and community care, and community support service sectors.

Inter-professional Team - Improving access to Primary Care

Oakridge (East Toronto)

- One full-time registered nurse and three full-time social workers to work with an existing primary care physician serving high needs patients in one of the Toronto Community Housing Apartments in the Oakridge Neighbourhood
- The clinic is fully operational and staffed, serving residents within the Community Housing Units
- The clinic is expected to serve approximately 800 unique patients per fiscal year, of which it is expected that at least 50% will be clinically complex

Mount Dennis/Rockcliffe Smythe Inter-Professional Health Team (West Toronto)

- Partnering with Unison CHC to service high needs patients in the Mount Dennis/Rockcliffe Symthe Neighbourhoods to those whose main primary care provider is in a fee-for-service model and whose clients do not have access inter-professional service
- The clinic is fully operational and is expected to serve approximately 600 uniquepatients

Health Access Thorncliffe Park (HATP) – (East Toronto)

- Health Access Thorncliffe Park (HATP) inter-professional team model expanded its operations from a two day per week clinic to five days per week and relocated its clinic to the lower level of the East York Town Centre. The mall is a central location to the community and HATP is expected to relocate to the larger community hub anticipated to open within the East York Town Centre in 2020
- The model is designed to be a complement to existing primary care services provided in the community, including providing much needed inter-professional team care that is available to practices within the neighbourhood who currently do not have access to these services
- HATP is an innovative partnership with Flemingdon CHC (a health service provider) and The Neighbourhood Office (a community service provider) to provide holistic health and social services to the community
- HATP is expected to serve a minimum of 1,600 registered patients

Access to Specialized Services

Access to specialized services is a key strategy to complement our sub-region and population health strategy. Through our partnerships with primary care, community and hospitals, Toronto Central LHIN aims to model a consistent approach and method, to improve access specialized services for appropriate patients within the LHIN and those who access these services across the Greater Toronto Area (GTA) and the province.

SCOPE (Seamless Care Optimizing the Patient Experience)

In 2017-18, Toronto Central LHIN expanded the highly regarded SCOPE program (Seamless Care Optimizing the Patient Experience) from its successful implementation at University Health Network Hospital to West and Mid East Toronto via St. Joseph's and St. Michael's Hospitals respectively. SCOPE provides primary care physicians with a single point of access to select hospital and community resources including;

- Access to a General Internal Medicine Specialist and a Radiologist to determine urgency and seek clarification and advice on treatment options within a brief timeline
- Access to a System Navigator for information and connection to hospital and community resources/services
- Access to a Toronto Central LHIN Home and Community Care Coordinator to obtain information on services a patient is receiving, and if needed to gain expedited access to Home and Community assessments and services

In West Toronto, the SCOPE program is targeting approximately 27% of practicing family physicians to be on-boarded into the program and Mid-East Toronto is targeting approximately 10% of practicing family physicians within the fiscal year 2017-18.

Digital Health Strategy

The purpose of a digital health strategy is to identify clear digital priorities, as well as define an approach for how to deliver on those priorities in order to support a healthier Toronto for citizens through seamless care built on a connected digital ecosystem.

In alignment with the Toronto Central's LHIN's mandate letter, key goals include:

- Information flowing freely for more coordinated and integrated patient care delivery
- Accessible data and information, that supports continuous quality improvement at the front line and for system planning
- Primary care practices that are connected with the system and patients, communicating securely about their health
- Deeply integrated technology infrastructure within our sub-regions and care communities, and
- An economically viable, and sustainable digital environment

The work plan and activities will be achieved over a multi-year period with progressive milestones that work towards greater digital connectivity across the region.

In the past year, we have established the Toronto Central LHIN Digital Health Advisory Council (DHAC), with membership that includes: Chief Information Officers/Executive Directors; Ministry of Health and Long-Term Care; physicians; CEOs from Provincial Agencies; patients; and other leading experts. Confirmed as one of two early adopter regions for provincial regional delivery model. The strategy has also achieved various digital project milestones, including:

- Successful expansion of MyChart to two additional organizations
- Increased adoption of HRM contribution from hospitals (4 sites)
- Signed partnership MOU with eHealth Ontario and OntarioMD to initiate work to rollout bundled technology (ONE mail, eConsult, and Connecting Ontario) to primary carephysicians
- Initiation of Specialist Directory and Electronic Coordinated Care Plan (eCCP) initiatives

Looking ahead, we are currently engaged in:

- Implementing of the Toronto Central LHIN Digital Delivery Centre of Excellence
- Defining key initiatives within identified priority focus areas, including enabling seamless transitions and giving patients access to their information and providers
- Continuing implementation activities for priority projects, including Specialist Directory rollout, ONEID bundle implementation, and eCCP)

Strategic Updates: Achieving Excellence in Operations

The Toronto Central LHIN is continually striving to strengthen our own capacity. Over the past decade, the LHIN model has matured, evolving over time from simply carrying out the management of contracts for the provision of health care services to an organization that is leading data-driven planning for the populations we serve.

Toronto Central LHIN has a proven track record of leveraging emerging technology and building analytic capacity to carry out effective planning. We believe that to effectively manage the health care system, we will need to continue focuse on operational excellence in areas such as the following:

CHRIS Refresh

Client Health Related Information System (CHRIS) is an important tool that provides infrastructure to support integrated service delivery and the movement of clients between LHINs. Enhancements to CHRIS were released by Health Shared Services Ontario in 2017-18 to upgrade the program with new features that include:

- Enhanced Coordinated Care Plan developed by Health Quality Ontario, allowing access through the Health Partner Gateway platform to external partners to view and update the CCP for Health Links patients
- Introduction of One CHRIS, a single shared patient profile that can be accessed by all LHINs to ensure clients have a unique record within CHRIS
- InterRAI HC, a modernized assessment tool with associated algorithms to support long-term care placement and personal support worker service ordering

Key Accomplishments:

In supporting the roll-out of the enhanced CHRIS tool, the Toronto Central LHIN managed:

- Significant technology changes and software releases, including technical release management
- Comprehensive testing
- Business process change management
- Staff training, communication and post-release support

interRAI – HC Implementation

In 2017-18, all LHINs transitioned from using the Resident Assessment Instrument – Home Care (RAI-HC) to a new, up-to-date standardized assessment tool, the interRAI Home Care (HC). This tool is designed to be a user-friendly, reliable, person-centered system for assessing a person's needs, strengths, and preferences. It includes revised Clinical Assessments that are evidence-based, in addition to many clinical outcome scales that consider factors like a person's need for support with activities of daily living, cognitive status, level of pain, risk of adverse outcomes, mental health, medications and many other factors. All of these outputs will help guide home and community care decision-making, and will inform Toronto Central LHIN Care Coordinators in developing individualized service plans for clients. This tool will serve to promote more equity and fair distribution of services to clients on a province-wide basis.

The project required work at both the local and provincial levels to ensure successful implementation, transition and adoption. It required the development of an extensive change management strategy, including training for staff; and a carefully executed technical implementation plan.

Improving Digital Communications

In 2017-18, the Toronto Central LHIN enhanced our digital presence by better utilizing our corporate website as a digital communications vehicle, building our social media channels by engaging on Twitter and communicating directly with our health service providers through a bi-monthly e-newsletter.

Integration of Internal and Corporate Websites

Prior to transition, a review of policies and organizational team pages was undertaken and TCNet (our internal website) was refreshed to better reflect the new organization. This work will continue in 2018-19 as we continue to improve our web presence. A pre-transition milestone was to integrate the home and community care content into the LHIN's corporate website. This interim solution was completed successfully and on time, and plans are now underway for further enhancements to the site so that it will provide an optimal user experience. To achieve this, we will engage our Home and Community Care Patient and Family Advisory Committee to update content and design to improve the user experience, including making it easier for people to find information about services.

In the last fiscal year, the LHIN's corporate website has seen the following updates:

- Onboarding of legacy CCAC information through the home and community care tab with an estimated 30 webpages updated to reflect the change in organizational leadership
- Completed more than 500 updates to the website, including creating sub-region pages, a new palliative network section, integration knowledge station, regular updates to the CEO Message and more. Also, ensured communications are compliant with all necessary requirements, including Accessibility and translation standards
- In the last fiscal year, the website was visited by 67,301 returning users which is an 11% increase (or nearly 10,000 users), we have also seen 66,053 new users and experienced 270,458 page views

Health Service Provider Supplemental Information Initiative

The Health Service Provider Supplemental Information Initiative was launched to collect and collate data around service delivery, including hours of access, geography served, service delivery locations, populations served, specific conditions targeted, funding by other organizations, and quality improvement capacity. These data were first collected in February of 2017. Both the Toronto Central LHIN and health service providers recognized that comprehensive data would be of great benefit as it would allow for informed, data-driven planning and integration sessions and considerations, improved service coordination amongst HSPs and deeper local neighbhourhood analyses.

A submission form was circulated to 143 HSPs, with 140 of them returned (99%). This data was compiled and shared with HSPs. We have used this data to help produce sub-region service profiles and various analytic products, and inform planning activities and/or ad-hoc requests.

Centre for Addictions and Mental Health (CAMH): developer and caretaker of the LHIN-funded business intelligence platform known as HSP360 provides interactive dashboards to showcase the information, and houses the new data submission form and data collected.

Financial Excellence

In fiscal year 2017/2018 Finance successfully delivered against all strategic and operational performance measures including the delivery of a balanced budget of Toronto Central LHIN operations, clean audit for the organization, fully implemented Auditor General's recommendations in investments, exceeded target by delivering 96% of funding letters within 10 working days and completed all Ministry reporting requirements including Program Review Renewal and Transformation Report for staffing and operating budget planning.

Funding Management System

Following the Auditor General's recommendations Toronto Central is the leading LHIN to design and implement a Funding Management System (FMS). The FMS centralizes streamlines the complete funding management process from initiating funding requests to final reporting to Finance and Audit Committee. The FMS increases quality control and provides a more transparent and standardized process through the ability to rank business cases and prioritize funding requests against criteria aligned to the PAN-LHIN Decision Making Framework for funding decision making. This FMS also increases visibility to health service providers as they are able to view and track their funding and performance information through real-time reporting ensuring accountability of the use of funds.

Strategic Updates: Leading and Supporting Our People

Integrated People and Culture Plan

The Toronto Central LHIN, and everyone who works here, has an important role to play in improving the lives of the people we serve by improving their health and experience of health care. That is why it is a priority for the LHIN to support the full potential of all members of our team by investing in their learning and development, and in staff engagement.

Providing positive encouragement is key to building a vibrant culture and a quality work environment that will support both the success of individuals and of the organization as a whole.

In addition to a formal recognition program and strengthened engagement activities such as an employee pulse survey, the organization launched a number of initiatives to support staff development and engagement, both as part of the transition to the merged organization and as part of our ongoing operations.

Key Accomplishments include:

- Aligned and integrated: payroll and benefits; recruitment practices and processes; our Learning Development and Support Policy; and our HR Policies and Procedures to build the foundation to enable the organization to support its people strategies
- Focused on Labour Management Relations. A positive labour relations environment is key as the organization reviews structures, processes, and people practices to align organizational capacity to business strategy
- Developed a robust Performance Management process, aligned with organizational mandate, strategic directions, values and fiscal responsibility
- Delivered mandatory training identified as part of transition (e.g., Ethics 101, WHMIS, Privacy, Travel and Meal Expenses)

Development of Organizational Values

Values provide the foundation of how an organization delivers on its strategic plan, and so a critical focus for us has been the development and implementation of a plan to gather meaningful feedback from staff and management to create the candidate value themes, and behavioural anchors. Looking ahead, these values are now in the final stages of approval, and will be launched as part of the implementation of the new Toronto Central LHIN Strategic Plan in 2018-19.

Information Technology

In support of the transition, significant technical work was required to create an integrated IT environment for the new organization. The two organizations that came together to form the new Toronto Central LHIN

had separate networks, policies, security standards, and help desk support models; different shared services models; different hardware and software standards; and separate intranet and internet models.

Having an integrated network and domain was a critical first step to full organizational integration, to allow seamless movement of staff between physical sites and co-location of integrated teams; enable integration of the email and telephone systems; and provide one-stop access to support for all information technology tools.

The project deliverables were a single IT environment for all staff, continuity of access to existing systems, and compliance with provincial and local security requirements.

Key Accomplishments include:

- Creation of harmonized IT policies and procedures and integration of network environment at all four sites
- Migration to a single user name and password for all corporate applications
- Support of migration of provincial assets including CRM, SharePoint/LHIN Portal, Finance and HR systems, and external websites
- Consolidation of Help Desk function for all staff, training orientation for all staff on new policies and procedures

Communications in Support of Change Management

The Toronto Central LHIN renews its internal and external communication plan on a yearly basis. As our organization has changed, our communication channels and resulting tactics have broadened as well. Last year, we focused on updating and strengthening our internal communications channels to ensure that staff were well supported through transition and beyond.

Support the Senior Management Team and Staff

A strong communications culture is a key attribute of a high functioning organization.

The communications team has worked closely to partner with management and staff to assist them with achieving their business objectives through strategic communications planning and implementation. The team has created dynamic content and explored new ways to communicate both about the LHIN as an organization and also about specific LHIN programs. Some innovative communication opportunities that have been leveraged over the last year include:

- Developing an interactive presentation on the expanding role of Toronto Central LHIN for the CEO to deliver to Breakfast with the Chiefs, a speakers' series that provides an opportunity for invited Chief Executives within health care to share new ideas, policies and best practices with their colleagues. This engagement sold out with more than 430 people registering to attend
- Creating a Twitter account for the CEO to complement the corporate social media efforts
- Our corporate Twitter following increased by 732 followers last fiscal, an increase of84%
- The CEO launched her Twitter account in November 2017 and has gained 266 followers in the past 6 months
- Updating the speakers' bureau to support community outreach and building the profile of the LHIN
- Renewing provider-facing forms and client communications materials
- Distributing 6 issues of our external TC Link newsletter highlighting activities LHIN and partner initiatives, with an open rate of over 46%

Support Change Management Tactics throughout Transition

During transition, Communications played a key role in ensuring staff had the tools and knowledge they needed to understand the changes going on in the organization and speak about them confidently with external partners and clients. Ongoing communications in the form of a CEO Blog and internal newsletter were created to communicate with staff about operational and strategic updates, along with staff-focused content to support change management, such as staff recognition and milestones.

In 2017-2018, the Toronto Central LHIN created a new Community Engagement Strategy that focuses on expanding outreach into commonly unengaged populations and continuing to build capacity with already engaged citizen advisors.

This will form part of our efforts going forward, along with a plan to enhance knowledge exchange. In 2017-18, we met with numerous health service provider partners to discuss and plan strategies to exchange information and engage their served populations, in addition to creating channels to communicate new initiatives. One such strategy would connect Citizen Panel representatives to external citizen advisor tables. The Toronto Central LHIN will continue to enhance and expand its citizen and community engagement strategy and initiatives in 2018-2019.

Local Collaboratives

There are five Local Collaboratives across Toronto Central LHIN. Comprising of participants from across sectors, these Collaboratives are intended to build stronger networks aimed at improving health outcomes.

Over this past two years, the Local Collaboratives identified priority areas for improvement, informed the development of a Collaborative Agreement, and delved deeper into data that captured the unique needs of the neighborhoods each Collaborative represents.

In 2017-2018, Toronto Central LHIN organized two sets of Local Collaboratives. More than 200 representatives from health service providers, citizens and community partners participated in the sessions held in the summer of 2017.

During our winter Local Collaborative sessions, more than 300 providers, partners, members of our Citizens' Panel and Citizen Advisors came together as part of our ongoing efforts to develop a deeper understanding of our diverse neighborhoods and their local populations.

One of the biggest undertakings of the Local Collaboratives so far has been the participation of each cross- functional team in the IDEAS Advanced Learning Program.

- Starting July 2017, the five teams participating in IDEAS used data from our analytics team to identify areas of high population need, and then developed quality improvement projects to target those needs
- Community engagement with the identified population was a crucial component to the process
    - Teams held one-on-one interviews and peer-led focus groups to help identify root causes.
    - The solution design process included co-creation sessions with citizens and embedding citizens into project working groups
- The resulting quality improvement projects focused on areas such as increasing attachment to primary care for marginalized populations, reducing caregiver distress and connecting individuals with mental health and/or addictions issues to continuing care

The work of Local Collaboratives has continued to evolve and now includes Advisory Tables that bring together leadership from across a variety of sectors, representing the various populations and geographies. The purpose is to provide a broad perspective and advance ideas through organizational support and leadership that further the health and social goals of the region. The Tables identify local needs and prioritize local action planning in collaboration with key stakeholders.

Advisory Tables continue to identify quality improvement opportunities using data to drive decision-making. In addition, each one will identify priority project opportunities in the areas of key of populations such as Seniors and Mental Health and Addictions.

2017-2018 Performance Results

Toronto Central LHIN continues to focus on system performance and is committed to deliver on our Ministry LHIN Accountability Agreement (M-LAA) indicators for 2018-19. We have developed and continue to evolve our internal performance management frameworks and dashboards, which are key tools in providing our leadership up-to-date information to direct our performance improvement plans.

Performance Indicators:

- Of the five indicators for which we have full 2017-2018 results, one does not have a provincial target. Of the four indicators with provincial targets, Toronto Central LHIN has met the target for three of the measures. For the indicator without a provincial target, Toronto Central LHIN's annual performance has remained constant over the last two fiscal years
- For the seven indicators calculated using Q1-Q3 data, we expect to meet target (or be within 10%) for three of the seven indicators by year end
- For the last indicator, calculated using Q1-Q2 data, we expect to be within 10% of target by year-end.

Monitoring Indicators:

- Toronto Central LHIN performance has improved for MRI and CT scan access indicators in response to focused work and investments
- Toronto Central LHIN is performing above provincial average for three indicators
    - › Rate of emergency visits for conditions best managed elsewhere per 1,000 population
    - › Hospitalization rate for ambulatory care sensitive conditions per 100,000 population
    - › Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge
- Toronto Central LHIN has seen declining results in the Cataract Surgery Access Targets
- There are two indicators Toronto Central LHIN is unable to report on at this time due to data quality concerns

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

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

The Toronto Central LHIN is developing supplementary indicators for the MLAA Indicator Report submitted to the Board of Directors on a quarterly basis to fully understand the complexity of performance in some of

the clinical areas and to provide a clearer picture of what is driving performance from a broader perspective. The supplementary indicator on HIG Readmissions has been shared with the ministry for further discussion.

With system focus and Toronto Central LHIN investments, the following MLAA indicators are projected to meet their targets (or be within 10% of them) once the Q1-Q4 performance data is available for all of them:

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

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

MLAA – Addiction Services

One of the MLAA areas of focus is addiction services in the hospital Emergency Departments. Toronto Central LHIN has targeted these services with recent investments that were initiated in Q4 17/18 and will continue into 2018-19.

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

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

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

Emergency Room Wait Times

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

- Engage with all hospitals for Emergency Department related activities
- Focus on implementing the Pay for Results funding allocation among the eight (8) hospitals Emergency Department

- Collaborate with Toronto Paramedics Services to re-scope Patient Distribution System (PDS) among hospitals' emergency departments to ensure appropriate distribution of patients.

Wait Times for Surgical and Diagnostic Imaging procedures

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

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

Health System Funding Reform

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

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

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

Performance Indicators Results:

Indicator	Provincial	Provincial				LHIN			
		2014-15 Fiscal	2015-16 Fiscal	2016-17 Fiscal	2017-18 Fiscal	2014-15 Fiscal	2015-16 Fiscal	2016-17 Fiscal	2017-18 Fiscal
1. Performance Indicators									
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care	TBD	7.00	7.00	7.00	7.00	7.00	7.00	8.00	8.00
90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.47	4.50	4.58	4.65
Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	85.53%	80.19%	90.28%	91.75%
Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	85.61%	84.05%	90.89%	91.85%
ALC rate	12.70%	13.70%	13.98%	15.19%	15.49%	10.33%	11.97%	12.58%	11.38%
The following indicators show results for **FY 2017-18 up to Q3**. Full year performance is not yet available.									
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36 %	89.86 %	88.50 %	85.47%	85.03%	93.95%	93.77% Q3 Results
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%	94.00 %	96.07 %	96.21 %	93.64%	93.50%	96.19%	96.12% Q3 Results
90th Percentile Wait Time from community for Home Care Services -Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	25.00	26.00	26.00	26.00 Q3 Results

90th percentile emergency department (ED) length of stay for complex patients*	8 hours	10.13	9.97	10.38	10.75	12.17	12.18	12.85	13.08 Q3 Results
Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50 %	15.69 %	15.18%	9.79%	10.46%	12.86%	10.70% Q3 Results
Repeat Unscheduled Emergency Visits within30 Days for Mental Health Conditions*	16.30%	19.62%	20.19 %	20.67 %	20.97%	26.59%	28.54%	27.90%	28.06% Q3 Results
Repeat Unscheduled Emergency Visits within30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01 %	32.50 %	32.25%	40.84%	43.17%	41.95%	38.56% Q3 Results
The following indicator show results for **FY 2017/18 only up to Q2**. Full year performance is not yet available.									
Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65 %	16.74 %	16.41%	17.89%	18.13%	17.72%	17.75% Q2 Results

*FY 2017/18 is based on the available data from the fiscal year (Q1-Q3, 2017/18)

**FY 2017/18 is based on the available data from the fiscal year (Q1-Q2, 2017/18)

Monitoring Indicators Results:

Indicator	Provincial	Provincial				LHIN			
		2014-15 Fiscal	2015-16 Fiscal	2016-17 Fiscal	2017-18 Fiscal	2014-15 Fiscal	2015-16 Fiscal	2016-17 Fiscal	2017-18 Fiscal
2. Monitoring Indicators									
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09 %	85.01 %	83.95%	88.43%	86.55%	80.12%	79.36%
Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58 %	67.57 %	69.77%	52.48%	50.43%	47.95%	55.23%
Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18 %	82.11 %	84.73%	65.24%	67.68%	69.15%	75.61%
Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	14.00	3.00	NR	N/R*	N/R*
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	11.00	NR	N/R*	N/R*
Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	12.06	6.90	6.73	6.32	4.13
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	243.31	259.37	244.27	250.57	196.16
Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61 %	47.43 %	47.31%	49.89%	50.52%	51.59%	51.22%

*FY 2017/18 is based on the available data from the fiscal year (Q1-Q3, 2017/18) **FY 2017/18 is based on the available data from the fiscal year (Q1-Q2, 2017/18) NR - data have not been reported due to concerns with data quality

Home and Community Care Indicators

In Toronto Central LHIN, the percentage of home care clients who received nursing visits within target increased similarly to the province, whereas the percentage of clients who received personal support services increased substantially (8.30% higher in Toronto Central LHIN vs. 3.11% higher provincially).

To maintain and improve performance, Toronto Central LHIN continues to initiate services based on patients' personal preference date and clinical planning; prioritize services for populations with multiple chronic and complex health issues; deliver the most appropriate care to patients and their families to meet their health, social and economic needs; and implement performance improvement plans. To improve overall performance, the Toronto Central LHIN has redesigned its Client Access policy and Practice Standards to better meet the needs of clients within the target timeframes. Toronto Central LHIN has also developed a Right Place of Care Strategy, aligned with the Personal Support Services Regulatory Amendments Policy, which supports the transitioning of clients with low needs from Home and Community Care to community support services providers, which increases the capacity of home care to focus on clients with more complex care needs.

The Toronto Central LHIN will continue to work on ensuring data collection methodology is standardized to ensure high data quality and reliability, and will continue to implement key operational strategies to address wait times in the organization. The Home and Community Care division is also realigning its nursing clinics to enhance access and meet the needs of clients in a timely manner.

Emergency Department Wait Time Indicators

Emergency department wait time is a continuous focus for the Toronto Central LHIN. The LHIN continues to work closely with its Emergency Department Network to:

- Engage with all hospitals for emergency department related performance activities, identifying best practices/standards for spread and scale across the hospitals
    - Hospitals will continue to focus on efficiencies, quality and process improvement initiatives to mitigate challenges
- Implement the Pay for Results funding allocation among the eight hospitals' emergency departments to ensure appropriate distribution of patients
- Implement a new model of care to mitigate arrival times between 1 a.m. and 7a.m.
    - Increased physician coverage past 12 a.m.
- Better align the staff to patients' arrival and the use of physician assistants
- Review data at the hospital level and develop mitigation plans to meet the provincial wait time and length of stay targets

In 2017-18, Toronto Central LHIN provided targeted funding to improve wait time for minor patients. Despite strong engagement from the hospitals and collaborative implementation, the results did not improve. The increased population growth in the Toronto Central LHIN continues to place a challenge on

this performance. Toronto Central LHIN has also seen growth in ambulance calls and hospital deliveries. In 2018-19, Toronto Central LHIN will collaborate with the ministry and Toronto Paramedic Services to investigate options under the new legislation to direct appropriate patients away from Emergency Rooms and to alternate destinations to better meet their care needs.

Wait Times for Surgical Procedures (Hip and Knee Replacement)

The Toronto Central LHIN met the targets for both of the Wait Time for Surgical Procedures indicators in fiscal year 2017-18. Both showed increasing percentages (~6.2% each) of cases completed within target over the last four fiscal years, whereas the province's performance on these indicators decreased steadily during the same timeframe and are not meeting either target.

Contributing to indicator performance, the Toronto Central LHIN Orthopedic Planning Committee's strategy focused on wait time and access, sub-specialties, and performance and data. The Toronto Central LHIN collaborated with the ministry on spreading the MSK Rapid Access Centres to all Toronto Central LHIN hospitals and an audit strategy in each hospital was implemented to identify patients waiting beyond the performance target.

Alternate Level of Care (ALC)

Toronto Central LHIN met the target for ALC rate, and is anticipating that when Q4 results are available the results for percentage of ALC days will meet the target (or within 10%). Toronto Central LHIN continues to work closely with its ALC Transition and Flow Task Group to create new capacity in non-hospital settings to transition patients designated or at risk of ALC (including Non- OHIP patients) from hospital. The LHIN is also continuing to support hospitals in implementing ALC avoidance and management practices. Toronto Central LHIN continues to leverage new investments in transition and flow of patients, namely Short-term Transitional Care Models and Seniors at Home to support patients' transition in the new Reintegration Care Models (205 additional units) and Caregiver ReCharge Program.

Mental Health and Addictions Services

The Toronto Central LHIN met neither target during 2017-18 for the percentage of repeat unscheduled emergency visits within 30 days for mental health or substance abuse conditions. Factors contributing to this performance include increasing volume of patients, the ongoing opioid crisis, and increasingly vulnerable populations such as the homeless, complex patients and seniors.

Toronto Central LHIN sees this as an indicator that requires additional system attention. In 2017-18, there was targeted work across all emergency departments to implement Rapid Access Addiction Medicine Clinics – which ideally provide good continuity of care after an emergency department visit. Despite successful implementation, the performance of this indicator remains a challenge. Toronto Central LHIN has worked collaboratively with the Mental Health and Addictions Acute Care Alliance, which brings together the seven Toronto Central LHIN hospitals with inpatient adult psychiatric units to identify opportunities to address these two MLAA indicators and engage stakeholders in co-development of solutions. One such initiative saw the development of emergency department care pathways for adults

with developmental disabilities and dual diagnosis. These promote stronger connections with the community sector to better meet the health care needs of this vulnerable population, known to be high-cost users of emergency department services for ambulatory sensitive conditions.

Providers have put in place a new model of transitional care coordinators and mental health care workers as part of Inter-professional care teams. This will support patients with mental health and substance abuse diagnoses referred through local networks.

Through a collaboration between Toronto Central LHIN and Toronto Public Health, three new six month short-term overdose prevention sites (St. Stephen's Community Centre, Regent Park CHC and Street Health) have been approved to open in 2018. Also in alignment with Ontario's Opioid Strategy and the Toronto Overdose Action Plan (Toronto Public Health), the Toronto Central LHIN made a $2.2M investment in front line harm reduction resources, medical services across all five withdrawal sites and peer case management program for the LGBTQ youth using substances. Toronto Central LHIN will continue to monitor these investments. Work continues at University Health Network, St. Michael's Hospital, St. Joseph's Health Centre, Michael Garron Hospital and Sunnybrook Health Sciences Centre to fully implement the five new Rapid Access to Addiction Medicine Clinics, which will be complete in September 2018. Additionally, safe injection sites at South Riverdale CHC, Parkdale – Queen West CHC, The Works (TPH) and Fred Victor are now operational and are providing services to clients.

This remains a strong focus in 2018-19 – and we are developing plans to target root cause elements. Alternate ambulance destinations are being explored to provide better care for this population.

Readmissions for Selected Health Based Allocation Model Inpatient Grouper Conditions

Toronto Central LHIN has undertaken analysis to understand which populations are driving the negative performance. The focus is on four clinical populations: Congestive Heart Failure, Congestive Obstructive Pulmonary Disease, Community Acquired Pneumonia and Gastro-intestinal Pathologies - these conditions are represented in patients with the highest readmission rates. Working with its Clinical Effectiveness Clinical Utilization Committee, the Toronto Central LHIN is identifying existing initiatives that are appropriate to expand across the system. The recommendations from the Health Based Allocation Model Inpatient Grouper Readmissions Working Group have been approved and funding has been allocated to providers to address these readmissions at hospital, primary care and community levels. A governance structure has been established to provide oversight to the implementation of interventions.

Impact of this work is expected to accumulate and have an impact on end of year performance results.

Monitoring Indicators

Monitoring Indicators are indicators that LHINs are expected to oversee to ensure performance remains stable. The two monitoring indicators for wait times for long-term care settings have not been reported due to data validity. The Toronto Central LHIN is the only LHIN that uses Resource Matching and Referral (RMR) instead of Client Health Record Information (CHRIS) System for long-term care indicators. There is currently an initiative to investigate moving Toronto Central LHIN to CHRIS for this reporting. The LHIN will also work to see if it is possible to produce the indicator from RMR for the next reporting quarter.

The Path Forward

In the year since the formation of the new Toronto Central LHIN we have made significant progress toward improving health care for our residents:

- We are ensuring the system is sustainable for many years to come by actively supporting the integration of services to reduce cost, increase efficiency and meet local population needs.
- We have developed strong partnerships outside of health care and are looking at the broader factors that impact people's health.
- We have created innovative tools to gather data that helps us better understand the unique needs of the people we serve.

Operating as one cohesive team, we are well positioned to continue to support health system transformation and service delivery in the future. Looking ahead, while maintaining our core business of funding, performance management, planning, design and delivery of home and community care, Toronto Central LHIN will be guided by what we have heard matters most to clients, patients, caregivers and citizens:

- They want **simple and timely access** to care and support that allows them to be healthy and at home where possible.
- They don't want the added stress of searching for care. They want a system that is **easy to navigate** and they want their care to be **coordinated.**
- They want to be an equal member of the care team. They want a system where providers and patients **communicate** and work together.

Our actions as an organization are and will continue to be guided by citizen voice. We have heard from citizens that their priorities include expanding access to mental health and addictions services, initiatives that support seniors, and reducing the number of people who are waiting in a hospital bed for the right level of care.

The role of the Toronto Central LHIN in creating an integrated, sustainable health care system is to continue bringing citizens and partners to the table and to create a strong foundation for, and be an enabler of, transformation. These are the keys to unlocking our system's potential, and we intend to use them. We also intend to create a health care system that delivers positive patient experience and a healthier Toronto—this is the commitment we make to the people we serve, and working together we will achieve it.

Board of Directors

Toronto Central LHIN Board of Directors				
Name	**Position**	**Appointed**	**End of Current**	**Length of Term**
Vivek Goel	Chair	November 16, 2016	November 15, 2019	3 years
Christopher ,Hoffmann	Director (Interim Vice	October 22, 2014	October 21, 2020	3 years
Yasmin Meralli	Director	September 8, 2014	September 7, 2020	3 years
Felix Wu	Director	October 22, 2014	October 21, 2020	3 years
Jason Madden	Director	November 30, 2016	November 29, 2019	3 years
Pamela Griffith-Jones	Director	November 16, 2016	November 15, 2019	3 years
Carolyn Acker	Director	February 2, 2017	February 1, 2020	3 years
Myra Libenson	Director	May 10, 2017	May 9, 2020	3 years
Karen Sadlier-Brown	Director	May 10, 2017	May 9, 2020	3 years
Dunbar Russel	Director	June 2, 2017	June 1, 2020	3 years
Natasha VandenHoven	Director	June 27, 2017	June 26, 2020	3 years
Vacant (1)				

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Canada

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Independent Auditor's Report

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

We have audited the accompanying financial statements of the Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2018, and the statements of operations and changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2018 and the results of its operations, change in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 27, 2018

Toronto Central Local Health Integration Network

Statement of financial position

As at March 31, 2018

	Notes	2018	2017
		$	$
Assets			
Current assets			
Cash		**18,245,200**	1,096,486
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding operations		**1,281,400**	—
Due from MOHLTC regarding HSP transfer payments	13	**17,461,797**	21,813,625
Due from Health Shared Services Ontario ("HSSOntario")		**337,700**	25,129
Accounts receivable		**1,391,167**	197,765
Prepaid expenses		**338,477**	15,308
		39,055,741	23,148,313
Rental and security deposits		**107,501**	—
Capital assets	7	**570,887**	200,031
		39,734,129	23,348,344
Liabilities			
Current liabilities			
Accounts payable and accrued charges		**21,367,069**	1,306,471
Due to Health Service Providers ("HSPs")	13	**17,461,797**	21,813,625
Due to MOHLTC	4	**334,376**	28,217
		39,163,242	23,148,313
Deferred capital contributions	8	**570,887**	200,031
		39,734,129	23,348,344
Commitments	9		
Net assets		**-**	-
		39,734,129	23,348,344

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

Approved by the Board

Toronto Central Local Health Integration Network

Statement of operations and changes in net assets

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Revenue			
MOHLTC - Transfer payments	13	**4,844,923,299**	4,896,026,687
MOHLTC funding - Operations and initiatives		**225,896,238**	14,877,647
Amortization of deferred capital contributions		**2,003,047**	1,083,269
Other revenue		**1,181,989**	—
		229,081,274	15,960,916
Total revenue		**5,074,004,573**	4,911,987,603
Expenses			
HSP transfer payments	13	**4,844,923,299**	4,896,026,687
Operations and initiatives			
Contracted out			
In-home/clinic services		**146,082,690**	—
School services		**4,679,809**	—
Hospice services		**2,152,076**	—
Salaries and benefits		**53,088,680**	9,999,365
Medical supplies		**7,590,514**	—
Medical equipment rental		**2,693,060**	—
Supplies and sundry		**6,229,687**	4,144,161
Building and ground		**1,972,437**	670,646
Amortization		**2,003,047**	1,083,269
Repairs and maintenance		**420,484**	63,474
		226,912,484	15,960,916
Total expenses		**5,071,835,783**	4,911,987,603
Excess of revenue over expenses before the undernoted		**2,168,790**	—
Net liabilities assumed on transition	11	**(2,168,790)**	—
		—	—
Net assets, beginning of year		**—**	—
Net assets, end of year		**—**	—

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

Toronto Central Local Health Integration Network

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		**—**	—
Cash received on transition	11	**16,468,992**	—
Net liabilities assumed on transition	11	**2,168,790**	—
Less amounts not affecting cash			
Amortization of capital assets		**2,003,047**	1,083,263
Amortization of deferred capital contributions		**(2,003,047)**	(1,083,263)
Transfer of deferred capital contributions		**—**	(410,980)
Transfer of tangible capital assets to HSSO		**—**	410,980
		18,637,782	—
Changes in non-cash working capital items	10	**(1,489,068)**	(319,821)
		17,148,714	(319,821)
Investing activity			
Purchase of capital assets		**(429,140)**	(179,288)
Financing activity			
Increase in deferred capital contributions		**429,140**	179,288
Net increase change in cash		**17,148,714**	(319,821)
Cash, beginning of year		**1,096,486**	1,416,307
Cash, end of year		**18,245,200**	1,096,486

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

1. Description of business

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

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

The LHIN has also entered into an accountability agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandate of the LHIN is as follows:

(a) Plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of City of Toronto. The LHIN enters into service accountability agreements with health service providers.

(b) Effective June 7, 2017, the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOHLTC represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOHLTC are set up as repayable to the MOHLTC at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant accounting policies (continued)

Ministry of Health and long-term care funding

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

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

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

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated lives of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful lives as follows:

Furniture and equipment	5 years
Computer and communications equipment	3 years
Client serving equipment	5 years
Leasehold improvements	Life of lease

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amorized to income at the same rate as the corresponding capital asset.

Adoption of PSAS 3430 – Restructuring transactions

The LHIN has implemented Public sector Accounting Board ("PSAB") section 3430 Restructuring Transactions. Section 3430 requires that the assets and liabilities assumed in a restructuring agreement be recorded at the carrying value and that the increase in net assets or net liabilities received from the transferor be recognized as revenue or expense. Restructuring is an event that changes the economics of the recipient from the restructuring date onward. It does not change their history or accountability in the past, and therefore retroactive application with restatement of prior periods permitted only in certain circumstances. The impact of this policy on the current year is detailed in Note 11.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations and changes in net assets.

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 amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in accounting policy

As a result of the transition of responsibility for the delivery of certain services related to home care as described above, there has been a significant change in the operations of the LHIN over prior year. As a result of these changes, the LHIN has determined that the adoption of Canadian public sector accounting standards for government not-for-profit organizations is appropriate.

Previously the LHIN followed Canadian public sector accounting standards. The adoption of this policy has no impact on numbers previously reported. The impact of the change is limited to presentation only, and as a result the prior year figures presented for comparative purposes have been reclassified to conform with the current year's presentation.

4. Due to MOHLTC

In accordance with the MLAA, 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.

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

	2018	2017
	$	$
Due to MOHLTC, beginning of year	**(28,217)**	(4,707)
Funding repaid to MOHLTC	**28,217**	2,807
Funding repayable to the MOHLTC related to current year activities	**(334,376)**	(26,317)
Due to MOHLTC, end of year	**(334,376)**	(28,217)

5. Enabling technologies for integration project management office

Effective April 1, 2013, the LHIN entered into an agreement with Central, Central West, Central East, Mississauga Halton and North Simcoe Muskoka LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Office for its Cluster and related expenses. During the year, the LHIN received MOHLTC funding for $423,000 ($423,000 in 2017).

6. Related party transactions

Health Shared Services Ontario ("HSSOntario")

HSSOntario is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under the Local Health System Integration Act with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSOntario as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSOntario and the Minister of Health and Long-Term Care.

During the year, an allocation of $1,080,000 of additional Pan-LHIN support funding was made to the LHIN to be applied to salary and benefit costs related to the support of transition and implementation of the expanded LHIN mandate. Of this, $360,000 was incurred directly by the LHIN on eligible expenses. $414,445 was distributed to other LHINs as follows:

	$
Central West LHIN	168,948
North East LHIN	65,497
South East LHIN	180,000
	414,445

The remaining unspent funds of $305,555 is payable to MOHLTC, and has been included in the Due to MOHLTC balance on the statement of financial position.

Prior year statement of operations includes the transactions of LHIN Shared Services Office (LSSO) and LHIN Collaborative (LHINC) up to February 28, 2017 as they were divisions of the LHIN. As of March 1, 2017, these balances and results of operations are included in the accounts of HSSOntario.

7. Capital assets

	Cost	Accumulated depreciation	2018 Net book value	2017 Net book value
	$	**$**	**$**	$
Computer and communication equipment	**13,802,756**	**13,802,756**	**—**	156,305
Leasehold improvements	**4,304,402**	**3,875,262**	**429,140**	—
Furniture and equipment	**2,160,107**	**2,158,680**	**1,427**	43,726
Client serving equipment	**233,866**	**93,546**	**140,320**	—
	20,501,131	**19,930,244**	**570,887**	200,031

8. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**200,031**	1,514,992
Capital contributions received during the year	**429,140**	179,288
Capital contributions assumed on transition	**1,944,763**	-
Transfer of deferred capital contributions to HSSO	**—**	(410,980)
Amortization for the year	**(2,003,047)**	(1,083,269)
Balance, end of year	**570,887**	200,031

9. Commitments

The LHIN has commitments under various operating leases as follows:

	$
2019	2,833,778
2020	2,543,868
2021	2,000,505
2022	1,587,846
2023	1,603,896
Thereafter	7,567,892
	18,137,785

10. Change in non-cash working capital items

	2018	2017
	$	$
Due from LHINs	**—**	79,564
Due from HSSOntario	**(312,571)**	(25,129)
Due from MOHLTC regarding operations	**(1,281,400)**	—
Due from MOHLTC regarding HSP transfer payments	**4,351,828**	(3,782,831)
Accounts receivable	**890,703**	103,431
Prepaid expenses	**489,120**	88,620
Rental and security deposits	**(107,501)**	—
Accounts payable and accrued charges	**(1,473,578)**	(589,817)
Due to HSPs	**(4,351,828)**	3,782,831
Due to MOHLTC	**306,159**	23,510
Total change in non-cash working capital items	**(1,489,068)**	(319,821)

11. Transition of Toronto Central Community Care Access Centre

On April 3, 2017, the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Toronto Central Community Care Access Centre ("CCAC"), to the Toronto Central LHIN, including the transfer of all employees of the Toronto Central CCAC. This transition took place on June 7, 2017. Prior to the transition, the LHIN funded a significant portion of the CCAC's operations via HSP transfer payments. Subsequent to the transition date, the costs incurred for the delivery of services previously provided by the CCAC were incurred directly by the LHIN and are reported in the appropriate lines in the statement of operations.

The LHIN assumed the following assets and liabilities, which were recorded at the carrying value of the CCAC.

	$
Cash	16,468,992
Accounts receivable	2,084,105
Prepaid expenses	812,289
Tangible capital assets	1,944,763
	21,310,149
Accounts payable and accrued liabilities	21,534,176
Deferred capital contributions	1,944,763
Total liabilities	23,478,939
Net liabilities assumed	(2,168,790)

The net liabilities resulting from this transaction are recorded as an expense in the statement of operations and changes in net assets.

11. Transition of Toronto Central Community Care Access Centre (continued)

During the year, transition costs of $180,000 were incurred and are comprised of the following:

	$
Salaries and benefits	179,773
Travel	227
Total	180,000

Funding of $180,000 received from the Province of Ontario to offset these transition costs is included in MOHLTC funding – Operations and initiatives revenue in the statement of operations and changes in net assets.

12. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 717 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 2018 was $4,331,114 ($567,348 in 2017) for current service costs and is included as an expense in the statement of operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2017. At that time, the plan was fully funded.

13. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $4,844,923,299 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors as follows:

	2018	2017
	$	$
Operations of hospitals	**3,762,942,504**	3,651,802,995
Grants to compensate for municipal taxation – public hospitals	**715,050**	751,425
Long-term care homes	**286,436,318**	281,028,865
Community care access centres	**45,672,039**	250,537,181
Community support services	**121,219,547**	103,132,111
Assisted living services in supportive housing	**61,296,702**	60,388,749
Community health centres	**101,968,489**	97,270,624
Community mental health addictions program	**146,069,582**	143,110,762
Addictions program	**39,665,607**	37,951,625
Acquired brain injury	**3,096,818**	3,091,657
Specialty psychiatric hospital	**275,791,593**	266,911,643
Grants to compensate for municipal taxation – psychiatric hospital	**49,050**	49,050
	4,844,923,299	4,896,026,687

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $17,461,797 ($21,813,625 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and changes in net assets and are included in the table above.

13. Transfer payment to HSPs (continued)

Pursuant to Note 11, effective June 7, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the Toronto Central CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC up to the date of transfer.

14. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

15. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor 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.

16. Board Costs

The following provides the details of Board expenses reported in the statement of operations and changes in net assets:

	2018	2017
	$	$
Board Chair per diem expenses	**14,700**	11,200
Other Board members' per diem expenses	**52,100**	50,025
Other governance and travel	**509**	4,407
	67,309	65,632

References:

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2. North America Population. (2017-11-06) http://worldpopulationreview.com/continents/north-america-population/ Accessed May 28, 2018
3. Health Analytics Branch (HAB), Ministry of Health and Long-Term Care; LHIN sub-region social, economic and population profile February 2017
4. Population Projections 2041, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: June 20, 2018
5. Health Analytics Branch (HAB), Ministry of Health and Long-Term Care; LHIN and sub-region Census profile – 2016 Census, Final, March 2018
6. Health Analytics Branch (HAB), Health System Information Management Division, Ministry of Health and Long-Term Care, Health Care Experience Survey, February 2018 update: October 2016 - September 2017
7. Buajitti E, Watson T, Kornas K, Bornbaum C, Henry D, Rosella LC. Ontario atlas of adult mortality, 1992-2015: Trends in Local Health Integration Networks. Toronto, ON: Population Health Analytics Lab; 2018.
8. Research and Information, Strategic Initiatives, Policy & Analysis, City Planning Division, City of Toronto:
    - Toronto Neighbourhood Estimates 2016, prepared Sept. 15, 2017
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