Central **LHIN**

Annual Report 2017-2018

Strengthening Patient Experience and Outcomes

Ontario
Local Health Integration Network

Putting Patients First

The Central LHIN and its many partners
are working collaboratively together to transform the local health system
with a patient-centred focus and an emphasis on accessibility, equity and integration
to support better experiences and outcomes for patients and caregivers.

Vision

Caring Communities, Healthier People

Mission

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

IHSP 2016-2019 Strategic Priorities

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

Goals

- Access
- Connect
- Inform
- Protect

Levers

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

Values

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

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Introduction:
Patients First

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established in 2006 by the Ontario government to plan, coordinate, integrate and fund health services at the local level. LHINs are organized around geographic regions to support system-wide planning that is informed by local population needs.

In 2017, in accordance with the *Patient First Act, 2016*, the LHINs received an expanded mandate which included new governance and oversight for home and community care service delivery.

The *Patient First Act* also confirmed the establishment of a Patient and Family Advisory Committee in every LHIN, enhanced the relationship between local boards of health and LHINs, added primary care models as health service providers funded by LHINs, and expanded LHIN responsibilities in the areas of health promotion and equity.

As part of implementing the *Patients First Act*, the Central LHIN established six sub-regions – smaller geographic areas within the Central LHIN geography – to enable more focused local population health planning and collaboration with stakeholders.

As we strive to create a robust, integrated system of care and service delivery for nearly 1.9 million people who live in the Central LHIN, across a range of very diverse communities, the LHIN is committed to transforming our local health care system and helping to achieve the best health care outcomes for everyone.

We continue to work with patients, caregivers, families and a wide range of community and health sector stakeholders to improve the patient experience, plan for care that is responsive to patients' needs, values and preferences, addresses the root causes of health inequities, and reduces the burden of chronic illness and disease.

Message from the Chair and CEO

We are pleased to share the Central LHIN 2017-2018 Annual Report, which highlights changes in our organization and progress we have made this past year – supported by many stakeholders and community partners – toward our shared goal of creating an integrated, patient-centred and more equitable and accessible local health system.

Patients First
We reflect on the 2017-2018 fiscal year with a sense of pride and accomplishment. With the passage of the *Patients First Act, 2016*, the Central LHIN has a renewed and expanded mandate to deliver home and community care services and collaborate on health system transformation.

Home and Community Care
A key milestone achieved was the transition of the legacy Central Community Care Access Centre (CCAC) to the Central LHIN to form a single organization responsible for the provision of more consistent and accessible home and community care.

The new Central LHIN organization has assumed the role of delivering front-line home and community care services to about 93,000 people a year – 13,000 on any given day. With great thanks to our staff and service provider partners, the transition was completed seamlessly in June 2017. *(Data source: Health Indicator Tool, 2017-2018, MOHLTC and CHRIS).* LHIN-delivered home and community care services continue to be delivered seamlessly for patients and their families.

System Transformation
In addition to new accountabilities for home and community care service delivery, the LHIN is working more closely with the three Public Health Units (i.e., Toronto Public Health, York Region Public Health and Simcoe Muskoka District Health Unit) operating in our region along with engaging Primary Care Providers and broader system partners toward a more integrated system.

Responding to Patient Needs, Values and Preferences
In all that we do, listening and learning from patients and families is a priority. The Central LHIN is committed to hearing and understanding the voices of patients, families and caregivers as part of planning a health system that will lead to improved outcomes for people.

In 2017, we leveraged the experience and talent from the existing Citizens Health Advisory Panel to form a new 16-member Patient and Family Advisory Committee. In the short months since inception, this committee has provided advice on programs, issues and engagement strategies from the perspective of patients, families and caregivers on initiatives such as the LHIN's 2018-2019 Annual Business Plan, Quality Framework, Dementia/Caregiver Framework, and a Community Consultation Survey.

Strengthening the Local Health Care System
In partnership with patients, caregivers, health service providers, contracted service providers and other stakeholders, Central LHIN advanced the strategic priorities in our Integrated Health Service Plan 2016-2019, *Caring Communities, Healthier People*.

Aligned with provincial priorities set out in Ontario's *Patients First: Action Plan for Health Care*, our endeavours this past year were guided by the action plans in Central LHIN's 2017-2018 Annual Business Plan.

We made solid progress in each of the six areas of focus including Better Seniors Care, Better Palliative Care, Better Care for Kids and Youth, Better Community Care, Better Care for Underserved Communities and Better Mental Health. Impacts and outcomes from this collaborative work are highlighted in greater detail throughout this Report.

Applying a Local Planning Lens
Central LHIN remains focused on closer collaboration with providers and community partners at the sub-region level. Our six sub-regions enable us to look at care patterns through a smaller, more local lens and ensure the voices of those residing in specific areas – including Indigenous and Francophone populations – inform our thinking. Population health based decision-making helps us to collaborate, co-design and deliver more effective and integrated care models for patients and families in their communities.

Successful examples of this approach include a recent comprehensive review of Specialized Geriatric Services, which resulted in development of a more coordinated model of care to make better use of existing resources and improve access and patient outcomes. We also introduced dedicated palliative care teams to mobilize care at the sub-region level.

First-of-its-kind 'Out of the Box' Collaboration
This past year, the Central LHIN and five of the region's hospitals collaboratively launched a first-of-its-kind Reactivation Care Centre (RCC), bringing together five hospitals under one roof to provide specialized care to support patients in transitioning out of hospital.

With capital funding support from the Ministry of Health and Long-Term Care, the RCC repurposed the former Humber River Hospital-Finch site to create 150 new specialized care beds. The RCC enables Central LHIN hospitals to provide the right care in the most appropriate setting, and support the best possible patient outcomes for hundreds of people living and receiving care in the Central LHIN.

A Stronger, More Sustainable Health System
A sincere thank you to our valued health service providers, service provider organizations, vendors, community partners, patients, families and caregivers, for their ongoing collaboration and support of the Central LHIN and our mandate to improve the health system and make it more accessible, seamless and equitable for everyone living in our communities.

At the same time, we are deeply grateful to the Central LHIN Board of Directors and our staff for their passion and commitment to advancing health system planning and service delivery that reflects the needs of our communities and patients.

We are excited by the tremendous opportunities we experienced this past year – and those yet ahead of us – to work together to make a meaningful difference in the lives of patients and their families and build a stronger, more sustainable and better health system for everyone.

Warren Jestin

Chair, Board of Directors

Kim Baker

Chief Executive Officer

Board of Directors

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

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

The following individuals served on the Central LHIN Board of Directors during the reporting period of this Annual Report (April 1, 2017 to March 31, 2018).

Warren Jestin – Board Chair
October 22, 2014 – October 21, 2020
Markham

Graham Constantine
April 5, 2017 – April 4, 2020
Aurora

Charles Schade – Board Vice Chair
May 17, 2017 – May 16, 2020
Toronto

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

Michael MacEachern – Board Vice Chair
February 2, 2017 – February 1, 2020
Alliston

Heather Martin
May 8, 2017 – May 9, 2020
Thornhill

Stephen Smith – Board Secretary
April 5, 2017 – April 4, 2020
Markham

Elspeth McLean
September 13, 2017 – September 12, 2020
Bradford

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

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

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

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

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

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

Mark Solomon
July 11, 2017 – July 10, 2020
Innisfil

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

Further information about the Central LHIN Board of Directors may be found online at www.centrallhin.on.ca and www.pas.gov.on.ca.

About the Central LHIN

About the Central LHIN

The Central LHIN, a crown agency of the Government of Ontario, is responsible for planning, funding, delivering and integrating local health services to nearly 1.9 million residents across many diverse communities in our catchment area.

Annually, the Central LHIN funds, monitors and delivers approximately $2 billion in health services *(Data source*. The LHIN holds accountability agreements with over 80 health service providers, including hospitals, long-term care homes, community health centres, mental health and addictions service providers, and other community support services organizations. The LHIN also directly provides home and community services, and contracts with Service Provider Organizations and vendors for services provision.

The Central LHIN also works with and values the contributions of Public Health Units, Primary Care Providers and many other stakeholder groups to improve the coordination and integration of patient services across the full continuum of health care.

Our Geography

The Central LHIN covers an area of 2,731 square kilometres, and includes sections of northern Toronto, a portion of Etobicoke, most of York Region and South Simcoe County.

The geography of Central LHIN is varied. The vast majority – 88 per cent – of Central LHIN residents live in a large urban centre with a population above 100,000, while just 4 per cent live in a rural area. This rural segment is in the northern part of the LHIN. *(Data source: 2016 Census)*

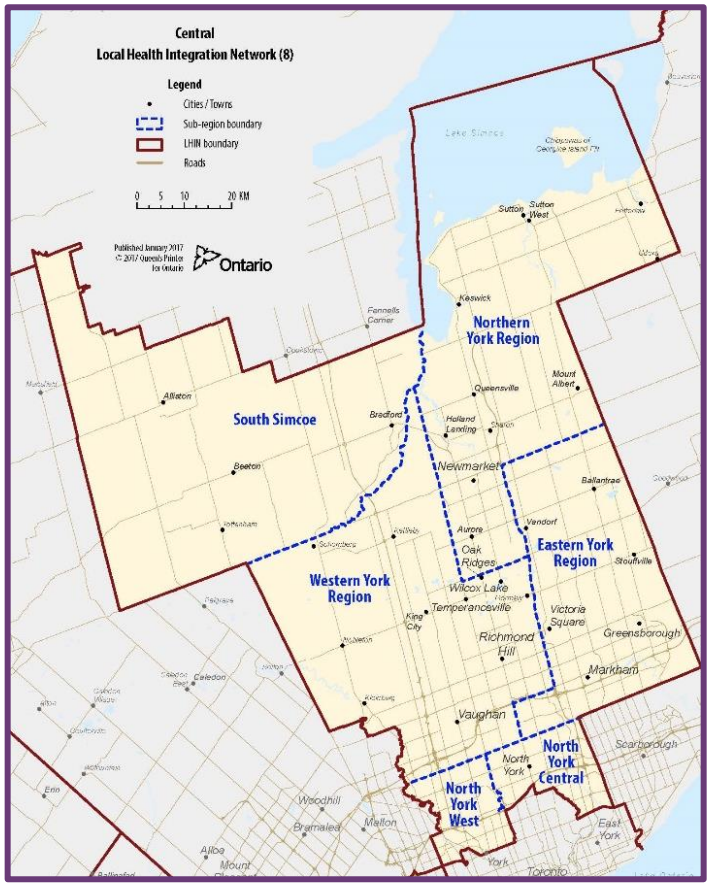
The three largest concentrations of residents, as a percentage of the Central LHIN's total population, are in the following communities:

1) Toronto – 36 per cent
2) Markham – 18 per cent
3) Vaughan – 15 per cent

For health care planning purposes, the Central LHIN is divided into six sub-regions. On average, there are 310,675 residents per sub-region. The smallest sub-region by population is South Simcoe (75,676 residents), while the largest is Western York Region (511,646 residents).

(Data source for population size and residency: 2016 Census Profile and 2015 Population Estimate, MOHLTC).

Map of the Central LHIN



Population Profile

With nearly 1.9 million residents, or 13.6 per cent of Ontario's total population, Central LHIN is the most populous LHIN in the province.

Three key demographics continue to drive an increased need for care and services in our region and are paramount as we plan and fund the delivery of accessible, linguistically, culturally and age-appropriate health services in Central LHIN:

- **Growth** – Population growth of 5.9 per cent in the Central LHIN outpaced the provincial average of 4 per cent between 2011 and 2016. We are forecasted to grow a further 18 per cent from by 2025.

- **Diversity** – Central LHIN is among the most diverse jurisdictions in the province (49.3 per cent compared to provincial average of 29.1 per cent)

- **Aging** – Central LHIN has absolute number of seniors among all LHINs (268,750 people over the age of 65). This population is expected to grow by 22.4 per cent by 2035.

Growth

Central LHIN's population is growing faster than almost anywhere else in Ontario. Between 2015 and 2025, the Central LHIN's population is projected to grow at a rate of 18 per cent, making us one of the fastest growing LHINs in the province. A rapidly growing population brings increased need to develop capacity.

Diversity

Among all LHINs, Central LHIN has the highest proportion of newcomers – 49 per cent or 820,580 people. (*Statistics Canada source note: Newcomers refers to landed immigrants who have come to Canada up to five years prior to a given census year.)*

Recent immigrants, having arrived in Canada between 2011 and 2016, make up 7 per cent or 116,000 people, which is the second highest number in the province. Central LHIN has the second highest proportion of residents among all LHINs, who are visible minorities – 51.9 per cent or 933,000 people.

Of all residents, 97,000 people, or 5.4 per cent of the population, report having no knowledge of either official language, English or French. This is the highest proportion in the province.

Indigenous Communities

Approximately 0.6 per cent of Central LHIN's population – or 91,000 people – are First Nations, Inuit or Métis. The majority of the Indigenous population in Central LHIN lives off-reserve, primarily in Northern York Region and South Simcoe. The Chippewas of Georgina Island, which is the only First Nations on-reserve community in the Central LHIN, has approximately 200 residents. *(Data source: 2016 Census and Ministry of Finance estimates (2011-2016) and projections (2017-2014) for LHINs, July 2017, MOHLTC)*

Francophone Communities

Central LHIN's Francophone population, at 1.7 per cent, includes 31,000 people, per the provincial inclusive definition. Comparatively, 50 per cent (901,000 people) report English as their mother tongue, and 5.4 per cent (97,000 people) report having no knowledge of French or English. *(Data source: 2016 Census)*

Aging

With almost 270,000 residents aged 65+, the Central LHIN has the highest absolute number of seniors across all LHINs. Seniors accounted for 14.5 per cent of the Central LHIN's population. By 2035, it is projected there will be over half a million people (563,279) in the LHIN over the age of 65 – a growth of 109.1 per cent compared to 2015 – the fastest growth rate in Ontario. Seniors over the age of 85 are projected to increase by 59 per cent in the next 10 years. *(Data source: Ministry of Finance estimates (2011-2016) and projections (2017-2014) for LHINs, July 2017, MOHLTC)*

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

Health Profile

Increasing Equitable Access To Health Services

Having an understanding of the people living within Central LHIN, their health status, and the health services currently available helps us identify priorities and allocate resources effectively so that we can improve the overall health system while increasing equitable access to the right care and services for everyone living in the LHIN.

Population health planning allows us to address the needs of the entire population, while reminding us that special attention needs to be paid to existing disparities in health.

A population health approach:

- Considers the social determinants that cause poor health outcomes
- Looks at the distribution of health across populations and communities and identifies patterns
- Requires partnerships in and outside the health sector to address barriers to good health
- Takes a long-term approach

Population Health

In collaboration with our Health Service Providers, Public Health Units, and other quality and data stakeholders, the Central LHIN uses population health data to better understand the unique characteristics and attributes of local populations as well as existing care patterns, which informs our planning at the local level.

In 2013, 32 per cent of Central LHIN residents over the age of 12 had a chronic condition – such as asthma, diabetes, heart disease or high blood pressure.

While the rate of prevalence for most of these chronic conditions has decreased since 2009-2010, the rate of prevalence for high blood pressure is on the rise, with 17.1 per cent of the population experiencing this condition.

Moreover, 11.1 per cent of the population aged 14 and over have arthritis, five per cent have diabetes, and 4.3 per cent have asthma.

Of the nearly 600,000 residents (32 per cent of the population over the age of 12) with a chronic condition, over 9 per cent have multiple chronic conditions. This rate of prevalence for multiple chronic conditions has decreased since 2009-2010.

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

Over time, Central LHIN residents' mortality rates for diabetes, heart disease and stroke have decreased while the rates for Chronic Obstructive Pulmonary Disease (or COPD) and hypertension have increased.

Planning Through a Sub-Region Lens

The Central LHIN has used informal planning areas for many years as one way to help identify and address gaps in the Central LHIN health system.

In 2017, the Central LHIN established six sub-regions to enhance our local planning and health service provider engagement efforts. Sub-region planning supports the LHIN's goal to better understand, listen to patient voice at the local level, and plan care that is innovative, sustainable and closer to home to strengthen the patient experience. Sub-regional planning help providers build and strengthen interdependent networks of care at the local level to transform the patient experience. By focusing on population health, providers can work better together on access, transparency and equity to strengthen patient outcomes and experience.

Central LHIN's Six Sub-Regions

The Central LHIN takes a social determinants of health approach to planning health care services in our geography. Social determinants of health considers upstream impacts on what makes Canadians sick – including numerous factors within each individual's biology, environment, life and health care. The Central LHIN considers unique population data and population health indicators in each of the six sub-regions. Various data sources support assessing community characteristics, opportunities or gaps that may require targeted approaches.

Some of the population health highlights in the sub-regions include:

- **South Simcoe –** With just over 75,000 residents, South Simcoe is the smallest of Central LHIN's sub-regions. It has the highest proportion of people living in rural areas (31 per cent) and the lowest proportion of residents living in low-income (7.4 per cent). This area has a higher rate of chronic obstructive pulmonary disease and asthma compared to the LHIN average. Along with Northern York Region, it has the highest rates for mental health-related physician visits for adults 10 per cent), but the lowest percentage of repeat emergency department visits for mental health (11 per cent).

- **Northern York Region –** Almost 220,000 people live in this sub-region. It has the second lowest percentage of residents living in low income (8.5 per cent) and a low percentage of seniors over the age of 65 (13.6). Combined with South Simcoe, Northern York has the highest rates for mental health physician visits for adults (10 per cent) but, in a variance from South Simcoe, this sub-region has the highest percentage of repeat emergency department visits within 30 days (20 per cent).

- **Western York Region –** With over 510,000 residents, this is the most populous Central LHIN sub-region. It has the lowest unemployment rate (4.3 per cent), the lowest percentage of lone-parent families (12.6), and the lowest percentage of seniors (13.6). All five prevention and screening indicators for this sub-region are better than the provincial rates. This sub-region also has a lower rate of emergency department visits compared to the rest of the LHIN and provincially (288 per 1,000).

- **Eastern York Region –** Over 375,000 people live in this sub-region. It has the highest proportion of visible minorities – 67.1 per cent, versus the LHIN average of 46.9 per cent and the provincial average of 25.9 per cent. Other than English, the most common languages spoken at home are Chinese (Cantonese and Mandarin), Tamil and Persian Farsi. All five prevention and screening indicators in this area are better than provincial rates. There is a higher rate for diabetes here (13.1 per cent) compared to LHIN and provincial averages, but lower rates for asthma (11.7 per cent) and COPD (5.6 per cent). Eastern York Region has the lowest rate of emergency department visits (268 per 1,000 people).

- **North York West –** With almost 285,000 residents, this sub-region is entirely in a large urban setting. This area has the lowest percentage of adults who have completed post-secondary education (52 per cent), the highest unemployment rate (5.9 per cent), and the highest percentage of lone-parent families. At 21.8 per cent, this area has more people living in low income than anywhere else in the LHIN, well exceeding the provincial rate of 13.8 per cent. North York West has higher disease prevalence compared to the LHIN average in all four indicators (asthma, diabetes, high blood pressure and chronic obstructive pulmonary disease). Diabetes in this sub-region is particularly higher than the provincial average.

- **North York Central –** With over 395,000 residents – this is the second largest sub-region by population – and all of these people live within a large urban centre. Many residents are new to the area. This sub-region has the highest percentage of newcomers (about 71 per cent) among all of the sub-regions. This area also has the highest percentage of seniors. While 79.4 per cent of adult residents have completed post-secondary education, 20.2 per cent are living in low-income, the second highest in the LHIN after North York West. North York Central has lower or comparable rates to the LHIN and provincial rates in all four disease prevalence indicators: asthma, diabetes, high blood pressure and chronic obstructive pulmonary disease.

Creating a Sustainable Health Care System

Accountability

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

Priorities for health care planning in the Central LHIN are outlined in the:

- Patients First: Action Plan for Health Care
- Minister's 2017-2018 Mandate Letter to the LHIN
- Ministry-LHIN Accountability Agreement
- Central LHIN's 2016-2019 IHSP
- Central LHIN's 2017-2018 Annual Business Plan

These documents are available at www.centrallhin.on.ca.

In 2017-2018, the Central LHIN entered into 99 Service Accountability Agreements with 83 Health Service Providers (HSPs), some offering services in one or more locations or sectors. The Central LHIN also maintains contracts with 21 Service Provider Organizations (SPOs).

Service Accountability Agreements are a key mechanism used in the oversight of the health system – they detail the funding the LHIN provides, the services to be provided, performance indicators, reporting requirements and the terms and conditions of the funding.

2017-2018 Service Accountability Agreements

- 9 Hospital Agreements with:
  - 7 public hospitals
  - 2 private hospitals
- 40 Long-Term Care Agreements with:
  - 46 long-term care homes
- 50 Multi-Sector Agreements with 50 agencies with:
  - 33 offering community support services
  - 23 offering mental health and addictions services
  - 2 Community Health Centres
  - 1 Community Care Access Centre

Note: Long-Term Care Home operators with more than one location may be covered by a single agreement, while agencies with a Multi-Sector Agreement may provide more than one type of community service. Hospital agreements include an agreement with West Park Healthcare Centre for a ventilator bed program.

Note 2: The Multi-Sector Agreement with Community Care Access Centre (CCAC) concluded in Q1, with the transfer of the CCAC's assets, liabilities and responsibilities to the LHIN on June 7, 2017.

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

In June 2017, the Service Accountability Agreement funding that the Central LHIN provided to the (former) Central CCAC was transferred to the LHIN spending plan per Minister's Transfer Order and the LHIN's expanded mandate accountabilities.

Funding Allocation

In 2017-2018, and through 99 Service Accountability Agreements, the Central LHIN authorized transfer payments of over $1.9 billion to its providers in the following sectors:

- Hospitals
- Long-Term Care Homes
- Community Care Access Centres
- Community Support Services
- Community Mental Health and Addictions
- Community Health Centres

The chart below outlines 2017-2018 funding allocations by sector.

Performance Targets

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

The MLAA includes consistent province-wide targets to assess the LHIN's performance. These measures may be updated from time to time. In 2015-2016, the Ministry moved from LHIN-specific targets to provincial level targets to strengthen provincial performance and allow for standard cross-provincial comparisons. In 2017-2018, the MLAA included 13 performance indicators and eight monitoring indicators.

- Performance Indicators: The provincial targets for the 13 performance measures are based on best practice and clinical evidence where possible.

- Monitoring Indicators: The eight monitoring measures can provide supplemental or explanatory information about the performance measures.

The table on pages 16 and 17 outlines each MLAA Indicator along with the provincial target and the Central LHIN's 2017-2018 results, and pages 18 and 19 provide specific commentary on each of the performance indicators. The Central LHIN reports to the Ministry on the performance of these indicators quarterly.

Funding Allocations By Sector	2018	2017
Hospitals	$1,326,779,317	$1,259,701,164
Long-Term Care Homes	355,313,627	347,927,561
Community Care Access Centres	57,841,705	318,610,800
Community Support Services	95,501,061	92,076,075
Community Mental Health and Addictions	84,902,155	82,431,488
Community Health Centres	13,397,510	12,891,912
TOTAL	**$1,933,735,375**	**$2,113,639,000**

Central LHIN Performance and Targets as Defined by the Province of Ontario 2017-2018

No.	Indicator	ON target	Province			Central LHIN		
			2015/16	2016/17	2017/18 YTD	2015/16	2016/17	2017/18 YTD
1. Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.36%	89.86%	88.50%	83.68%	92.39%	93.14%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.00%	96.07%	96.21%	94.23%	96.65%	96.47%
3	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	30.00	29.00	33.00	33.00	22.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	6.00	6.00	5.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.97	10.38	10.75	9.80	10.20	10.35
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.07	4.15	4.38	3.33	3.50	3.80
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	79.97%	78.47%	77.99%	97.46%	97.90%	97.40%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.14%	75.02%	73.72%	96.20%	96.41%	95.31%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.50%	15.69%	15.18%	14.36%	15.95%	16.79%
10	ALC rate	12.70%	13.98%	15.19%	15.68%	13.87%	15.72%	15.14%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	20.19%	20.67%	20.97%	18.99%	19.28%	19.99%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	33.01%	32.50%	32.25%	26.02%	25.12%	25.24%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.65%	16.74%	16.41%	15.92%	15.94%	15.78%

No.	Indicator	ON target	Province			Central LHIN		
			2015/16	2016/17	2017/18 YTD	2015/16	2016/17	2017/18 YTD
2. Monitoring Indicators								
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	88.09%	85.01%	83.95%	98.46%	96.69%	99.68%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	62.58%	67.57%	69.77%	67.66%	69.42%	67.87%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.18%	82.11%	84.73%	83.75%	82.66%	83.87%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	13.00	14.00	22.00	19.00	21.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.00	4.00	6.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	18.47	17.12	12.06	6.87	6.41	4.37
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.13	321.18	243.31	177.72	177.24	145.67
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.61%	47.43%	47.31%	54.31%	54.83%	53.80%

*FY 2017-2018 is based on the available data from the fiscal year (Q1-Q3, 2017-2018)
**FY 2017-2018 is based on the available data from the fiscal year (Q1-Q2, 2017-2018)
NA = Not Available

See the following pages for commentary on the performance indicators.

Home and Community Care

Performance Indicators 1-4

Central LHIN continues to perform well in the Home and Community Care performance indicators, and is either at or near the Ontario target. While the LHIN faced increased demand for services in 2017-2018, targeted investments in key service areas, along with improvement strategies with our service providers allowed the LHIN to maintain or improve performance.

Similar to 2016-2017, the LHIN continued to fund additional capacity in Nursing and Personal Support Services to address increased demand for services. Additional investments in the community to assist with demand for services include expanding enhanced Assisted Living services, Adult Day Programs, and Attendant Outreach programs.

Our staff have also been working closely with our service provider organizations on a variety of improvement activities aimed at improving access to care and better patient outcomes.

System Integration and Access

Performance Indicators 5-6

Wait times for patients in Emergency Department (ED.)

Central LHIN continues to meet the provincial target for length of stay for minor/uncomplicated patients. We have been unable to meet the target for length of stay for complex patients. This is largely due to the increasing volume of complex patients seen in our hospitals. Central LHIN continues to have the highest emergency department volumes for complex patients among all 14 LHINs. Four of our hospitals are among the top 10 hospitals in the province with the highest emergency department volumes with complex patients.

Our hospitals have focused initiatives to improve patient flow through emergency, such as expanding clinic hours to weekends to offset demand, as well as activities targeting length of stay for complex admitted patients. Central LHIN implemented a transitional care model that provided restorative care services to facilitate patient transitions to home.

All hospitals continue to receive emergency department pay for results funding to implement programs to improve patient flow through the emergency departments and improve patient satisfaction.

Performance Indicators 7-8

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

Central LHIN maintained its strong wait time performance for hip replacement and knee replacement surgeries. Central LHIN's Total Joint Assessment Centre for hip and knee replacements will be expanded, and five Central LHIN hospitals will be implementing a musculoskeletal central intake, assessment and management program to improve patient access to musculoskeletal specialists.

Performance Indicators 9-10

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

ALC continues to be a challenge for Central LHIN, largely due to patients waiting for Long-Term Care Home placements. Central LHIN is one of the top four LHINs with the longest wait times in the province (*source: Health Quality Ontario Wait Times for Long-Term Care Homes).*

The LHIN has funded additional capacity in the community, through enhanced assisted living programs and transitional care model to provide an alternative to long-term care or as an interim step while patients wait placement.

In addition, the LHIN has funded programs to assist with patient flow. Examples include LOFT's Behavioural Support Transition Resource Team, which provides transitional support services to hospital inpatients with cognitive and/or responsive behaviours, which may have been a barrier to their discharge; and Humber River Hospital's ALC dashboard which has been implemented in five hospitals to improve patient flow.

Central LHIN's Reactivation Care Centre, opened in December 2017, provides much needed additional capacity at the LHIN. The focus on reactivation will improve patient flow in the hospitals.

Health and Wellness of Ontarians – Mental Health

Performance Indicators 11-12

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

Mental Health and Addictions is a specific area of focus by the LHIN, as noted by our Better Mental Health Strategic Priority. While the LHIN did not achieve our targets in these two areas, we continue to have better than the provincial average, and the LHIN expects to see the impact of the 2017-2018 investments into 2018-2019.

Targeted initiatives include the expansion of an Assertive Community Treatment Team in the South Simcoe Region, Rapid Access Addictions Medicine Clinics across the LHIN and expansion of withdrawal management services.

Sustainability and Quality

Performance Indicator 13

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

Central LHIN's performance on this indicator improved in 2017-2018 and is within 10 per cent of the target. The LHIN continues to monitor performance on a number of initiatives including COPD clinics, telehomecare program, and exercise and falls programs across the LHIN. Central LHIN's five Health Links facilitate community connections, strengthen linkages across care providers, and highlight opportunities to better coordinate care across organizations and sectors.

Strategic Priorities

Central LHIN's Integrated Health Service Plan (IHSP4) 2016-2019 aligns with our accountabilities under the *Local Health System Integration Act*, the obligations in our Ministry LHIN-Accountability Agreement and Memorandum of Understanding and our commitments under the *Patients First Act, 2016* – to put patients at the centre of the health system by improving their health care experience and outcomes.

As health system planning and care delivery evolves in response to the changing needs of patients and their families, Central LHIN leads collaboratively with our stakeholders to improve people's access to the right care, deliver better coordinated and integrated care in the community, inform people so they can make good decisions about their health and to protect our universal public health care system by making evidence-based decisions on value and quality.

Ongoing collaboration with valued partners and stakeholders includes validating our priorities in the context of changing local health needs, environmental scans, and reviewing insights and data from system partners – including Public Health Units and Primary Care Providers – also inform our action plans and initiatives.

Our six IHSP4 strategic priorities are:

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

With the passage of *Patients First*, along with stronger links to public health and primary care, Central LHIN has an expanded mandate to deliver home and community care in our region.

The following pages of this report provide greater detail on each of our strategic priorities, including why a focus on each priority is important – in context of the local health system and local health needs, what we did last year to move towards our goals under each priority, and how this benefits patients, families and caregivers.

Better Seniors' Care

"Help me to live at home as long as I can"

A key planning consideration for Central LHIN is our population of older adults. Among all LHINs, Central LHIN has the highest absolute number of seniors who are aged 65 plus, and projections show that we will continue to have the highest number over the next twenty years. By 2035, over half a million seniors will live in the Central LHIN – comprising over 22 per cent of the total population.

Our rapidly aging population contributes to a greater need for targeted services and supports for elderly patients living with increasingly complex and chronic health conditions – including home and community care, convalescent care, assisted living, adult day programs, mental health and behavioural supports and many other community based programs and services.

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

Through the action plans under this priority we aim to ensure seniors have more timely access to appropriate care, quality, viable choices when living at home is no longer possible, and better overall outcomes.

2017-2018 Priority Action Areas and Successes

1. **Based on the LTC Capacity Plan, develop and implement community-based alternatives to traditional institutional LTC for seniors.**

- Expanded the Assisted Living model of care for an additional 70 high risk seniors to help more seniors live independently at home.

- Established an Enhanced Adult Day Program Working Group who conducted a current state analysis, client profile and provided recommendations for future adult day program design and delivery. This work contributed to the development and implementation of a new Adult Day Program best practice manual.

- Expanded three Adult Day Programs to support an additional 58 clients and their caregivers.

2. Continue to develop, implement and evaluate sustainable improvement strategies that enhance system capacity for patients waiting for Alternate Levels of Care (ALC) in Central LHIN hospitals.

- Continue to support initiatives through the Central LHIN ALC Collaborative to improve patient flow in hospitals and identify opportunities to enhance care transitions and system capacity. This collaboration includes membership from six hospitals and the Central LHIN.

- Opened the *Reactivation Care Centre (RCC) – a Central LHIN Hospitals Collaborative*. This site repurposed the former Humber River Hospital-Finch site to create 150 new beds to address bed capacity issues in local hospitals. The model of care follows Ministry guidelines for Assess and Restore, including enhanced activation and restoration typically not provided within an acute care setting. Within seven days of opening, the RCC achieved 95 per cent occupancy rate.

- Also at the *RCC*, an additional 56 beds are used by Mackenzie Health to support patients requiring complex continuing care or rehabilitation as an interim measure until their new hospital site is ready.

- Implemented the Transitional Care at Home pilot program to support patients who have been discharged from the hospital. This program provided resources, including enhanced activation and restorative care services, to 154 patients in 2017-2018 *(Data source: CHRIS)*. The program helps patients remain at home and in the community for as long as possible.

- Developed and implemented a Behavioural Support Transitions Resource (BSTR) team to focus solely on the provision of behavioural support services to patients admitted to Central LHIN hospitals with cognitive and/or responsive behaviours which have been identified as "barriers" to discharge destinations. Through early identification, assessment and stabilization the BSTR team provides a coordinated approach to assist patients in transitioning to their discharge destinations to support is "flow" from the hospital to appropriate housing and supports.

- Developed a standardized Discharge Planning Pathway in collaboration with six hospitals and Central LHIN Home and Community Care to allow for the early identification, engagement and management of patients requiring discharge planning interventions. Aligned with the implementation of *iPlan*, a new technology that integrates elements of the discharge pathway with hospital electronic medical records for use by the hospitals and the LHIN to facilitate timelier patient care transitions across all sites.

3. Continue to implement, evaluate and spread assess/restore pilot projects to enhance rehabilitative and restorative care services that prevent functional decline for frail elderly patients.

- Continued to support the Assess and Restore pilot project at North York General Hospital and Central LHIN Home and Community Care to provide early screening and assessment to identify seniors at risk of functional impairment. These patients may receive enhanced rehabilitative services in the hospital, at home or in an outpatient exercise program.

4. Strengthen the alignment between Specialized Geriatric Services (SGS) and LTC Homes within sub-region planning areas to improve resident care through stronger coordination and access to service delivery.

- Led a comprehensive review of SGS with providers, subject matter experts and LTC Homes to develop an integrated and coordinated SGS Outreach Team model of care. This approach create stronger linkages across SGS teams to improves care access and outcomes, and reduce patient transfers to hospitals.

- Increased use of *ConnectingOntario*, which is a secure, web-based portal that provides real-time access to digital health records including dispensed medications, laboratory results, hospital visits, home and community care services, mental health care information, and diagnostic imaging reports in four Central LHIN hospitals and two LTC homes.

5. Continue to develop and formalize the Central LHIN Dementia and Caregiver Support Strategy.

- Established a Central LHIN Dementia Strategy Advisory Committee with a mandate to develop a local strategy that aligns with the Provincial Dementia Strategy.

- Released *A Planning Framework for Improving Supports to Caregivers – A Discussion Document* for review by key stakeholders, with a plan to more broadly release the framework in 2018-2019 for structured consultation, input from caregivers and Health Service Providers.

- To better meet the needs of seniors with responsive and complex behaviors, supported additional specialized staffing resources in LTC and community settings to strengthen provincial Behavioural Supports Ontario (BSO) initiatives.

Better Palliative Care

"Support me to live and to die with quality and dignity"

Central LHIN's *Better Palliative Care* strategic priority aims to help patients with progressive, life-limiting illness to live as they choose, and to die in their preferred location – with quality of life, comfort, dignity and security.

To help achieve those goals, the Central LHIN funds and collaborates with a variety of providers, and also provides direct services, to support palliative and end-of-life care. Improved access to integrated palliative supports and services is a key focus.

2017-2018 Priority Action Areas and Successes

1. Continue to implement the Central LHIN Palliative Care Action Plan in alignment with sub-region planning through our Regional Palliative Care Network.

- Managed a centralized access and registry service for all Central LHIN hospice providers which provided 725 patients with information and support and facilitated admission of 182 patients into residential hospice care.

- Introduced new community-based dedicated palliative nursing and personal support providers.

- Provided funding to Hospice Palliative Care (HPC) Teams. Operating 24/7, the HPC Teams received 1,567 referrals and provided 22,917 consultations for palliative pain and symptom management and 2,290 home visits. *(Data source: HPC Teams for Central LHIN)*

- To expand system capacity, funded HPC Teams to provide palliative care education to other providers (physicians, palliative care providers, LTC homes and volunteers). HPC Teams provided palliative care education to 2,197 providers across the LHIN in 2017-2018. *(Data source: HPC Teams for Central LHIN)*

- Using the new OTN equipment for education to LTCHs, HPC Teams provided 10 monthly education sessions, which were archived for future viewing.

- Funded four other Community Support Service providers to provide visiting hospice services to 1,200 patients and their families.

- Funded support services to residential hospices.

- Additional support was provided through 1-844-HERE-4ME – a 24/7 Palliative Care Crisis Line. Over the phone, Registered Nurses provided expertise and support to 133 patients and their families on urgent issues related to worsening or changing physical pain or symptoms, medical equipment or supply concerns, or patient or caregiver emotional well-being.

- Enhanced the online directory for palliative care and end-of-life resources for patients, caregivers and providers, available at *www.centralhealthline.ca.*

- Measured and responded to patient experience through the "Voices Survey", which was sent to all palliative caregivers for evaluation on the care and services received from the LHIN or other organizations during their family member's last three months of life.

Feedback is used for continuous quality improvement in service design and delivery. In the first half of 2017-2018 (available at the time of writing of this report), 88.8 per cent of respondents provided a positive overall rating (good, very good or excellent). *(Survey source note: McMaster University/NRC Health)*

2. Continue to operationalize Ministry-approved residential hospices.

- Continued to advance the residential hospice bed strategy. At the beginning of 2017, Central LHIN had three residential hospices operating 17 palliative care beds. Work has been underway to increase this to six hospices operating 52 residential hospice beds by 2020. Some of the success notes for this year included:

- The Margaret Bahen Hospice for York Region opened with 10 new residential hospice beds. Operationalizing this hospice resulted in a successful integration between Better Living Community Services and Pal Care Network for York Region, and an updated model for quality-focused hospice palliative care.

- Hospice Vaughan, which currently operates a visiting hospice program, received capital funding to plan and construct a new 10-bed residential hospice facility to open in 2019. Also operating will be the Hospice Vaughan Centre of Excellence in Hospice Palliative Care offering counselling and day programs for families, as well as patient care research and education services.

- Neshama Hospice received a $2 million capital planning grant to prepare a new 10-bed residential hospice to open in North York in 2019.

3. Develop a comprehensive Palliative Care Strategy for Central LHIN that incorporates community need within a broader spectrum of palliative and end-of-life care.

- Guided by the Central LHIN Regional Palliative Care Network, work is underway to develop a comprehensive, patient-informed regional strategy aligned with Ontario Palliative Care Network's (OPCN) Action Plan and Health Quality of Ontario's Palliative Care Standards.

Better Care for Kids and Youth

"Provide my kids with the best care, that's close to home"

In 2017, an estimated 308,379 children aged 0 to 14 years old were living in Central LHIN, representing 15.9 per cent of the population. This is the highest number of children among all LHINs *(Source: Ministry of Finance, July 2017).* Central LHIN also has the second highest number of births (~18,000) of all LHINs; it is projected that the population of children in our LHIN will increase by 15.8 per cent in 10 years. In addition, the Central LHIN has the highest number of youth with medical complexity in Ontario.

Central LHIN's *Better Care for Kids and Youth* strategic priority is focused on developing new partnerships and innovative models to bring specialized care closer to home for children and youth.

2017-2018 Priority Action Areas and Successes

1. Review the final 2017 evaluation of the Cross Sector Complex Care Model and investigate expansion.

- Completed an evaluation of the Cross Sector Complex Care Model. Findings noted that the congregate care model of care enabled highly individualized care, integrated health and developmental sectors and enhanced social determinants of health. While still in early stages, the report suggests that congregate care may be a promising approach to support young adults with medical and development complexities which may not be as supported in other care models. *(Source: Cross Sector Complex Care Model: Evaluation Report April 2017)*

- The Cross-Sector Model was recognized as a Minister's Medal Honour Roll Recipient for Transforming Ontario's Health Care System in October 2017.

- Building on the innovation of our Cross Sector Complex Care Model, the Ministry of Community and Social Services led a process to bring together 10 social service type agencies from across Ontario as a consortium to develop a provincial strategy and approach for congregate care solutions. The Central LHIN's location, Reena Residence, is a partner in this consortium.

Additional Progress

- Co-chaired the *York Region Planning Collaborative for Children, Youth and Families* with Kinark Child and Family Services, a cross-sector, cross-ministerial table that provides planning support for services for children and youth with complex needs, including mental health conditions.
- Supported expansion of the Ontario Midwifery Program for low-risk women living in Markham, Richmond and North York. Research advises that midwives can offer unique support to women who may have difficulty navigating the health system due to language, culture or other constraints, and thus strengthen patient experience.
- North York General Hospital began redevelopment of its Phillips House building to be completed in 2018-2019. This redevelopment project will integrate the hospital's ambulatory and transitional mental health care services and create an accessible, multi-purpose mental health facility for children, adolescents, young women and their families.
- Provided one-time funding for two years to North York General Hospital to mitigate gaps in access to care and patient safety in its Maternal, Newborn and Paediatric Program and to support expansion of paediatric ambulatory clinical services.
- Markham Stouffville Hospital announced it is joining the Kids Health Alliance to support children with improved access to care closer to home and enhanced care coordination, transitions, research and clinical practice sharing between facilities and the care continuum.

Better Community Care

"Give me a system of integrated health services in my community"

Patients and families have identified that a more seamless health care system, easier to navigate and easier to transition between home and community care, primary care and acute care would make the system more patient-focused.

There are just under 1,800 Primary Care Physicians, 11 Family Health Teams and two Nurse-Practitioner-Led Clinics in the Central LHIN.

There are also seven public Hospitals, two Community Health Centres, eight Central LHIN Community Clinics and dozens of Community Support Service Agencies, many of whom the Central LHIN held Accountability Agreements and funded in 2017-2018. Moreover, the *Patients First Act, 2016* outlined requirements for more formal linkages between LHINs and Primary Care and Public Health Units.

Central LHIN's *Better Community Care* strategic priority aims to create stronger links to integrated community services and to primary care to help patients recover and receive more of their health care at home with safety and independence.

Through the Accountability Agreements, the Central LHIN Sub-Region Collaborative Tables, and other network tables and engagements, the Central LHIN worked with providers and patient partners to address gaps and help plan needed services to improve patient experience and outcomes.

2017-2018 Priority Action Areas and Successes

1. **Partner with primary care providers and specialists to improve patient connectivity and access to care within the Central LHIN's six sub-regions.**

- Over 94.4 per cent of adults within the Central LHIN are attached to a primary care provider. Through the Central LHIN's Information and Referral Team, our centralhealthline.ca resource, and referrals to Health Care Connect service, we provided patients with critical information on how to secure a primary care provider *(Data source: Health Care Experience Survey, 2017-2018, MOHLTC).*

- Central LHIN staff engaged with primary care providers to advance awareness of services and processes to support patient transitions.

- Established the Central LHIN Sub-Region Collaborative Tables, which includes health care providers from primary and acute settings and other sectors, to review opportunities to strengthen and integrate care.

- Expanded implementation of eNotification to Markham Stouffville Hospital and North York General Hospital. eNotification is a near real-time electronic message sent to primary care providers to notify them when their patients are discharged from the Emergency Department or are admitted or discharged from in-patient units.

2. Strengthen community-based collaborative care through sub-region initiatives to improve the continuity of care for patients, clients and caregivers receiving services in Central LHIN.

- Continued to fund two Community Health Centres (CHCs) which provided inter-professional care services to over 14,700 people in 2017-2018 *(Data source: Health Indicator tool, MOHLTC)*

- Central LHIN funded 33 community support service (CSS) providers to provide services to support independent living in the home or in supportive residential settings. Services included homemaking, dining and meal services, security checks, transportation services, respite care and palliative care services. The LHIN also engaged with these CSS providers on new guidelines for care.

- Launched several population health programs in collaboration with the three public health departments in the Central LHIN – Simcoe Muskoka District Health Unit, Toronto Public Health and York Region Public Health Services – including holiday surge planning, opioid abuse harm reduction and smoke cessation.

- Collaborated with three municipal Paramedic Services to develop a Community Paramedicine Strategy. This program relies on paramedic professionals to support non-emergency, in-home care for patients.

- Continued to fund iRIDE^{Plus} which provides transportation services to help vulnerable patients – frail seniors/adults with age-related conditions, adults with physical/cognitive disabilities or mental illness not eligible for municipally funded mobility transit – to attend medical and other critical appointments.

- Funded 33 adult day programs and 630 exercise/falls prevention classes. Also worked with York Region Public Health and other community partners to develop a regional integrated falls prevention strategy. *(Source Central LHIN internal data)*

- In total, 2,785 people received Assisted Living services, 4,273 people received 379,00 meal deliveries, and over 9,000 patients received close to 235,000 rides to medical appointments or other LHIN funded programs such as Adult Day Programs in 2017-2018.

- Increased the number of Central LHIN primary care providers to over 1,000 who now receive hospital reports and laboratory test results directly into their Electronic Medical Record through Health Report Manager and Ontario Laboratory Information System.

- Expanded eConsult adoption by primary care providers: 461 primary care providers in Central LHIN are now live with eConsult, which supports sending electronic consultation requests to specialists.

3. Begin implementation of Central LHIN's three year strategy to reduce wait lists and service pressures for Acquired Brain Injury (ABI) and Attendant Outreach services.

- Expanded Acquired Brain Injury services – including personal support, independence training and psychology. This increased support helped decrease wait times, decrease inappropriate living situations, and improve system capacity.

- Expanded Mobile Attendant Outreach Services to support an additional seven community-based adults with physical disabilities with around-the-clock pre-scheduled and on-call care.

4. Continue to improve consistency and equity in service provision for home care clients.

- Please see page 29 (Home and Community Care section).

Better Care for Underserved Communities

"Respond to my community's unique needs in an equitable way"

Central LHIN's highly diverse demographics contribute to the depth and richness in our communities. It also adds complexity in addressing the health care needs of residents.

Central LHIN's *Better Care for Underserved Communities* strategic priority aims to create organized, integrated systems of care to improve early intervention and disease treatment in neighbourhoods where there are recurring patterns of chronic and acute or episodic health conditions. We are also looking to develop partnerships that will improve long-term health by addressing the key factors that determine healthy outcomes.

In support of these goals, Central LHIN relies on strong collaborations among our many system partners including: Public Health Units, Health Service Providers (funded and non-funded), Entité 4, Indigenous community leaders, municipalities, patients and families. Planning at a sub-region level will enable providers and partners to better understand specific population characteristics, service capacity and areas in need of improvement.

2017-2018 Priority Action Areas and Successes

1. **Continue to work with Public Health Units and explore opportunities to collaborate on joint priorities at neighbourhood, sub-regional and regional levels.**

- Central LHIN funded Black Creek Community Health Centre in partnership with Toronto Public Health, to employ and train Peer Harm Reduction Workers to further support harm reduction activities in response to the opioid crisis.

- Provided funding to Addiction Services for York Region, working with York Region Public Health, to train youth Peer Educators to engage in harm reduction activity for at-risk youth and other individuals.

- Engaged all three Public Health Units (Toronto, York Region and Simcoe Muskoka) as participants in the Central LHIN Sub-Region Collaborative Tables.

- Partnered with all three Public Health Units – Toronto Public Health, York Region Public Health Services, and Simcoe Muskoka District Health Unit – to discuss a unified approach for addressing opioid addiction and overdose prevention in support of the Addiction Strategy.

2. **Continue to identify, support and coordinate services for priority neighbourhoods within LHIN sub-regions (e.g. North York West) that address gaps in equity and access to care.**

- Strengthened relationships with Primary Care and Public Health Units, and leveraged their expertise in health population planning, through engagement and representation on Central LHIN's six Sub-Region Collaborative Planning tables.

- Increased the use of telemedicine across the Central LHIN to make care more accessible; achieved an average of 1,600 telemedicine events per month.

3. **Develop a comprehensive sub-region based strategy for delivering coordinated and accessible Chronic Disease Prevention and Management (CDPM) programs.**

- Through a partnership between Black Creek Community Health Centre, Vaughan Community Health Centre and other community providers, launched a mobile teleophthalmology retinal screening program to better support people with diabetes.

4. **Continue to co-design and support solutions for improved access to culturally appropriate services with Central LHIN urban Indigenous communities and those residing on Georgina Island.**

- In collaboration with Georgina Island leaders and residents, co-designed and implemented new and expanded programs, including transportation, exercise and nutritional classes, counselling and quarterly cultural ceremonies to support improved health outcomes.

- Worked with off-reserve leaders and Health Service Providers (HSP) to provide culturally safe services for improved health outcomes. Initiatives included the development of an Urban Indigenous Health and Community Engagement Strategic Planning Report and expansion of Indigenous cultural healing programs and services into York Region and South Simcoe.

- Continued to encourage completion of Indigenous Cultural Safety Training.
    - In 2017-2018, and supported by Ministry funding, 47 Central LHIN staff and 123 HSP staff completed the online Ontario Indigenous Cultural Safety Training course.
    - Additionally, 180 HSP staff (including mental health and addictions and community services) received in-person Indigenous Cultural Competency Training.

5. In collaboration with Entité 4 and two other LHINs, leverage current resources to implement the Mental Health and Addictions access pathway for Francophone services.

- Continued partnership with Entité 4 to support the Joint Action Plan through implementation of a French Language Service (FLS) Mental Health and Addictions outreach worker to facilitate access to linguistically and culturally appropriate community mental health and addictions services for the Francophone community.
- Partnered with four other LHINs (Central East, Toronto Central, Central West and Mississauga Halton) to develop and implement a cognitive health project model to focus on early detection, intervention and treatment for Francophone seniors experiencing slight cognitive health issues.
- In preparation for the City of Markham's FLS designation on July 1, 2018, established a working group for FLS Act readiness and compliance.
- Supported Markham-based HSPs and Service Provider Organization readiness for Markham's FLS designation by, in partnership with Entité 4, hosting a series of education sessions which provided information and resources on FLS compliance and "Active Offer".
- To increase access to primary care services in French, developed business cases in partnership with Entité 4 to expand inter-professionals primary care in North York West and North York Central. The business cases took into in considerations Francophone residents' health needs and Health Services Providers' capacity to deliver services in French.

Better Mental Health

"Give me help and support so I can recover and stay well"

It is estimated that one in five Canadians experience mental health and/or addiction problems, and up to 20 per cent of youth are affected by a mental illness or disorder (*Source: Mental Health Commission of Canada Report, 2013).*

Addiction and mental health are complex issues caused by many contributing factors. Solutions that address the needs of those experiencing mental health and/or addiction challenges are best developed with active, meaningful participation of everyone involved: people with lived experience, families, and service providers.

Aligned with provincial directions and priorities, Central LHIN's *Better Mental Health* strategic priority aims to integrate a supportive system of programs and services to enhance the wellness of people with mental illness and addictions and to promote and sustain recovery.

The Central LHIN led and contributed to a number of initiatives in partnership with our stakeholders, including patients with lived experience and their families, to develop and support mental health and addictions programs.

A focal point was increasing access, coordination and integration of services, including stronger links with primary care, reducing wait lists and increasing program capacity. There was also extensive work conducted to assess and respond to the opioid crisis developing across Canada and Ontario.

2017-2018 Priority Action Areas and Successes

1. Evaluate the impact and efficiency of mobile crisis co-responder models for possible expansion throughout Central LHIN.

- Partnered with Canadian Mental Health Association York Region and South Simcoe and the Centre for Excellence in Economic Analysis Research at St. Michael's Hospital on an economic analysis of mental health and addictions initiatives in Central LHIN. The LHIN will leverage this analysis to inform future investments in mental health and addictions services.

2. Partner with stakeholders to develop and implement a three-year Addictions Strategy aligned with the provincial Opioid Strategy.

- Collaboratively developed a three-year Addictions Strategy to enhance coordination and service integration and provide recommendations for future Central LHIN investments.

- Partnered with all three Public Health Units – Toronto Public Health, York Region Public Health Services, and Simcoe Muskoka District Health Unit – to discuss a unified approach for addressing opioid addiction and overdose prevention in support of the Addiction Strategy.

3. Integrate access to mental health and addictions services throughout the Central LHIN with a focus on waitlist management, prioritization and standardized eligibility criteria.

- Funded 24 community mental health and addictions agencies to serve almost 50,000 patients in 2017-2018 with case management, diagnosis help, peer support, vocational support, court support, support within housing, crisis services, opioid addiction and problem gambling.

- Provided base funding to support services in coordination with 23 new supportive housing rent supplement units for people with serious mental health issues and/or problematic substance use who are homeless or at risk of being homeless.

- Partnered with Ontario Shores to work on the Increasing Access to Psychological Therapies (IAPT) demonstration project to improve access to structured psychotherapy and reduce wait times for critical mental health services.

- Funded the continuation of the Rapid Access Addiction Medicine (RAAM) Clinic at Southlake Regional Health Centre in partnership with Addiction Services York Region to improve the quality of care for people with substance abuse or addictions conditions in York Region and South Simcoe, inclusive of care pathways to and from primary care providers.

- Supported an additional RAAM Clinic at Humber River Hospital through Addiction Services York Region to service individuals with substance use issues in North York.

- Through system collaboration, introduced a new Winter Solstice Program to provide life skills, recreation programs and hot meal in combination with group interactions and peer support, as well as drop-in services for individuals with substance use issues.

- Established a new Assertive Community Treatment (ACT) Team in South Simcoe to provide intensive treatment, rehabilitation and support services for individuals who have the most serious mental illness, severe symptoms and impairments, and have not benefited from traditional out-patient programs.

- Partnered on the York Region Mental Health Hub Committee. With representatives from the federal and provincial government, hospitals, community-based mental health and addictions service providers, and York Regional Police and Paramedic Services, this committee is developing a collaborative model for individuals with mental health and addictions issues.

- In collaboration with Canadian Mental Health Association Toronto, piloted a safe bed program in Toronto aimed at preventing the criminalization of individuals with mental health and addictions issues.

- Through our Sub-Region Collaborative Tables, Central LHIN supported cross-sector dialogue on mental health and addictions challenges and services utilization rates to enhance collaborative awareness and responses for mental health and addictions services.

LHIN Delivered Home and Community Care

Provide me with information and services to help me remain independent at home

As part of the *Patients First Act, 2016* priorities for system integration, the Central LHIN became accountable for the delivery of home and community care services in 2017.

Aligned with *Patients First: A Roadmap to Strengthen Home and Community Care*, the Central LHIN is committed to providing consistent, efficient, high-quality home and community care that is evidence-based and supports patients and caregivers to live independently at home for as long as possible. We also want to support caregivers in their important role.

Key partners include patients, families, service providers and other providers across the care continuum to co-design integration and innovations in home and community care services to increase equity of access and improve care transitions.

Three unique demographic factors have driven a significant increase in the need for need for home and community care in the Central LHIN: rapid population growth that is outpacing the provincial average, an aging population, and more people with increasingly complex care needs receiving services at home and in the community.

The number of individuals receiving home and community services has increased 19.3 per cent over the past five years. In 2017-2018, the Central LHIN served over 92,000 patients, the highest number among the 14 LHINs. *(Source: Healthcare Indicator Tool, MOHLTC)*

The demand for home and community care services is expected to continue to grow as the population ages and long-term care capacity is challenged. On average in 2017-2018, the Central LHIN received 1,600 new referrals to home and community care every week.

A fundamental way that we support patients and families is through care coordination provided by a team of Regulated Health Professionals who provide health assessment and care planning for patients. In-home services include: specialized nursing, physiotherapy, occupational therapy, speech-language therapy, personal support, social work, nutritional counseling, medical supplies and equipment and system navigation.

As well, Central LHIN operates eight community nursing clinics which provide specialized nursing care, close to where people live and work.

We also provide information and referral services, and coordinate access (assessment, eligibility and waitlist management) to a range of programs and services such as long-term care, assisted living, adult day programs, group exercise and falls prevention classes, palliative care and residential hospices.

2017-2018 Priority Action Areas and Successes

1. **Strengthen home and community care services to provide patients with timely and equitable access and improved outcomes.**

- Completed the Central LHIN/Central CCAC integration while providing seamless patient services.
- Provided over four million hours of personal support to 27,700 patients, with a focus on patients with high and very high needs *(Source: Healthcare Indicator Tool, MOHLTC).*Improved Home and Community Care wait times measure to enable more patients to receive their first nursing or personal support visit within five days. *(Source: Ministry-LHIN Quarterly Stocktake Report 2017-2018 Q4).*
    - 96.1 per cent of patients received their first nursing visit within 5 days, up from 95.6 per cent a year ago
    - 92.4 per cent of complex patients received their first personal support service within 5 days, up from 89.15 per cent a year ago
    - 90 per cent of new community referred patients received their first visit within 22 days of referral, an improvement from 24 days a year ago
- Provided over 199,000 in-home respite hours to support 1,200 patients with complex needs, and their families.
- Supported patients by providing almost 156,000 nursing care services in our eight community clinics (S*ource: Healthcare Indicator Tool, MOHLTC).* These clinics enable serving more patients. The 2017-2018 clinic utilization rate was 78 per cent *(Source: Central LHIN Nursing Capacity Report).*

- Implemented a new Telehomecare program to support patients in the community who have been diagnosed with early Chronic Obstructive Pulmonary Disease or Congestive Heart Failure.
- Central LHIN Mental Health and Addictions Nursing (MHAN) team helped over 980 patients with moderate or chronic mental illness with assessments, care planning, and services linkages.
- In response to patient preferences, our MHAN team piloted Personal Computer Video Conferencing (PCVC) to communicate with patients who preferred to meet in the privacy of their own homes. Patient feedback was very positive, and the team plans to expand the use of PCVC with other patient populations.

2. Engage with other sectors and partners to advance priorities for seamless health care and a better patient experience.

- Engaged with Primary Care Providers to advance awareness and processes in support of seamless patient transitions between primary care and other services.
- The five Health Links teams in Central LHIN completed new Coordinated Care Plans for 2,285 complex patients. *(Source: Central LHIN internal data)*
- Collaborated with retirement homes to create and test a new model of care to improve communication and coordination of care and increase patient satisfaction.
- Helped 2,093 people find a new home in long-term care, when they could no longer manage their health and personal needs independently at home. *(Data Source: LTC System Report March 2018, includes transfers).*
- To support equitable access and improve coordination of palliative care services, managed centralized access and registry services for all hospice providers in Central LHIN:
    - Palliative Patient Registry – Supported 401 patients and caregivers in need of information and support. *(Data source: CHRIS, 2017-2018)*
    - Residential Hospice Bed Registry – Facilitated admission of 182 patients. New residential hospices will be added to this registry as they open to increase coordination and capacity across the LHIN. *(Data source: HPC Teams for Central LHIN)*
- As part of the LHIN's regional palliative care teams model, introduced dedicated nursing and personal support palliative providers in each sub-region to allow interdisciplinary care partners to work more collaboratively and to provide improved patient and caregiver experience and support.
- Following extensive consultation and engagement with other LHINs, legal experts and bio-ethicists, developed processes and training to adhere to legislated guidelines to support patients and families seeking information on Medical Assistance in Dying (MAID). The LHIN's process includes providing patients and families with information and linkages to MAID resources.
- Collaborated with North York General Hospital to support Integrated Funding Models that focused on mid-to end-stage Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF), and stroke care for patients transitioning from hospital to home.
- Collaborated with Sunnybrook Health Sciences Centre, St. John's Rehab and Providence Healthcare on a pathway to support early discharges for stroke patients.

3. Improve the patient experience by partnering with patients in health care planning and service delivery.

- Established our 16-member Patient and Family Advisory Committee to provide advice on local health issues, programs, engagement and communications from the patient, family and caregiver's perspectives to embed the patient voice and experience.
- Continued to secure valuable feedback from Home and Community Care patients and their caregivers through the Client and Caregiver Experience Evaluation (CCEE) survey. Patient responses from the first half of 2017-2018 available at the time of writing this report included:
    - 96 per cent would recommend Central LHIN to their family or friends if they needed help;
    - 96 per cent felt they were treated with courtesy/respect by their Care Coordinator;
    - 94 per cent felt their Care Coordinator understood what was most important to them; and
    - 94 per cent felt they were given enough information about home and community care services.

Integration Opportunities and Successes

In keeping with the accountabilities defined in the *Local Health Integration Network Act, 2006* and a commitment to health system transformation, the Central LHIN works collaboratively with Health Service Providers to identify opportunities to integrate services to support an effective and transparent process that results in more efficient, timely and seamless coordination of care across the system.

By definition, integration can encompass everything from simply coordinating services or partnering with others to provide service, to transferring or fully merging services, operations and organizations. There were several integrations – organizations and projects that occurred in 2017-2018, including:

Home and Community Care Integration

Stemming from the *Patients First Act, 2016*, and executed by Minister's Transfer Order, the assets, responsibilities and liabilities and staff of all 14 Community Care Access Centres (CCACs) transferred to their respective Local Health Integration Networks (LHIN) in 2017.

Thus, the Central LHIN and Central CCAC become one integrated organization effective June 7, 2017, and the LHIN's expanded mandate for the delivery of home and community care services took effect. Collaborative planning between the two organizations and the Ministry of Health and Long-Term Care resulted in a smooth transition for all processes and programs. Patient care continued seamlessly.

Integrated Palliative Care Services

There was an integration between Better Living Health and Community Services (BLHCS) and Palliative Care Network for York Region (PalCare) which leveraged existing relationships and built new networks with hospice palliative providers, including hospices, palliative care teams, primary care and Southlake Regional Health Centre.

This integration supports the continuity of Palliative Care Network for York Region training expertise for non-medical staff and volunteers. BLHCS will further enhance service access by developing new networks to provide services to underserved communities (i.e. newcomers, Indigenous communities; Francophones; the homeless/underhoused; and individuals with mental health and addictions challenges).

As a result of the integration, a new integrated model of hospice palliative care will provide more accessible, equitable, and quality-focused hospice palliative care in York Region.

Health Information System Integration

In June 2017, the Central LHIN supported a proposed voluntary integration of health information technology services between three hospitals: Southlake Regional Health Centre, Markham Stouffville Hospital and Stevenson Memorial Hospital.

This voluntary integration is aligned with the recommendations of the Ministry of Health and Long-Term Care Health Information System (HIS) Renewal Advisory Panel.

By establishing a HIS cluster that shares a common platform and related services, this initiative is aimed to improve the exchange of health information electronically within the hospital – and across multiple sites – to improve patient outcomes, quality of care and system integration.

Electronic patient records allow providers to better manage patient care by:

- Providing accurate, up-to-date, and complete patient information at the point of care,
- Enabling quick access to patient records for more coordinated, efficient care,
- Securely sharing electronic information with patients and amongst clinicians,
- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care,
- Enhancing privacy and security of patient data, and
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health.

As the partnership and implementation evolves, each hospital is committed to ongoing dialogue with their Patient Family Advisory Councils regarding HIS impacts to the patient experience. As well, Central LHIN continues to work with the hospitals to monitor the initiative over a two year period.

Community Engagement

Central LHIN engages on a regular basis with a broad range of stakeholders including patients, families, caregivers, providers and community partners. By involving the right partners at the right time enables our local health system to adjust planning and make informed evidence-based decisions.

Community engagement ensures our work is grounded in the patient voice and experience. It supports collaboration with partners across the system to improve access and services for residents in our communities. And it enables Central LHIN to collaboratively lead health system transformation in and beyond our region.

In accordance with the LHIN Community Engagement Guidelines (posted on our website) and in keeping with our accountabilities under the *Local Health System Integration Act, 2006,* each year the Central LHIN develops and posts a Community Engagement Plan that aligns with our Annual Business Plan and IHSP.

We recognize that community engagement is a dynamic process, with an overarching purpose to inform, educate, gather input, consult, involve, collaborate and empower stakeholder in the planning and decision-making as we collectively work towards improvement in the health care system

Our Community Engagement Plan sets out the best practice strategies that the Central LHIN will use throughout the year to engage with our many stakeholders on key focus areas, particularly where there is an opportunity to further develop relationships with Health Service Providers and help advance Central LHIN's strategic priorities.

Through continued engagement Central LHIN is building health system partner capability to generate innovative ideas, develop implementation plans through new and existing partnerships and measure success against performance system level indicators.

Highlights from the Central LHIN's community engagement activities, consultation and input structures in 2017-2018, which embraced a focus on identification of services for underserved communities and populations included the following:

Central LHIN Patient and Family Advisory Council

The Central LHIN refreshed its patient voice committee in 2017 with the introduction of the Patient and Family Advisory Council. This 16-member panel, which includes representation from each of the LHIN's six sub-regions, meets regularly to provide advice on local health issues and programs from the patient, family and caregiver's perspectives, and advise on strategies to engage and communicate with patients, their families and friends. See more information in section below.

Indigenous Community Engagement

Approximately 91,000 Indigenous people reside in the Central LHIN, representing 0.6 per cent of the population. In 2017-2018, the Central LHIN engaged in face to face meetings with the Health Services office for the Chippewas of Georgina Island along and NinOskKomTin, an urban Indigenous community group, located in Northern York Region, in addition to other Indigenous and non-Indigenous stakeholders to understand key considerations within sub-region planning contexts. *(Data source: 2016 Census, MOHLTC)*

The Central LHIN continues to explore innovative and improved sustainable funding mechanisms to support Indigenous people living both on and off-reserve by asking local Indigenous leaders what their community needs are and how best to meet those needs.

In 2017, meetings with both Georgina Island and NinOsKomTin were held to co-design programs and services that would best meet the need of the local populations. Georgina Island expanded their Central LHIN funded health services to include exercise classes, nutrition classes, transportation and traditional ceremonies. NinOsKomTin expanded their traditional drumming program, and service provision beyond northern York Region and into South Simcoe. NinOsKomTin also developed an Urban Indigenous Health and Community Engagement Strategic Planning Report.

Central LHIN will continue to partner with Indigenous communities to further understand how to support and co-design culturally appropriate, connected and safe services for improved health outcomes.

As part of our planning and service delivery, the Central LHIN has invested in Indigenous Cultural Competency Training for the past four years and continues to support Health Service Providers to better understand the importance of adopting culturally safe practices. Additionally, the Central LHIN was allocated 175 online Indigenous Cultural Safety training seats in 2017-2018 by the Ministry of Health and Long-Term Care for Health Service Provider staff for a more in-depth education opportunity.

Francophone Community Engagement

The Central LHIN is home to over 31,000 Francophones, or about 1.9 per cent of our population according to the provincial inclusive definition of Francophone. *(Source: Inclusive Definition of Francophone (IDF), 2011 Census IDF by Health Analytics Branch, MOHLTC).*The Francophone community in Central LHIN is most represented in the North York Central, North York West sub-regions and in York Region.

To help respond to the health needs of this community, Central LHIN continued to partner with Entité 4 to support the 2017-2018 Joint Action Plan through implementation of a number of initiatives such as French Language Service (FLS) Mental Health and Addictions outreach worker.

Furthermore the engagement with Central LHIN Health Service Providers and Francophone stakeholders (i.e. school boards) continued through the FLS Advisory Committee for North York West and the establishment of a FLS Mental Health Advisory Committee. These committees enabled partnerships between Health Services Providers and other partners in order to facilitate access to linguistically and culturally appropriate community mental health and addictions services for the Francophone community.

In preparation of the designation of the City of Markham under the FLS Act (FLSA), the Central LHIN in partnership with Entité 4 provided a series of education session. The target audience was HSPs and Services Providers Organizations located in Markham. The objective of these sessions was to provide information on the designation process and the implications for the Central LHIN funded Health providers. Information on how to apply the concept of *Active Offer* along with resources to assist organizations with FLSA compliance was also shared.

Health Service Provider Engagement

In addition to Central LHIN's ongoing work with our funded Health Service Providers (HSP) on their individual Service Accountability Agreements and ongoing performance and program dialogues, the Central LHIN Board of Directors, led by the Board Chair, conducted two Governance Council Meetings (May 2017 and November 2017). All Central LHIN-funded HSP Board Chairs, or their delegate, were invited to share governance updates and dialogues.

In addition to in-person meetings, the LHIN periodically provided email updates to LHIN-funded HSP Board Chairs. Also, the Central LHIN Chair and CEO, and occasionally other Board Directors, attended HSP board meetings, annual general meetings, events, or individual briefing and update sessions. In return, public notice is provided for all Central LHIN Board Meetings should any HSP representative or members of the public wish to attend.

Sub-Region Tables for System Collaboration

Enhancing Central LHIN planning and engagement at the local neighbourhood level provides a foundation to advance system transformation through sub-region planning. Moving towards stronger alignment to each of our six sub-regional planning geographies provides opportunity to better integrate care delivery and strengthen patient experience.

Membership at the Central LHIN Sub-Region Collaborative Tables was selected through a robust Expression of Interest process. The first step for these new tables was to collectively identify, plan and implement change opportunities that address unique sub-region challenges as identified through public engagements, data and system analysis.

Central LHIN Sub-region Collaborative Tables are tasked with the following:

- Create strong local and regional partnerships to improve local access to care
- Define opportunities to improve service delivery, build capacity and improve integration across the health system that facilitates seamless transitions for patients, caregivers and providers
- Work together with the LHIN to engage with patients, residents, patients and system partners to best understand sub-region needs at the neighbourhood level
- Prepare recommendations to improve local care that is aligned with the *Patients First* mandate as identified in Central LHIN sub-region reports and summaries
- Plan, implement and monitor local improvements

Through continued engagement, Central LHIN will build health system partner capacity to generate innovative ideas, build implementation plans through new and existing partnerships, and measure success against performance system level indicators. Engagement across the continuum also provides an opportunity to enable technology and information management to connect various sectors of the system and enable patients to access services through enhanced technology utilization.

Integrated Health Service Plan Consultation

The Central LHIN's Integrated Health Service Plan (IHSP) 2016-2019 is in its final year of implementation. Developing this IHSP involved engagement with a broad range of patients, caregivers and Health Service Providers about the barriers and challenges in achieving accessible, equitable and integrated health care. In 2017-2018, the Central LHIN began planning engagement structures and activities that will be introduced throughout 2018-2019 to support the development of the Central LHIN's IHSP 2019-2022.

Board Meetings

All members of the public are welcome to attend Central LHIN Board of Directors open meetings and education sessions. Dates, times and location details for these meetings along with briefing notes and presentation materials are posted to our website.

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

Local Leaders

The Central LHIN Board of Directors, led by the Chair and supported by other Board Members and the Chief Executive Officer, leads outreach activities with local leaders – federal, provincial, regional and local government representatives – who have constituents in the Central LHIN. In 2017-2018, we shared written updates on strategic priorities and coordinated in-person meetings to share dialogue on our strategic priorities, and receive updates on constituent views on health care access, navigation and quality.

Meeting Notices and Guidelines

Public meeting invitations and the LHIN Community Engagement Guidelines are available on our website at: www.centrallhin.on.ca

Sector Tables and Engagement

Many of our stakeholders are invited to participate in Central LHIN committees with the goal to gather input, consult and collaborate in planning activities and decisions. Central LHIN committees that were operational in 2017-2018 included:

- **Acute Elevated Risk Table** – Co-chaired by York Regional Police and the Canadian Mental Health Association, membership of this group also includes Central LHIN, Streamline Access, LOFT Community Services, York Region Paramedic Services, York Support Services Network, Addiction Services York Region, Children's Aid Society and Region of York Social Services. They meet twice weekly to review at-risk individuals who might benefit from services.

- **Adult Day Program Advisory Committee** – Consisting of adult day program providers and Central LHIN staff, this committee meets quarterly to review the status of Central LHIN programs, including current needs and capacity. They continually explore options for collaboration to increase access and equity, improve care, and strengthen the experience of patients and their families who use or require these respite services.

- **Alternate Level of Care (ALC) Collaborative** – Comprised of Central LHIN hospitals and Central LHIN staff, this table provided collective resources to enhance the flow, efficiency, effectiveness and system capacity across the continuum of patient care. The table engaged with hospitals, community and other system partners throughout its mandate of December 2015 to March 2018, and leveraged task groups, including the ALC Working Group and ALC for Rehab Working Group.

- **Assisted Living Advisory Committee** – With representation from the LHIN and assisted living providers, this committee reviews wait times and capacity of assisted living services, and provides a forum to review standardized approaches and service equity for Central LHIN patients, and opportunities to enhance the experience of patients and their families.

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

- **Central LHIN Patient and Family Advisory Council (PFAC)** – The Central LHIN originally established a Citizens Health Advisory Panel (CHAP) in 2013-2014. Aligned with the *Patients First Act, 2016*, the LHIN evolved to a PFAC in 2017. This 16-member panel, which includes representation from each of the LHIN's sub-regions, provides advice on local health issues and programs from the patient, family and caregiver's perspectives and advises on strategies to engage and communicate with patients, their families and friends to support improved patient and health system outcomes

- **Citizens' Health Advisory Panel (CHAP)** – As mentioned above, CHAP was established in 2013-2014 to give voice to the community in the LHIN's system planning initiatives. The CHAP membership and mandate was updated to the Ministry-mandated Patient and Family Advisory Committee in 2017.

- **Clinical Services Vice President Planning Group** – This group consists of clinically-focused senior leaders from Central LHIN hospitals and home and community care to provide specific support for major clinical program/service plans and explore opportunities for patient access to new innovations and expertise. This group makes recommendations using a system-wide planning approach and explores opportunities to scale and spread better practices that can be supported through evidence and data.

- **Collaborate Nottawasaga** – With participants from social service agencies and non-profit organizations, this group collaboratively assists community members identified as an acutely elevated risk to be in an emergency situation for housing, food, mental health, and physical or emotional abuse, and enables immediate multi-agency intervention in high-risk/high-need situations.

- **Community Paramedicine Working Group** – The mandate of this Working Group is to develop a community paramedicine strategy, including recommendations for consideration for investments toward community paramedicine initiatives. The Working Group was established in 2017. Members include Central LHIN staff, York Region Paramedic and Seniors Services, City of Toronto Paramedic Services, and Simcoe County Paramedic Services.

- **Community Sector Working Group (CSWG)** – The CSWG meets quarterly to support the LHIN's IHSP priorities, advise on ways to advance the local health system to achieve desired outcomes, and provide enhanced understanding and insights into sector specific issues. Communiques with key updates from the meetings are shared with all community sector health service providers.

- **Critical Care Network** – Co-chaired by the Central LHIN's Critical Care Physician Lead and Director of Strategic Initiatives, membership includes administrative and clinical leads from each Central LHIN hospital, CritiCall Ontario and other LHIN staff. The group meets bi-monthly and holds additional meetings as required to plan, implement and evaluate performance measures related to Critical Care Services delivery in Central LHIN hospitals.

- **Dementia Strategy Advisory Committee** – Established in 2017, this Advisory Committee is mandated to develop a local Central LHIN strategy that aligns with the provincial strategy and priorities. This strategy will include recommendations and advice on services, programs and allocation of resources to meet priorities over the next three years.

- **Digital Health Advisory Council** – Central LHIN's Integrated Health Service Plan 2016-2019 identifies digital health as a key enabler for achieving priorities of the Ministry, the LHIN and its partners. The Council, which is composed of Information Technology leadership from various care sectors, meets to support the development and implementation of the Central LHIN Digital Health Strategic Plan aligned with the Ministry-LHIN Accountability Agreement and provides guidance and advice on digital health implementations.

- **Emergency Department Working Group** – This working group, which is mandated by the Ministry of Health and Long-Term Care Emergency Department Network, has representation from Central LHIN Hospital's Emergency Department Physician Chiefs and Directors and Emergency Services. They meet bi-monthly to collaborate and exchange best practices and plan, implement, and evaluate performance measures to improve emergency services delivery in local hospitals.

- **Health Links System Planning Committee** – Health Links provides care coordination for patients with complex health and social needs. Initiated in 2012 to oversee and coordinate the implementation of Health Links in Central LHIN and monitor performance of patient and system outcomes. The Operational Working Group is a function of this Committee which works to collaborate and standardize tools, resources, processes to increase adoption of the Health Links approach to care across Central LHIN.

- **Integrated Care Advisory Council (ICAC)** – This cross-sectoral senior leadership group was established in January 2017 to advise on the development of sub-region planning and engagement. Having provided advice on the approach, structure and mandate for the six sub-region collaborative tables, which launched in November 2017, ICAC's mandate has been successfully completed.

- **Integrated Funding Model Implementation Group (NYGH)** – This working group is responsible for the development and operationalization of a pilot project in home and community care. The purpose of this project is to improve care along the continuum, from hospital to home, for patients with chronic obstructive pulmonary disease and congestive heart failure. The group is led by North York General Hospital in partnership with the Central LHIN, Saint Elizabeth, North York ProResp and Circle of Care

- **Long-Term Care Homes (LTCH) Palliative Care Work Group** – The mandate for this work group is to develop and implement a Central LHIN Palliative Care LTCH Strategy, in alignment with the Central LHIN Board Approved Palliative Care Action Plan.

- **Long-Term Care Sector Working Group (LTCWG)** – Works to support the Central LHIN Integrated Health Service Plan priorities, advise on ways to advance the local system to achieve desired outcomes, support knowledge building and exchange to enhance understanding and address of LTC sector specific issues, and improve MLAA performance in the Central LHIN

- **The Mental Health and Addictions Service Coordination Council** – Canadian Mental Health Association-York Region is responsible for the implementation of the Central LHIN Mental Health and Addictions Supports within Housing Action Plan for York Region, working closely with the Central LHIN. To guide the implementation, the Canadian Mental Health Association-York Region is required to establish and support the Mental Health and Addictions Service Coordination Council (SCC). The mandate of the SCC is to collaborate and provide guidance on how to continue moving forward with coordinated mental health and addiction services in the Central LHIN.

- **Mental Health Hub Committee** – Established in 2016 with a focus to improve timely access to high quality crisis services in the right place, while alleviating pressures faced by hospital emergency departments and first responders. The committee has representation from federal and provincial parliamentarians, regional police, emergency medical services, and various providers across the health sector, including York Region hospitals.

- **Musculoskeletal (MSK) Intake & Assessment Steering Committee** – Brings together stakeholders to guide implementation of a centralized intake and assessment model in Central LHIN. Phase 1 (2017-2018) focused on the referral process for total hip and knee replacement. Phase 2 (2018-19 and onwards) will focus on spreading this model to other select MSK conditions. Committee membership includes a patient advisor and Central LHIN clinical and administrative hospital representatives active in hip and knee replacements. Additional sub-groups from this committee focus on components to develop and implement the model.

- **Regional Palliative Care Network** – Advises the LHIN on priorities and needs, oversees the Central LHIN Palliative Care Action Plan., and provides leadership to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care.

- **Regional Palliative Care Teams Implementation Working Group** – Provides strategic advice and recommendations to advance the Palliative Hub Model aligned with Central LHIN sub-regions.

- **Seniors Care Network Steering Committee** – Works with community partners to advance a system of integrated, accessible, patient-centred, and evidence-based services for elderly patients and their caregivers.

- **South Simcoe Integrated Mental Health and Addictions Council** – Is focused on improving mental health and addictions services. The group is chaired by the Canadian Mental Health Association and York Support Services Network, and includes representatives from the Central LHIN, LOFT Community Services, Stevenson Memorial Hospital, My Sister's Place, Krasman Centre, and individuals who have experienced mental health and addictions issues.

- **Stroke Planning and Care Council (SPCC)** – Brings stakeholders together for collaborative planning, input and advice on service integration opportunities and performance improvement to support achievement of targeted performance metrics. Working in alignment with the Ontario Stroke Network's (now Cor'Health) vision and mission, the SPCC provides guidance to the Central LHIN and other stakeholders in stroke care, supporting them to achieve current best practices for stroke care.

- **Sub-region Collaborative Tables** – Established in 2017, six Central LHIN Sub-region Collaborative Tables are working to identify, plan, implement and evaluate transformation opportunities to address unique sub-region challenges as identified through engagement and data analysis.

- **York Region Planning Collaborative for Children, Youth and Families** – Mandated to collaboratively plan for, deliver, and improve system access, responsiveness and integration with a focus on services for children and youth with complex need, including mental health conditions. It is co-chaired by Central LHIN and Kinark Child and Family Services and has memberships from a number of ministerial agencies and sectors.

Progress on Ministry Priorities

Central LHIN's strategic priorities are further guided by a mandate letter from the Ministry of Health and Long-Term Care that reinforces the *Patients First Action Plan* to deliver integrated and comprehensive health services across primary and specialist care, home and community care, hospitals, and other health care settings. The following table outlines the Central LHIN's progress in 2017-2018 as it aligns with the Government's priorities.

Mandate Letter Priorities	Central LHIN Progress on Priorities
Transparency and Public Accountability	• Reviewed and confirmed local health system performance targets in collaboration with the Ministry of Health and Long-Term Care. • Re-negotiated and monitored accountability agreements and funding plans with 83 Health Service Providers. This included hospitals, community health centres, long-term care homes, community service organizations and mental health and addictions service providers. • Contracted with and monitored quality and performance targets with 21 Service Provider Organizations and vendors for home and community care service delivery. • Prepared and shared 2017-2018 Quality Improvement Progress Reports and 2018-2019 Quality Improvement Plan. • Engaged with and supported Health Shared Services Ontario, the pan-LHIN shared services provider. • Posted Board of Director meeting materials – funding decisions, program status updates and briefing notes – as well as Quarterly Stocktake Reports for open reporting and access.
Improve the Patient Experience	• Established a 16-member Patient and Family Advisory Committee to advance the patient voice in system planning. • Surveyed home and community care patients about their services and experiences, and used this information to assess for quality and service opportunities. • Surveyed caregivers about the palliative care and services that their loved one received to support our goal that patients and caregivers will contribute to ongoing quality improvement and health service design and planning. • Funded development of a Planning Framework to help improve supports for caregivers. • Provided enhanced and coordinated respite services for children with complex conditions to support caregivers during school breaks. • Supported expansion of the Ontario Midwifery Program to better support women who may have difficulty navigating the health system due to language, culture or other constraints. • Supported patients and families with easy-to-access information by enhancing the palliative resources at www.centralhealthline.ca.

Mandate Letter Priorities	Central LHIN Progress on Priorities
	• Selected the Coordinated Care Plan (CCP) in Health Partner Gateway (HPG) as our interim electronic CCP management solution for our five HealthLinks. • Expanded eConnect solution to two LTC homes to strengthen integrated care planning and SGD requirements. • Expanded eConsult adoption by Primary Care Providers. eConsult is now used by over 460 Primary Care Providers in Central LHIN. • Over 1,000 Central LHIN Primary Care Providers are now receiving Hospital Reports and Laboratory test results directly into their Electronic Medical record through Health Report Manager and Ontario Laboratory Information System. • Increased number of Telemedicine events across the Central LHIN to an average of 1,600 events per month making care more accessible. • On several different organization initiatives, patients and caregivers provided the Central LHIN with suggestions and feedback on care deliver and system level issues.
Build Healthy Communities Informed by Population Health Planning	• Established six Sub-Region Collaborative Tables with membership from all sectors, including public health, to support integrated local-level patient-centred care. • Implemented dedicated regional palliative care teams, aligned to our sub-regions, to improve care and provide integrated services. • Supported the integration of Better Living Community Services and Pal Care Network for York Region to increase access and equity of quality hospice palliative care. • Evaluated Minister's Medal Honour Roll recipient the "*Cross Sector Complex Care Model"* to inform future services for young adults with medical/development complexities whose needs are not being met in traditional models of care. • Engaged with community partners on expanding inter-professional care in response to feedback from Patients First and sub-region planning consultation sessions in the past two years. • Developed a Central LHIN Community Paramedicine Strategy. • Expanded acquired brain injury services to decrease wait times, improve system capacity and improve quality of life for clients and families. • Expanded Mobile Attendant Outreach Services to support an additional seven community dwelling adults with physical disabilities to receive attendant outreach services 24 hours/day with pre-scheduled and on-call availability. • Continued to fund iRIDEPlus to enable vulnerable populations not eligible for Wheel Trans to attend medical and other critical appointments. • Developed a regional integrated falls prevention strategy in partnership with York Region Public Health.

Mandate Letter Priorities	Central LHIN Progress on Priorities
	• Led outreach to increase care access for people traditionally marginalized, vulnerable and living with chronic conditions. • With Georgina Island leaders and residents, co-designed and implemented new and expanded programs to support improved health outcomes. • Worked with off-reserve Indigenous leaders and Health Service Providers to develop an Urban Indigenous Health and Community Engagement Strategic Planning Report. • Continued to support Indigenous Cultural Safety Training for hundreds of health sector staff to support the provision of culturally safe services. • Expand access and completion of Indigenous cultural healing programs and services to support improved health outcomes. • In partnership with Entité 4, implemented a French Language Service Mental Health and Addictions outreach worker to facilitate access to linguistically and culturally appropriate mental health and addictions services for Francophones. • Implemented a new cognitive health project model in collaboration with other LHINs to support Francophone seniors with detection, intervention and treatment.
Equity, Quality Improvement, Consistency and Outcomes-Based Delivery	• Initiated development of a patient-informed regional palliative strategy aligned with Ontario Palliative Care Network's Action Plan and Health Quality of Ontario's Palliative Care Standards. • Implemented a new Quality framework to help guide system improvements. • Enhanced palliative care capacity in long-term care homes through education and training, including adoption of the Quality Palliative Care in Long-Term Care Toolkit. • Implemented the *Policy Guideline for CCAC and CSS Agency Collaborative Home and Community-Based Care Coordination*, and the *Policy Guideline Related to the Delivery of Personal Support Services by CCAC and CSS Agencies*. • Met or surpassed targets for 57 per cent of indicators of the Home and Community Care Quality Improvement Plan.
Primary Care	• Engaged with Primary Care Providers through the sub-region collaborative tables and one-on-one meetings to discuss system integration opportunities, and to increase awareness of supports and services available through home and community care to support consistent access and referrals. • Advanced inter-professional models of care funding to deliver increased services – including establishing of new satellite location. • The five Health Links teams in Central LHIN completed new Coordinated Care Plans for 2,285 complex patients (4,977 since 2013).

Mandate Letter Priorities	Central LHIN Progress on Priorities
Hospital and Partners	• Opened the Central LHIN Reactivation Care Centre, a five hospital collaborative, to address capacity issues and improve patient access to specialized rehabilitation. • Piloted Transitional Care at Home to support patients to remain in the community as long as possible. • Supported North York General Hospital capital project to integrate ambulatory and transitional mental health care services, enhance maternal, newborn and pediatric programs, and create an accessible, multi-purpose mental health facility for children, adolescents, young women and their families. • Supported Markham Stouffville Hospital membership in the Kids Health Alliance, to improve access to quality care for children closer to home, improving their health through best clinical practices, enhancing coordination of health-care delivery, facilitating transitions between facilities across the care continuum, and driving innovation through collaborative research and education.
Specialist Care	• Collaboratively managed residential hospice applications and waitlists to increase equitable access for palliative patients. • Reviewed Specialized Geriatric Services and developed a new model that creates stronger linkages, improves access to care and patient outcomes, enhances use of existing resources, and minimizes avoidable transfers to hospitals. • Provided more specialized staffing resources in long-term care and community settings to better support senior with behavioural issues. • Improved care quality by funding best practice-based palliative education for physicians, health professionals, care providers and volunteers.
Home and Community Care	• Aligned with the *Patients First Act, 2016*, and by Minister's Transfer Order, completed the transfer of Central CCAC (Home and Community Care) to the Central LHIN without any interruption to patient care services. • Improved home and community care wait times so more patients received their first Nursing/Complex Personal Support service visit within five days. • Enhanced services by initiating in-home respite hours for over 800 patients with complex needs. • 24 per cent of patients requiring nursing services received care in our cost-effective community clinics. • Increased funding, supports and leading practice working group for adult day programs and assisted living model of care. • Advanced the Assess and Restore pilot program to support frail seniors.

Mandate Letter Priorities	Central LHIN Progress on Priorities
	• Created new model of care in collaboration with retirement homes. • Improved coordination and access to palliative support through centralized patient and bed registries and a 24/7 Palliative Care Crisis Line. • Developed processes to adhere to legislated guidelines and provide support to patients and families who elect for medical assistance in dying. • Expanded implementation of eNotification to two Central LHIN hospitals (Markham Stouffville Hospital and North York General Hospital).
Mental Health and Addictions	• Established a Dementia Strategy Advisory Committee to develop a strategy, aligned with provincial direction, to meet local needs. • Developed a three-year Addictions Strategy to enhance coordination and service integration and provide recommendations for future Central LHIN investments. • Partnered with public health to develop a unified approach for addressing opioid addiction and overdose prevention, in support of the Addiction Strategy. • Aligned with the provincial Opioid Strategy, provided increased funding to support treatment for substance abuse and addiction treatment services, including Rapid Access Addiction Medicine (RAAM) Clinics. Supporting services included life skills, peer supports, recreation programs and meals programming. • Created a new Assertive Community Treatment (ACT) Team in South Simcoe to provide intensive treatment, rehabilitation and support services for individuals who have the most serious mental illness, severe symptoms and impairments, and have not benefited from traditional out-patient programs. • Funded mental health and addictions outreach to the French speaking newcomer population to build knowledge, facilitate early detection, and improve linkages to appropriate services. • Improved access to psychotherapy and reduced wait times for critical services in mental health care through a partnership demonstration project with Ontario Shores. • Funded support services in coordination with 23 new supportive housing rent supplement units for people with serious mental health or substance use issues who are homeless or at risk of being homeless. • Began working with Canadian Mental Health Association Toronto to pilot a safe bed program in the City of Toronto aimed at preventing the criminalization of individuals with mental health and addictions issues. • Participated on the York Region Mental Health Hub Committee to develop a proposal for a Mental Health Hub to address the increasing trend of emergency department use by people with mental health or addictions issues.

Mandate Letter Priorities	Central LHIN Progress on Priorities
Innovation, Health Technologies and Digital Health	• Supported patients to self-manage their chronic diseases and improve their outcomes through Telehomecare. • Piloted use of Personal Computer Video Conferencing equipment to increase patient access to Mental Health and Addictions Nurses. • Supported our Hospice Palliative Care teams to use Ontario Telemedicine Network technology to facilitate education in long-term care homes. • Supported community partnership launch of a mobile Teleophthalmology retinal screening program to better support people with diabetes. • Central LHIN now has five of six public hospitals contributing to *ConnectingOntario*: Humber River Hospital, North York General Hospital, Southlake Regional Health Centre, Stevenson Memorial Hospital, and Markham Stouffville Hospital.

Financial statements of

Central Local Health Integration Network

March 31, 2018

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Independent Auditor's Report

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

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

Deloitte LLP

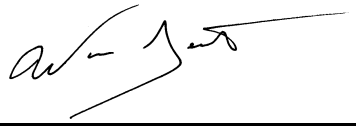
Chartered Professional Accountants
Licensed Public Accountants
June 26, 2018

Central Local Health Integration Network
Statement of financial position
as at March 31, 2018

	Notes	2018	2017
		$	$
Assets			
Current assets			
Cash		**31,095,681**	343,604
Due from Ministry of Health and Long-Term Care ("MOHLTC")	14	**9,674,366**	2,624,828
Accounts receivable		**6,840,697**	43,704
Prepaid expenses		**694,096**	64,973
		48,304,840	3,077,109
Capital assets	7	**1,684,930**	109,388
		49,989,770	3,186,497
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**37,016,366**	396,174
Due to Health Service Providers ("HSPs")	14	**9,674,366**	2,624,828
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**1,614,108**	56,107
		48,304,840	3,077,109
Deferred capital contributions	8	**1,684,930**	109,388
		49,989,770	3,186,497
Commitments	9		
Net Assets		**—**	—
		49,989,770	3,186,497

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

Approved by the Board



Warren Jestin, Chair of the Board of Directors

David Lai, Chair of the Audit Committee

Central Local Health Integration Network

Statement of operations and changes in net assets

year ended March 31, 2018

	Notes	2018 Actual	2017 Actual
	3	$	$
Revenue			
MOHLTC funding - transfer payments	14	**1,933,735,375**	2,113,639,000
MOHLTC funding - Operations and Initiatives		**298,813,918**	5,558,208
Other funding sources:			
Enabling technologies	5	**476,000**	423,000
Cancer Care Ontario		**1,528,783**	—
Interest income		**324,652**	—
Amortization of deferred capital contributions	8	**407,687**	37,513
Recoveries		**382,976**	—
		301,934,016	6,018,721
		2,235,669,391	2,119,657,721
Expenses			
HSP transfer payments	14	**1,933,735,375**	2,113,639,000
Operations and Initiatives			
Contracted out:			
In-home/clinic services		**203,891,670**	—
School services		**8,222,182**	—
Hospice services		**1,139,444**	—
Salaries and benefits		**60,803,103**	4,586,840
Medical supplies, equipment rental and minor equipment		**13,250,625**	—
Supplies and sundry		**3,003,701**	982,500
Accommodation		**3,062,114**	331,686
Amortization		**407,687**	37,513
Information technology		**1,483,685**	80,182
		295,264,211	6,018,721
		2,228,999,586	2,119,657,721
Excess of revenue over expenses before the undernoted		**6,669,805**	—
Expenses of the restricted contribution fund		**(41,097)**	
Net liabilities assumed on transition	12	**(6,628,708)**	—
Excess of revenue over expenses		**—**	—
Net assets, beginning of year		**—**	—
Net assets, end of year		**—**	—

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

Central Local Health Integration Network

Statement of cash flows

year ended March 31, 2018

	Notes	2018	2017
	3	$	$
Operating activities			
Excess of revenue over expenses		—	—
Cash received on transition	12	22,852,650	—
Net liabilities assumed on transition	12	6,628,708	—
Less amounts not affecting cash			—
Amortization of capital assets		(407,687)	(37,513)
Amortization of deferred capital contributions	8	407,687	37,513
		29,481,358	—
Changes in non-cash working capital items	11	1,270,719	(37,149)
		30,752,077	(37,149)
Investing activities			
Purchase of capital assets		—	(65,322)
Leasehold improvement		(1,273,656)	—
		(1,273,656)	(65,322)
Financing activity			
Deferred capital contributions received	8	1,273,656	65,322
Net increase (decrease) in cash		30,752,077	(37,149)
Cash, beginning of year		343,604	380,753
Cash, end of year		31,095,681	343,604

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

1. Description of business

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

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

The mandate of the LHIN is as follows:

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

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

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.

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.

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 approved by the MOHLTC to support LHIN managed Health Services Providers and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC in the MLAA. 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 to the Health Service Provider and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds 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 life of an asset, are capitalized

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

Furniture and equipment	5 years
Computer and communications equipment	3 years
Leasehold improvements	Over the term of the lease

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized 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 is permitted only in certain circumstances. The impact of this policy on the current year is detailed in note 12.

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 and 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 home and community care services as described above, there has been a significant change in the operations of the LHIN over the 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 to the current year's presentation.

4. Funding repayable to the 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	**56,107**	36,158
Funding repaid to MOHLTC	**(56,107)**	(634)
Funding repayable to the MOHLTC related to current year activities	**1,614,108**	— 20,583
Due to MOHLTC, end of year	**1,614,108**	56,107

5. Enabling technologies for integration project management office

Effective February 1, 2012, the LHIN entered into an agreement with Central West, Mississauga Halton, Toronto Central, Central East 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 Offices for its Cluster and related expenses. During the year, the LHIN received funding from Central West LHIN of $476,000 (2017 - $423,000).

6. Related party transactions

Health Shared Services Ontario ("HSSO")

HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under the Local Health System Integration Act, 2006 ("LHSIA") with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long-Term Care.

As of March 31, 2018, an amount of $45,628 is due from HSSO and is included in accounts receivable.

7. Capital assets

	Cost	**Accumulated amortization**	**2018 Net book value**	2017 Net book value
	$	**$**	**$**	$
Computer equipment	**982,709**	**982,709**	**—**	516
Computer software	**1,135,469**	**1,135,469**	**—**	—
Leasehold improvements	**2,454,793**	**1,048,772**	**1,406,021**	8,130
Furniture and equipment	**2,137,230**	**1,858,321**	**278,909**	100,742
	6,710,201	**5,025,271**	**1,684,930**	109,388

8. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**109,388**	81,579
Capital contributions transferred from CCAC	**709,573**	—
Capital contributions received during the year	**1,273,656**	65,322
Amortization for the year	**(407,687)**	(37,513)
Balance, end of year	**1,684,930**	109,388

9. Commitments

The LHIN has commitments under various operating leases as follows:

	$
2019	1,795,724
2020	1,586,890
2021	1,527,705
2022	1,419,442
2023	1,437,377
Thereafter	6,874,980

10. Contingencies

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

The LHIN has been named as defendants in various claims. Based on the opinion of legal counsel as to the realistic estimates of the merits of these actions and the LHINs potential liability, management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

11. Change in non-cash working capital balances

	2018	2017
	$	$
Due From Ministry of Health and Long Term Care	**(7,049,538)**	(852,552)
Accounts receivable	**(3,891,546)**	(39,120)
Prepaid expenses	**136,181**	8,806
Accounts payable and accrued liabilities	**11,731,463**	(130,919)
Due to Health Service Providers	**7,049,538**	852,552
Due to LHIN Shared Services Office	**—**	(7,801)
Due to Ministry of Health and Long Term Care	**1,558,001**	(52,840)
Deferred Operating contributions	**(8,263,380)**	—
Total change in non-cash working capital items	**1,270,719**	(221,874)

12. Transition of 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 Central Community Care Access Centre the ("CCAC"), to the Central LHIN, including the transfer of all employess of the Central CCAC. This transition took place on June 7, 2017. Prior to the transition, the LHIN funded a significant portion of the CCACs operations via HSP transfer payements. Subsequent to 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 and changes in net assets.

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

	$
Cash	22,852,650
Accounts Receivable	2,905,447
Prepaid Expenses	765,304
Tangible Capital Assets	709,573
Total Assets	27,232,974

	$
Accounts Payable and Accrued liabilities	24,888,729
Deferred Capital contributions	709,573
Deferred operating contributions	8,263,380
Total liabilities	33,861,682
Net Liabilities assumed on transition	6,628,708

The Net liabilities resulting from this transaction is recorded in the Statement of operations and changes in net assets.

Included in net liabilities assumed on transition was a restricted contribution fund totalling $41,097. The balance of the fund was expensed during the year.

13. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 854 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 $4,431,605 (2017 - $418,654) for current service costs and is included as an expense in the 2018 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.

14. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $1,933,735,375 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**1,326,504,067**	1,259,701,164
Grants to compensate for municipal taxation – public hospitals	**275,250**	—
Long-Term Care Homes	**355,313,627**	347,927,561
Community Care Access Centres	**57,841,705**	318,610,800
Community support services	**95,501,061**	92,076,075
Community health centres	**13,397,510**	12,891,912
Community mental health addictions program	**84,902,155**	82,431,488
	1,933,735,375	2,113,639,000

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $9,674,366 (2017 - $2,624,828) 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 are included in the table above.

Pursuant to note 12, effective June 7, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the 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.

15. Board expenses

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	**15,500**	18,725
Other Board members' per diem expenses	**47,175**	38,775
Other governance and travel	**31,195**	41,124
	93,870	98,624

16. 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.

17. 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.

Central **LHIN**

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Ontario
Local Health Integration Network