Central West **LHIN**




Together, Building a **Healthier** Community for All

Annual Report 2017 - 2018

July 2018

Ontario
Local Health Integration Network

CONTENTS

MANDATE

At the Central West Local Health Integration Network (LHIN) we are responsible for planning, funding, integrating and monitoring health care services, and for the delivery of home and community care services, to help improve the health and wellbing of residents that live within our local geographic area.

MISSION

Partnering to achieve excellence in health and health care.

VISION

A healthier community for all.

VALUES

Compassion
Innovation
Collaboration
Accountability
Respect
Excellence

Carmine Domanico
Board Chair

Scott McLeod
CEO

Together, Building a Healthier Community for All

A Message from the Board Chair and CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its 2017/18 Annual Report (AR 2017/18), showcasing the progress and achievements made between April 1, 2017 and March 31, 2018.

In a year underscored by implementation of the *Patients First Act (2016)* and the emergence of a new LHIN organization, the Central West LHIN remained focused on developing a more accessible and integrated local health care system, responsive to the needs of residents and patients while delivering better value for money.

Throughout the past year, acute and home and community care providers worked more closely with primary care to support patients with complex health care needs. LHIN sub-regions and their associated collaboratives were established and have already begun to effectively advance local and system objectives. Integrated systems of care, at the sub-region level, evolved as health system partners, patients and caregivers continued to develop Coordinated Care Plans. Targeted investments helped to provide local residents with improved access to much needed services including acute care, home and community care, long-term care and mental health and addictions. So too did the LHIN establish its first Patient and Family Advisory Committee (PFAC), binging the highly valued patient experience and voice to the planning table.

While the pages that follow highlight these accomplishments and more, there remains much work to be done. With a successful LHIN transition behind us and an enhanced LHIN mandate ahead of us, the important work of health system transformation has now begun.

Together, Building a Healthier Community for All takes its title from the LHIN's new Vision statement and a shared sense of responsibility. It reflects an understanding and acceptance that by working together, as a collaborative team of health system partners (Health Service Providers (HSPs), Service Provider Organizations (SPOs), community partners, residents, patients and LHIN organization) we can do so much more when it comes to creating a healthier community for all.

Both residents and health care professionals alike place a high value on their health care system and the need for it to be responsive to local communities. The Central West LHIN thanks the many health system partners who have actively engaged in helping to bring about healthy change across their local health care system.

Kindest regards.

Carmine Domanico
Board Chair, Central West LHIN

Scott McLeod
Chief Executive Officer, Central West LHIN

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OVERVIEW

Each year, the Central West Local Health Integration Network (LHIN) releases an Annual Report which, as an extension of the LHIN's strategic plan - otherwise known as an Integrated Health Service Plan (IHSP) - outlines progress and achievements made during the past fiscal year.

The Central West LHIN is pleased to present its 2017/18 Annual Report (AR 2017/18), showcasing the progress and achievements made between April 1, 2017 and March 31, 2018. Throughout this period, working collaboratively with a variety of health system partners, the LHIN remained focused on the development of a more accessible, integrated and responsive local health care system while simultaneously delivering better value for money.

Highlights include:

Context | An overview of Central West LHIN strategic directions; alignment with Ministry of Health and Long-Term Care (MOHLTC) and pan-LHIN priorities; population and health profiles of local LHIN residents, and LHIN renewal and the Patients First Act (2016).

Building a Healthier Community | Progress and achievements made in support of IHSP 2016-2019 and the LHIN's 2017-2018 Annual Business Plan (ABP 2017/18).

LHIN Performance | A review of 2017/18 system performance and financial accountabilities established between the MOHLTC and Central West LHIN.

Engaging LHIN Communities | A summary of communications and community engagement activities during the 2017/18 fiscal year.

The Road Ahead | Planning for and realizing the future health care needs of Central West LHIN residents and communities.

Financial Statements | The Central West LHIN's 2017/18 audited financial statements including an independent auditor's report, statements of financial position, activities, changes in net debt and cash flows.

CONTEXT

Provincial and Local Alignment

Meeting the health care needs of a rapidly growing, aging and culturally diverse population, like that of the Central West Local Health Integration Network (LHIN), requires smart local planning and an ability to address broader provincial priorities.

The Central West LHIN's strategic directions and initiatives, identified in its 2016-2019 Integrated Health Service Plan - IHSP 2016-2019, are rooted in the common objectives of Ontario's 14 LHINs and broader provincial priorities identified through a variety of strategic documents including:

- Ontario's *Patients First*: Action Plan for Health Care
- Minister Mandate Letter
- *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario
- *Patients First*: A Roadmap to Strengthen Home and Community Care

Developed in collaboration with a host of stakeholders, the LHIN's IHSP is also used by health system partners to inform their strategic planning.

Population Profile

Having grown substantially over the past decade, from 740,000 residents in 2006 to over 922,000 in 2016, Central West LHIN residents now account for seven per cent of Ontario's total population. With the highest projected growth rate in the province (over 17,000 new residents each year), the LHIN's population is expected to grow to almost 1.1 million by 2025.

Not only is the LHIN population growing, it is aging. By 2025, the population of seniors (those aged 65 or older) is expected to increase by 62 per cent, from 111,000 to 180,000. Meanwhile, as one of the most geographically and culturally diverse LHINs in the province, the Central West LHIN has the highest (over 63 per cent) visible minority population. Forty-eight percent of LHIN residents are immigrants, six per cent of whom are new to Canada within five years. Only 57 per cent of all LHIN residents report English as their first language, the second lowest rate in the province, and four per cent of residents report no knowledge of English or French. The LHIN is also home to over 10,400 residents whose first official language is French and 7,100 residents who self-report as Indigenous.

Eighty-seven per cent of LHIN residents reside in urban areas, seven per cent in a suburban setting, and six per cent in rural communities.

Over the past number of years, notable investments have improved access to a variety of health care programs and services within the Central West LHIN. Despite the challenges associated with the realities of a rapidly changing population, the LHIN and its health system partners have remained committed to the planning, development and delivery of innovative health care programs and services that meet the current and future needs of LHIN communities.

Central West LHIN Paliative Care Network Annual Conference – November 2017

LHIN Transition

In December 2016, Passage of Ontario's *Patients First Act (2016)* was a significant milestone for all of Ontario's LHINs. It laid the foundation for future transformation of both provincial and local health care systems, and set in motion collaborative planning that brought the Central West Community Care Access Centre (CCAC) and Central West LHIN together as a new LHIN organization on May 31, 2017.

This transition marked a new beginning and, with an expanded LHIN mandate, the important work of health system transformation began, including the planning and delivery of health care services at a sub-region level.

Sub-region Collaboratives were established in September 2017. Recognizing a need to to strengthen coordinated care planning across all health care sectors including primary care, Sub-Region Clinical Leads were added to the Collaboratives in October and, in an effort to further improve system navigation, System Resource Navigators were added in March 2018. Providing valuable lived experience to the planning process, the LHIN's inaugural Patient and Family Advisory Committee (PFAC) came together in October and, with a want to support the further integration of public health into local health system planning activities, a new LHIN/Public Health forum was established in February 2018.

Operationally, the Central West LHIN successfully transitioned a new Board of Directors – including Board Chair, Senior Management Team, and overall management team; implemented a new organizational structure; identified a new set of annual priorities; and began the process of developing a new corporate culture, including development of a new mission, vision and set of values to guide our work.

Thanks to months of detailed planning, the dedication and commitment of staff, and the tremendous support of our valued health system partners, LHIN transition went smoothly, providing a seamless delivery of programs and services for patients and their families.

Sub-Regions and Sub-Region Collaboratives

In support of Ontario's Patients First Act (2016), the Central West LHIN created five sub-region planning areas in 2017/18, all of which were aligned to pre-existing Health Links boundaries. They include Bolton-Caledon, Bramalea and Area, Brampton and Area, Dufferin and Area, and North Etobicoke-Malton-West Woodbridge. By looking at care patterns through a smaller geographic lens, system planners will now be able to better identify and respond to community needs, and be able to ensure that patients across the LHIN will have access to the care they need, when and where they need it.

Sub-regions:

- Enable a more focused approach to assessing the distinct health needs and service capacity of local communities
- Help to better identify health disparities across the province as well as determining whether health care services are meeting the needs of the population
- Help identify local factors that prevent our health system from improving
- Allow the community and providers to engage in a way that is focused on local circumstances and issues.

With 38,478 residents, **Bolton-Caledon** has the second highest rural population in the Central West LHIN at 22 per cent. In this area, 22 per cent of residents are immigrants, less than one per cent are new to Canada within the last five years, and just under 12 per cent are of a visible minority. Eighty-eight per cent of residents report English as their most frequently spoken language in the home, and roughly one per cent report no knowledge of either English or French. This sub-region has the lowest emergency department (ED) use overall, and lowest ED use for mental health, in the Central West LHIN as well as the highest proportion of primary care physicians per 100,000 people (82.7) across the Central West LHIN.

The **Bramalea and Area** sub-region has experienced nearly 15 per cent growth between 2011 and 2016, bringing the population to 275,774 residents. This urban area has one of the highest proportions of visible minority populations in the province at 78 per cent – 54 per cent of the population are immigrants with just under seven per cent being new to Canada within the last five years. Bramalea has the lowest proportion of residents who report English as their first language in the Central West LHIN and just 54 per cent of residents reporting English as the most frequently spoken language in the home, and nearly six per cent report no knowledge of either English or French. Punjabi, Gujarati and Tamil make up the top three languages spoken by residents in this area after English. With the second lowest proportion of primary care physicians per 100,000 residents in the LHIN, the area has no FHTs and one CHC.

Accounting for the largest proportion of residents among the five sub-regions, 36 per cent (333,320) of Central West LHIN residents reside in the **Brampton and Area** sub-region. Brampton has one of the highest proportions of visible minority populations in the province at 68 per cent. Fifty per cent of residents are immigrants and just under seven per cent are new to Canada within the last five years. Sixty-three per cent of residents report English as the most frequently spoken language in the home and four per cent report no knowledge of either English or French.

The **Dufferin and Area** sub-region has experienced nearly seven per cent growth between 2011 and 2016, making this area home to approximately 74,303 residents. This area has the highest proportion of LHIN residents living in rural communities at 55 per cent. Fourteen per cent of the population are immigrants and approximately eight per cent are of a visible minority. Dufferin and Area also has the highest proportion of residents who self-identify as Indigenous. English is reported as the most frequently spoken language in the home (95 per cent), and less than one per cent of residents report no knowledge of either English or French.

With the lowest population increase between 2011 and 2016 among LHIN sub regions (less than one per cent growth), the urban **North Etobicoke, Malton, West Woodbridge** (NEMWW) sub-region has approximately 200,365 residents. At 65 per cent, NEMWW has one of the highest proportions of visible minority populations in the province. Fifty-five per cent are immigrants with over eight per cent arriving in Canada within the last five years, 58 per cent report English as the most frequently spoken language at home, and just over five per cent of residents report no knowledge of either English or French. At 32 per cent, this sub-region has one of the highest proportions of children under six years old living in low-income households (after tax) in the province.

The Art of Collaboration

Made up of health system partners, LHIN representatives and patients, the Central West LHIN has established Sub-Region Collaboratives within each of its five sub-region planning areas.

In partnership, these teams will be working toward the creation of innovative solutions that are tailored to the unique challenges faced by their local populations.

Solutions will be driven through formal collaboration, active participation and the integration of services, with the goal of improving the overall care experience and health outcomes for the patients, clients and their families.

Health Profile and Access to Care

Improving timely and appropriate access to primary health care is a key objective of Ontario's *Patients First*: Action Plan for Health Care and the Central West LHIN. While almost all LHIN residents (94 per cent) report having a regular primary care provider, just under half (49 per cent) report having the ability to see their primary care provider on the same or next day when sick. Given the prevalence of certain chronic conditions such as diabetes (16 per cent in 2016 – highest in the province), unprecedented growth in our senior's population and premature mortality, making inroads on this indicator is particularly important for the Central West LHIN.

Based on the most recent data available, in 2016/17 residents in the Central West LHIN made 318,013 visits to emergency departments (ED) in Ontario. Most of these visits (71 per cent) were to one of the three EDs and one urgent care centre (UCC) within the Central West LHIN. Meanwhile, in 2017/18, there were a total of 322,844 ED visits to Central West LHIN hospitals, including 61,000 visits to the new UCC at Peel Memorial Centre for Integrated Health and Wellness. In 2017/18, Brampton Civic Hospital had the second busiest ED in Ontario with 18 per cent more visits than the next busiest ED (135,143 visits, as compared to 114,346 at North York General Hospital).

Hospitals in the Central West LHIN also had the lowest rate of visits for conditions best treated in alternative primary care settings. This suggests that the high number of ED visits may be appropriate. The length of stay for patients discharged home from EDs in the Central West LHIN consistently meets provincial targets but, the length of stay for patients requiring admission to an inpatient bed is substantially higher than target, suggesting a need for greater inpatient capacity.

In 2017/18, home and community care services were provided to nearly 45,000 patients. Based on the most recent data, in 2016/17, of the 23,600 residents who received in-home services, 57 per cent were long-stay (received care for more than 90 days), 38 per cent received two or more services (excluding care coordination), and in-home nursing services (visits) were provided to nearly 11,000 residents.

Central West LHIN Brain Health Symposium
August 2017

Health Care Resources and their Use

Over the past nine years, the Central West LHIN has received a 29 per cent increase ($187 million) in base funding, resulting in improved access to a variety of health care programs and services across the local health care spectrum.

In 2017/18, through a budget of $838 million provided by the Ministry of Health and Long-Term Care (MOHLTC), the LHIN funded 53 health system partners including:

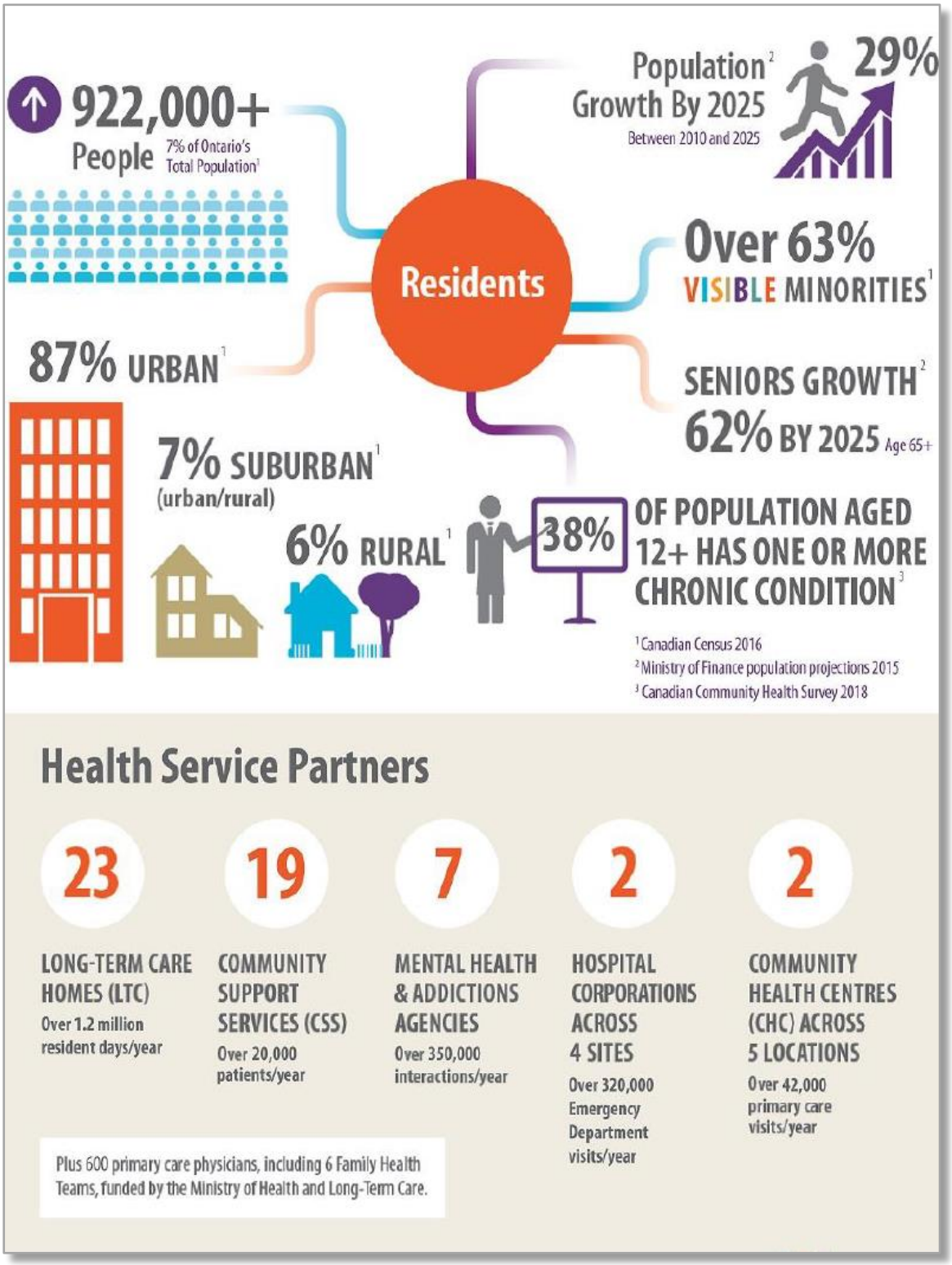
- Two hospital corporations across four sites receiving over 320,000 Emergency Department visits/year (2017/18)
- Twenty-three Long-Term Care (LTC) Homes providing over 1.2 million resident days/year
- Two Community Health Centers (CHC) across five locations delivering over 42,000 primary care visits/year
- Nineteen Community Support Service (CSS) agencies offering services to over 20,000 clients/year
- Seven mental health and addictions organizations providing over 350,000 interactions to local LHIN residents/year.

In addition, post transition, the Central West LHIN became directly responsible for the planning and delivery of home and community care services to over 45,000 patients within its region.

SIGNIFICANT sector investments* over the past seven years to improve the health and healthy outcomes of Central West LHIN residents. *(*Increase from 2009/10 year-end, to 2017/18 year-end)*

	2009/10	2017/18	$ Increase	% Increase
Community Health Centres	5,695,761	13,243,463	6,574,693	133
Community Support Services *(*incl. Assisted Living)*	11,523,426	26,369,572	14,846,146	129
Hospitals	465,884,631	585,426,691	119,542,060	26
Long-Term Care	136,059,183	170,764,034	34,704,851	26
Mental Health and Addictions	30,647,492	41,770,141	11,122,649	36
Total *($ in millions)*	**649,810,493**	**837,573,901**	**186,790,399**	29

**Home and Community Care: On May 31, 2017 the Central West LHIN assumed the assets, liabilities, rights and obligations of the Central West Community Care Access Centre (CCAC). The CCAC received $19,851,161 in transfer payments prior to integration. The remaining funds allocated to CCAC became part of the LHIN operating budget after integration.*


922,000+
People
7% of Ontario's Total Population[1]
Population[2] Growth By 2025
Between 2010 and 2025
29%
Residents
Over 63%
VISIBLE MINORITIES[1]
87% URBAN[1]
SENIORS GROWTH[2]
62% BY 2025 Age 65+
7% SUBURBAN[1]
(urban/rural)
6% RURAL[1]
38%
OF POPULATION AGED 12+ HAS ONE OR MORE CHRONIC CONDITION[3]
[1] Canadian Census 2016
[2] Ministry of Finance population projections 2015
[3] Canadian Community Health Survey 2018
Health Service Partners
23
LONG-TERM CARE HOMES (LTC)
Over 1.2 million resident days/year
19
COMMUNITY SUPPORT SERVICES (CSS)
Over 20,000 patients/year
7
MENTAL HEALTH & ADDICTIONS AGENCIES
Over 350,000 interactions/year
2
HOSPITAL CORPORATIONS ACROSS 4 SITES
Over 320,000 Emergency Department visits/year
2
COMMUNITY HEALTH CENTRES (CHC) ACROSS 5 LOCATIONS
Over 42,000 primary care visits/year
Plus 600 primary care physicians, including 6 Family Health Teams, funded by the Ministry of Health and Long-Term Care.

Building a Healthier Community

With the emergence of a new LHIN organization post-transition, came the development of a new mission, vision and set of values to guide our work. *Building a Healthier Community* takes its name from the LHIN's new vision statement, reflecting on the progress and accomplishments made in support of the LHIN's 2016-2019 Integrated Health Service Plan - IHSP 2016-2019.

Build Integrated Networks of Care

Ontario's health care system can be challenging to both navigate and access, especially for patients with complex health care needs who find themselves involved with the system more often than most.

Throughout 2017/18, the Central West Local Health Integration Network (LHIN) remained committed to improving health system navigation and access to care by further integrating existing resources into stronger networks of care, continuing to invest in areas that require additional capacity to meet the needs of a growing and aging population, and by looking for new and innovative ways to deliver care effectively, efficiently and more suitably in support of an ethnically, geographically and socio-economically diverse population.

Primary Care & Coordinated Care Planning

PRIMARY CARE

In 2017/18, the Central West LHIN continued to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and primary care providers practicing in other models of organized care, to ensure residents have timely access to multi-disciplinary primary care, delivered in appropriate settings close to home. More specifically, the LHIN worked with health system partners to enhance systems and processes that prevent and/or delay deterioration in activities associated with daily living, reduce avoidable Emergency Department (ED) visits and hospital admissions, and shorten ED wait times and applications to Long-Term Care (LTC).

Upwards of 600 family physicians are now providing care throughout the Central West LHIN. Local residents have access to six FHTs, two CHCs, 29 Family Health Groups (FHGs) with 308 physicians, 16 Family Health Organizations (FHOs) with 157 physicians, 26 physicians practicing in a Comprehensive Care Model (CCM), and 100 individual fee-for-service practitioners. While most residents have a primary care physician, the LHIN continues to support initiatives that improve access to primary care on the same or next day when sick, thus aiming to reduce visits to local EDs for conditions that can be managed within the community.

To assist in building stronger links between primary care and other health system partners, the LHIN embedded Clinical Leads within each of its five sub-regions. Important members of the LHIN Sub-region Collaboratives, Clinical Leads are working closely with primary care providers, inter-professional care teams and community partners to help strengthen and develop integrated networks of care including primary care, public health, home and community care, mental health and addictions, long-term care and acute care.

Hospitals in the Central West LHIN are among the busiest in the province. Additional investments to funding in 2017/18 - $538,878,562 million for William Osler Health System (Osler) and $46,548,129 million for Headwaters Health Care Centre (Headwaters) - helped to reduce wait times and support increased access to services that LHIN patients and families rely on.

If You Build it They Will Come

As an alternative to seeking care in an acute care setting, the Urgent Care Clinic (UCC) at William Osler Health System's (Osler) Peel Memorial Centre for Integrated Health and Wellness has seen over 61,000 patients since opening its doors in early 2017.

In November 2017 it was announced that a major expansion of Osler's Peel Memorial site will move forward, increasing access to care and reduce wait times for patients in Brampton.

The Central West LHIN has one of the fastest growing and aging populations in the province, and Brampton Civic has one of the business Emergency Departments in all of Canada. Within the context of a long-range acute care capacity plan, this investment will help to ensure residents of Brampton and surrounding communities continue to access and receive high quality, patient-centred care well into the future.

As a result of these efforts, LHIN residents appear to be seeking care in appropriate locations rather than turning to local EDs. The three EDs in the Central West LHIN have fewer low acuity visits compared to the province as a whole, and the lowest rate of ED visits across the province for conditions such as conjunctivitis, cystitis, otitis media and upper respiratory infections, all of which can be treated in alternative primary care settings.

HEALTH LINKS & COORDINATED CARE PLANNING

One of the first LHINs in Ontario to fully implement Health Links across its geographic area, the Central West LHIN has maintained a leadership role in the collaborative design, implementation and evolution of this approach to care at the provincial level. In support of *Patients First*, existing Health Links boundaries were leveraged to create the Central West LHIN's five sub-regions, thereby promoting the further development and growth of enhanced care coordination. As a result, health system partners are now better able to support patients with complex care needs, improving their health and healthy outcomes.

Health Links bring together multiple health care providers from across the continuum of care so everyone involved in a patient's circle of care knows and understands their health goals. As a result, providers can share information and work collaboratively to put the patient's needs first. Health Links partners can include hospitals, family doctors, LTC homes, community partners and other organizations.

Services for Seniors

To further reduce avoidable ED visits, unnecessary hospital admissions and Alternative Level of Care (ALC) designations, the Central West LHIN continued to work with health system partners in developing strategies that support seniors services in the community: social/safety visitation, congregate dining, adult day programs, transportation, exercise/falls prevention, chronic disease management, caregiver support, independence training, psychogeriatrics, assisted living, respite and palliative care.

In addition, as part of its enhanced mandate post transition, the LHIN assumed direct responsibility for the planning and delivery of home and community care services includinge nursing care, rehabilitation and personal support services, rapid response nursing, palliative care, community clinics and supportive living, and the coordination of admissions for 23 Long-Term Care (LTC) homes across the region.

In 2017/18 the Central West LHIN also remained mindful of caregivers, including family and friends, who often take on the immense responsibility of caring for their loved ones and require the proper supports in order to do so. The LHIN's BSO and Home and Community Care teams, in collaboration with the Region of Peel, hosted a joint caregiver "Compassion Fatigue" workshop family members who use the Peel Manor Adult Day Program, and those who are on its wait list. At the workshop, caregivers were able to connect face-to-face with community resources and health system partners to learn more about supports and strategies available to them.

Long-Term Care Renewal

Kipling Acres – Phase II | In June 2017, Kipling Acres celebrated completion of its $102-million, two-phase redevelopment. An important part of the north Etobicoke community since it opened in 1959, this redevelopment will help continue its tradition of quality care for both residents and program users.

Phase 1, which saw construction of a new 192-bed long-term-care building featuring a public art display, secure courtyard and green roof, opened in early 2014. After completion of Phase 1, the original Kipling Acres building was demolished to allow for Phase 2 including the addition of 145 long-term care beds and a 5,500 sq. ft. community hub space. Phase 2, which was completed and began admitting residents in May 2017, includes four 32-bed resident home areas and a 17-bed convalescent care program. The community hub portion of the new Kipling Acres is home to an Adult Day Program, the Kipling Early Learning & Child Care Centre, and the West Acres Senior Centre, which offers wellness and recreation programs for local community seniors.

BSO Geriatric Development Days

The Central West Behavioural Support program, in partnership with the Region of Peel and William Osler Health System, was pleased to host two Geriatric Development Days in 2017/18.

Attended by combined audiences of over 200 health care professionals and direct care providers, these innovative and interactive workshops support those who care for geriatric residents at risk of dementia and responsive behaviours.

Since 2012, the Behavioral Supports program has been helping to improve individual care plans for seniors both in Long-Term Care and those still living in their private homes. During this time, health care partners have been able to successfully reduce the numbers of unnecessary ED visits and hospital admissions, and enabled a significant decline in the reported use of daily physical restraints.

With a focus on behavioural supports, these workshops came at a time when, through the provision of additional Behavioural Supports Ontario (BSO) funding, two new Nurse Practitioners (NPs) were added to support the Central West LHIN's 23 Long-Term Care (LTC) homes. Employed by the Region of Peel, these NPs are now functioning as mobile specialty resources to homes offering support to in-house BSO champions, as well as medical and nursing staff in the area of behavioural and psychological symptoms of dementia.

In 2016, a pilot project of this model of care resulted in significant improvement in LTCH resident behaviours and a significant reduction in the number of ED visits for responsive behaviours.

Peel Manor Long-Term Care Centre | Peel Manor Long-Term Care Centre in Brampton is slated for redeveloped into a Seniors Health and Wellness Village. The new building is intended to replace the existing structure and will feature 177 LTC beds, space for up to 100 Adult Day Program participants (including seniors with complex needs) and a community hub with health, social, community and retail services. Construction is expected to begin in 2019 with goal of completing construction on the new Seniors Health and Wellness Village in the fall of 2021.

Mental Health and Addictions

In 2011, the Ontario government released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, a long-term comprehensive approach to transforming the mental health system. In 2017/18, the LHIN collaborated with community and hospital partners to expand the scope of the strategy, improving access to adult community-based services for all residents regardless of where they turn for help.

The Central West LHIN funds seven mental health and addictions organizations, including six community-based providers and an acute care facility operating two sites with inpatient units and community programs. Mental health and addictions services provided in the Central West LHIN, offer a broad range of health and social supports that vary in function, intensity and duration. Based on the most current data, in 2016/17, these organizations collectively delivered services to over 24,600 unique individuals and an additional 14,000 people received support from other sources such as peer/self-help programs and crisis services. Given the variability along the continuum of care, people who access these services receive an average of three to 76 visits. Just over 74 per cent of unique participants in 56 per cent of the programs receive fewer than 10 visits annually. The most broadly used mental health and addictions service is supportive housing, which serves just over 1,600 people and has an equal number waiting to access this service.

OPIOID STRATEGY

The Central West LHIN, with its seven funded providers and other health care organizations that have partnered on the Central West LHIN Narcotics Strategy, are committed to improving the mental health of residents by building a strong continuum of high quality, coordinated and efficient mental health and addictions services.

From January to October 2017, there were 1,053 opioid-related deaths in Ontario, as compared with 694 during the same time period in 2016. This represents a 52 per cent increase year over year. From January to December 2017, there were 7,658 emergency department visits related to opioid overdoses, as compared with 4,453 during the same time period in 2016. This represents a 72 per cent increase.

In response to the growing opioid crisis and the need for increased supports for those with addictions, CMHA Peel Dufferin has established a Rapid Access Addiction Clinic (RAAC) to provide immediate access to lifesaving treatment by offering same-day counselling and addiction medication. This clinic model has been shown to help save lives by engaging people with short- and long-term treatments as soon as they are ready and interested. Addictions service providers are also interested in exploring how they can provide an urgent reponse should a local crisis arise.

CMHA Peel Dufferin's RAAC, the first clinic of its kind in the Central West region, accepts all patients - including self-referrals and walk-ins - in addition to referrals from family doctors, hospitals and EDs, and the community.

Led by Nurse Practitioners, the RAAC works in collaboration with primary care, EDs at Brampton Civic and Etobicoke General Hospitals, shelters and other health service partners and first responders to assess, diagnose, treat and monitor clients who use substances. There is an emphasis on non-judgmental interactions, which include health promotion and education to clients, community providers, and primary care in an effort to prevent overdoses.

Seeing the Invisible More Clearly

In April 2017, Mind Forward – formerly Peel Halton Dufferin Acquired Brain Injury Services – was pleased to formally expand its service offering within the Central West and Mississaugua Halton LHINs.

A number of years ago, in large part due to the impassioned voices of local caregivers, families and patients alike, a need for enhanced acquired brain injury (ABI) services was identified in Dufferin County. Working in partnership with the Mississauga Halton LHIN and Mind Forward, the Central West LHIN sought to address this need.

Now, almost a decade later, Mind Forward continues to grow in response to the changing needs and demands of the local ABI community, providing a full spectrum of invaluable services to ABI survivors and their families within the Central West LHIN.

Online ABI Education, now a provincial initiative, was pioneered by the Agency through staff and group work in Orangeville. The case management, day programs, counselling through an ABI-specialized Neuropsychiatrist and ABI-specialized Psychologists, psychosocial peer and family support groups make this an impressive compilation of services that is enhanced through community partnerships with Avalon Care Centre, Peace Ranch, Island Lake and Glenn Haffey Conservation Areas, Headwaters ABI and others.

In collaboration with provincial, regional and local partners the Central West LHIN is proud to support this body of work, and the many caregivers who deliver it.

Brain injury is a largely invisible disability. It is because of organizations like Mind Forward that we are all seeing what has been invisible more clearly.

Palliative and End-of-Life Care

The 2016 *Palliative and End-of-Life Care Provincial Roundtable Report* outlined key themes to improve palliative and end-of-care in Ontario. Locally, the Central West LHIN's palliative care portfolio has identified key actions that will be undertaken to address the key findings of this report.

The LHIN has honed its palliative and end-of-life care portfolio to align with the four priority areas identified within the *Ontario Palliative Care Network Action Plan*. More specifically, the Central West LHIN Palliative Care Network (CWPCN) is working to ensure residents in this region are serviced by a health system that has:

- Earlier and more equitable access to end-of-life and palliative care services
- Increased access to home-based palliative care
- Enhanced connections across settings and providers
- Improved patient and caregiver experiences by aligning with patient goals.

With a vision to provide exemplary hospice palliative care for all, the CWPCN remained focused on advancing palliative and end-of-life care across the region in 2017/18, delivering services to over 1,300 palliative patients. With a growing and aging population, local palliative care needs will increase and improve care planning and communication between patients, caregivers and providers will be required to manage symptoms and avoid unnecessary visits to the ED.

Launched in 2016 and winner of the System Partnership Award at Health Shared Services Ontario's (HSSO) 2017 Achieving Excellence Conference, the Early Palliative Identification Project continues to improve the lives of patients and families living with life-limiting illness. In 2017/18, early identification education and supporting processes helped to identify 1,138 palliative patients sooner, enabling them to experience a higher quality of life in their final days.

In support of an enhanced palliative and end-of-life care mandate, the CWPCN aligned itself with evolving provincial priorities and emerging local needs, designing and implementing an *Authentic Collaboration Model* to enhance cooperation among more than 90 partners from 27 organizations across the Central West LHIN. The model is built on three tenets:

- **Shared Leadership** | In 2017, leaders from across the CWPCN came together establish working groups to advance collective patient-centred priorities to improve effective knowledge transfer, consistency, and efficiency.
- **Quality Improvement** | Members participate in learning opportunities from Health Quality Ontario (HQO), leverage data in planning activities, using proven testing tools, and explore opportunities through their daily work.
- **Patient / Caregiver Voice** | Patients, family members and caregivers are embedded into the model through participation in working groups, committee meetings, and advisory councils to help identify gaps and opportunities in the health care system.

On November 15, 2017 the Central West Palliative Care Network hosted its 10th annual conference. This sold-out event brought together attendees from across the Central West LHIN and beyond to learn from leaders in the palliative care field. The conference also included a welcome from Nancy Naylor, Associate Deputy Minister of Health, as well as inspirational workshops and insightful speakers, aimed at expanding knowledge and deepening understanding of palliative care.

Watch the anniversary video presented at the conference.

Drive Quality and Value

Aligned with the objectives of Ontario's *Patients First*: Action Plan for Health Care, enhancing the patient experience is recognized as being a major deliverable in achieving a high-quality, high performing, and value-driven health care system.

The Central West LHIN is focused on improving the health and health status of local residents by strengthening its accountability and service delivery. This can only be accomplished through effective partnerships with a broad range of health system partners, where collaboration on local and provincial quality-focused and evidence-informed initiatives are aligned.

As a primary funder of health care services, the LHIN must support the sustainability of health system partners within available financial resources. Health care decisions must be evidenced-based and reflect the patient experience. The Central West LHIN is committed to funding and using health care resources in a sustainable, effective and efficient way that demonstrates quality and value to the community. This is realized through ongoing provincial processes designed to ensure accountability and transparency, development of the Central West LHIN Patient and Family Advisory Committee (PFAC), working in partnership with Health Quality Ontario (HQO) on the implementation of quality standards, and local level planning and support for quality with Central West LHIN HSPs and SPOs.

Digital Health

Information technology (IT) and information management (IM) are key elements that help to empower patients and connect health care providers in their circle of care. In support of a seamless patient experience, digital health solutions enable patients, their caregivers and their health service providers to share information, and coordinate services quickly and efficiently at each transition point.

Digital health solutions enable authorized health care providers to quickly access shared health information in their efforts to make informed care decisions by viewing a patient's complete record regardless of how many different providers they are seeing. Access to virtual care is helping to reduce wait times for some services, such as Mental Health and

Addictions, and there is also increased adoption and growth of digital health solutions by patients and providers across the LHIN.

In support of health system transformation, digital health is being used as an important channel for delivering care to those who need it the most. Throughout 2017/18, The Central West LHIN remained focused on the ongoing adoption and use of digital technologies to advance the modernization of integrated patient-centred care and, in so doing, strengthening quality, effectiveness and accountability while stimulating innovation and growth in the digital health sector. Over the past year, the LHIN has continued to make progress on enabling clinician access technology to benefit patient care and work flow in their practices. As of March 2018, within the Central West LHN:

- 273 physicians are now using eNotifications, real-time alerts sent to physicians and their practices when a patient has been discharged from an ED or admitted/discharged from an inpatient unit
- 39 per cent of physicians with an electronic medical record (EMR) are using Health Report Manager (HRM), which delivers clinical and diagnostic imaging reports to a patient's health record in their physician's EMR
- 100 per cent of Central West hospitals are using eNotifications and HRM
- 43 per cent of physicians are now using the Ontario Lab Information System (OLIS)
- 180 physicians and 27 specialists are using eConsult, a provincial digital health service that lets family physicians consult with specialists across the province
- Over 1,000 residents have signed up to eVisit, a secure web-based method for patients to conduct a virtual medical visit with a primary care provider being piloted in the Central West LHIN, and over 406 patient-initiated visits occurred through eVisit in 2017/18

In addition to the ongoing uptake of digital solutions by physicians throughout the LHIN, progress was made with respect to identifying and defining patient care pathways that would benefit from and support the implementation of a single referral management solution. Planning began on an initiative that will increase opportunities for eReferral in the Central West LHIN, by establishing a Central Intake Program and Rapid Access Centre for patients with moderate to severe hip and knee osteoarthritis pain.

Governance and Leadership

Throughout 2017/18, the Central West LHIN's Board of Directors Quality Committee continued to provide leadership and oversight for the quality of local health care services while also advancing a culture of quality and continuous improvement. Regular governance-to-governance engagement with local partners continued, resulting in meaningful discussions focused on creating a culture of quality through the further development of quality improvement initiatives. This culture of quality will demonstrate improved patient outcomes, patient experiences and value for money.

The Regional Quality Table (RQT) realigned with newly formed Sub-region Collaboratives, to ensure appropriate support for local, regional and provincial quality improvement priorities and, following engagement of key internal and external health system partners, a three-year Integrated Quality Plan was developed to achieve measureable improvements in system access and performance through enhanced enhanced integration and collaboration accorss the Central West LHIN.

Quality and knowledge sharing often go hand in hand. In partnership with HQO, the Central West LHIN was proud to support Ontario's inaugural *Change Day* initiative. Designed to to drive positive social change, Change Day is about people connecting with people through the sharing of ideas and stories, engaging with one another, overcoming barriers, and helping to improve health care for patients and providers alike. With a want to drive positive change Central West LHIN staff committed to over 100 individual and group pledges regarding how cabout how we collectively intend to show RESPECT (our corporate theme) to patients, families, colleagues and ourselves in our daily work.

Governance and Leadership Forums

From Transition to Transformation... the road ahead for health care in Ontario and the Central West LHIN – November 2017

In November 2017, over 200 health care leaders, board members and representatives from across the LHIN came together to focus on the transformative road ahead.

Ontario's *Patients First Act* laid the foundation or a significant transformation of provincial and local health care systems. With LHIN transition having taken place earlier in the year, Dr. Bob Bell, Ontario's Deputy Minister of Health and Long-Term Care, LHIN CEO Scott McLeod and Kim Delahunt, LHIN Vice President of Health System Strategy, Integration and Planning, provided participants with important insights into the future of the health care system and the transformative work underway provincially and locally.

Focus on Population Health – March 2018

In March 2018, upwards of 200 leaders, board members and representatives reconvened from health care organizations across the Central West LHIN to focus on population health.

Population growth, aging and socio-economic diversity all have a significant impact on population health. Earlier support for those at risk, equitable access to care and a focus on upstream efforts to promote health and prevent disease will ultimately improve health within local communities. Meanwhile, a population-based approach will form the cornerstone of sub-region planning.

Working in partnership with three Public Health Units in its geographic area, the LHIN was pleased to welcome Medical Officers of Health Dr.'s Eileen de Villa, Jessica Hopkins and Nicola Mercer who were well positioned to provide their unique perspectives about population health. Dr. Tamara Wallington, LHIN Vice President Clinical, moderated a lively conversation and Q&A on how a population- based health approach is essential to achieving meaningful health system transformation.

Health System Funding Reform (HSFR)

The Central West LHIN and many of our health system partners operate under a patient-based funding environment known as Health System Funding Reform (HSFR). HSFR funds hospitals and community providers based on the burden of illness and care needs in the community, where patients actually go for care, the quality of providers' care, and the efficiency of that care. It represents a more consistent approach to funding health care across the province, providing incentives for the best possible care in the most efficient way.

In 2017/18, the LHIN continued to advance the provincial HSFR strategy, actively implementing HSFR initiatives among partners. The LHIN also continued to identify and monitor targeted health service needs at the sub-regional level, working to ensure the needs of local communities were being met in an affordable and sustainable manner.

Health system partners also actively supported HSFR quality improvement and change management strategies by participating in the provincial Improving and Driving Excellence across Sectors (IDEAS) program, and through the ongoing collaboration and implementation of Quality-Based Procedures (QBPs). To date, partners have established a number of QBP implementation teams that have or are currently implementing strategies for alignment with best practice and health outcomes. Planning is currently underway to work more closely with HQO, in a manner that will further align QBP and quality goals at the LHIN and sub-region levels.

In September 2015, the MOHLTC announced six innovative projects - focused on the patient experience - that would test innovative integrated approaches of service delivery and new integrated funding models intended to improve the delivery of quality, evidenced-based care to patients. *Hospital to Home (H2H): The Central West Integrated Care Model* was selected as a three-year proof of concept project. A joint initiative of the Central West LHIN, Headwaters Health Care Centre (Headwaters) and William Osler Health System (Osler), and in partnership with OTN, H2H has demonstrated its ability to better enable seamless patient transitions from hospital to community. Over the past year, the Central West LHIN continued to implement and scale this innovative model of care, helping improve clinical handoffs and information-sharing when patients leave hospital.

H2H employs direct care nurses in the delivery of in-home care to patients who need additional post-discharge support.. The model supports a strategic shift to more community-focused, scheduled care, supporting people to receive care in their homes or in the community, helping prevent unnecessary emergency department visits and hospital admissions, shortening the acute length of stay for admitted patients, providing greater continuity of care and enhancing the patient experience.

In collaboration with Osler, the LHIN also invested in development of an *Integrated Cross-Continuum Stroke Rehabilitation Model* to address system access challenges for patients navigating the health system following a stroke. An integrated team of specialists from both organizations has been working to minimize access and flow challenges related to rehabilitation patients. Central West LHIN investment strategies are informed through assessment of local health needs and a prioritization analysis, established through the application of a process setting and decision-making framework with rating criteria aligned to provincial and local health service priorities and identified

service delivery gaps. These kinds of targeted investment strategies help assure that the application of available funding is undertaken in a prudent, cost effective and beneficial manner that is aimed at maximizing the impact of the investment on improvement in the health status of the local population. The LHIN will continue to encourage and provide support where applicable for health service providers to continue to participate in the provincial IDEAS program to build quality and change management capacity locally.

Patient Experience

In 2016/17, the provincial government took steps to establish a provincial Patient and Family Advisory Council (PFAC), advising government on health priorities that have an impact on patient care and patient experiences across Ontario. In support of Ontario's Patients First Act (2016), Ontario's 14 LHINs have since established Patient and Family Advisory Committees to inform health system planning at the local level.

In October 2017, comprised of representation from across all five sub-regions, the Central West LHIN established its inaugural PFAC to engage and empower patients, families and caregivers in helping to shape their local health care system.

Through the sharing of unique health care stories, opinions, perspectives and experiences, the LHIN's PFAC members will help to inform, influence and, in some instances, co-design programs and services within their local health care system. Members of the PFAC are now integrated across a number of LHIN committees and tables, enabling them to inform discussions and decisions about our local health system and patient care.

Meet the Central West LHIN PFAC

The Central West LHIN PFAC is made up of 10 highly engaged and impassioned individuals, committed to improving and enhancing the patient experience across our region.

- Sarabjit (Sarb) Kaur Rana (Brampton and Area) – Co Chair
- Robert Appelbe (Bolton Caledon)
- John Birks (Bramalea and Area)
- Nathasha Swaminathan (Bramalea and Area)
- Gurjit Kaur Bains (Brampton and Area)
- Jameel M. Lodhi (Brampton and Area)
- Debora Sipkema (Dufferin and Area
- Colette Smith (Dufferin and Area)
- Tino Sequeira (North Etobicoke, Malton, West Woodbridge
- Anthony Schettini (North Etobicoke, Malton, West Woodbridge)

Connect and Inform

The Central West LHIN is committed to improving population health and reducing disparities through inclusive, evidence-based and coordinated actions across the continuum of care. In support of Ontario's Patients First Act (2016), the LHIN is working with public health, community and health system partners to launch health promotion strategies that connect, inform and support better population health outcomes across its sub-regions. These partnerships have resulted in the development of the Healthy Communities initiative, a Heath Equity Charter, and population level data analysis at the sub-region level.

Population Health

The Central West LHIN is a rapidly growing, aging and culturally diverse community. These characteristics have significant implications for the health of the local population, and the health care system as a whole. Groups or individuals who live in social isolation, environments that do not support health, face barriers to access, or receive a lower standard of care often experience poorer health, greater strain on limited health care resources, and ultimately higher costs for poor outcomes.

Over the past year, supported – in part – by newly established sub-region collaboratives, the LHIN took a conscious population-based approach to health care planning, examining the local context, health disparities, and service needs of communities across its region. Through the effective collection, sharing and analysis of data, the LHIN will continue to assess current and future service delivery requirements to create healthier environments, and improve access to and quality of care. Much of this can be achieved through continuing to actively engage system partners, including public health units and community agencies, in creating supportive environments that facilitate healthier choices and better utilization of the local health care system.

To further support the transformative work that lies ahead, the LHIN maintained its focus on cross-reference health care utilization data with socio-demographic and health status information at the sub-region level. This foundational work will help to identify key disparities, barriers and priorities moving forward. An early opportunity emerging from such analysis is the Healthy Communities Initiative, a joint partnership between the Central West LHIN, Region of Peel and William Osler Health System.

Developed in response to high diabetes prevalence rates, unhealthy built environments and a population with high genetic predisposition to diabetes, this initiative is facilitating cross-sector partnerships between public health units, primary care providers, school administrators, the business community, the faith community, and other stakeholders to promote an coordinated, integrated and comprehensive approach when it comes to addressing a health disparity while simultaneously promoting population health.

Indigenous Peoples

As a member of the Provincial Indigenous Leads Network (PILN), the Central West LHIN is committed to addressing a range of health care topics that impact Indigenous people from constructs of wellness to mental health, chronic disease management and palliative care. This work includes collaborating with local health system partners - Peel Aboriginal Network (PAN), Dufferin County Cultural Resource Circle (DCCRC) and Credit River Metis Council (CRMC) - to ensure Indigenous residents receive culturally appropriate care that recognizes and is tailored to the social, cultural and linguistic needs. Designed to ensure better heath and healthier outcomes, this work aligns local health care programs and services with existing regional, provincial and federal health planning, health programming and service delivery systems.

In 2017/18, the Central West LHIN worked in collaboration with PAN, CRMC and the Mississauga Halton LHIN to develop an Indigenous Advisory Health Circle (IAHC). This partnership aims to provide guidance and advice to both LHINs in the planning, implementation, and evaluation of culturally based, culturally secure, health programs and services for Indigenous communities.

A key outcome of this and other engagements is the implementation of the 2018/19 Indigenous Holistic Health and Wellness project, a cost-shared initiative with the Central West and Mississauga Halton LHIN's and the MOHLTC. Funding will be provided to the Canadian Mental Health Association (CMHA) Peel Dufferin Branch to hire Indigenous Elders and Métis Senators at PAN and CRMC. These human resources will help build capacity for culturally appropriate direct care/services, and provide on-site mentorship, relationship and capacity building opportunities to support cultural safety across health service providers. As a result, PAN and CRMC will also be able to increase the number of traditional ceremonies and community events led by Elders, Métis Senators, and Knowledge Keepers, whereby families and individuals will have the ability to register for traditional indigenous ceremonies.

The Central West LHIN also continued to support local non-Indigenous health system partners in their desire to complete Indigenous Cultural Safety training. An additional 65 health care professionals from across the Central West LHIN completed this training in 2017/18. Delivered by the Provincial Health Services Authority of British Columbia, this facilitated on-line training program is designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Indigenous people.

French Language Services

The Central West LHIN includes a vibrant community of over 13,000 francophone residents who are looking for better access to health care services in French. With a shared commitment to engage and better understand the needs of the local francophone population, we are pleased to have maintained a strong collaborative relationship with French language planning entity Reflet Salvéo. It is through this partnership that the LHIN is better able to understand the needs of the francophone community, and collaborate with health service partners to ensure the needs of this patient population are met.

Throughout 2017/18, the Central West LHIN worked with local health care system partners, including Reflet Salvéo, to develop and implement a French Language Services (FLS) Joint Action Plan (Action Plan). The Action Plan speaks to a need to account for how the LHIN, in accordance with the FLS Act, will assume responsibility for the provision of home and community care services available in French. Priorities include:

- Increased active offer of FLS
- Enhanced mental health status of francophone newcomers
- Promotion of health equity
- Support for the integration of francophone perspectives in health system planning activities.

In particular, Rexdale CHC and Four Corners Health Centre were engaged to explore opportunities for FLS planning within their core services. Discussions between both partners and Reflet Salvéo led to the discovery of new and existing opportunities that can be leveraged to further enhance and support the development of FLS within existing service offerings.

In 2017/18 the Ministry of Health and Long-Term Care released its Guide to FLS, clearly outlining the roles, responsibilities and accountabilities with respect to the development, provision and subsequent progress reporting of FLS. While all health system partners will be required to submit FLS status reports through OZi, an online reporting platform, in 2018, the Central West LHIN continued to receive and evaluate Designation Readiness Assessments from partners, as it relates to the provision of active offer and the delivery of health care services in French, this past year. From these assessment, the LHIN will continue to work with partners to prioritize actions and create roadmaps that will help to enable full or partial FLS designation in 2018/19.

Demonstrate System Leadership

The Central West LHIN is responsible for ensuring that the local health system delivers the best possible outcomes in terms of population health, patient experience and value. To carry out these responsibilities, the LHIN works with health system partners to provide system leadership that includes capacity planning, guiding system-wide initiatives, and supporting stakeholders to provide the best possible care and outcomes for patients. Direction and support is provided to health system partners on provincial priorities that increasingly call for collaboration with other levels of government, across LHIN boundaries, and beyond the health sector.

Healthy Communities Initiative

Building healthy communities is more than bricks and mortar, which is why the Central West LHIN has is continuing to build upon the Healthy Communities Initiative, originally launched in 2015.

Like many communities across Canada and around the world, Brampton is addressing a common need: ensuring children, youth, adults and families are engaged in active healthy living to reduce their risk of poor health and chronic illness. Associated in large part with poor eating habits and physical inactivity, rates of diabetes in Peel Region are among the highest in the province. More specifically, it is projected that by 2027, one out of every six residents in Peel Region will have developed diabetes.

In response to high diabetes prevalence rates, unhealthy environments and a population with a high genetic predisposition to diabetes, the Healthy Communities Initiative is enabling cross-sector partnerships – Public Health Units, primary care providers, school administrators, the business community, the faith community, and other stakeholders – to create supportive environments that promote informed decision making, promoting healthier choices and better use of the overall health care system.

Over the past year, the LHIN continued to engage with partners at Peel Public Health, Osler, the City of Brampton and community partners across the city to advance the Healthy Communities Initiative, setting the stage for coordinated delivery of multi-pronged strategies to promote healthy behaviours and create supportive environments for healthy living.

Health Equity

By addressing health equity issues, we create a more sustainable health care system by reducing the incidence of costly, preventable illnesses and related treatments. In support of Ontario's Patients First Act (2016), and the MOHLTC's Public Health Workstream Report, published in November 2017, the Central West LHIN has evolved its approach to health equity, engaging with health system partners and pan-LHIN stakeholders to collectively work toward the improvement of equitable access to care and minimization of barriers for vulnerable populations. More specifically, this includes:

- Evolution of health equity planning into sub-region planning
- Production of the Central West LHIN Health Equity Symposium
- Implementation and review of Health Equity Progress Reports
- Piloting of equity based data at time of intake
- Development of a Health Equity Charter

The creation of a Health Equity Charter reflects accountability and responsibility among health system partners and the LHIN to improve health equity across the region. The Charter acknowledges that achieving equity is a gradual process that requires ongoing reflection, efforts and collaboration. As a living document, the Charter is used to ensure equity planning reflects the evolution of the Central West LHIN's landscape and diverse health care needs of its population.

Moving forward, the LHIN will continue to work with health system partners to increase awareness of health disparities across the health care system, and to develop action plans that ensure charter principles are adopted by organizations across the LHIN. The LHIN will also continue to complete health equity impact assessments (HEIA) for all initiatives at the sub-region level, enabling a greater understanding of the effective collection and analysis of socio-economic data to improve program effectiveness, future planning and improved access/quality of health care services.

Home and Community Care

In December 2016, passage of Ontario's *Patients First Act (2016)* was a significant milestone for all of Ontario's LHINs. It laid the foundation for future transformation of both provincial and local health care systems, and set in motion collaborative planning that brought the Central West Community Care Access Centre (CCAC) and Central West LHIN together as a new LHIN organization on May 31, 2017.

With an expanded mandate, the Central West LHIN also became responsible and accountable for the planning, coordination and delivery of home and community care services to nearly 45,000 patients across the region. Twenty experienced and highly valued service provider organizations and vendors assist the LHIN with delivering on this mandate, providing patients with a full spectrum of community health care needs. They are also an important part of local health system planning, helping to inform the LHINs understanding of the ever changing needs of patients and families from a front-line perspective.

Throughout 2017/18, the LHIN remained focused on developing a more accessible and integrated local health care system, responsive to the needs of residents and patients while delivering better value for money. Additional investments in 2017/18 resulted in more than 900 waitlisted patients receiving access to home and community care services, enabling them to remain safe, healthy and in their homes longer. However, with a rapidly growing and aging population, there is a conscious shift within the health care system from acute care to more community-based services. As the demand and need for these services increases, the LHIN must consider the capacity of home care services required in order to meet future demand.

Alignment with Primary Care

Over the past year, through a neighbourhood model of care coordination, the Central West LHIN continued to expand and enhance its relationship with primary care providers in the community. Every primary care provider in the LHIN has been aligned with a dedicated LHIN care coordinator so that patients who need home and community care services are better supported through enhanced collaboration. Care coordinators regularly connect with primary care providers to participate in inter-professional rounds, consult and engage physicians in care plan development, and/or help physicians in problem solving regarding the most complex patients on their caseload.

Adding another dimension to primary care engagement, the LHIN embedded Clinical Leads and System Resource Navigators within its newly created sub-regions. Bringing physician leaders from the community to local and regional planning tables is an essential component to developing a more effective model of primary care.

As respected clinicians in the community, each Clinical Lead is responsible for local quality initiatives, working closely with primary care providers, inter-professional teams, and administrative leads in their sub-regions to achieve provincially defined performance metrics, and to develop a more integrated system or network of care at the sub-region level, including primary care, public health, home care and community care, mental health and addictions, long-term care, community support services, and acute care.

Equally respected for their diverse backgrounds and wealth of combined experience, System Resource Navigators are responsible and accountable for the expansion of the Health Links approach of coordinating care for patient populations with complex needs across care providers within their associated sub-regions, according to sub-region and regional work plans. They are enabling an environment of inter-professional practice that follows quality based and evidence-informed best practices within a patient-centered care philosophy, and they work collaboratively with primary care practices and community provider teams and partners to help assess priorities, establish goals and develop program strategies with a focus on enhancing quality, safety and patient centered care.

Partnering with Long-Term Care

In late December 2017, during the holiday season, King Nursing Home in Bolton experienced a mechanical boiler failure that resulted in a facility-wide evacuation to ensure all residents remained safe and comfortable until repairs could be completed over a six week period.

Quick action and strong, committed partnerships resulted in minimal impacts to system flow, and the community crisis list remained stable as a result of home and community care supports provided to patients waiting for a bed.

Repairs to the facility took approximately three weeks to complete, and another two weeks were required to return the facility's heat and hot water temperatures to safe levels. As a result of careful planning by King Nursing Home and the Central West LHIN, a majority of residents returned to the home over two weeks.

It is often the case that successful outcomes in the delivery of home and community care require innovative solutions and unwavering collaboration. This outcome was no exception, with credit being given to a collective willingness to ensure each resident remained comfortable and safe throughout.

This truly brought all elements of the local health care system together, demonstrating the strength of effective collaboration.

Enhanced Wound Care Program

In 2017, the Central West LHIN launched an initiative to address the prolonged healing times, inconsistent practices and documentation, and associated costs with the management of chronic wound care patients. In so doing, the LHIN developed 11 wound care pathways that apply evidence-based best practices for wound care to improve the quality of care, enhance the patient experience and create efficiencies in the use of resources.

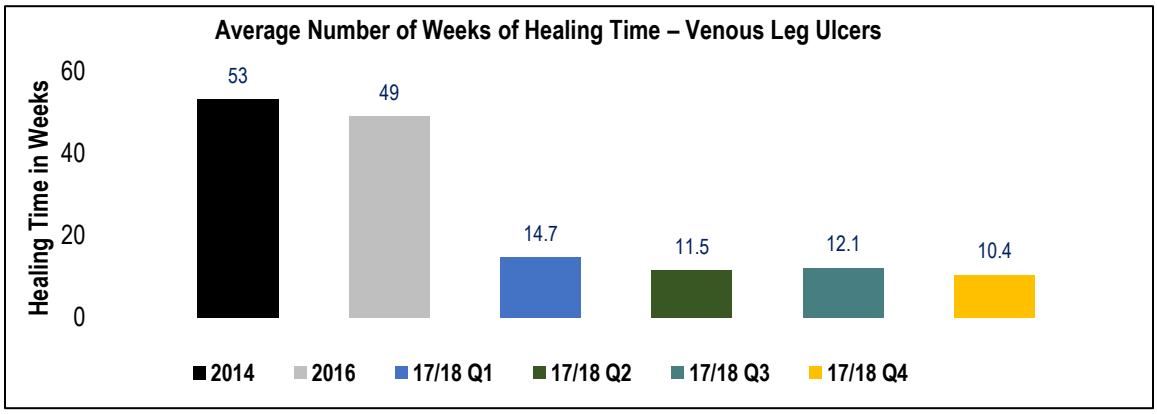
Following education and training, contracted Service Provider Organizations (SPOs) and LHIN staff jointly implemented these evidenced based pathways, which are showing substantive results, including:

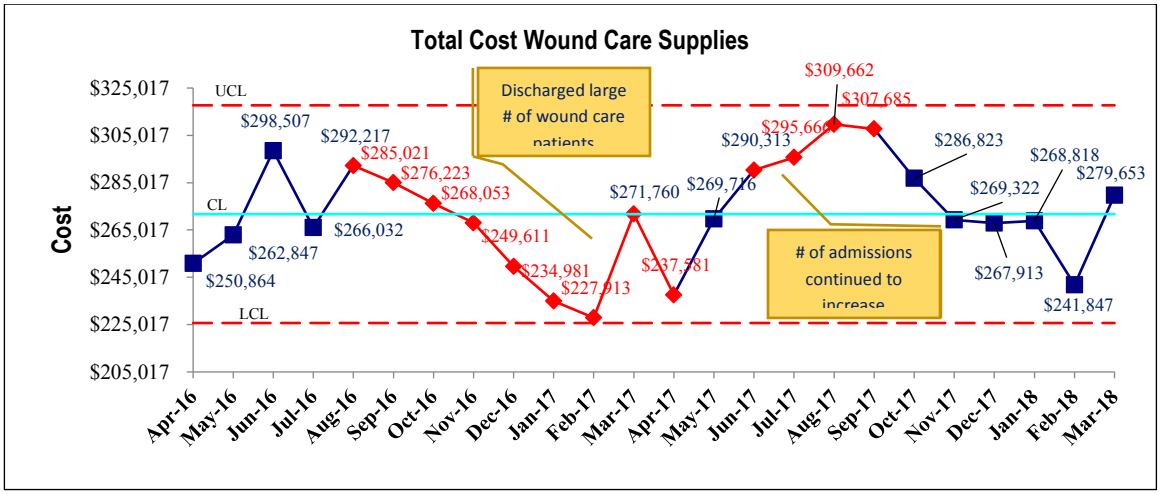
- An increase from 49 per cent to 87 per cent in consistent completion of e-documentation by service providers, thereby allowing for quality indicators to be measured
- An overall decrease in the average number of weeks of healing time from 41 weeks to 7.9 weeks. Specifically, the time to heal for Venous Leg Ulcers decreased from an average of 49 weeks to 10.4 weeks.
- Ninety-six per cent of patients discharged with healed wounds met the predicted healing times measured by the Bates-Jensen Wound Assessment Tool (BWAT), which is a validated wound continuum /acuity instrument.
- Monthly hospital readmissions reduced from a range of 8 – 15 readmissions per month to 0 – 3 readmissions per month post one year implementation. This represents an estimated annualized savings of $278,785.
- The mean cost to treat a patient on wound care has decreased from $11,072.70 to $1,384.39 post implementation, thereby freeing up resources to provide wound care for additional patients
- Since the inception of the wound care program, the number of newly admitted patients per month has increased from a range of 108 – 166 patients per month to 432 – 595 patients per month post implementation, while the average wound care supply costs have remained relatively stable.

Although the Wound Care Program has documented results and has been proven successful, the program now endeavors to further expand the self-management program that puts the patient experience in the forefront of program design.

The proposed Experience Centered Self-Management Program is directly aligned with Ontario's 2015 Amendment to the Excellent Care for All Act and Ontario's Action Plan – Putting Patients First, which requires healthcare organizations across Ontario to engage patients, caregivers and families in designing and evaluating Quality Improvement Programs.

The Experience Centered Self-Management Program utilizes Experience Based Design to develop a program that empowers and engages our patients. The program is designed to capture and constantly evolve based on our patients' experiences.


Average Number of Weeks of Healing Time – Venous Leg Ulcers
Healing Time in Weeks
60
40
20
0
53
49
14.7
11.5
12.1
10.4
2014
2016
17/18 Q1
17/18 Q2
17/18 Q3
17/18 Q4


Total Cost Wound Care Supplies
Cost
$325,017
$305,017
$285,017
$265,017
$245,017
$225,017
$205,017
UCL
CL
LCL
$250,864
$298,507
$262,847
$292,217
$266,032
$285,021
$276,223
$268,053
$249,611
$234,981
$227,913
$271,760
$237,581
$269,776
$290,313
$295,666
$309,662
$307,685
$286,823
$269,322
$267,913
$268,818
$279,653
$241,847
Discharged large # of wound care patients
# of admissions continued to increase
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
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Jul-17
Aug-17
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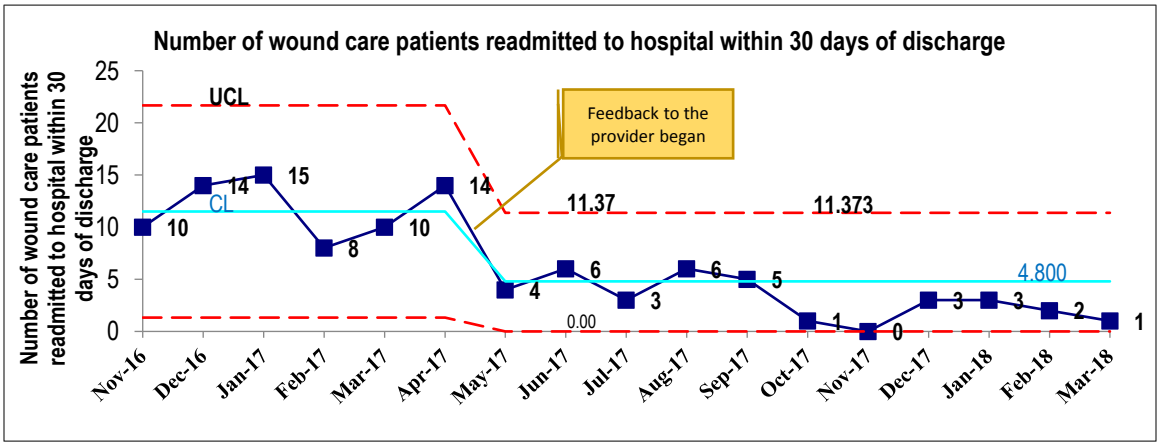
Feb-18
Mar-18


Number of wound care patients readmitted to hospital within 30 days of discharge
Number of wound care patients readmitted to hospital within 30 days of discharge
25
20
15
10
5
0
UCL
CL
11.37
11.373
4.800
0.00
Feedback to the provider began
10
14
15
8
10
14
4
6
3
6
5
1
0
3
3
2
1
Nov-16
Dec-16
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Community Outreach Stroke Rehabilitation

In 2017, the Central West Local LHIN and William Osler Health System (Osler) partnered with rehabilitation service provider 1to1 Rehab and the West GTA Stroke Network to address acute care length of stay (LOS) and outpatient waitlists for mild stroke patients, along with the timeliness and location of rehabilitation interventions for this patient population.

Using one-time Pay for Results funding, the LHIN's Home and Community Care team worked with Osler to co-design and pilot a six-month bundled rehab approach to stroke rehabilitation that would meet best practice targets for mild stroke patients being discharged from hospital. Patients who met pilot criteria received the support of an inter-professional Community Outreach Stroke Rehabilitation (COSR) team including a stroke care coordinator from the LHIN's Home and Community Care team, occupational therapist, physiotherapist, speech-language pathologist and rehab assistant from Osler's Brampton Civic Hospital (BCH) Outpatient Rehab Department, and therapy and communication assistants from 1to1 Rehab.

Throughout the pilot, there was a sustained focus on positively impacting both patient-centred and health system outcomes. Patients were provided with individualized therapy treatment plans to meet their goals in a timely manner, and to improve their transitions to community living post-stroke. After six months, patients reported excellent outcomes in terms of their experience, goal achievement and satisfaction upon discharge from the program. There was also demonstrated improved patient flow through the hospital by reducing the number of mild stroke patients transferring from acute care to inpatient active rehab beds as well as decreasing stroke patients' overall LOS in acute care (from six days to 5.2 days). The overall inpatient LOS for mild stroke patients was reduced by 3.8 days. In many cases, this represents an overall reduction of 4.8 days. The program also had a positive effect on the waitlist for an existing outpatient Neuro Rehab Program at Osler, reducing the current wait time for patients who had already returned to the community by approximately eight weeks.

This partnership between the hospital and community rehabilitation providers has established a strong foundation for continued collaboration, service integration, learning and capacity building across the care continuum, setting the stage for future system improvements to stroke care in the LHIN.

Collaborative Care with Community Services

Social determinants of health – income, access to care, social and physical environments, and individual behaviour – play a large role in the health and well-being people. This is particularly true for communities in the LHIN's North Etobicoke-Malton-West Woodbridge (NEMWW) sub-region, where a number of lower-income patients with complex health care needs, who rely on home and community care services and also live in public housing, reside. To support this patient population, the Central West LHIN partnered with Toronto Community Housing (TCH), providing "wrap around" support for mutual patients/residents. An emphasis was placed on proactively enhancing safety and reducing barriers to care.

Social determinants of health - challenges that are often thought of as being outside of health care including infestations, hoarding, and home maintenance – have a defined impact on the effective delivery of care. They can pose a risk to patient/resident safety and impede the caregiver's ability to not only access the home but, more importantly, provide quality care. In addition, unsafe conditions can result in missed visits which in turn can result in patients/residents frequenting hospital emergency departments (EDs) for conditions that could have otherwise been treated in a more appropriate and/or home setting. There is also an ever present concern of eviction.

Addressing these issues "upstream" or at the root resolves both housing concerns and the ripple effect it can have on public health, home care and, potentially, local EDs.

It is through this partnership that the Central West LHIN and Toronto Community Housing (TCH) are now working together to identify these issues sooner, allowing earlier interventions that result in better health and social outcomes. Between October 2017 and February 2018, this collaborative approach prevented the evictions of four residents, reducing the risk factors created by precarious housing. Meanwhile, knowledge sharing has resulted in best practices being passed to other community groups through the Rexdale Focus Table. This group focuses on collaboration to identify the most complex at-risk and vulnerable populations and advocate for care planning resources to keep patients safely in the community.

Give Up or Stand Up: Robert's Story

By his own admission, Robert has lived a tough life. At 70 years old, he is a relatively young senior who should be enjoying the later years of his life. But after working with race horses at Woodbine Racetrack in Etobicoke for 30 years, he struggles daily with a number of chronic conditions, limited income and few social supports as he tries to maintain his health and remain in his home.

More common than people think, Robert's case is complicated by social determinants of health including income, access to care, social and physical environments, and individual behavior.

Working with Canes Community Care and Toronto Community Housing, the Central West LHIN is helping to ensure Robert has the right support in place to keep him safely in his home for as long as possible.

Watch Robert's Story

HOME AND COMMUNITY CARE

DID YOU KNOW ?

BY THE NUMBERS 2017/18

44,951
Patients Recieving LHIN Services

6,511
H2H Visits

274,287
In-Home Nursing Visits

59,548
In-Home OT, PT, and SLP visits

1,138
People Early Identified as Palliative

2,010
In-Home Nutritionist/Dietition Visits

1,426,383
In-Home PSW Support Hours

294,256
Visits to centralwesthealthline.ca

100%
of PCPs Alingned with Care Coordinators

3,415
Coordinated Care Plans Completed

Celebrating Heroes in the Home

Caregivers are essential to the delivery of care in our region, often going to extraordinary lengths to improve the lives of those limited by age, illness and/or disability. This is why the LHIN's Heroes in the Home program is so important.

Most caregivers go quietly about their compassionate work, but this does not mean they should not be recognized for their selfless contributions to the lives of others and to the local health care system.

Heroes in the Home recognizes caregivers - both paid and unpaid - who support patients in the community. The LHIN invited health care professionals and members of the public to nominate family, friends, co-workers, care coordinators, personal support workers, health care professionals or anyone who goes above and beyond to help others live fulfilling lives in the community.

All nominees, their nominators and guests were invited to an inspiring and emotional celebration at Millennium Gardens Banquet Centre in November 2017, where 62 individual and groups of Heroes were recognized in four heroic categories:

- 28 Health Care Professionals
- 2 Teams
- 4 Friends and Community Volunteers
- 28 Family Members

Congratulations to all of our heroes, who go above and beyond to provide compassionate care in the Central West LHIN!

Health Shared Service Ontario (HSSO) Awards for Excellence

In June 2017, the Central West LHIN team had four big reasons to celebrate when, at the HSSO Achieving Excellence Together Conference, LHIN teams were recognized for exceptional achievement.

At the conference's Awards for Excellence – which recognize the exceptional achievements of LHIN employees from across the province –teams received awards in four of the six categories!

Congratulations to:

- Joy Brown, Rapid Response Nurse, who received the Citizenship Award
- Patricia McKernan, Director of Quality, Risk and Professional Practice, who took home the Leadership Award
- Our Wound Care Program, which was recognized with the Staff Team Award
- Our Early Palliative Identification Program, which won the System Partnership Award

The annual conference brings together Ontario's 14 LHINs with patients, caregivers, providers and key partners to celebrate innovation, integration and excellence in health care delivery. We were proud to represent and be recognized for the excellent work of the Central West LHIN!

PERFORMANCE

The Ministry-LHIN Accountability Agreement (MLAA) is an agreement between each of Ontario's 14 LHINs and the Ministry of Health and Long-Term Care (MOHLTC). It outlines the obligations and responsibilities of both organizations with respect to the planning, funding and integration of local health care services.

The MLAA includes measures used to assess the LHINs performance which, from time-to-time, are modified according to the changing priorities of the health care system. As of fiscal year 2017/18, the MLAA lists 20 measures in two categories:

Performance: Provincial targets have been established for the 13 performance measures, based on best practice and clinical evidence where possible. LHINs must report to the MOHLTC on their performance against these targets on a quarterly and annual basis.

Monitoring: Provincial targets have been established for some, but not all, of the seven monitoring measures. LHINs are not required to report on monitoring measures but they often provide important supplemental or explanatory information about the performance measures.

CENTRAL WEST LHIN MLAA INDICATORS

2017/18 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	88.50%	92.23%	88.97%	85.31%	89.91%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.21%	96.52%	95.43%	95.17%	95.09%
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	29.00	30.00	29.00	19.00	21.00	24.00	29.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	7.00	8.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	10.85	10.57	11.23	9.72
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	3.50	3.68	3.85	3.63
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	47.47%	67.50%	75.90%	68.81%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	47.88%	72.19%	64.65%	53.70%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.18%	7.14%	6.38%	8.12%	8.38%
10	ALC rate	12.70%	13.70%	13.98%	15.19%	15.68%	6.26%	5.53%	6.44%	8.11%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	20.97%	24.74%	24.84%	24.37%	26.79%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.25%	27.59%	31.89%	33.78%	35.83%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.41%	15.90%	15.91%	16.20%	17.06%
2. Monitoring Indicators										
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	89.21%	87.08%	92.63%	96.74%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	64.37%	88.05%	NA	NA
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18%	82.11%	84.73%	72.78%	78.42%	95.41%	97.53%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	14.00	20.00	21.00	18.00	19.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	12.00	13.00	11.00	13.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	12.06	5.25	4.93	4.17	4.00
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	243.31	279.11	273.16	272.23	211.61
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.43%	47.31%	55.41%	56.52%	56.65%	57.01%

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

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

The following section provides an overview of MLAA indicators grouped by which sector of the health care system they are measuring.

Primary Care

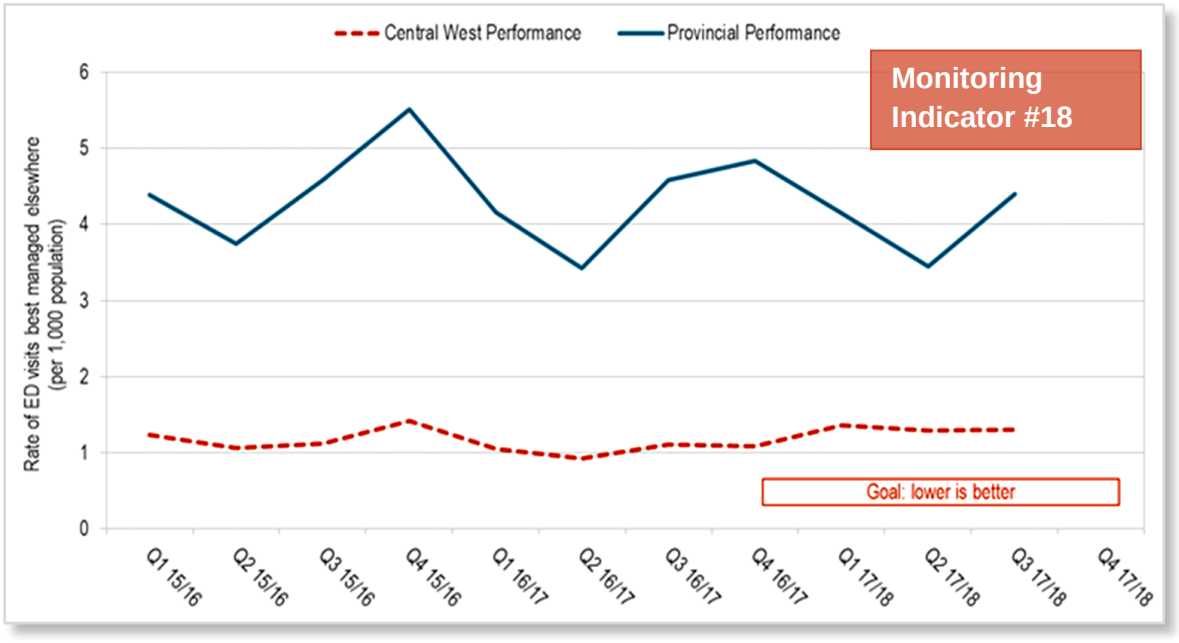
Primary care is the day-to-day health care provided by family doctors and other health care professionals in the community. Primary care measures in the Central West LHIN are included as monitoring indicators, but do not have target performance associated with them.

Monitoring Indicator #18: Rate of emergency visits for conditions best managed elsewhere per 1,000 population | Rate of low acuity emergency visits that could be treated in alternative primary care settings for patients aged one through 74 years. Conditions include:

- Conjunctivitis (pink eye)
- Upper Respiratory Infection (cough/cold)
- Otitis Media (earache)
- Cystitis (urinary tract infection)

For patients who are not seniors and have no other complications, these conditions are not emergencies and should be treated in a setting other than the emergency department (ED). If patients are arriving at EDs for these conditions, it indicates that these patients did not have adequate access to primary care.

In 2017/18, the Central West LHIN was ranked best in the province for this indicator. This suggests that residents have better mechanisms for dealing with urgent, non-life threatening health care issues than most Ontarians.

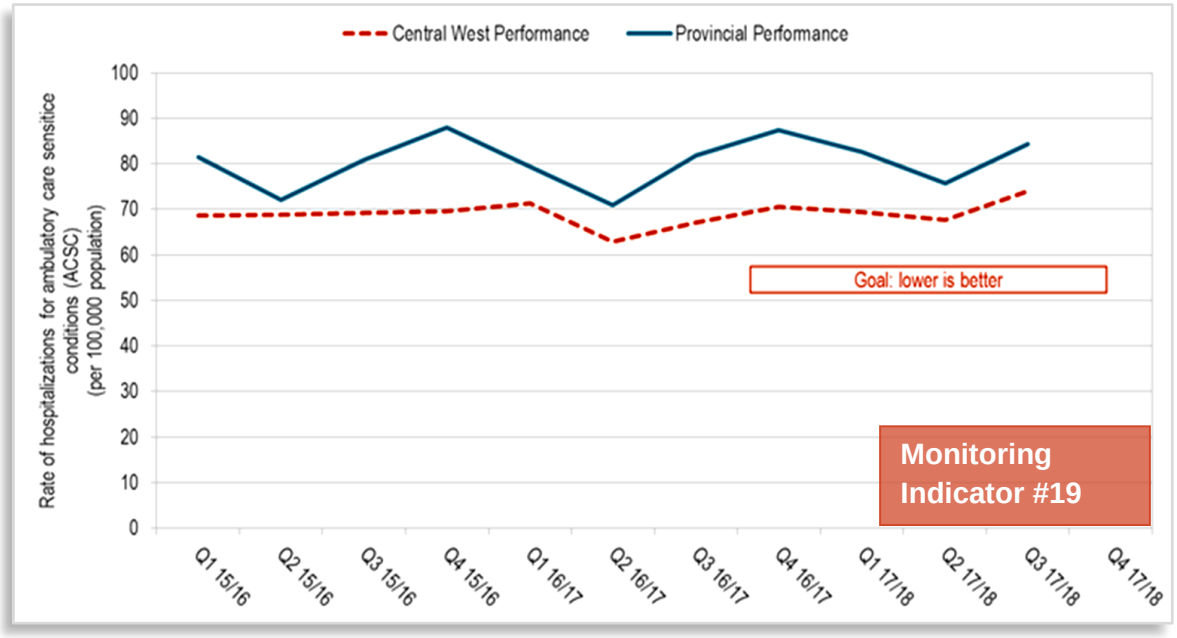


Monitoring Indicator #19: Hospitalization rate for ambulatory care sensitive conditions per 100,000 population | Rate of hospitalization for ambulatory care sensitive conditions per 100,000 population age < 75. Conditions include:

- Grand mal status and other epileptic convulsions
- Congestive heart failure (CHF) and pulmonary edema
- Chronic obstructive pulmonary disease (emphysema and bronchitis)
- Asthma, diabetes, hypertension and angina

When managed effectively in primary care and/or the community, ambulatory care sensitive conditions should not lead to hospitalizations. Commonly referred to as avoidable hospitalizations, these admissions indirectly measure the ability of the health care system to manage chronic conditions, access to primary care and care in the community. Optimizing management of these conditions can potentially contribute to both improved patient health outcomes and more efficient resource utilization.

In 2017/18, the Central West LHIN ranked among the top five LHINs in the province for this indicator.



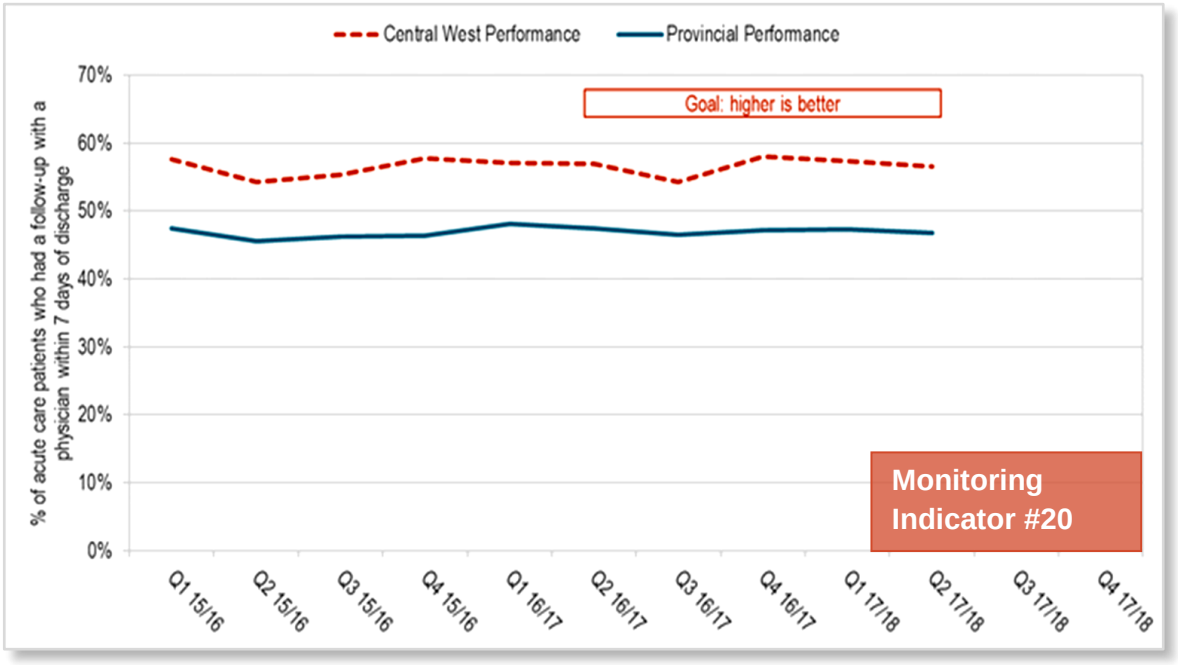
Monitoring Indicator #20: Percent of acute care patients who had a follow-up with a physician within 7 days of discharge | Percentage of patients with a hospital stay for specified conditions who saw their physician within seven days of discharge. Conditions include:

- Acute myocardial infarction (heart attack) (age 45+)
- Cardiac conditions other than heart attack (age 40+)
- Congestive heart failure (age 45+)
- Chronic obstructive pulmonary disease (emphysema and bronchitis) (age 45+)
- Pneumonia
- Diabetes
- Stroke (age 45+)

- Gastrointestinal disease

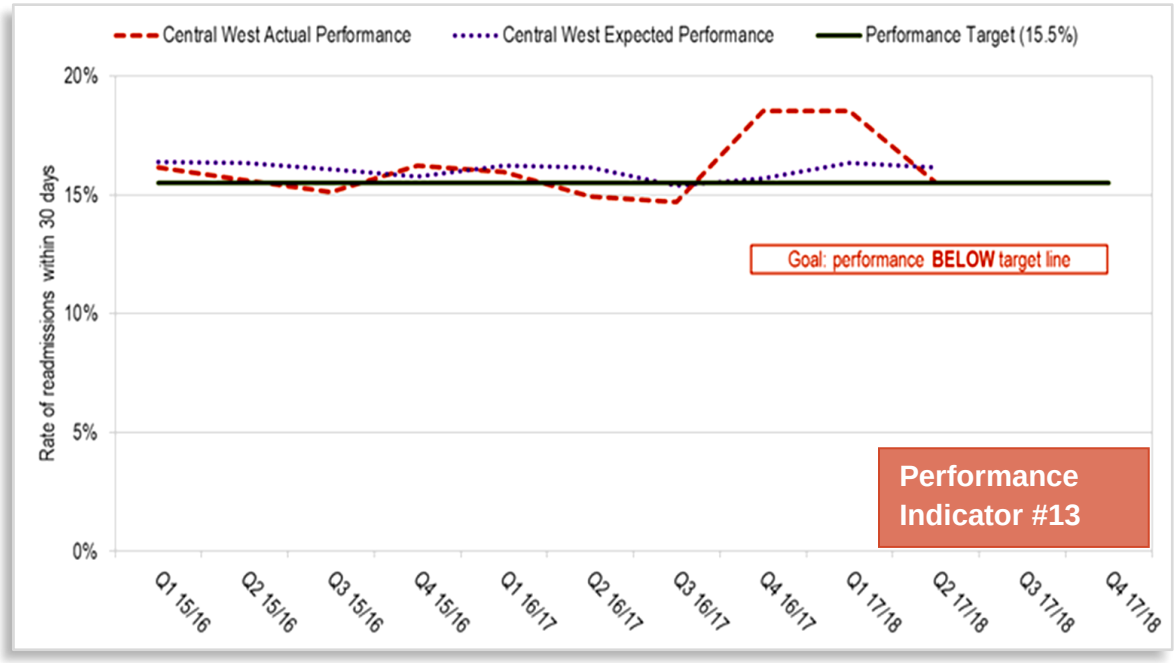
Chronic conditions that are not managed appropriately can cause substantial avoidable interactions with the health care system. When a patient's chronic condition is exacerbated, it often requires an ED visit and admission to an inpatient bed. The combination of appropriate care while in hospital, seamless hand off to community providers, and appropriate follow-up and preventative care in the community can prevent recurrence of exacerbations and repeated visits to the ED or admissions the hospital.

One of the most important steps in this preventative sequence is connection with the patient's primary care provider shortly after discharge from hospital. In 2017/18, the Central West LHIN ranked best in the province for this indicator.



System Integration and Access

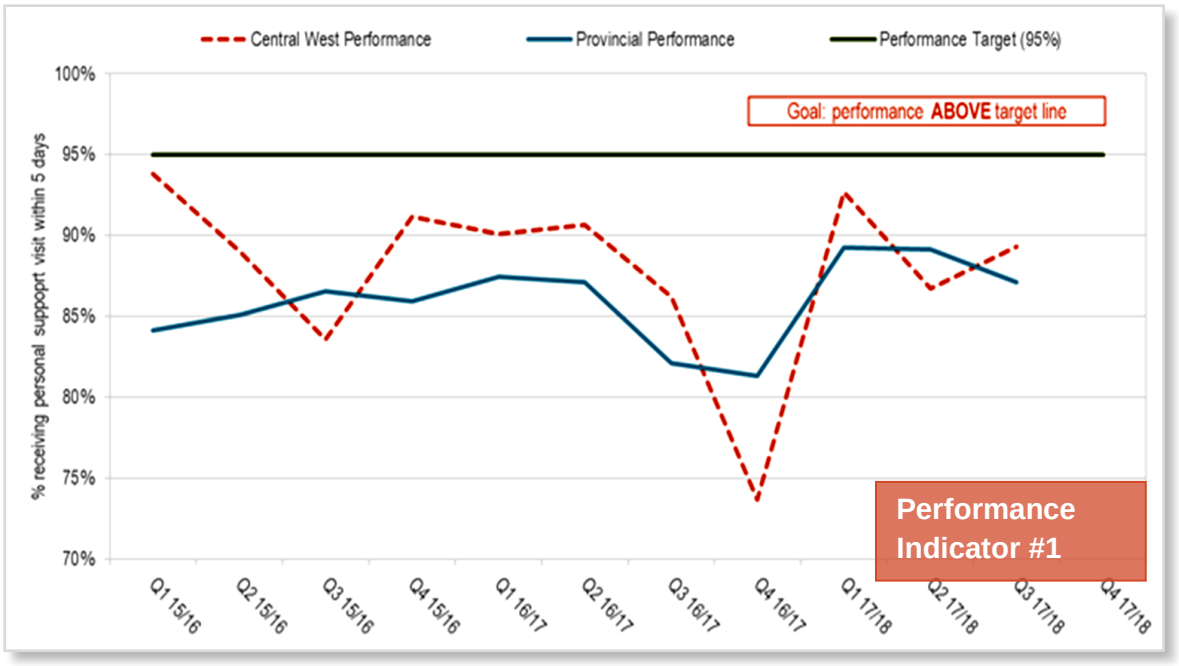
Performance Indicator #13: Readmission within 30 days for selected Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) conditions | This indicator measures the proportion of patients being treated for chronic disease(s), who required subsequent admissions to hospital after an initial hospital stay. This performance indicator is closely related to Monitoring Indicator #20. The chronic conditions being addressed are the same, and follow-up with a primary care provider after discharge is one of the interventions likely to prevent readmission.



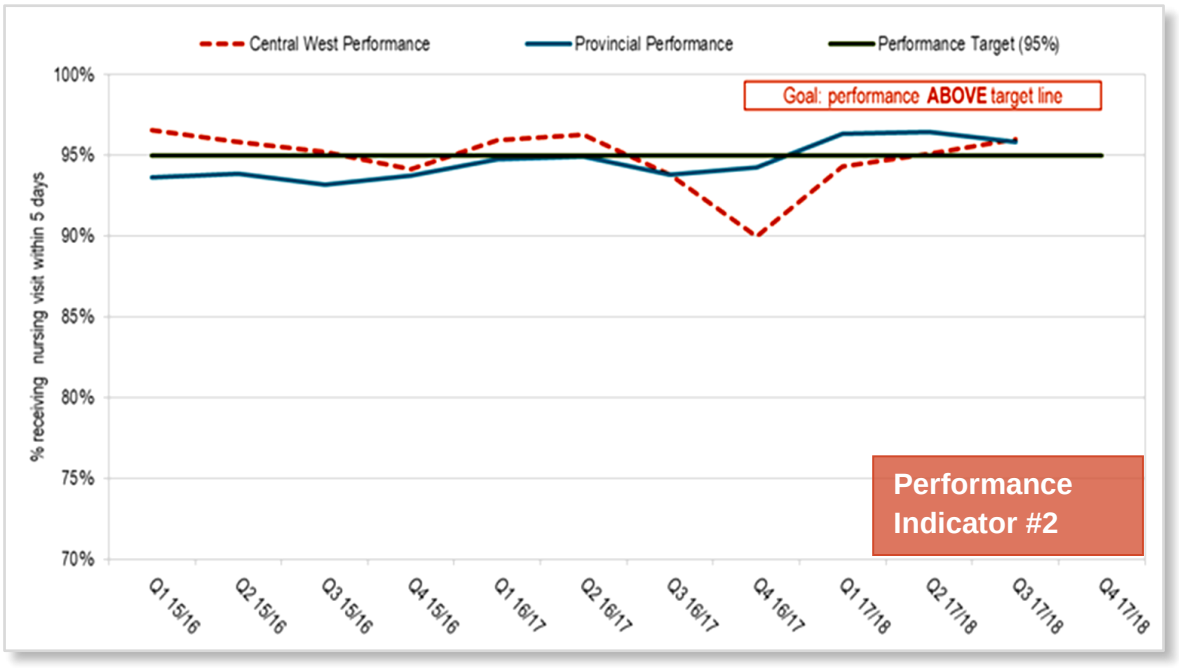
Home and Community Care

To prevent or delay ED visits, hospitalizations, Long-Term Care (LTC) applications, and to enable discharge from hospital, the LHIN provides a variety of in-home services to support patients in the community. LHINs are measured on the time it takes for a resident to receive home and community care support services after application. This period includes both the time from application to assessment and assessment to delivery of services.

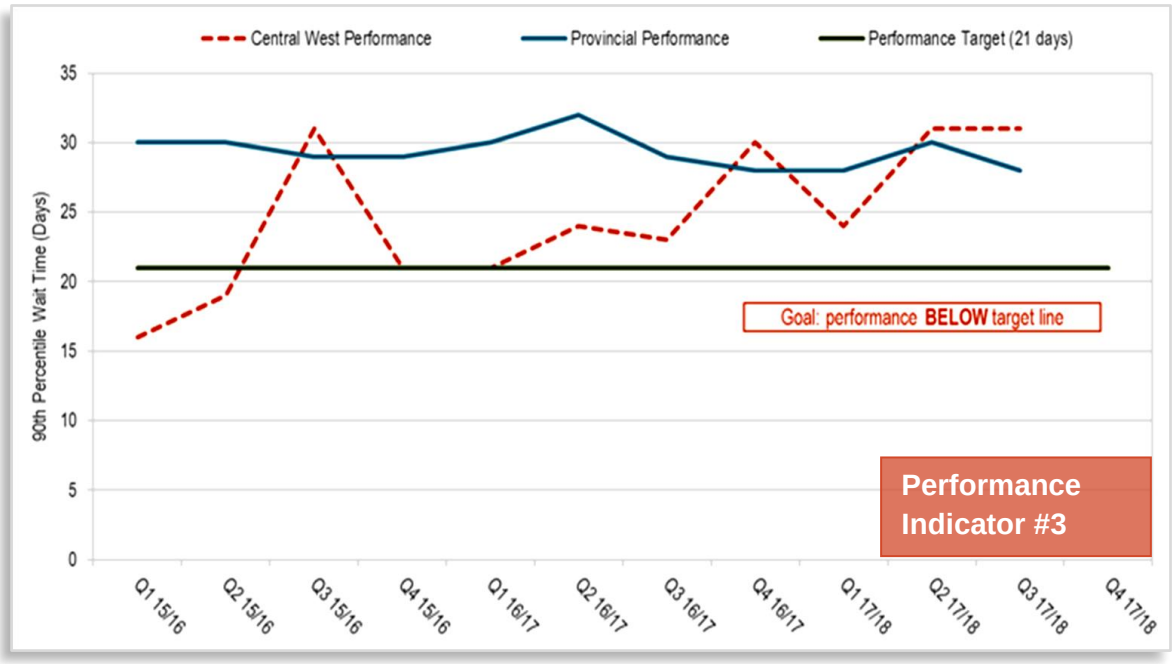
Performance Indicator #1: Percentage of home care patients with complex needs who received their personal support visit within five days of the date that they were authorized for personal support services | Services provided in the home prevent or delay ED visits and hospitalizations. The provincial access target for the time between when patients are authorized and/or available for personal support and the time that they begin receiving that support is five days. At a system level, we measure what proportion of the clients receiving services are receiving them within that provincial target.



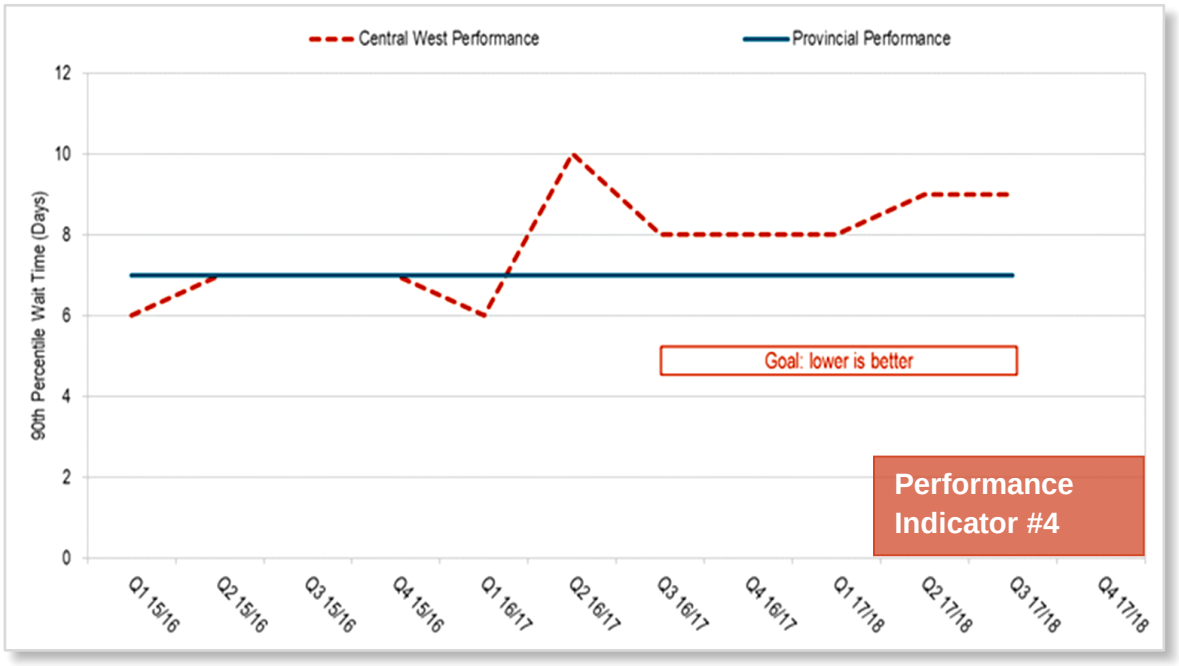
Performance Indicator #2: Percentage of home care patients who received their nursing visit within five days of the date they were authorized for nursing services | Services provided in the home prevent or delay ED visits and hospitalizations. The provincial access target, for the time between when patients are authorized for nursing services and the time that they begin receiving those services, is five days. At a system level, we measure what proportion of the clients receiving services are receiving them within that provincial target. With 95 per cent of patients having received their nursing visit within 5 days, the Central West LHIN has met the 2017/18 provincial target thus far.



Performance Indicator #3: 90th percentile wait time from community for home-care services: application from community setting to first home-care service | This indicator measures the time in which 9 out of 10 clients receive their first in-home service (excluding case management) when applying from the community. The longer a patient who needs in-home service waits to receive it, the more likely it is that the patient's condition will deteriorate and they will require a visit to the ED and potential hospitalization. The provincial access target for the time between when clients apply for in-home services and the time that they begin receiving that support is 21 days.



Performance Indicator #4: 90th percentile wait time from hospital discharge to service initiation for home and community care | This indicator measures the time in which 9 out of 10 clients receive their first in-home service (excluding case management) after discharge from a hospital. The longer a patient who needs in-home service waits to receive it, the more likely it is that that patient's condition will deteriorate and they will revisit the ED and potentially be hospitalized. There is currently no provincial access target for this indicator.

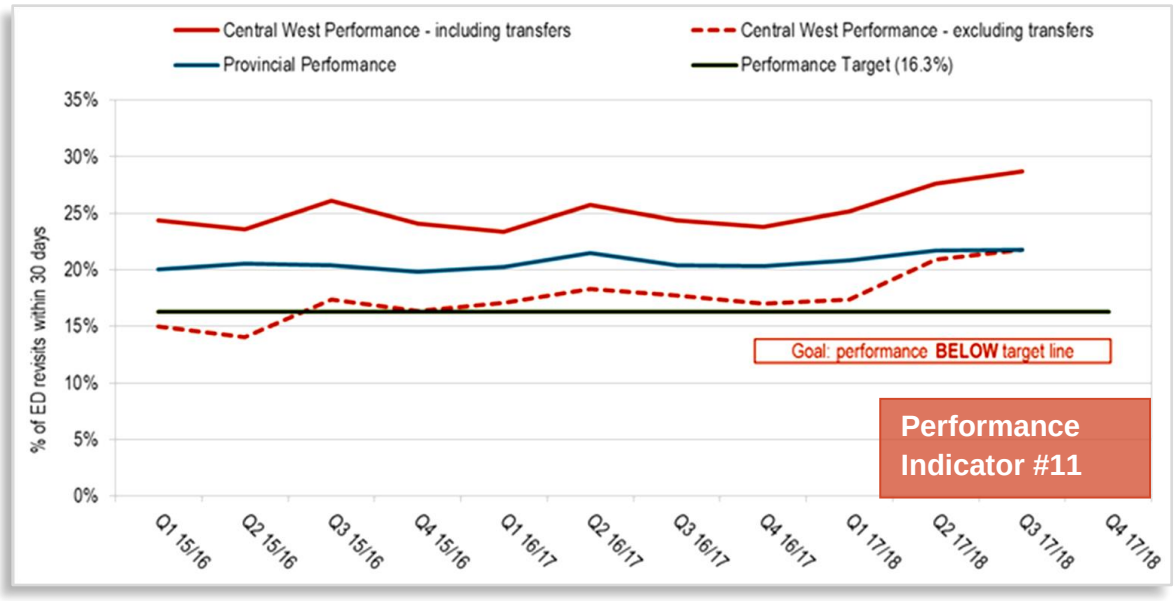


Mental Health and Addictions

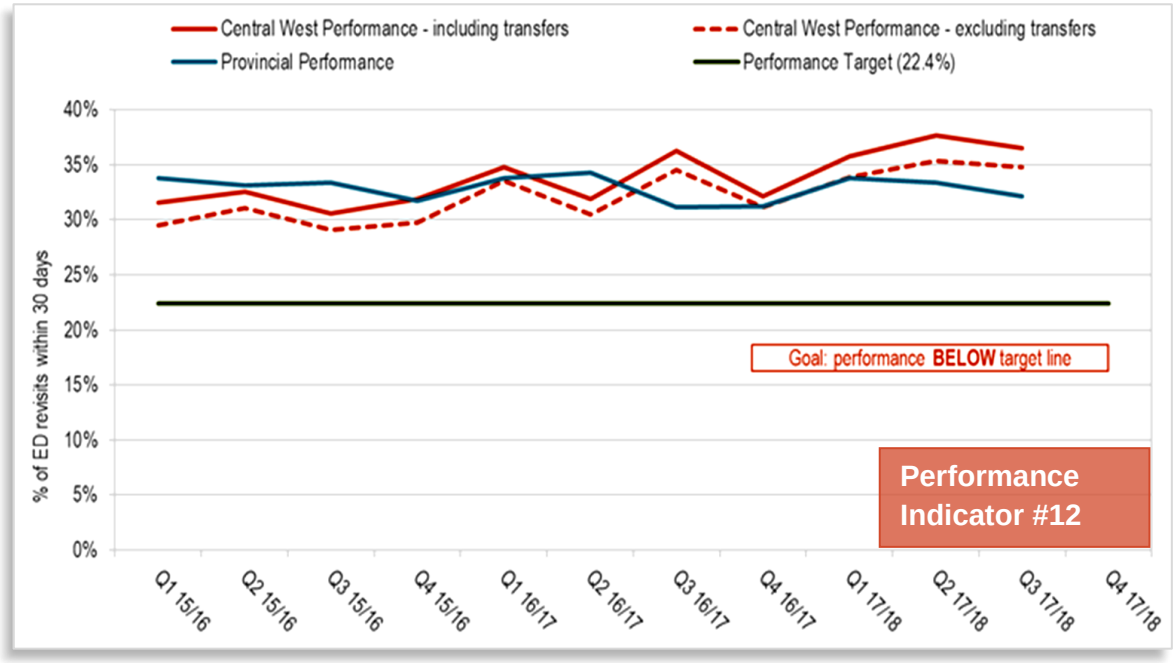
Visits to hospital EDs may be the appropriate point of access to care for individuals with mental health and addiction conditions who are in crisis. Repeat ED visits generally indicate premature discharge or a lack of coordination with post-discharge care and can contribute to ED pressures.

Given the chronic nature of mental health and addictions conditions, access to effective community services should reduce the number of repeat unscheduled ED visits for Ontario residents. This measure attempts to indirectly gauge the availability and quality of community services for patients with mental health and addictions conditions. It also enables the collection of data that can be used to measure the quality and availability of community mental health and substance abuse services, especially as it relates to wait times.

Performance Indicator #11: Repeat unscheduled emergency visits within 30 days for mental health conditions | Within this calculation, the MOHLTC considers a repeat visit to have occurred every time a patient is transferred from one ED to another, despite the fact that these transfers took place within the same "episode of care" and with no opportunity for the patient to receive community services. In-depth analysis at the Central West LHIN suggests that when these types of transfers are excluded from the measurement, actual performance is much better than what is purported by the provincial calculation.



Performance Indicator #12: Repeat unscheduled emergency visits within 30 days for substance abuse conditions | Within this calculation, the MOHLTC considers a repeat visit to have occurred every time a patient is transferred from one ED to another, despite the fact that these transfers took place within the same "episode of care" and with no opportunity for the patient to receive community services between the two departments. In-depth analysis at the Central West LHIN level suggests that when these types of transfers are excluded from the measurement, actual performance is much better than what is purported by the provincial calculation. More Central West LHIN residents are likely receiving the care they need in the community to prevent repeat visits to EDs.



Wait Times

Wait time indicators measure the proportion of patients who received their surgical or diagnostic imaging procedures within established provincial access targets. Patients waiting for these procedures are placed, by their physician, into one of four categories according to how quickly they need the procedures. LHIN performance is measured for patients in the all but the most urgent category as Priority I patients are expected to receive services immediately.

Diagnostic Imaging

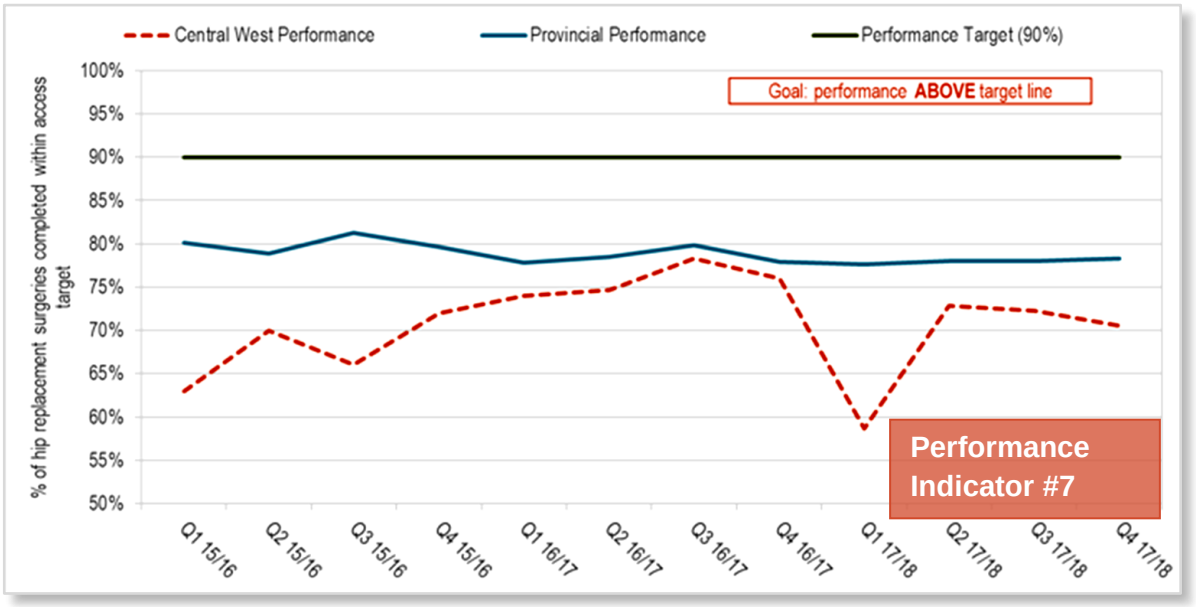
Monitoring Indicator #15: Percent of priority 2 and 3 cases completed within access targets for MRI scans

Monitoring Indicator #16: Percent of priority 2 and 3 cases completed within access targets for CT scans

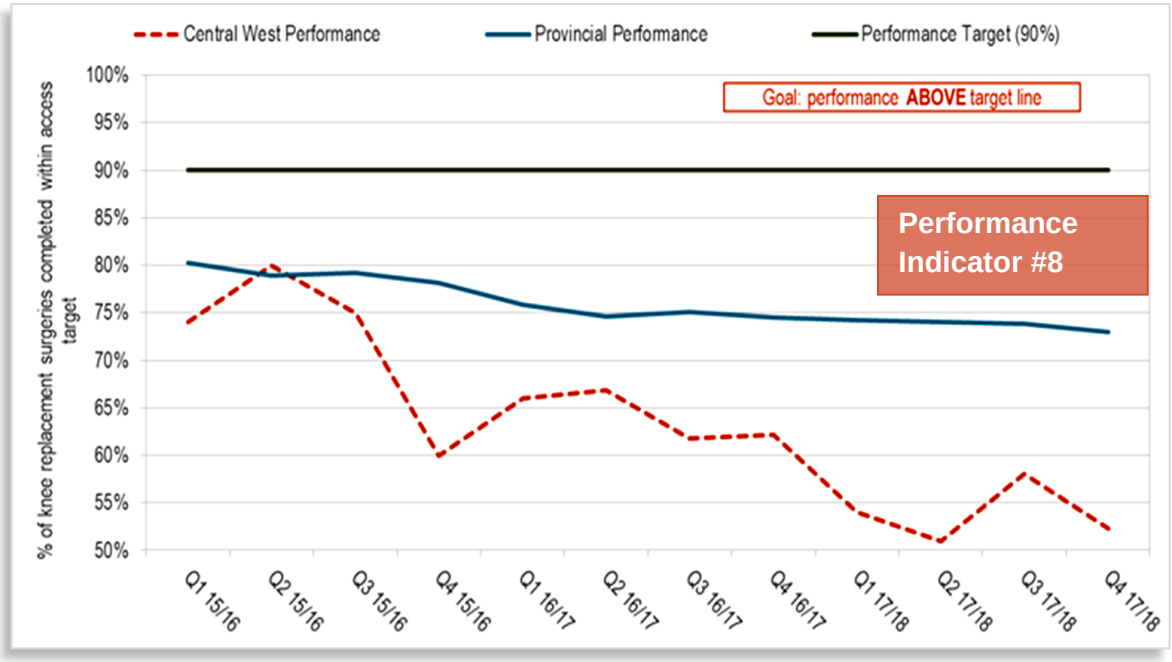
Data quality issues for diagnostic imaging data submitted by Central West LHIN hospitals have been identified. The review is ongoing and the expectation is that wait time information for MRI and CT scans will be reported in next year's annual report.

Surgical Procedures

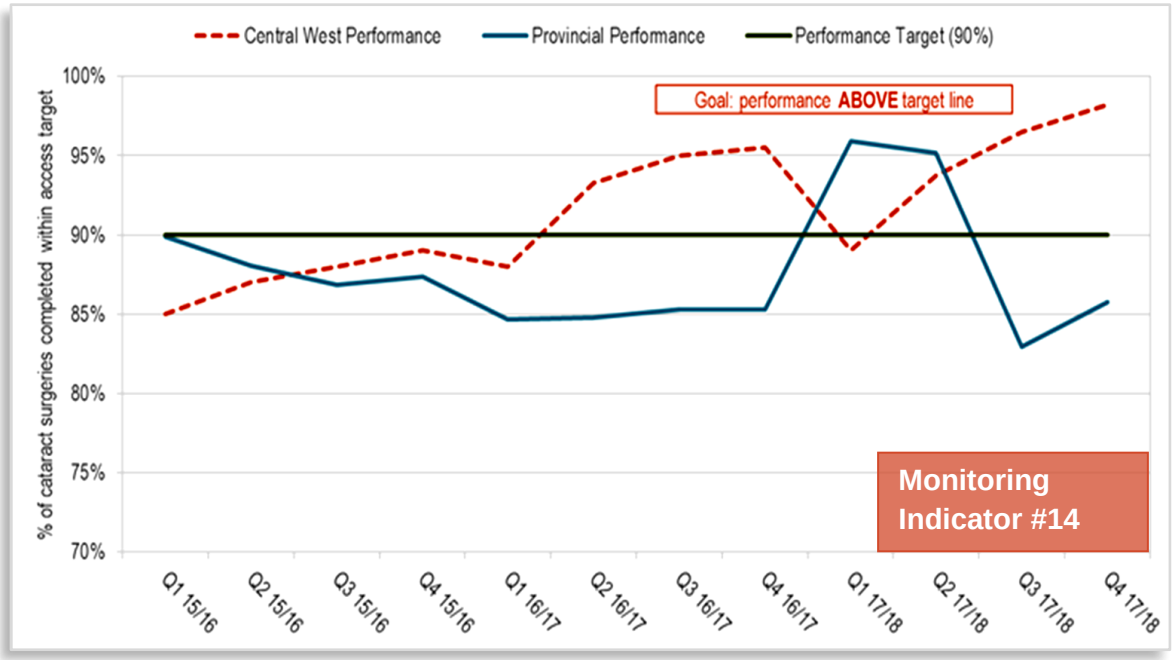
Performance Indicator #7: Percent of priority 2, 3 and 4 cases completed within access targets for hip replacement | While demand for joint replacement elective surgeries continues to outstrip funded supply, Central West LHIN hospitals completed all surgeries for which the MOHLTC allocated funding for in 2017/18. These numbers were not sufficient to clear the wait list.



Performance Indicator #8: Percent of priority 2, 3 and 4 cases completed within access targets for knee replacement | As with hip replacement surgeries, the demand for knee replacement elective surgeries exceeds the supply currently funded by the MOHLTC.



Monitoring Indicator #14: Percent of priority 2, 3 and 4 cases completed within access targets for cataract surgery | In 2017-18, the Central West LHIN exceeded the provincial target of 90 per cent, and provincial performance.



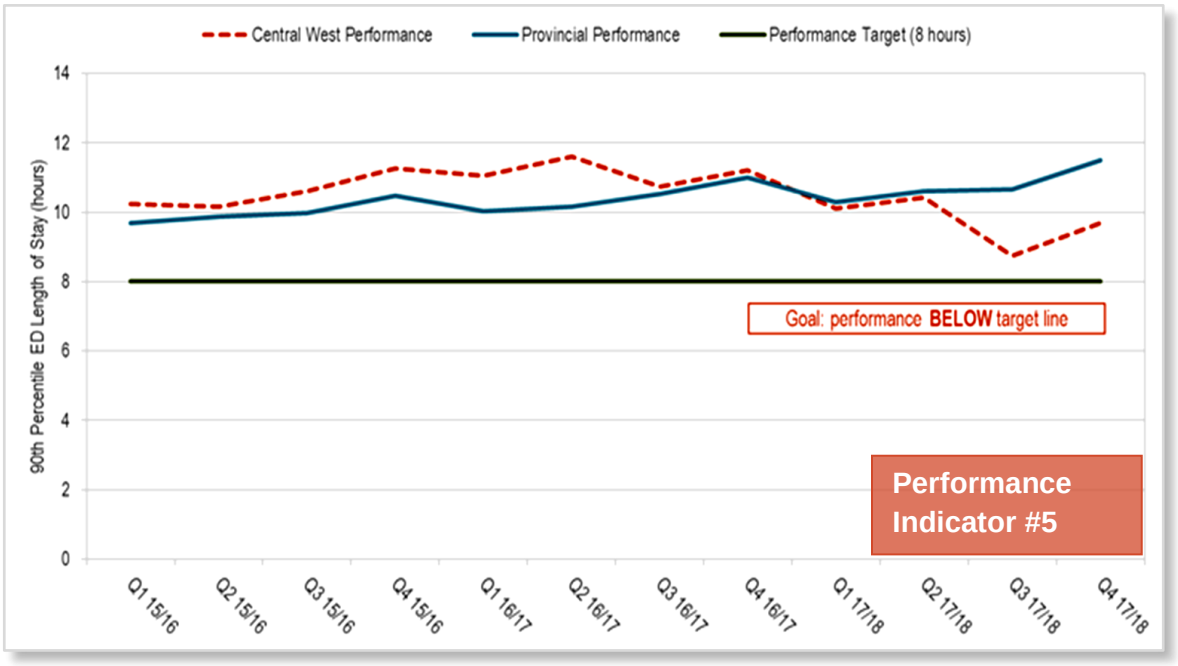
Hospital Care

ED Length of Stay (LOS)

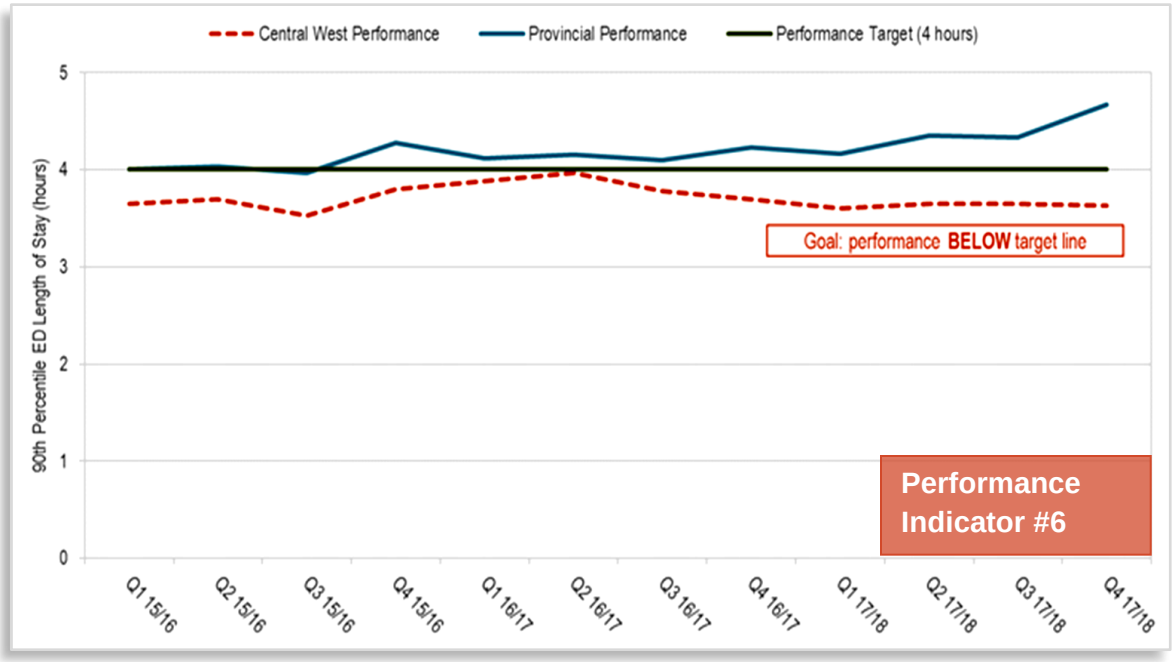
ED indicators measure the length of time from patient arrival at the ED to patient discharge from the ED. Discharge could include the patient's home, place of residence, admission to hospital or other. This measure includes wait time as well as diagnosis, treatment and monitoring time.

Performance Indicator #5: 90th percentile ED length of stay for complex patients | Most patients who are triaged as high acuity, or who require admission to an inpatient bed, benefit from up to eight hours in the ED. This time is spent being assessed, treated, and stabilized, allowing the physicians to decide whether the patient can be discharged or admitted to an inpatient unit. After eight hours, it is more likely that additional time spent in the ED does not add value to the patient's care, and if they have not already been discharged, they would benefit from longer-term and more specialized care on an inpatient unit.

Central West LHIN performance in 2017/18 missed the provincial target by approximately two hours. This performance is due to the time experienced by patients waiting in the ED for admission to an inpatient unit. The Central West LHIN has the highest proportion of high acuity ED visits of any LHIN. It also has the lowest ALC rate of any LHIN. However, Brampton Civic Hospital (BCH) consistently experiences some of the highest volumes of any ED in Ontario, leading to a greater need for acute hospital capacity than exists in the LHIN. Fluctuations in performance indicate the LHIN's response to and management of these volumes.



Performance Indicator #6: 90th percentile ED length of stay for minor/uncomplicated patients | Most patients who are triaged as having a minor or uncomplicated problem benefit from up to four hours in the ED. This time is spent being assessed, treated, and stabilized. After four hours, it is more likely that additional time spent in the ED does not add value to the patient's care and that at least some of the time spent in the ED has been spent waiting. Despite increased ED volumes in 2017/18, Central West LHIN LOS for low acuity patients was among the best in the province, well within the four hour provincial target.



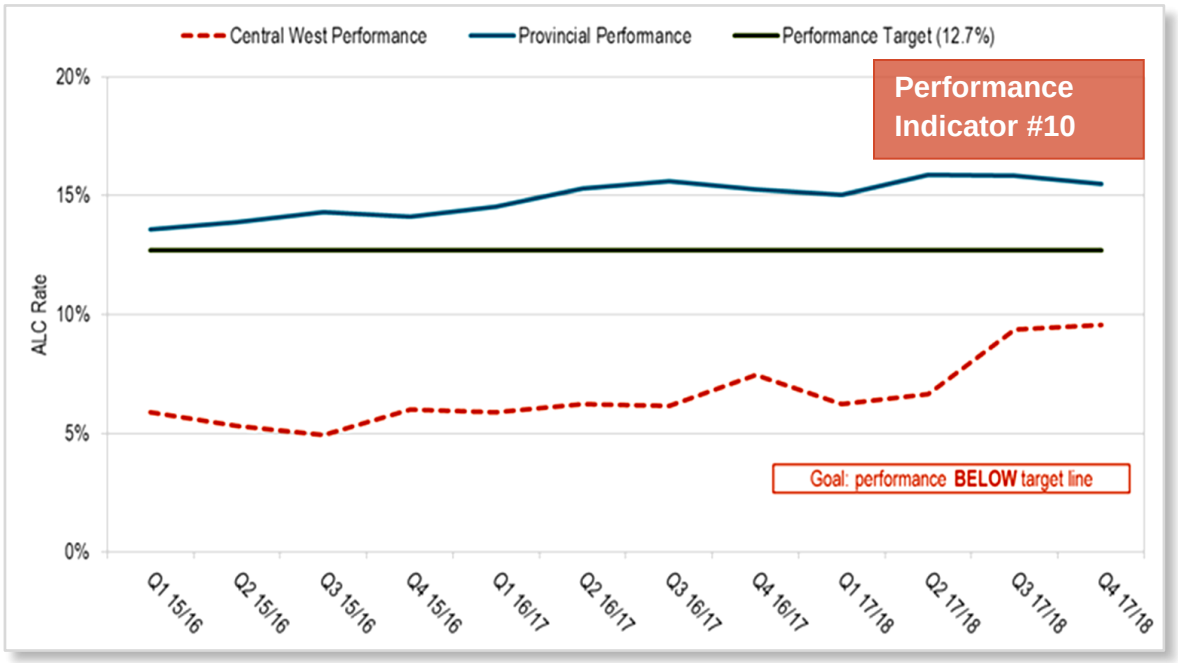
Alternate Level of Care

When a patient has completed their hospital stay, they should be discharged to the next most appropriate destination for their condition. Alternate Level of Care (ALC) refers to those patients who continue to occupy hospital beds after they have completed a course of treatment for which they were admitted and no longer require the care associated with those beds. For a variety of reasons, these patients experience barriers to discharge from hospital. The patient could be waiting for a lower level of care within a hospital, in the community or LTC.

Performance Indicator #10: ALC Rate | Every hospital bed occupied by a patient designated as ALC is a bed that is no longer included in the overall hospital's capacity. A patient who is designated ALC is occupying a hospital bed that, in many cases, is needed by a patient waiting in a different part of the system, like the ED. Additionally, a day in a higher level of care costs the system more than a day in a lower level of care. A reduction in ALC days results in more beds being available for those who need in-hospital treatment and makes better use of health system resources.

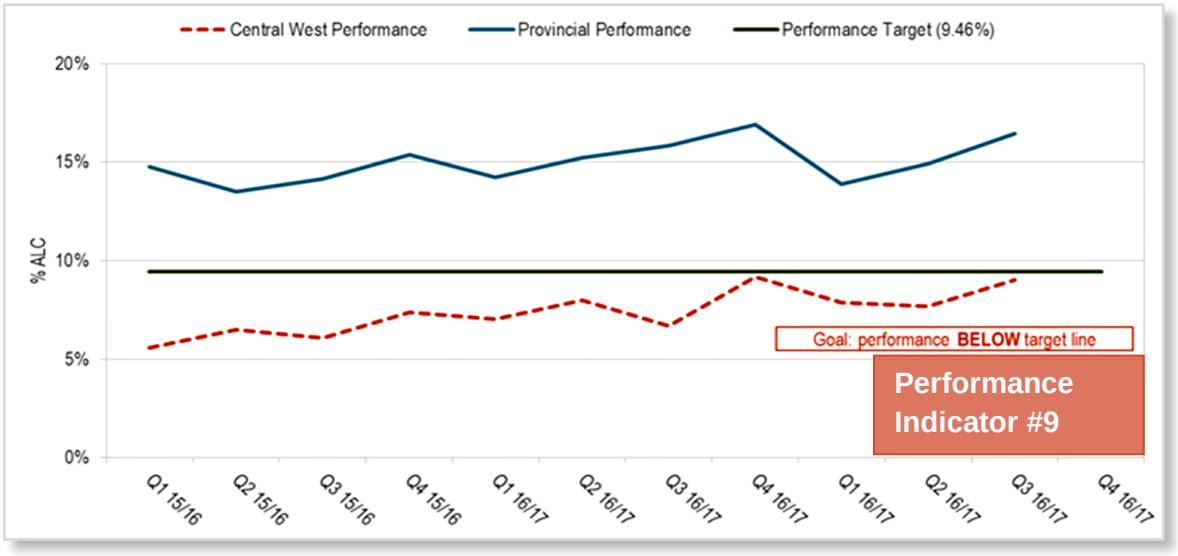
In 2017/18, the Central West LHIN had the lowest (best) ALC rate in the province, keeping the majority of inpatient capacity in use by patients needing it at the time.

Note: Due to a methodological change, the rate for Q1 2017/18 only includes April and May.



Performance Indicator #9: Percentage of ALC days experienced by patients discharged from acute inpatient hospital beds | All ALC days are non-value added for the patient. They are pure wait time where the patient is not receiving the care they need. In addition, a patient who is designated ALC is in a riskier environment than necessary, potentially exposed to hospital-acquired infections and not being activated and socialized. Patients remain in hospital longer than necessary for various reasons, including room availability in residential facilities, delays in discharge, and social and familial situations.

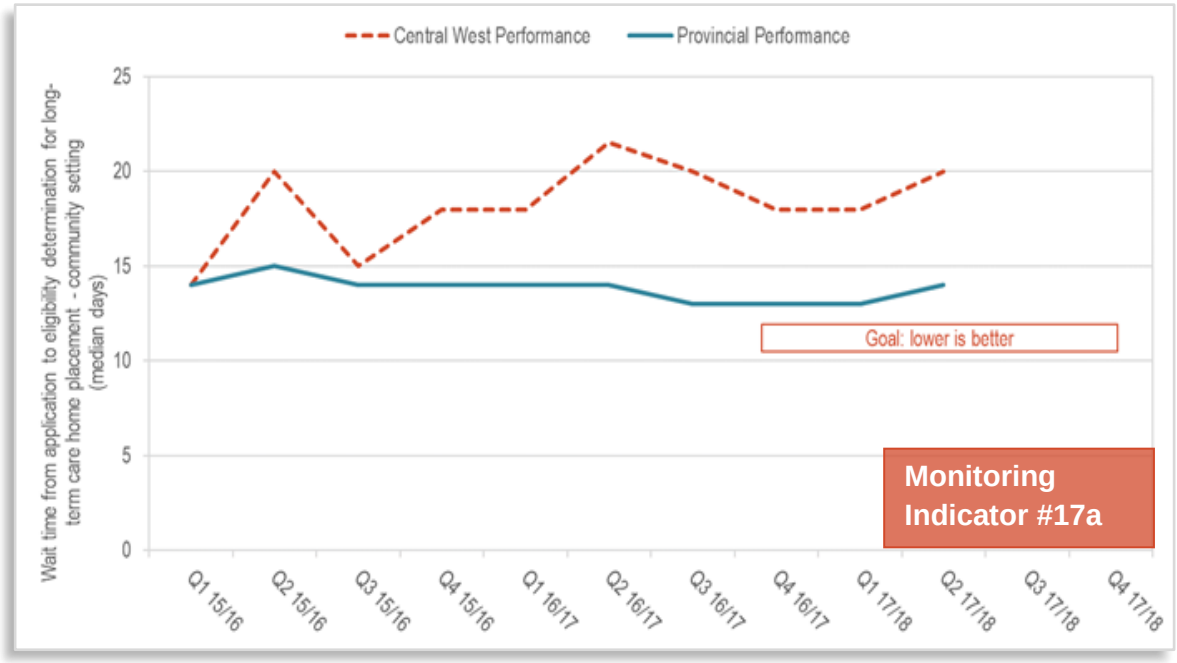
At the time of this report, the Central West LHIN had the best performance of all 14 LHINs year-to-date, meaning that patients who were discharged from Central West LHIN hospitals spent less time waiting for care in their homes, in LTC or in post-acute beds.



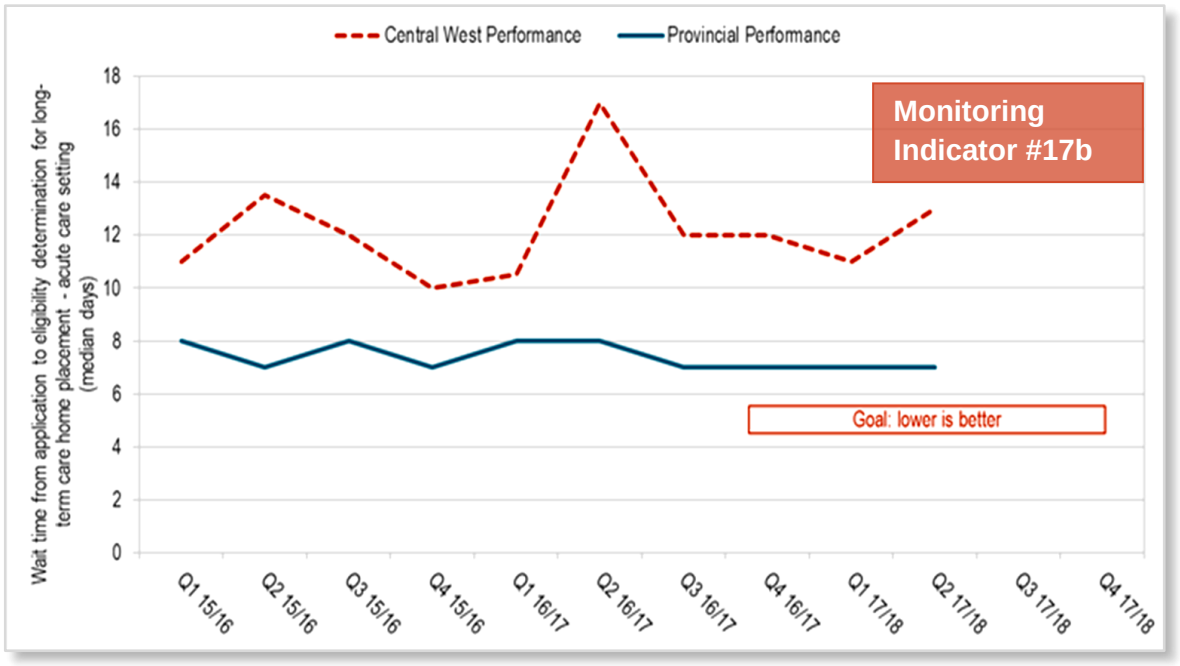
Long Term Care

These measures are indications of the Central West LHIN resident's experience of how long it took for residents to be evaluated for eligibility for care in a LTC home. All of the time measured for this metric is wait time, and therefore non-value added. The LHIN determines a person's eligibility for admission to an LTC home based on parameters and requirements outlined by the MOHLTC. There are no performance targets for these measures.

Monitoring Indicator #17a: Wait times from application to eligibility determination for long-term care home placement: from community setting (median days) | Half of Central West LHIN residents assessed for LTC eligibility and referred from the community waited up to 19 days for this assessment between April 2017 and September 2017.



Monitoring Indicator #17b: Wait times from application to eligibility determination for LTC home placement: from acute-care setting (median days) | Half of Central West LHIN residents assessed for LTC eligibility and referred from a hospital waited up to 13 days for this assessment between April 2017 and September 2017.


Central West Performance
Provincial Performance
Monitoring Indicator #17b
Wait time from application to eligibility determination for long-term care home placement - acute care setting (median days)
18
16
14
12
10
8
6
4
2
0
Goal: lower is better
Q1 15/16
Q2 15/16
Q3 15/16
Q4 15/16
Q1 16/17
Q2 16/17
Q3 16/17
Q4 16/17
Q1 17/18
Q2 17/18
Q3 17/18
Q4 17/18

ENGAGING LHIN COMMUNITIES

At the Central West Local Health Integration Network (LHIN), we understand that the health care needs of local communities are best understood and defined by the people who live and work in them. As such, we are committed to building strong relationships and directly engaging with our local residents to ensure we fully comprehend and act on their needs and ideas. In addition, we strive to enrich our communities' knowledge of the health care system, both locally and provincially.

With the addition of Home and Community Care this past fiscal year, we had an increased opportunity to connect with local community groups, organizations, businesses, elected officials and more, to share information on home- and community-based services and programs. Additionally, we leveraged these presentations and information booths to further residents' understanding the local health system, and to hear their ideas and feedback, and to encourage them to be active participants in the planning process.

The Central West LHIN's communications and community engagement activities in 2017/18 were aligned with the 2017/18 Annual Business Plan. More specifically:

- Provide health system partners and the broader general public with further understanding of Ontario's Patients First Act (2016) and how it will improve the patient/client experience in the new LHIN organization
- Forge links between home and community care and primary care
- Raise awareness of work related to system access, particularly in regard to home and community care as well as primary care
- Build public confidence in the positive change taking place within their provincial and local health care systems
- Create awareness of LHIN sub-regions and how they will strengthen health care planning in the Central West LHIN
- Reassure broader stakeholder audiences that there will be no disruption in home care services to patients/clients

During the 2017/18 fiscal year, the LHIN used many channels and embraced a variety of opportunities to build relationships in our communities.

Engagement highlights include:

News Releases	Inform	As in previous years, the LHIN continued to support and promote government and ministry news releases on its website and by sharing through its social media accounts and in staff and community eNewsletters. Additionally, the LHIN worked with local MPPs to issue several echo news releases pertaining to the localization of provincial announcements. Several of these stories were picked up by local media outlets.
eNewsletter(s)	Inform and Involve	In April 2017, prior to transition, the LHIN issued the final edition of its monthly external newsletter, *Working Together for Healthy Change.* The newsletter was targeted to all stakeholders including health system partners, MPPs and other publicly elected officials, governors, and the general public. With an enhanced mandate, the Central West LHIN took the opportunity to refresh its external newsletter while establishing an internal eNewsletter as well. In August 2017, the LHIN launched its new external eNewsletter *LHINsights,* and internal eNewsletter *LHINsider*. *LHINsights* is being sent to over 850 stakeholders, including elected officials, health system partners, governors, community partners and the general public. In the 2017/18 fiscal year, the LHIN issued three editions of its new newsletter, which contains notable updates from the LHIN and its partners, as well as provincial updates, select media stories, and more.
Governance and Leadership Forum	Involve	The Central West LHIN's Governance and Leadership Forums continue to be popular events, drawing attendance of approximately 200 health care leaders, governors and professionals from around the LHIN to each event. In 2017/18, the LHIN hosted two sessions:

		▪ November 2017: From Transition to Transformation…the road ahead for health care in Ontario, with special guest speaker Dr. Bob Bell, Deputy Minister of Health and Long-Term Care ▪ March 2018: Focus on Population Health…an exciting panel discussion with Dr. Eileen de Villa (Medical Officer of Health, City of Toronto), Dr. Jessica Hopkins (Medical Officer of Health, Region of Peel) and Dr. Nicola Mercer (Medical Officer of Health, Wellington-Dufferin-Guelph Public Health).
Special Events	Involve	The Central West LHIN was proud carry on the tradition of hosting the Heroes in the Home Awards. The program recognizes caregivers – both paid and unpaid – who go to extraordinary lengths to improve the lives of those limited by age, illness and/or disability. The Central West LHIN invited the public to nominate family, friends, co-workers, care coordinators, personal support workers, health care professionals or anyone who goes above and beyond to help others live fulfilling lives in the community. This year, the LHIN recognized 62 individuals and teams at an inspiring and emotional celebration in November 2017. The Central West Palliative Care Network hosted its annual Conference in November 2017. The sold-out event featured a variety of inspirational workshops and insightful speakers, aimed at expanding knowledge and deepening understanding of palliative care. In addition, the LHIN was honoured to spotlight its local health partnerships by participating in special events, such as: ▪ The ribbon cutting at Kipling Acres' Phase 2 opening ▪ The 'topping off' ceremony at Etobicoke General Hospital ▪ The official ribbon cutting at the Peel Memorial Centre for Integrated Health and Wellness

		▪ The opening of Headwaters Health Care Centre's Ambulatory Care Wing ▪ The celebration of Bethell Hospice's successful Accreditation ▪ The volunteer recognition celebration at Brampton Meals on Wheels.
Community Forums/Events	Inform	In 2017-18, the Central West LHIN was pleased to support 33 events hosted by community organizations, businesses and elected officials. At these events, the LHIN educated and informed the public about their local health care system, as well as the services and programs available to them through the LHIN's Home and Community Care team. Specifically, LHIN staff and leaders: ▪ Provided 21 presentations to local residents ▪ Manned 11 educational displays and information booths at local events ▪ Participated in 1 panel discussion focused on caregiving. The LHIN's participation at these events was very well received. Guests appreciated the opportunity to ask questions and receive answers directly from the experts. Highlights include: ▪ A series of Falls Prevention and Exercise classes, offered in Punjabi, to CANES Community Care clients ▪ An educational session for Personal Support Worker students at Georgian College's Orangeville campus ▪ An information display at Canada Revenue Agency's Black History Month celebration ▪ Participating in events hosted by elected officials like Councillor Vincent Crisanti, MPP Steven Del Duca, and MPPs Yvan Baker and Peter Milczyn.
Partner Annual General Meetings (AGM)	Inform	In support of its valued local health care partners, the LHIN was pleased to provide remarks at 11 AGMs in 2017/18.
Operational Publications – Annual Business Plan / Annual Report	Inform	The LHIN's Annual Business Plan and Annual Report were both distributed to broad stakeholder audiences as effective tools to help educate and inform regarding the LHIN's ongoing priorities.

Central West LHIN Gets Social!

Recognizing the powerful reach and scope of social media, the Central West LHIN refreshed and increased its social media presence this year.

In April 2017, the LHIN relaunched its Twitter account after a three year hiatus. At first, posts occurred once per week. Gradually frequency increased to its current daily state. Content is pulled from the LHIN's own activities, and those of partner organizations as well. In particular, posts relating to health tips and health promotion are especially popular with followers.

Through a combination of frequent posting and compelling content, the LHIN increased its number of followers by 43 per cent in its first year, averaging approximately 33 new followers per month. Followers range from local health system partners, to elected officials, advocates and members of the general public – both local and from beyond our borders.

In order to highlight our organization as an employer of choice, the LHIN also took to LinkedIn, establishing a presence on this corporate networking and information sharing application for the first time. Through weekly updates, we have shared career opportunities and given our followers a taste of life at the Central West LHIN. In addition, we also showcase opportunities that might be of interest to people working in health care, such as conferences, award nominations and more.

Our LinkedIn followers have grown exponentially since we launched our account, and we look forward to continue to highlight our excellent staff and engaging corporate culture.

The Road Ahead

As the communities within the Central West LHIN continue to grow, age and diversify we need to actively plan for the future health care needs of residents.

Capital Investments

After a number of infrastructure announcements in 2013 and 2014, this past year saw continued advancement on a number of essential projects designed to meet the current and future needs of the patients we serve.

Reaching New Heights at Etobicoke General Hospital (EGH)

In June 2017, a momentous milestone was reached in the “topping off”of EGH’s new four-storey patient tower, as well as the site’s new seven-storey Ancillary Services Building (ASB).

“Topping off” is a milestone widely recognized in the construction industry and signifies the building reaching its highest point and completion of the building’s structure.

When it opens in 2018, EGH’s new patient tower will add 250,000 square feet of space for new and expanded departments, such as a larger state-of-the-art emergency department, new intensive and critical care units, new cardiorespiratory and neurodiagnostic services, and expanded women's and children's space. The new 200,000 square foot, seven-storey Ancillary Services Building will replace the aging, existing medical office building with more than twice the square footage of contemporary medical space to house existing ambulatory care clinics and a new satellite dialysis program.

Doors Open at Peel Memorial Centre for Integrated Health and Wellness (Peel Memorial)

In April 2017, Peel Memorial held its official grand opening to the public.

Located in the heart of downtown Brampton, the new, state-of-the-art outpatient hospital focuses on treatment of patients who do not require an overnight stay in hospital and offers an extensive list of specialty and day clinics, as well as health services and programs focused on the unique needs of seniors, children, people requiring mental health services, and individuals living with chronic conditions such as diabetes or asthma.

Osler's two other hospital sites – Brampton Civic and Etobicoke General - will work seamlessly with the new Peel Memorial closely so that patients can easily move between the three facilities, depending on their needs.

Major Expansion for Peel Memorial

Following its official opening in April 2017, it was announced in November of 2017 that a major expansion of the facility has been approved.

The next phase of redevelopment at Peel Memorial will add more inpatient services including complex continuing care and rehabilitation.

Also highlighting the addition of 37 beds at Brampton Civic, the announcement addressed the imediatae need for additional acute care capacity while helping to ensure that residents in Brampton and surrounding communities will be able to access and receive high quality, patient-centred care well into the future.

Expanding Headwaters Health Care Centre

Nearly a year after breaking ground on its redevelopment project, Headwaters opened its new ambulatory care unit in September 2017. The project is a significant step forward in increasing access to important health care services for the growing community in Dufferin.

The addition of the new 8,700 square foot space is the first major expansion of the hospital since opening at the current location in 1997. The new wing is now home to high-demand clinics, services and programs such as dialysis, chemotherapy, minor procedures, orthopaedics and plastics.

The completion of the expansion signaled the kick off to the second phase of the redevelopment project: an exciting renovation of 11,800 square feet of existing hospital space to add another operating room, improve reception, and expand pre- and post-surgical recovery areas. This phase of redevelopment is targeted for completion in 2018.

Health System Transformation

In reflecting back on the progress and accomplishments made throughout 2017/18, there is much work to be done as we leave LHIN transition in the rearview mirror, while setting our sight on the transformative road ahead.

With transition now complete, the important work of health system transformation has begun and will continue to define the LHIN's priorities throughout 2018/19. Designed to enable a more patient-centered health care system, the Patients First Act is intended to enhance patient experiences and smoother care transitions by improving connections between primary care providers, interprofessional care teams, hospitals, public health, and home and community care.

In 2018/19, the Central West LHIN will continue to collaborate with health system partners to improve the patient experience, increase access to care and reduce wait times – while working to reduce health disparities. With an eye to ensuring the best health outcomes for all, our collective focus will be to:

- Deliver care that reflects the patient voice and is responsive to patients' needs, values and preferences
- Address the root causes of health inequities and social determinants of heath by investing in health promotion and reducing the burden of disease and chronic illness
- Create healthy communities for patients by improving access to primary care and reducing wait times for acute care, specialist care, mental health and addictions services and, home and community care

- Break down silos between health care sectors and providers to ensure seamless transitions for patients
- Support innovation by delivering new models of care and digital solutions to make accessing care easier for patients and more efficient for health care providers

As we deliver on our mandate, we will also continue to:

- Promote health equity and reduce health disparities and inequities
- Respect the diversity of local LHIN communities including the promotion of culturally safe care for Indigenous people and meeting requirements contained in the French Language Services (FLS) Act
- Strengthen local engagement with Francophone and Indigenous communities
- Work with local partners to plan and deliver health services

2018/19 will also mark the final year of the LHIN's 2016-2019 Integrated Health Service Plan (IHSP 2016-2019). IHSP 2019-2022 will support a new LHIN organization with an enhanced mandate, along with a new Mission, Vision and set of Values to guide its work. It will define the LHIN's strategic directions over the coming three years and outline how, in collaboration with health system partners, the LHIN will set about achieving them.

Ontario's health care system has improved significantly over the past decade but we cannot take our foot off the gas. In the work that lies ahead, the LHIN remains committed to improving access, connecting services, supporting people and patients, and protecting the local health care system now and for future generations.

By working together with health system partners, we will build a healthier community for all.

Financial statements of

Central West Local Health Integration Network

March 31, 2018

Deloitte LLP
400 Applewood Crescent
Suite 500
Vaughan ON L4K 0C3
Canada

Tel: 416-601-6150
Fax: 416-601-6151
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Independent Auditor's Report

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

We have audited the accompanying financial statements of the Central West 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
May 23, 2018

Central West Local Health Integration Network

Statement of financial position

As at March 31, 2018

	Notes	2018	2017
	3	$	$
Assets			
Current assets			
Cash		**14,006,796**	1,617,589
Due from Ministry of Health and Long-Term Care ("MOHLTC")		**2,765,654**	3,937,890
Due from other LHINs - Enabling Technologies for Integration	5	**20,346**	63,414
Accounts receivable		**1,253,589**	102,730
Prepaid expenses		**617,335**	87,984
		18,663,720	5,809,607
Capital assets	7	**810,955**	16,538
		19,474,675	5,826,145
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**13,917,016**	750,155
Due to Health Service Providers ("HSPs")	15	**2,411,674**	3,937,890
Due to other LHINs		**101,351**	147,557
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**2,115,340**	974,005
Deferred operating contributions	8	**118,339**	-
		18,663,720	5,809,607
Commitments and contingencies	10 and 11		
Deferred capital contributions	9	**810,955**	16,538
Net assets		**19,474,675**	5,826,145

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

Approved by the Board

Director

Carmine Domanico

Director

Adrian Bita

Central West Local Health Integration Network

Statement of operations and changes in net assets

Year ended March 31, 2018

	Notes	2018	2017
	3	$	$
Revenue			
MOHLTC funding - transfer payments	15	**857,425,062**	926,396,097
MOHLTC funding - Operations and Initiatives		**122,663,280**	8,646,024
Interest income		**153,435**	-
Amortization of deferred capital contributions		**304,502**	22,149
Other revenue		**1,448,200**	178,680
Total LHIN Operations, Initiatives, Amortization		**124,569,417**	8,846,853
eHealth-Enabling Technologies for Integration allocated to LHIN's	5	**(1,932,719)**	(1,915,863)
Funding repayable to the MOHLTC-unrestricted revenue		**(22,780)**	(732)
Funding repayable to the MOHLTC-restricted revenue		**(1,307,215)**	(563,932)
Total revenue		**978,731,765**	932,762,423
Expenses			
HSP transfer payments	15	**857,425,062**	926,396,097
Operations and Initiatives			
Contracted out			
In-home/clinic services		**72,233,803**	-
School services		**183,695**	-
Hospice services		**5,930,984**	-
Salaries and benefits		**30,728,787**	4,607,652
Medical supplies		**4,984,437**	-
Medical equipment rental		**1,275,625**	-
Supplies and sundry		**3,066,308**	1,477,995
Building and ground		**1,339,955**	258,530
Amortization		**304,502**	22,149
Repairs and maintenance		**148,627**	-
LHIN Operations, Initiatives, Amortization		**120,196,723**	6,366,326
		977,621,785	932,762,423
Excess of revenue over expenses before the undernoted		**1,109,980**	-
Net liabilities assumed on transition	13	**(1,109,980)**	-
		-	-
Net assets, beginning of year		**-**	-
Net assets, end of year		**-**	-

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

Central West Local Health Integration Network

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		-	-
Cash received on transition	13	**4,991,591**	-
Net liabilities assumed on transition	13	**1,109,980**	-
Less amounts not affecting cash			
Amortization of capital assets		**304,502**	22,149
Amortization of deferred capital contributions		**(304,502)**	(22,149)
		6,101,571	-
Changes in non-cash working capital items	12	**6,287,636**	365,815
		12,389,207	365,815
Investing activities			
Purchase of capital assets		**(257,310)**	(21,675)
Increase in deferred contributions		**257,310**	21,675
		-	-
Net change in cash		**12,389,207**	365,815
Cash, beginning of year		**1,617,589**	1,251,774
Cash, end of year		**14,006,796**	1,617,589

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

1. Description of business

The Central West 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 West 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:

a) Plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto. 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.

b) Effective May 31, 2017, the LHIN assumed the responsibility to provide community services legislated in the Home Care and Community Services Act, 1994. These services include health and related social services, medical supplies and equipment for the care of persons in home and community 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 to provide information to the public about, and make referrals to, health and social services. See note 13 for further details.

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	3-10 years
Computer and communications equipment	3 years
Medical Equipment	4 years
Leasehold improvements	Over the term of the lease

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

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 permitted only in certain circumstances. The impact of this policy on the current year is detailed in note 13.

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 with 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	**974,005**	624,171
Due to MOHLTC transferred from CCAC	**453,294**	—
Funding repaid to MOHLTC	**(1,140,052)**	(214,830)
Funding repayable to the MOHLTC related to current year activities	**1,549,061**	334,560
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities	**279,032**	230,104
Due to MOHLTC, end of year	**2,115,340**	974,005

5. Enabling technologies for integration project management office

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

The Central West LHIN is designated the Lead LHIN with this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus, the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2018 was $2,988,000 ($3,060,000 in 2017).

Funding of $1,932,719 ($1,979,277 in 2017) was allocated to other LHIN's within the cluster who incurred eligible expenses of $1,912,373 ($1,915,863 in 2017). The LHIN has set up a payable to the MOHLTC for $279,032.

The following provides condensed financial information for the ETI PMO funding and expenses for the cluster:

			2018	2017
	Funding allocated	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Central West LHIN	**1,055,281**	**796,595**	**258,686**	166,690
Allocation to Other LHINs				
Central LHIN	**476,000**	**476,000**	**—**	—
Central East LHIN	**317,250**	**304,896**	**12,354**	51,584
Toronto Central LHIN	**423,000**	**423,000**	**—**	—
Mississauga Halton LHIN	**336,969**	**336,969**	**—**	—
North Simcoe Muskoka LHIN	**379,500**	**371,508**	**7,992**	11,830
Total Other LHINs	**1,932,719**	**1,912,373**	**20,346**	63,414
Total All LHINs	**2,988,000**	**2,708,968**	**279,032**	230,104

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.

7. Capital assets

	Cost	Accumulated depreciation	2018 Net book value	2017 Net book value
	$	$	$	$
Furniture and equipment	2,565,681	2,113,513	452,168	12,528
Computer equipment	282,654	280,649	2,005	4,010
Medical equipment	634,810	455,935	178,875	—
Leasehold improvements	2,397,984	2,220,077	177,907	—
	5,881,129	5,070,174	810,955	16,538

8. Deferred operating contributions

Deferred operating contributions represent the unamorizted amount of grants and other contributions received to fund expenditures of future periods BTI equipment leases represent the unamortized amount of grants received from Health shared Services Ontario for the payment of computer leases under the Base Technology Infrastructure Project.

	2018	2017
	$	$
Balance, beginning of year	—	—
Operating contributions received during the year	181,413	—
Operating contributions transferred from CCAC	111,166	—
Amount recognized as revenue in the year	(174,240)	—
Balance, end of year	118,339	—

9. Deferred capital contributions

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

	2018	2017
	$	$
Balance, beginning of year	16,538	17,012
Capital contributions received during the year	257,310	21,675
Capital contributions transferred from CCAC	841,610	—
Amortization for the year	(304,502)	(22,149)
Balance, end of year	810,956	16,538

10. Commitments

The LHIN has commitments under various operating leases as follows:

	$
2019	1,724,623
2020	1,658,965
2021	194,185
2022	9,948
2023	8,040

11. 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.

12. Change in non-cash working capital balances

	2018	2017
	$	$
Due From Ministry of Health and Long Term Care	**1,172,236**	(3,498,357)
Due from other LHINs – Enabling Technologies for Integration	**43,068**	(23,511)
Accounts receivable other	**72,537**	3,176
Prepaid expenses	**(102,089)**	(79,379)
Accounts payable and accrued liabilities	**5,979,092**	(20,521)
Due to Health Service Providers	**(1,526,216)**	3,498,357
Due to other LHINs	**(46,206)**	136,218
Due to Ministry of Health and Long Term Care	**688,041**	349,832
Deferred Operating contributions	**7,173**	—
Total change in non-cash working capital items	**6,287,636**	365,815

13. Transition of Central West 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 West Community Care Access Centre the ("CCAC"), to the Central West LHIN, including the transfer of all employess of the Central West CCAC. This transition took place on May 31, 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	4,991,591
Accounts Receivable	1,223,396
Prepaid Expenses	427,262
Tangible Capital Assets	841,609
Total Assets	7,483,858

	$
Accounts Payable and Accrued liabilities	7,187,769
Due to Ministry of Health and Long Term Care	453,294
Deferred Capital contributions	841,609
Deferred operating contributions	111,166
Total liabilities	8,593,838
Net Liabilities Assumed	(1,109,980)

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

14. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 345 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 $2,434,260 ($372,398 in 2017) 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.

15. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $857,425,062 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**585,329,716**	563,812,751
Grants to compensate for municipal taxation – public hospitals	**96,975**	96,975
Long-Term Care Homes	**170,764,034**	160,057,019
Community Care Access Centres	**19,851,161**	123,234,690
Community support services	**15,166,565**	15,701,088
Assisted living services in supportive housing	**11,203,007**	10,999,045
Community health centres	**13,243,463**	12,639,799
Community mental health addictions program	**41,770,141**	39,854,730
	857,425,062	926,396,097

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $2,411,674 ($3,937,890 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and changes in net assets and are included in the table above.

Pursuant to note 13, effective May 31, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the Central West 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.

16. 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	**48,478**	50,400
Other Board members' per diem expenses	**59,423**	58,807
Other governance and travel	**61,794**	35,812
	169,695	145,019

17. 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.

18. 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.

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