Ontario

Consolidated Local Health Integration Network Annual Report

2020/21

Ontario

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Message from the Local Health Integration Networks' Board Chair

On behalf of the Board of Directors, I am very pleased to share the Consolidated Local Health Integration Network Annual Report for 2020/21.

The 2020/21 year began with the COVID-19 pandemic which created an unprecedented challenge for our health care system and Ontarians. Together with partnership from Ontario Health, the Local Health Integration Networks (LHINs) played an integral role in activating the system's response, including an early and critical rapid response through frontline care delivery, as well as capacity planning and stabilization supports for health system partners to meet the urgent, complex and growing health needs of Ontarians.

Over the last year, the LHINs collaborated with the Ministry of Health and Ontario Health, as well as home and community care and other health system partners to increase service levels and ensure continuity of care during the COVID-19 pandemic response. They consistently demonstrated strong community relationships and local health system expertise by working together and with health service providers, contracted service providers, patients, families and caregivers to deliver uninterrupted, high-quality care and to support Ontarians throughout their care journey.

While supporting the provincial response to the pandemic was front and centre, the LHINs worked diligently to carry out their mandate to plan, integrate and fund local health care, and to deliver, and provide access to, home and community care.

It was anticipated that LHIN non-patient care functions would transfer into Ontario Health in early 2020 and as previously announced by the Minister of Health, that the home and community care and long-term care home placement functions would become known as Home and Community Care Support Services. This transition was paused due to the COVID-19 pandemic in order to maintain health system stability, and to ensure resources focused on addressing the pandemic and protecting the health and well-being of Ontarians.

Later in 2020, planning for this important piece of the government's plan for health system transformation resumed. The Ministry of Health, Ontario Health and the LHINs worked together to ensure a smooth transition of these functions and staff on April 1, 2021.

Integral to their success in 2020/21 was collaboration; the LHINs worked to break down silos, geographic lines and other barriers to work together as a united team. Despite the unprecedented demands put onto the LHINs and their staff this last year, the pages of this report detail the LHINs' continued leadership in providing innovative and collaborative solutions to support and coordinate the health care system in their regions and across the province.

The Board of Directors would like to extend our deep appreciation to the tremendously hard working and dedicated professionals throughout the LHINs, as well as to the heroic health care providers and community partners they serve.

Bill Hatanaka
Board Chair, Local Health Integration Networks

Introduction

In 2020/21 the province's 14 Local Health Integration Networks (LHINs) continued to build strong local health care systems, centred around the patient and in collaboration with health care and community partners. This work was guided by the health care system's Quadruple Aim, an invaluable compass for informing decisions and optimizing health care performance, which calls for improving population health outcomes, improving patient experience, improving frontline and provider experience, and achieving better value.

Throughout the year, LHINs supported the planning, implementation and ongoing operation of countless initiatives across the province in sectors including (but not limited to) home and community care, long-term care, hospitals, primary care, mental health and addictions, rehabilitation, occupational therapy and palliative care. Much of this work was guided by three key priorities: maintaining continuity of care while improving access and quality, supporting better connected care and supporting and stabilizing the health system and their regional communities through the first, second and third waves of the COVID-19 pandemic.

Supporting Pandemic Response

Throughout the fiscal year 2020/21 LHINs continued to find themselves in the midst of an unprecedented era in health care, supporting the provincial response to COVID-19. Through their regions, LHINs played an early and important role in supporting many health care sectors. This included work in capacity planning, obtaining and allocating personal protective equipment, stabilizing long-term care homes and other congregate care settings and supporting health human resources efforts through recruitment and staff redeployment, to name a few.

And through it all, home and community care continued to be delivered to Ontarians who needed it most through a robust delivery model that included in-home nursing and personal supports, while further leveraging virtual care platforms.

Through well-established relationships with system partners, LHINs supported increased testing capacity, ongoing personal protective equipment procurement and distribution planning with local supply chain organizations, capacity planning to reduce the risk of hospital overcrowding and added health human resources and expertise for long-term care to protect those most vulnerable to COVID-19.

Maintaining Continuity of Care

Despite the unprecedented pressures of the pandemic on human resources and maintaining continuity of care under capacity pressures and public health restrictions, the LHINs continued to plan, fund and integrate local health care and to manage and deliver high-quality home and community care, under the *Local Health System Integration Act, 2006* (LHSIA).

In order to maintain continuity of care during the COVID-19 pandemic and support health system partners in dire need, all LHINs worked to develop and establish regional COVID-19 response structures

in collaboration with local leadership from hospitals, community and public health agencies, and various multi-sector stakeholders.

The implementation of these response structures catalyzed development of strong inter-sectoral relationships and a much more integrated approach to delivering care. They enabled effective planning and implementation underpinning all key functions of the COVID-19 response including testing, capacity planning, support for congregate care settings and long-term care homes, infection prevention and control, access to equipment, and vaccination.

Supporting Better Connected Care

The *Connecting Care Act*, *2019* laid the foundation for the continued implementation of Ontario's phased strategy to transform and strengthen the public health care system.

The LHINs supported health system transformation by planning and preparing for the final transition and division of LHIN functions into Ontario Health and Home and Community Support Services.

Despite the resourcing challenges presented by the pandemic response, leading up to the official transfer as of April 1, 2021, in collaboration with Ontario Health, the LHINs supported the transfer of functions into Ontario Health and Home and Community Care Support Services as set out by the Ministry of Health.

The LHINs worked closely in advance of the transfer day to plan and implement communications tactics and strategies that supported staff and ensured adherence to ministry branding and name change guidelines.

With the previous establishment of the Ontario Health's Regions, in the 2020/21 year, LHINs were able to pool resources and expertise to apply a regional approach to their initiatives. This involved more coordination between individual LHINs and also at the regional level, resulting in better connected care for Ontarians and efficiencies within the health care system.

Population Profile

Below is a population profile of Ontario, which includes information on the number and type of health service providers across the province. Individual LHIN population profiles can be found in Appendix One.

Area (km2)	908,699 km2	**Health Service Providers:** • 149 Hospitals • 600 Long-Term Care Homes • 573 Community Services • 370 Mental Health Agencies • 61 Residential Hospices • 77 Community Health Centres
Total Population	13,448,494	
Population Age 65+	16.7%	
Population Growth Rate	4.6%	
Population Density	14.8/km2	
Rural Population	17.2%	
Indigenous Population	2.8%	
Francophone Population	4.7%	
Low Income Population	14.4%	

Sources:

- Statistics Canada. Canada, Provinces, Territories, Census Divisions, Census Subdivisions and Dissemination Areas tables. Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001.
- Land area and population density: 2016 Census Geographic Attribute File. Statistics Canada.
- Special Tabulations: Statistics Canada. 2016 Census. Detailed age and sex; Inclusive Definition of Francophone; Seniors living alone. Prepared by Health Analytics and Insight Branch (HAIB), March 2019.
- Population Health/Select Highlights from the LHINs' 2019-22 IHSPs and the 2019-22 Integrated Health Service Plan (IHSP) Environmental Scan document.

Description of Activities over the Year

In 2020/21, LHINs focused on advancing government priorities such as:

- Supporting provincial pandemic response
- Reducing hospital overcrowding
- Mental health and addictions
- Long-term care
- Home care
- Capacity planning
- Health system transformation

While work on the above priorities continued, the lens of what that work looked like in 2020/21 changed significantly with the unprecedented challenges of the COVID-19 pandemic. The LHINs quickly pivoted to be able to support the provincial response efforts and address the new and evolving challenges at the provincial and local levels, including access to personal protective equipment, staffing redeployments, COVID-19 testing, capacity planning, support for congregate care settings and long-term care homes, infection prevention and control, and vaccination efforts.

The strain on the health care system was tremendous in 2020/21, and the LHINs continued to support Ministry of Health priorities and the communities they serve, all while looking for ways to deliver their services effectively and efficiently, with the ultimate goal of improving health outcomes for Ontarians.

Supporting Provincial Pandemic Response

The emergence of COVID-19 refocused the attention and efforts of the health system across Ontario. The LHINs actively and tirelessly worked together and in collaboration with health system partners in their regions to support the provincial pandemic response in several priority areas.

Specifically, home and community care played an important leadership role in the pandemic response through regional IMS structures. Dedicated leadership and additional IPAC resources were provided for outbreak management across a number of settings (home care, retirement homes and long-term care).

Personal Protective Equipment

Early in the pandemic, for many LHINs it was difficult to secure a stable and steady supply of personal protective equipment (PPE).

To address these new challenges in PPE acquisition and distribution, in March 2020, the four Central Region LHINs (Mississauga Halton LHIN, Central LHIN, Central West LHIN, North Simcoe Muskoka LHIN) established the Central Region PPE and Critical Supplies Team, responsible for supplying eligible health care organizations with PPE inventory from the provincial stockpile. The team supplied over 49,577,410 PPE and testing items, including 3,140,711 PCR swabs and 1,643,819 rapid tests between April 22, 2020 and March 31, 2021. Through outreach and education, including a dedicated PPE web page, bulletins and the creation of the PPE Knowledge Exchange webinar series, health system partners were kept informed on vital PPE and critical supplies updates, guidance and directives. PPE Knowledge Exchanges brought together thousands of health system partners to learn from experts, collaborate to address challenges in PPE supply chain management and build resilient supply chains within Central region.

Garnering interest and recognition across the province, after four successful regional PPE Knowledge Exchanges, they were expanded provincially.

The West Region, comprised of Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN and Waterloo Wellington LHIN, mobilized with local supply chain partners to create a centralized warehouse of supplies and distribution hubs that allowed for good inventory management and stewardship and timely delivery of PPE for organizations experiencing urgent shortages. The South West LHIN specifically led the development of the COVID-19 Regional Allocation Committee (RAC) to promote fair decision-making when setting priorities for scarce resources, especially personal protective equipment. This included the development of a regional portal (https://hmmscovid19.ca/) and regular alerts to the West region stakeholders about PPE supplies and directives.

OH East, compromised of the Central East LHIN, the Champlain LHIN and South East LHIN, convened a multi-sectoral Critical PPE and Supplies Table to gather, manage and equitably distribute PPE and critical supplies to health service providers in the region. A regional team was formed to monitor regional PPE and critical supply issues, fulfill urgent requests for PPE from local inventories where possible, and escalate requests to Ontario Health and/or the Ministry of Health when PPE and critical supplies were required from provincial inventories.

Testing

LHINs across the province worked collaboratively with hospitals, Ontario Health Teams, paramedics, Public Health and municipalities to respond to local COVID-19 testing needs using a variety of approaches.

As part of the province's High Priority Communities Strategy, in December 2020, 15 priority communities were identified as the province's hardest-hit neighbourhoods, 10 of which resided in Central Region. The Central LHINs (Central LHIN, Central West LHIN, Mississauga Halton LHIN, North Simcoe Muskoka LHIN) identified 10 lead agencies to implement and execute tailored community outreach and engagement and increase access to testing. Between January and March 2021, these lead agencies partnered with 500 health or social service agencies; contacted 179,413 individuals through community outreach activities; distributed 70,326 PPE kits, provided 4,749 individuals with case management support; referred 328 to isolation centres; and delivered 27,127 meals.

The creation of a Regional Testing Advisory Committee engaged physicians, clinicians, public health and laboratory scientists to recommend a testing and assessment approach across the West Region aligned with provincial guidance and informed by emerging science regarding COVID-19. This resulted in the establishment of 50 Testing and Assessment Centres across the four LHINs in the West Region (Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN and Waterloo Wellington LHIN).

To ensure equitable access to testing for all, the Champlain LHIN supported community health centres in Ottawa to engage with and reduce barriers to testing for marginalized and high-priority communities through outreach and education.

Using a health equity lens, Toronto Central LHIN identified neighbourhoods that would benefit from additional localized testing and wrap-around supports and engaged a cross-sector of partners to operationalize the targeted strategy. Toronto Central LHIN ensured strategic alignment between city and health partners and monitored and evaluated neighbourhood-level data and testing uptake on an ongoing basis to ensure the strategy was responsive to needs.

Human Resourcing and Staff Redeployments

In April 2020, on the advice of the Chief Medical Officer of Health, the Ontario government introduced/amended emergency orders under subsection 7.0.2 (4) of the Emergency Management and Civil Protection Act to better support Ontario's long-term care homes. The orders allowed for the redeployment of staff to ensure they can work where they were needed most during the COVID-19 pandemic. Across the province, the LHINs worked to plan, coordinate and facilitate staffing redeployments.

LHIN staff have shown their dedication and commitment to the important work they do without hesitation, and have expanded and redefined their roles in order to fill gaps in response to COVID-19, demonstrating flexibility and adaptability, finding workable solutions to virtual visits with patients, and assisting with an 'all hands on deck' approach.

For example, the four Central Region LHINs (Mississauga Halton LHIN, Central LHIN, Central West LHIN, North Simcoe Muskoka LHIN) redeployed 456 staff this fiscal year. Health human resources were reallocated to telehealth, IPAC extenders, assessment centres, vaccinations, long-term care and other congregate settings.

In the West region, staff from Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN, Waterloo Wellington LHIN were also redeployed in conjunction with hospital teams to support residents in long-term care and retirement home facilities in outbreak.

Hundreds of Ontario Health East team members put their hands up to be reassigned to support the efforts to fight COVID-19 over these last several months. During Wave 1:

- 276 regional staff were deployed to front-line positions in hospitals, long-term care and other care facilities
- 31 people supported public health contact tracing
- 18 human resources staff supported assessment and recruitment

The Human Resources team in the East region also navigated a variety of challenges presented by the pandemic, while also focusing on a number of transition priorities. In the Ontario Health East Region, the HR Team worked as one integrated entity to support the Central East, Champlain and South East LHINs. This included managing an environment of constant change to accommodate staff, the LHIN organizations and the health care system overall. They worked to:

- Ensure safe workplaces in accordance with COVID-19 regulations and subsequent adjustments required
- Work with health system partners to redeploy staff to LTCHs, retirement homes and hospitals
- Provide timely and accurate information to staff
- Administer and implement new employment legislation, ensuring compliance and applying necessary measures
- Administer pandemic pay

The expertise afforded by the HR team played a direct role in helping alleviate additional stress, support staff in their work and personal lives, and displayed the true value the Human Resource function adds as strong foundation to organizational effectiveness.

Vulnerable and Underserved Communities

The COVID-19 pandemic exposed great inequities and disparities in health care across the province, and many LHINs developed programs and initiatives to serve their most vulnerable communities.

For example, the Erie St. Clair LHIN in partnership with Ontario Health and Home and Community Care Support Services supported multi-sectoral pandemic planning and response in regard to temporary foreign workers and COVID-19. This included mobile testing, health checks, stakeholder engagement, shelter and isolation sites and being integral members of the Incident Management System. Further, collaborative work continued in planning for improved access to primary care for temporary foreign workers.

The South West LHIN and Carrefour communautaire francophone de london (CCFL) initiated work to mobilize stakeholders and Francophone organizations to develop the Info Fran-Covid 19 web page. The web page is intended to act as a resource guide/directory of services and supports available in French in response to the Covid-19 pandemic. The main web page includes a phone number offering direct access to a system navigator offered through the Accès Franco-Sante London. The navigator is able to provide support and information on any health-related matters.

The Central East LHIN increased supports for the deaf community in Durham Region during COVID-19. Durham Deaf Services (DDS) is a non-profit organization offering services and educational programs that promote self-reliance within the deaf, deafened and hard of hearing community. DDS is the only centre between Toronto and Belleville where deaf individuals can find support services and social opportunities with their peers. Since March 2020, DDS received numerous calls for intervention for deaf individuals where distance visits were conducted to ensure individuals were safe and short-term supports put in place. However, there remained a group of deaf seniors at high risk who live alone and lack supports. Realizing this need, DDS proposed increased programming to support the deaf community during COVID-19. Funded by the Central East LHIN, DDS temporarily expanded their supports to include:

- Safe home visits and reassurance checks using American Sign Language (ASL)
- Translation of English COVID-19 content into ASL
- Technology options to allow deaf seniors to remain informed at home
- Education for providers on how to support the deaf community during COVID-19
- Support and referrals for mental health counseling using ASL
- Support accessing food banks and booking medical appointments using ASL
- Development of ASL videos to educate on the COVID-19 impact for the deaf community
- Information in ASL on elder abuse prevention education, and more

The Toronto Central LHIN established a comprehensive COVID-19 testing strategy to ensure testing and supports were accessible for Torontonians, particularly residents who were more vulnerable to impacts of COVID-19. The strategy included:

- Schools: In partnership with schools boards, testing partners and Toronto Public Health, the school testing strategy ensured a coordinated and timely response for case and outbreak investigations while offering flexible testing approaches (e.g., onsite testing, take away testing kits, allocated time at assessment centres) that supported the unique needs of each school population.

- Child care: In response to a growing number of outbreaks in child care centres, a coordinated testing response was developed (in partnership with Toronto Public Health and testing partners) to respond to case and outbreak investigations with a family-centred and child-friendly approach (including drive-thru testing, take-home kits and infant testing supports).
- Indigenous: Led by Toronto's Indigenous community partners, testing approaches were developed to be culturally safe and reach the Indigenous community that may not have otherwise accessed traditional testing venues. Anishnawbe Health Toronto used a mobile testing RV to provide testing, medical and social support directly to Indigenous communities. An Indigenous specific assessment centre was developed by Native Men's Residence, Seventh Generation Mid-Wives and Well Living House to provide a culturally safe location for Toronto's Indigenous community.
- Shelters: Toronto Central LHIN established a Toronto Region Shelter and Congregate Coordination Table with partners (hospital, community health centres/primary care teams, the city's Shelter Support Housing and Administration Division and Toronto Public Health) to support the development of a mobile testing strategy that enabled coordinated case and outbreak management within shelters. The strategy included infection prevention and control supports and coordinated surveillance testing, as well as the establishment of a COVID Recovery Site for people who are homeless to have a place to safely isolate with clinical, peer and harm reduction supports.

Crisis Management & Capacity Building

Responding the urgent capacity issues and evolving needs within their communities, all LHINs worked to develop and establish regional COVID-19 response structures in collaboration with local leadership from hospitals, community and public health agencies and various multi-sector stakeholders. Some examples include:

In the North West LHIN, to ensure timely effective crisis management, the LHIN's Emergency Response Team met frequently to review system issues and provincial directions and guidance and align operational policies and communications appropriately, including direct and virtual patient care, screening and risk assessments, PPE, staff and provider testing supports and work space use/design.

Throughout the pandemic, the South East LHIN decision support (DS) team collected, analyzed and distributed weekly reports to assist COVID-related monitoring and decision-making by key stakeholders in the South East LHIN and across the South East system of health service providers as well as broader system stakeholders. A weekly acute care surveillance report was designed to answer key questions focused on specific domains of interest that were vetted and modified to meet the needs of the decision makers. In addition, South East LHIN DS staff worked with Public Health in their region to design, create and distribute a weekly provincial report. Using data from the Acute Care Enhanced Surveillance (ACES) system, this report provided a syndromic-based overview of the impact of COVID-19 on acute care institutions across the province. This report was also distributed to key provincial contacts including the Chief Medical Officer of Health to assist monitoring and decision-making.

Many LHINs also directly increased capacity within their hospital networks by adding beds for patients with COVID-19, or establishing emergency department avoidance strategies. Examples include:

In the South West LHIN, the hospital sector mobilized and created approximately 1,200 new bed spaces to ensure care was available for patients with COVID-19 and those requiring urgent access to hospital-based care for other reasons.

The Erie St. Clair LHIN prioritized Care in Place and an Emergency Department avoidance strategy in congregate living settings. The LHIN also supported multi-partner response teams to assist congregate settings in outbreak, including long term care with clinical and non-clinical supports. Additionally, the Erie St. Clair LHIN supported load-balancing patients from across Ontario and their region to transfer patients into available ICU and acute medicine capacity as needed in an effort to maintain access and flow (starting March 5, 2021, the LHIN received 180 transfers; 123 of those from outside of their region).

Due to the escalating COVID-19 patient volumes in both the GTA and East Regions, the Central East, South East, and Champlain LHINs supported the transfer of 66 patients to or between our regional facilities, with strong support from the hospital patient-flow leads and emergency medical services. The transferred patient populations included acute COVID-19 positive, acute COVID-19 negative, alternative level of care and mental health.

Reducing Hospital Overcrowding

Increasing capacity in acute care and hospitals is one of the highest health priorities in the province. To address the many factors contributing to hospital overcrowding, LHINs across Ontario worked in collaboration with health service providers to support improved patient transitions across the health care system, enabling better access to acute care.

Alternate Level of Care

Alternate Level of Care (ALC) is a designation assigned to a hospitalized patient who no longer requires acute medical services, however remains in hospital. All LHINs continued to work to address the existing barriers for the ALC patient population, build local capacity and support care delivery in the appropriate care setting as close to home as possible. Across the LHINs, strategies for ALC avoidance and management continued to be coordinated and optimized across all hospital and home and community care partners. The approaches involved strong collaborative partnerships to develop and implement solution-focused initiatives.

The North East LHIN, for example, supported the creation of two Alternative Hospital Facilities (AHFs) in Timmins and North Bay. Creating a combined additional 45 beds (29 in Timmins and 16 in North Bay), these facilities alleviated ALC and other pressures on the North Bay Regional Health Centre and Timmins District Hospital and allowed for continued quality care and patient flow during the peak periods of the COVID-19 pandemic. Prior to opening these AHF beds, both hospitals had experienced an increase in ALC patients; however, the AHFs provided much needed flow, supporting additional patient pressures due to COVID-19, including reduced capacity in long-term care and community care.

Several programs across the LHINs helped create capacity in acute care, and for the potential surge of COVID-19 patients by transitioning patients out of hospitals and into community settings. These included the following:

Short-Term Transitional Care

In response to health system ALC pressures, the Ministry of Health invested in increasing hospital capacity and enhancing patient flow by implementing short-term transitional care models (STTCM). These initiatives provided appropriate care for patients outside of hospitals, supported patients and care providers through transitions in care, and assisted in maintaining overall system capacity. Many LHINs were able to open additional care beds in a variety of settings and using varied models of care at the local level. For example, Waterloo Wellington LHIN opened an additional 48 transitional care beds across multiple settings, and the LHIN supported the development of Greystone Manor, a 120-bed transitional care facility which supports transitions from hospital or community to long-term care, rehabilitation or other destinations.

Other LHINs, like the South East LHIN worked to expand existing short-term care units. The South East LHIN expanded their short-term unit from 30 to 70 patients, supporting Kingston Health Sciences Centre (KHSC) and KHSC@Home program to assist with ALC pressures during COVID-19.

High Intensity Supports at Home Programs

On December 2, 2020, the Government of Ontario announced one-time special funding for a new High Intensity Supports at Home (HISH) program to help address capacity challenges, including overcrowding in hospitals and long-term care homes as the health care system continued to respond to the COVID-19 pandemic and potential winter flu surge. The HISH program enabled patients who were designated alternate level of care in hospital or awaiting long-term care placement in community and at risk of hospitalization to receive enhanced care during the COVID-19 pandemic.

Across the Central LHINs, (Mississauga Halton LHIN, Central LHIN, Central West LHIN, North Simcoe Muskoka LHIN) Long-Term Care at Home and Rehab at Home models were offered. Enhanced Intensive Home and Community Care 2.0 offered a unique approach to supporting hospital discharges.
This program leveraged the Community Support Services sector, which proved critical in responding to hospital decanting directives, served patients at a lower cost, and provided a more flexible model of personal support worker care.

As a result of this program, at the local level in the Mississauga Halton LHIN, 345 home care patients received enhanced care from December 1, 2020, to March 31, 2021, which included over 131,000 hours and 4,200 visits during the 16-week funding period. Feedback from patients and caregivers showed 86% (LTC at Home) to 94% (Rehab at Home) are satisfied with the care they are receiving.

Remote Patient Monitoring

Many LHINs worked with their system partners to leverage existing or create new remote patient monitoring models to be able to assist and access patients virtually from their homes or long-term care. These initiatives not only helped to support hospital over-crowding, but also increased system capacity during the pandemic, and supported infection prevention control efforts for both COVID-19 positive and non-COVID-19 patients.

The collaboration between the Central East LHIN, Lakeridge Health, and Ontario Health is an example of an initiative that leveraged the structure of the COVID-19 Remote Monitoring Program. Through the new Central East Telehomecare Remote Surgical Monitoring Program, patients communicate their

symptoms through an app with a home and community care nurse seven days a week. The Remote Surgical Monitoring program was launched in collaboration with Lakeridge Health in July 2020 with thoracic surgery, then in August for orthopedic surgery, and finally for gynecologic-oncology surgeries in early 2021. More than 230 patients were enrolled in the Remote Surgical Monitoring program since the launch in July 2020. Since launching their remote surgical monitoring streams, Lakeridge Health has reported a drop in 30-day ED utilization by 10% across all three surgical cohorts compared to prior year data without remote monitoring. Scarborough Health Network joined with the surgical orthopedic pathway in February 2021 with 40 patients enrolled in the program at the end of fiscal 2021.

In the Hamilton Niagara Haldimand Brant LHIN, Remote Patient Monitoring programs were implemented to support COVID-19 positive patients recovering in their homes.

The South East LHIN facilitated the implementation of remote care technology at four hospital sites, various primary care, community and paramedic organizations. This supported virtual urgent care and monitoring for selected chronic conditions, including COPD, congestive heart failure and diabetes, benefiting more than 300 patients.

Intensive Home Care
Many ALC patients also benefited from hospital-to-home programs that offered short-term intensive home care and community support services. These targeted programs leveraged capacity within the community support sector to assist patients with customized care who would otherwise be unable to transition out of hospital. Effective examples include how Waterloo Wellington LHIN reinstated their Rapid Recovery program, a high intensity rehab program in the home setting to support discharge to home rather than waiting in hospital for a rehab bed, and how the North West LHIN implemented targeted expansion of two Wait-At-Home programs, which have been instrumental in reducing ALC-LTC patient populations in acute care settings.

Improving Mental Health & Addictions (MHA) Services

The demand for mental health and addictions (MHA) services increased significantly in the 2020/21 fiscal year due to the COVID-19 pandemic, and the LHINs continued to expand mental health and addictions services to ensure easier access to higher quality care and support in communities across the province. Through collaborations with the health system, justice system and municipal partners, as well as with patients, families and caregivers and other Ontarians, LHINs aimed to effectively respond to community needs through projects and investments, including:

Mobile Crisis Response Teams
Mobile Crisis Response Teams help connect people to the mental health services they need when they need them. Integrated with safe beds programs, and working in partnership with police and first responders, Mobile Crisis Response Teams engage individuals in crisis, de-escalate the situation, and help connect people with appropriate services in the community. The goal of Mobile Crisis Response Teams is to divert individuals experiencing a mental health or addictions crisis from incarceration, the justice system and/or unnecessary hospitalization. Many LHINs created or expanded on their mobile crisis response programs and teams in the 2020/21 fiscal year.

Central West LHIN continued to expand their Mobile Crisis Rapid Response Team. In 2020/21 Mobile Crisis Rapid Response Team operations, 2,355 calls for service were placed, 448 apprehensions (19%),

153 individuals were under the age of 16 (6%), with 1,137 referrals made to 24/7 crisis programs (48%). Additional support was provided to nearly 50% of clients in crisis, offering support and connection to services, and reducing the risk of future crises.

The South East LHIN provided support and funding to Addictions and Mental Health Services - Hastings Prince Edward for the development of the Integrated Mobile Police and Co-Response Team (IMPACT) program to assist individuals where and when most needed, while supporting police managing calls for individuals experiencing MHA-related concerns. This collaborative, integrated model assigns a MHA worker at each of the local police services, improving police response, decreasing hospitalization and facilitating immediate intervention.

The Central LHIN expanded the of operations of their Mobile Crisis Team, ensuring 321 individuals received services at a time of greatest need, and in the Hamilton Niagara Haldimand Brant LHIN, their Mobile Crisis Rapid Response Team (MCRRT) capacity was expanded to the Niagara region by hiring a team of mobile mental health crisis workers to provide primary crisis response together with police 12 hours per day, 7 days per week.

Withdrawal Management

Many LHINs have made investments into Withdrawal Management services and programs. These programs function as stabilization services to support people who want to detox from a substance they've been using. Many of these programs also support averting or reducing presentations at the emergency department for withdrawal treatment, and were therefore expanded to help support the pandemic response.

Erie St. Claire LHIN added interim withdrawal management beds to increase capacity and reduce pressures on their local hospitals. In North Halton, considered to be among the fastest growing region in Ontario, Mississauga Halton LHIN invested in expanding on an integrated addiction medicine service, helping to advert opioid-related presentations to the emergency department and inpatient admissions for medical withdrawal or medical complications of opioid misuse which have continued to rise annually in this community.

The North Simcoe Muskoka LHIN established an in-home/mobile withdrawal management service. This service is a mobile withdrawal management and stabilization service that supports people living in the community who want to detox from a substance they are using. Developed near the end of 2020/21 this program will pave the way to support 36 unique individuals and will deliver 800 service provider interactions annually.

Hamilton Niagara Haldimand Brandt LHIN supported the development of a clinical pathway for children and youth presenting to McMaster Children's Hospital in withdrawal or at risk of withdrawal. The LHIN also enhanced capacity of the community residential withdrawal management programs in Brant, Hamilton, and Niagara through the addition of a nurse practitioner in each program to improve the medical management of clients who are withdrawing from substances and need access to primary care and/or medications to manage the symptoms of withdrawal.

Support for Health Services Providers

Supporting those who provide health care services took on many forms across the LHINs, but many LHINs made providing funding, resources and supports for this group a priority in the 2020/21 fiscal year, but also as part of their pandemic response.

Waterloo Wellington LHIN co-led the development of a framework and resources for system-level partners' staff suffering from mental health issues, particularly but not limited to, in the area of bereavement and trauma. Targeted areas included staff working in highly destabilized congregate care settings, where significant outbreaks, illness and loss of life occurred.

South West LHIN identified and allocated three tranches of COVID-19 MHA emergency funds to health service providers to ensure robust resources were in place to allow health service providers to pivot services to virtual platforms and/or adopt infection prevention and control strategies. This work supported the safe and seamless transition of services across the MHA sector.

Toronto Central LHIN provided MHA health services providers support and access to Community Health Centre partners should they require support with navigating challenges related to COVID-19. These resource partners volunteered to share their knowledge, experience and resource materials to support MHA health services providers with questions related to Infection Prevention and Control (IPAC) training, accessing PPE supply chains, health and safety guidance, staff resilience, isolation capacity and operational approach to contract tracing.

In the North West LHIN, in collaboration with the Mental Health and Addictions Centre of Excellence, COVID-19 emergency funding was allocated to both mainstream and Indigenous providers of mental health and addictions services. These funds enabled virtual care delivery, safe re-opening of in-person services, as well as supporting critical one-time staffing related needs. For example, funding was provided for mobile devices to be used by clients staying within the Isolation Shelter to virtually connect with family or clinical supports during their stay. The Isolation Shelter was established for the vulnerable population increased the availability and accessibility of safe, voluntary isolation spaces for vulnerable persons who are precariously housed or experiencing homelessness, where an individualized assessment of needs related to substance use, mental health and other health conditions were completed. The mobile devices supported adherence to isolation requirements.

Enhanced Programming for Priority Populations

A critical focus for 2020/21 was providing short-term strategies and resources to help children and youth, as well as their parents, guardians and family members, recognize and address additional stresses related to the COVID-19 pandemic.

In the Central LHIN, mental health and addictions nurses engaged with local school boards and community partners to support school-aged children struggling with depression, addiction or other mental health issues. In 2020/21, the team provided over 3,500 video, telephone and in-person visits to 493 youth between the ages of four to 21 still attending secondary school. The nurses provide short-term support and therapy to help young patients stay well and remain in school while they await more intensive treatment. The team also provided health teaching to youth about eating disorders.

The Waterloo Wellington LHIN supported four CAIP (Child and Adolescent Inpatient Mental health) beds to remain open in hospital and the community aimed at reducing length-of-stay in ED for highly at-risk youth presenting to the hospital with significant issues.

The Erie St. Clair LHIN implemented Urgent Care Centre in Windsor/Essex to support crisis mental health needs and support hospital capacity and reduce overcrowding, and the Champlain LHIN participated in the integration initiative to bring the Ontario Structured Psychotherapy Program to all residents in the East Region. Partner organizations provided 19,409 therapy sessions to more than 2,000 clients. The program demonstrated its effectiveness with 57% of clients showing reliable improvement.

Improving Long-Term Care

Long-term care (LTC) homes were severely impacted by COVID-19 during the first and second waves of the pandemic, struggling with outbreaks due to poor infection prevention and control (IPAC) measures, overcrowding and health human resources issues. While the LHINs supported the LTC sector and continued to collaborate with administrators, operators, health service providers and community stakeholders to support planning for future capacity across the province, the primary focus in 2020/21 was preventing and addressing COVID-19-related concerns in long-term care homes.

Pandemic Response and Staffing

Due to the severity of the impact the COVID-19 pandemic has had on long-term care across the province, many LHINs worked quickly in 2020/21 to develop and implement staffing redeployment plans as well as strategies to communicate to stakeholders and partners more clearly and effectively, and to collaborate more efficiently.

In the North East LHIN, a North Region Community and Long-Term Care Working Group was formed to bring providers together from long-term care, retirement homes, home care, community support services (including independent living services) and emergency medical services from across the North. The group focused on sharing COVID-19 information, identifying pandemic preparedness gaps and seeking cross-sectoral resolutions wherever possible. For example, early in the pandemic, the group produced a paper on the negative consequences of the absence of family caregivers in LTC due to visitor restrictions, and the curtailing of death rites and rituals, especially for Indigenous people. The paper formed the basis of discussion among the community and home care sectors to achieving a balanced system response to necessary public health measures.

Central West LHIN Home and Community Care teams worked closely with long-term care operators and leaders across the Central West LHIN to support stability and flow across the system. With a large number of long-term care homes in outbreak within the LHIN, teams supported high-risk homes to manage through outbreaks and to recover to a state where patients could safely transition to the preferred home of their choice. This support included deploying frontline staff from Home and Community Care and service providers to work in long-term care homes to help stabilize staffing needs. In addition, teams and other system partners served as coaches and mentors and, in several instances, identified opportunities to strengthen long-term care home staffing resilience and used their system navigation experience to build temporary partnerships in areas such as mental health for several homes.

Waterloo Wellington LHIN acted as the lead partner responsible for assisting homes in a staffing crisis, through redeployment and procurement of appropriate agency staff. Staff were redeployed into

destabilized LTC homes to do laundry, provide personal support level services, nursing support, management level support, support with patient cohorting and staff scheduling.

South East LHIN hosted regular calls with LTC homes ensuring concerns were identified; established a common understanding of new directives, operating procedures and public health measures to avoid a crisis.

In Hamilton Niagara Haldimand Brand LHIN, staff were deployed into LTC to supplement staffing in caring for COVID-19 patients during a COVID-19 outbreak. This support also included working with LTC homes to secure agency staff to meet the homes staffing needs in caring for patients during outbreak situations. With HISH funding, Hamilton Niagara Haldimand Brand LHIN Home and Community Care (HCC) also supported long-term care with the additional nursing and PSW staffing needed to rapidly admit and isolate patients to their many vacant beds. This partnership between HCC, Service Provider Organizations (SPOs) and LTC was a successful health human resource initiative enabling rapid admission of greater numbers of patients from hospital and community into long-term care.

The Champlain LHIN invested $2,875,100 to hire additional IPAC personnel for long-term care homes and support the training of new and existing support staff to enhance their understanding of and skills related to IPAC practices and protocols. This initiative also ensured long-term care homes from across the region could participate in the IPAC community of practice support by the IPAC Hub. During the pandemic's second wave, the Champlain LHIN worked closely with public health units, hospital partners, long-term care and others to support the pandemic response and, ultimately, safely increase long-term care homes admissions.

IPAC Hubs

As part of the province's comprehensive Keeping Ontarians Safe: Preparing for Future Waves of COVID-19 plan, local networks of IPAC expertise (IPAC Hubs) were developed across the province to enhance IPAC practices in community-based, congregate living settings. Ontario Health identified organizations including hospitals, public health units and others from across the province to lead local IPAC Hubs, and many the LHINs were directly involved in this work.

The Champlain LHIN invested $950,000 to establish an IPAC Hub to support LTC and other congregate living organizations across the region. The IPAC Hub was led by The Ottawa Hospital, in partnership with local public health units, Champlain LHIN Home and Community Care, Public Health Ontario and others. Through the IPAC hub, LTC homes access expertise, education and training, best-practice recommendations and coaching. The IPAC Hub has also been instrumental in establishing a community of practice in the region to support system coordination and knowledge transfer.

In the North West LHIN, by advancing the IPAC Hub and Spoke model across the North and responding to all long-term care homes with COVID-19 concerns and challenges, including participation in outbreak meetings, LTC functions and care were protected and enabled a supportive community environment.

The South East LHIN ensured equitable distribution of IPAC funding to LTC to support staffing and training, and in the Toronto Central LHIN, the use of an IPAC Hub and Spoke model and IPAC extenders as well as mobile enhancement support teams decreased the level of risk in LTC and increased their ability to manage outbreaks when they occurred.

Improving Access to Long-Term Care and Planning for Future Capacity
The Ministry of Long-Term Care announced a transformational strategy in October 2019 to build 15,000 additional long-term care beds within five years and modernize an additional 15,000 older long-term care beds. In support of this strategy, LHINs conducted reviews of local long-term care sector needs in order to help inform the development of future long-term care capacity. For example:

A new 160-bed long-term care home under construction, Glen Hill Terrace in the Central East LHIN, is projected to be completed by May 2021, and in the South East LHIN, there were an additional 954 new beds allocated, and 1,871 beds (46% of current licensed beds) are expected to be redeveloped.

Toronto Central LHIN developed a Toronto Region Long-Term Care Home Recovery Plan which supported the Ministry of Long-Term Care's request for all long-term care homes to work with the regions to develop and implement an admissions plan. This plan enabled homes to implement a local framework to optimize capacity while managing risks.

In the South West LHIN, a long-term care home capacity plan was developed to understand the current and future priority needs of the overall region and geographic areas. Phase I (completed) focuses on the current state in each of the geographic areas of the Ontario Health West region, and Phase II (in progress) focused on the future state of long-term care.

The North West LHIN focused activities on preparation work for potential severe staffing shortage situations due to the COVID-19 pandemic by linking each long-term care home in the region with a hospital and bringing together a Mobile Enhancement and Support team (MEST) across the North West. This included working with partners such as regional public health units, EMS, supply chains and public health Ontario labs.

Behavioural Support Services in Long-Term Care Homes
Behavioural Supports Ontario (BSO) provides enhanced services for individuals with complex responsive behaviours associated with dementia, mental health, addictions and other neurological disorders, as well as supports for families and caregivers. Staff are specially trained to identify and reduce triggers, provide non-pharmacological interventions and improve engagement and quality of life for these individuals.

The pandemic increased stress for patients awaiting long-term care admissions and their families. The Central West LHIN's BSO program was instrumental in supporting these patients and families during the pandemic by offering more support and strategies to at-risk patients living with behavioural health and social issues, and their families. BSO nurses supported complex discharges and transfers of hospital patients in and out of region. Caregiver support was extended to families to provide emotional respite in the absence of traditional adult day programing. Additionally, they prevented escalation of personal expressions by diverting emergency department presentations and hospital admissions in partnership with primary care and geriatric outpatient services.

In collaboration and partnership with Behavioural Supports Ontario, and the three Alzheimer's Societies across the region, North East LHIN completed a regional High Intensity Needs Collaborative Pilot Project. Approximately 55 clients living with dementia with responsive behaviours were successfully transitioned to LTC from the acute care setting during the pandemic and were supported through the Infection Prevention and Control (IPAC) isolation requirements under public health measures. A quadruple aim evaluation is being finalized to measure the success of the project, which includes improving access to

long-term care for people with dementia and demonstrating safe practices for serving this population. The pilot is continuing through the first quarter of 2021/22.

Long-Term Care Behavioural Specialized Units
In December 2019, the Ministry of Long-Term Care announced funding for specialized long-term care support for residents with complex needs through its Behavioural Specialized Unit pilot program. The pilot program was developed with the goal of helping relieve hospital capacity pressures by assisting patients with complex behaviours move from hospitals to long-term care homes more quickly.

The South West LHIN's Behavioural Support Transition Unit in Grey Gables, Markdale (20 bed unit) has provided time-limited, specialized supports for individuals who have responsive behaviours. This unit offers a safe living environment that enhances a person's quality of life and identifies triggers and interventions to responsive behaviours. The program helps residents to improve coping skills and reduce responsive behaviours so that they can move on to other living arrangements.

Nurse Practitioners Supporting Teams Averting Transfers & Nurse-Led Outreach Teams
Two teams supported residents in long-term care by responding to acute health concerns that might otherwise result in an emergency transfer to hospital: Nurse Practitioners Supporting Teams Averting Transfers and Nurse-Led Outreach Teams.

As part of the Mississauga Halton LHIN's COVID-19 response in long-term care homes, the Nurse Practitioners Supporting Team Averting Transfers continued to support the residents and staff of all 28 long-term care homes in the Mississauga Halton LHIN with on-site acute episodic care, risk assessment, system navigation, emergency department and hospital flow.

Nurse Practitioners Supporting Team Averting Transfers worked closely with long-term care staff, medical team and other allied staff to support resident needs during COVID-19 outbreaks and contributed to the implementation of the provincial six point COVID-19 response plan. These teams assisted with COVID-19 testing and provided dedicated nurse practitioner resources to homes most impacted by COVID-19.

In the South East, a Nurse-Led Outreach Team played an important role in the delivery of care stabilization and assistances throughout the pandemic and particularly in assisting with the delivery of vaccines to LTC residents and staff.

Improving On-site Care for Long-Term Care Residents
The Champlain LHIN contributed to the rapid development of a provincial decision tool to guide patients and families considering taking their loved ones out of long-term care, and facilitated daily reporting on risks and mitigation strategies across key system partners. The LHIN worked to ensure the flow of accurate information from long-term care homes to inform admissions planning, and deployed numerous home care staff to help with staffing shortages. Through base funding for Behavioural Supports Ontario in Champlain, 1,149 long-term care staff received funded virtual education on behaviour supports.

Two initiatives taken on by the LHINs highlight the benefits of expanding on virtual care in long-term care. In the South West LHIN, 13 long-term care homes participated in Think Research to extend virtual consultations to enhance primary care capacity to support integrated digital strategy for long-term care homes inclusive of specialist and team-based care**.** The Mississauga Halton LHIN Nurse Practitioners

Supporting Team Averting Transfers team was instrumental in supporting long-term care homes to develop and implement virtual care options to support resident care early in the pandemic response.

The Erie St Clair LHIN ensured Digital Lab Access 24/7 for all long-term care homes in Erie St. Clair and South West regions to support prompt lab results for patients to enable better care.

Palliative Care in Long-Term Care

The Central LHIN developed a Palliative Care Resource Package which offers resources to optimize staff capacity, (including physicians, nursing staff, personal support workers, social workers, recreation therapists and registered dieticians) was introduced to all 46 long-term care homes in the region. This expansion was implemented after a pilot project in seven long-term care homes the previous year earned very high satisfaction responses from staff, patients and family members. The purpose of this electronic toolkit is to enable standardized, sustainable palliative/end-of-life care for residents of long-term care homes, support resident requests and reduce transfers to hospital. The electronic toolkit includes gap analysis tools to support decision-making along with resources to distinguish between palliative and end-of-life care. With the introduction of the Palliative Care Resource Package, long-term care homes in Central LHIN demonstrated improvement in avoidable emergency department visits with plans to continue this work to further reduce avoidable emergency department visits. The Palliative Care Resource Package was developed collaboratively by the Central LHIN Long-Term Care Working Group, with oversight provided by the Regional Palliative Care Network. The toolkit also supports the implementation of Quality Improvement Plans.

The Mississauga Halton Palliative Care Network Palliative Care Response Team in the Missisauga Halton LHIN has partnered with long-term care and retirement homes as they manage residents with a progressive, life-threatening illness and/or experiencing symptom burden at end of life. Support is offered through consultative assessment visits and focus on palliative care needs including symptom management, goals of care, end of life management, palliative care education and psychosocial and bereavement counselling for residents, families and staff. Since October 2020, they have supported eight long-term care homes and seven retirement homes, performing 226 clinical consults, seven virtual psychosocial consults and two virtual educational consults.

In the South East LHIN, South East Regional Palliative Care Network and Home and Community Care initiated a pilot program in two long-term care homes to ensure patients receive high-quality palliative care and die in their place of choice. Palliative Pain and Symptom Management Consultants were embedded part-time in the homes over a two-month period, providing bedside mentoring and customized curriculum based on identified needs. Results indicate the partnership improved long-term care home staff capacity and comfort in providing palliative care, and promoted an interdisciplinary approach to care. The success of this pilot will assist the expansion of this model into other long-term care homes.

Improving the Delivery of Home Care

LHINs delivered home and community care services to more than 700,000 people across the province in 2020/21. This work involved partnerships among care coordinators, physicians, nursing professionals, physiotherapists, occupational therapists, speech language pathologists, rehabilitation assistants, social workers, dietitians and others. As a result, LHINs continued to develop innovative and collaborative initiatives to safely transition patients along their care journey.

Addressing Personal Support Service Human Resource Challenges and Advancing Home Care Capacity and Consistency

In order to address previously identified challenges related to recruiting and retaining personal support workers (PSWs) in their regions, LHINs, in collaboration with local partners, have implemented a range of strategies and initiatives to support PSW job satisfaction and retention. Additionally, these initiatives also supported improved consistency in service delivery and patient satisfaction.

North Simcoe Muskoka LHIN implemented a new personal support services model designed to enhance the safety and wellness of both residents and staff in area retirement homes. The new 'shift-based' model saw PSWs adopt a shift approach, replacing multiple PSWs providing 30-minute service visits to clients at the retirement home. This new model also enhanced the safety of retirement home residents during the pandemic by limiting the number of care workers visiting the home. In addition, the model provides increased continuity of care for residents and more consistent work for PSWs.

To reduce their footprint, and enhance flexibility in care provision, Erie St. Clair LHIN implemented shift service delivery for PSW and occasional nursing in congregate settings.

Client-partnered scheduling was implemented in North East LHIN to increase provider flexibility scheduling PSWs, minimize missed care and foster improved relationships with patients. With this model, visit times are flexible and may change depending on the patient's needs and the needs of other patients. The provider contacts patients or their caregivers directly to arrange a visit schedule. Patients can contact the provider directly to discuss needs or concerns they might have about the timing of visits. When the care tasks are completed, the PSW proceeds to the next client, making better use of their time. This model is helping service providers make better use of the PSWs' time through improvements to scheduling, helping to reach more patients and retain more PSWs. During the pandemic, all nursing and PSW providers were aligned to individual retirement homes in order to minimize risk of COVID-19 transmission, improve efficiency for providers and build partnering relationships with retirement homes staff.

Care Coordination Initiatives

Recognizing the value of operating as an integrated team to support patients as they move through their care journey, Central West LHIN Home and Community Care staff in Dufferin/Caledon were cross-trained to mobilize resources, which enabled care coordinators to provide patient-focused care for patients in the community and during hospitalization. This integrated care coordination model has resulted in fewer hand-offs, an improved ability to advocate for the patient's needs, an increased awareness of the patient's story, and improved communication with stakeholders. In addition to a 29% increase in referrals following implementation, this new model has resulted in the following outcomes:

- reduced length of time to process long-term care applications
- fewer inappropriate service plans and home care referrals
- a streamlined opportunity for care coordinators to contribute knowledge directly to the hospital teams when complex patients are admitted to hospital and during the discharge planning process

Toronto Central LHIN implemented centralized hospital intake to facilitate community-based home care delivered at the neighbourhood level that improves transitions across the continuum of care and collaborative care planning for complex and chronic patients. The concept of a shared team with

hospital, local community providers and primary care was optimized by use of e-notifications and team-based model of care to address urgent client issues, with the goal of minimizing risk of readmissions for complex clients.

The initial implementation of Champlain LHIN's High Intensity Support at Home program supported 85 patients in several geographic clusters using a team-based model to provide wrap-around care. Innovative models of care were implemented in order to enhance quality and safety of patient care and utilize scarce resources through neighborhood and shift approaches. Earlier Hospital Discharges and hospital avoidance were facilitated through the implementation of nursing tele-monitoring models. Care coordinators work with partners to do "whatever it takes" to meet the needs of complex patients. Dementia support is also provided, including installation of wandering detection and diversion technology in the home.

The Community Stroke Rehabilitation Program shifted to virtual care in March 2020 and a supply of iPads for patient use. The program supported earlier hospital discharges and a higher number of referrals compared to previous years. The program expanded to provide Champlain-wide care. This involved a novel collaboration with Bruyere Hospital to develop an integrated community/outpatient partnership. The project has ensured better access to specialized interdisciplinary stroke care for patients while maintaining a high standard of patient centered outcomes. The CSRP had a hospital LOS savings of 3.48 days on average in an area where no specialized stroke outpatient care existed.

Palliative Care Initiatives

During the 2020/21 fiscal year, North Simcoe Muskoka saw a sharp increase in the care provided at home in the last weeks of life and record high medical assistance in dying numbers (MAiD), with at-home deaths increasing from 41.7 percent to 59 percent. Despite a pandemic and health and human resources challenges, caregivers responding to North Simcoe Muskoka LHIN's annual Caregiver VOICES survey reported an improvement in nearly all areas of support measured, and 99.3 percent believed their family member died in the right place. To preserve much-needed end-of-life medications and increase accountability with narcotics in the home, the team adjusted the contents of symptom relief kits to align with Ontario Palliative Care Network guidelines, strengthened accountability, and added an additional layer of review by nurse practitioners to ensure these vital medications went where they were most needed. The work done this year on safety, tracking and accountability will be further strengthened to ensure the ongoing safe usage of end-of-life medications in the home.

In April of 2020, partners including Heart House Hospice, Acclaim Health, Dorothy Ley Hospice and Mississauga Halton Palliative Care Network worked with the Mississauga Halton LHIN to develop a 24/7 Hospice Palliative Care Helpline. The regional Helpline provides patients, caregivers, long-term care home, retirement home partners, primary care physicians, service provider organization staff, etc. with palliative care information, education, counselling, emotional supports, and palliative care clinical support managed by Mississauga Halton Palliative Care Nurse Practitioners. Over 125 calls have been received with 40% deemed as urgent and have resulted in referrals to community palliative care providers. Beginning January 2021, palliative care nurse practitioner hours were extended to be available 24 hours a day, seven days a week. Over 290 calls were received between January and the end of April 2021 averaging 72 calls per month with 85% received on the weekends.

The South East Regional Palliative Care Network, in partnership with South East LHIN and other community stakeholders developed a COVID-19-specific Symptom Response Kit to improve access to

pain and symptom management for individuals at end-of-life, which also included strategies for managing potential shortages in palliative care medications during COVID-19. This also led to the development of a Goals of Care Guide for Talking About Wishes and Goals with COVID-19.

Using Digital Health Technology to Deliver High Quality, Innovative and Accessible Health Care

As a result of the COVID-19 pandemic, there has been a shift to virtual home care to support provincial public health self-isolation and social distancing efforts in a way that minimizes disruption to patient care. Such home and community virtual solutions support intake assessments, monitoring and treatment of patients presumed or confirmed with COVID-19, and virtual care for palliative care by using existing virtual care technologies, including videoconferencing tools provided through the Ontario Telemedicine Network (OTN) to support care.

Digital health technology is changing the way health care is delivered. Across the province, LHINs have worked with patients, caregivers, clinicians and other organizations to implement new tools to enhance connectivity between providers and patients.

Aligned with Ontario's Digital First for Health Strategy, and expedited to respond to evolving patient needs during the COVID-19 pandemic, Central LHIN expanded virtual care services significantly to home and community care patients in 2020/21. Within just a few weeks, over 200 registered health care professionals were trained to provide virtual care over a provincially approved secure video interface platform. This team – comprised of community care coordinators, including specialty caseloads, as well as direct care nurses – completed nearly 82,000 virtual care visits or phone assessments in 2020/21. In providing this critical patient care support, the team applied internationally recognized interRAI tools, which provide reliable, person-centred assessments for medical complexity, physical and cognitive ability, mental health, caregiver distress and more. These factors inform and guide comprehensive service planning and care. Patient feedback on virtual care services received was very positive, with 100% of surveyed patients and caregivers indicating they received adequate information about the virtual care process and felt comfortable exchanging information virtually. In addition to providing virtual care in 2020/21, Central LHIN Home and Community Care completed 10,000 face-to-face in-home visits with complex or at-risk patients.

Erie St. Clair LHIN implemented a digital triage tool across Erie St. Clair hospitals for utilization by care coordinators to decrease wait times, enable virtual referral flow from hospital to intake for support when needed.

In Hamilton Niagara Haldimand Brant LHIN, home care front line staff were supported with technology and policies which enabled them to remain connected with patients and support them during COVID-19 in both community and hospitals for discharge planning. Virtual care tools in the hand of care coordinators as well as service provider staff ensured no patients were left without support.

Waterloo Wellington LHIN rolled out InterRAI CheckUp, which is a new tool validated for virtual assessment of home care patients, and participated in the Safety Net program for COVID-19 positive patients convalescing at home and requiring remote monitoring.

Remote patient monitoring programs were also impended in Hamilton Niagara Haldimand Brant LHIN to support COVID-19 positive patients in their homes through home care teams and paramedicine

partnership programs, and care coordination supports were established to support high-intensity patients in the community while they waited for a long-term care bed.

Community Access Points
To further development and integration of community access points, Toronto Central LHIN launched an integrated work flow and call flow between Information and Referral and Toronto Seniors Helpline (TSH) to support system navigation and community service referrals. The LHIN streamlined access to the Community Behavioural Support Outreach team through TSH, leveraging live counselling and access to Crisis Outreach Services for Seniors. Toronto Central LHIN also piloted rapid access to the Community Behavioural Support Outreach team from the emergency department at Toronto Western Hospital and planned for expansion to other emergency departments. Referrals from ED to date are highly complex and patients have been successfully maintained at home with the benefit of a behavioural care plan and clinical assessment by a nurse practitioner

Capacity Planning

Capacity planning efforts involved the alignment of health system resources to meet the current and future needs of patients and families. LHINs worked with the Ministry of Health, Ministry of Long-Term Care and broader system partners to anticipate and respond to impending needs, such as those of a rapidly growing senior population.

Surge Planning
LHINs participated with acute care and community partners to plan and respond to higher than normal service demands, throughout the pandemic. These plans included solutions to expand beyond normal services to meet the increased demand for qualified personnel, medical care and public health to support surge planning.

With the decrease in the availability of long-term care beds, South West LHIN funded and opened 188 transitional beds in retirement homes across the region. Through partnerships with home care, patients and caregivers, hospitals and retirement homes, the LHIN was focused on ensuring patients received care in a safe environment while awaiting their next care destination, rather than staying in alternate level of care in hospital.

Waterloo Wellington LHIN moved to an informed triage and wait list system which ensured capacity as it was challenged in the system, and that the most vulnerable and complex patients did not go without care.

Capacity planning efforts in Central West LHIN focused on the expansion of acute, post-acute and critical care beds between April 2020 and March 2021, with the opening of 87 total beds at William Osler Health System and six total beds at Headwaters Health Care Centre, providing relief for the surge in critical and acute care volumes brought on by the pandemic.

Toronto Central, in collaboration with LHINs in the Central, East and West regions, supported the GTA COVID Hospital Incident Management Structure (IMS) to:

- Monitor hospital critical capacity needs in real time
- Respond in a timely manner to the pace of capacity issues, while targeting upstream engagement with hospitals and focusing on early warning signs
- Move patients to and from hospitals

- Engage the system to redirect resources as needed to preserve system integrity

The GTA Hospital IMS has been successful in ensuring the health care system can withstand the increased capacity pressures felt by the pandemic.

Wait at Home Initiatives

To improve the health system's capacity to respond to the COVID-19 pandemic, North West LHIN Home and Community Care implemented targeted expansion of two Wait At Home programs, which have been instrumental in reducing alternate level of care and long-term care patient populations in acute care settings. Through the Active at Home Program, 85 frail, complex patients with multiple comorbidities were supported, resulting in improved mobility, greater community independence, reduced hospital admissions and long-term care placement.

Community Paramedicine

In 2020/21, in response to COVID-19, the Ministry of Health provided funding to enhance system capacity in the community so that high-needs patients continued to receive timely, high-quality care in their home. Mississauga Halton LHIN expanded community paramedicine programs in Halton, Peel and Toronto to develop and implement a Home Visit Wellness Check program to support seniors and other vulnerable patient populations during COVID-19. Between December 1, 2020, and March 31, 2021, the three community paramedicine programs completed 759 home visits to 127 high-needs clients across Mississauga Halton LHIN, and the expanded community paramedicine services supported the COVID-19 response by administering COVID tests and vaccinations to over 450 individuals living in Oakville, Milton, Halton Hills, Mississauga and South Etobicoke.

North East LHIN established partnerships with multiple community paramedicine programs across the region, leveraging the use of a Health Partner Gateway platform for the bilateral referral of patients between the community paramedicine programs and home care.

Erie St Clair LHIN partnered with their community paramedicine program which resulted in increased opportunities to leverage emergency medical services and mobile teams to support testing, isolation, mobile health assessments and vaccinations.

Health System Transformation

Under the *Connecting Care Act, 2019*, Ontario Health Teams were introduced to provide a new way of organizing and delivering services in local communities. This new model of care brings together health care providers to work as one coordinated team that better connects patients and providers in their communities to improve patient outcomes. Throughout the year, LHINs also supported health system transformation by planning and preparing for the transitions of functions into Ontario Health and Home and Community Support Services.

Supporting the Development and Expansion of Ontario Health Teams

Starting in 2019, the Ontario government approved the establishment of 24 Ontario Health Teams (OHTs) to begin implementing a new model for organizing and delivering health care. Under Ontario Health Teams, a varied group of health care providers – including primary care, hospitals, long-term care home, emergency service providers, home and community care, and other providers from across the continuum of care – work together as one coordinated team.

The implementation of OHTs remains a key priority within the government's plan to modernize the health care system. In the last few months, five new Ontario Health Teams have been announced, and 17 additional teams are on a path to be the next cohort of approved OHTs, with an announcement of the successful teams expected soon.

Through Ontario Health Teams, patients will receive 24/7 access to seamless navigation and care coordination. Despite the pressures of the COVID-19 in 2020/21, significant progress was made in establishing additional OHTs, and also exploring and expanding services offered by the initial cohort of approved OHTs.

In the Central LHIN, with the announcement of the Western York Region OHT on July 23, 2020, there are now five OHTs approved to operate in Central LHIN in 2020/21. These teams introduced several new initiatives. Examples include:

The North Western Toronto OHT introduced Seamless Care Optimizing the Patient Experience (SCOPE+). This initiative provided a single telephone number for primary care physicians to call for an array of services – from setting up diagnostic imaging to arranging home and community care services for their patients and securing counselling on general medicine queries. A Central LHIN Care Manager served as the point person for this interdisciplinary care program. The North Western Toronto OHT also designed and implemented a new pilot program for patients with chronic obstructive pulmonary disease (COPD). The same Central LHIN Care Coordinator for SCOPE+ also supported multiple providers to ensure their COPD patients received consistent and streamlined care coordination, navigation and service levels using a consistently applied pathway. In 2020/21, the team also began preparations to expand this intensive case management model of care for patients with congestive heart failure.

Another OHT in Central LHIN, North York Toronto Health Partners, developed a new program called North York Community Access to Resources Enabling Support (North York CARES). Through the collaboration of 14 care providers, the focus of this program is to help transition patients from hospital to home with an integrated care program, which, depending on the patient's individual needs, could include home and community care services.

Toronto Central LHIN supported OHTs in the region to develop a coordinated flu vaccination plan for Fall 2020. OHT partners were able to implement a number of creative flu vaccine delivery models and modalities including: community pop-up flu clinics to increase access to vulnerable populations and less mobile clients; targeted mobile outreach to congregate and high density settings (including shelters, group homes and seniors housing buildings); shared clinics where cross-sector partners collaborated to share physical spaces and staffing to set up flu clinics; and establishing websites to provide a centralized point of access to information for providers, partners and community members, enabling consistency in messaging across OHT partners related to flu planning.

South East LHIN continued supporting regional OHTs, with two OHTs approved for Cohort 2 and one that has submitted a full application (Hastings Prince Edward), which will ensure that the entire South East region will be covered.

North East LHIN planning staff provided key support to contribute to the approval of the Algoma Ontario Health Team in July 2020, one of two OHTs across the North East Region (Nipissing Wellness Team, North Bay, 2019). The Algoma Ontario Health Team brings together health care providers to improve coordination of care for Algoma communities and build a more integrated system of care for people living in Algoma. Their work is focused on frail, elderly and patients with conditions that are best

managed in the community. As part of their commitment to meaningfully engage citizens in system design, the OHT convened a Citizens' Reference Panel to hear from a representative group of citizens that broadly reflect the diversity found within the community. Working together, this diverse group of randomly selected citizens provides the OHT with recommendations that help to shape the future of health in their region through a process known as "deliberative engagement".

Health Service Provider Integrations

Integrations in health care offer efficiencies in the system to support improved quality of care, patient and provider satisfaction and further sustainability.

In alignment with the province's transformation agenda focused on integrated care, the South West LHIN Community Support Services Bundled Care program integrates community support services, home care and community paramedicine support, providing discharge for hospital patients or patients in the emergency department. This integrated bundle of care lasts four weeks post-discharge, can be accessed through Community Support Services Central Intake, and includes: transportation home; medication pick up; two weeks of Meals on Wheels; two homemaking visits; two transportation rides to medical appointments; and caregiver supports.

Champlain LHIN provided project support to the Neighbourhood Integrated Care Model Project steering committee, core teams and allied partners who are implementing the project. The model is an innovative approach to planning, funding and delivering place-based supports in communities whose populations frequently use health services. In the 2020/21 year fiscal year, 13 housing, health and social service providers signed a letter of cooperation to implement interdisciplinary neighbourhood teams in three communities. The LHIN brought partners together to develop core team guides to respond consistently to ongoing and emergent mental and physical health needs, and transitions. Increased collaboration through this project led to a range of successful initiatives during the pandemic. Partners conducted wellness checks and addressed emerging needs (e.g., food baskets, face masks, cell phones to access virtual care and social programs). In the mixed-age dwelling, new members of the team were quickly integrated. The teams had early success in supporting transitions home from hospital, and for personal support and homemaking, the teams improved referral processes and coordination.

Integrating team-based care, Central West LHIN Home and Community Care team partnered to create a new COVID-19 monitoring program. Launched in April 2020, and led by the Dufferin County Paramedic Service, the LHIN and the Dufferin Area Family Health Team, the remote program provides monitoring by respiratory therapists 7 days a week, while actively involving primary care and specialist collaboration, and Hospice Dufferin. Patients and the clinical team received support through a centralized intake team coordination and monitoring, with effective transition from home and community care teams serving as the foundation to support the program.

COVID Response

North Simcoe Muskoka LHIN collaborated with local health units and local providers to deliver COVID vaccines to patients who were not able to leave their homes to get a vaccine. This Homebound Vaccination Program was unique to the North Simcoe Muskoka region and the South Simcoe area of Central Region. A significant volume of preparation work done in late 2020/21, including screening, identification and service authorization.

Implementing Wound Care Standards

Working to help ensure continuity and accessibility of care for wound patients in the home and community and supported by Central East LHIN, a consortium of leading Canadian organizations has come together to launch Telewound Care Canada, a virtual care initiative designed to help patients connect with their care teams while reducing unnecessary travel and in-person care. Telewound Care Canada aims to implement, evaluate and scale integrated, virtually enabled models of wound care that will impact over 1,000 wound patients in Ontario and Quebec by summer 2021.

North West LHIN established a Regional Wound Care Lead to help reduce the impact of wounds, amputation rates and pressure injuries. This was achieved through the development of pathways, chairing the Regional Wound Care Advisory and the provision of education in evidence informed best practices including Health Quality Ontario Standards.

Virtual Care and Digital Solutions

Leveraging virtual care platforms and digital solutions to ensure delivery of care in home and community by many LHINs was a key component of serving their populations during the pandemic.

Through the application of enabling technology, Waterloo Wellington LHIN implemented a strengthened, intelligent and patient-informed approach to virtual care. During 2020/21, virtual care delivery in home and community care was successfully expanded with over 1,300 unique patients served this past year in Central West LHIN. Home and community care teams and patients across the Central region have seen an increase in access and confidence using appropriate virtual models of care. Well received interventions include seniors-based exercise and falls prevention classes, reassessments and a variety of clinical intervention.

Working closely with their Digital Health Advisory Committee and Ontario Health Teams, Mississauga Halton LHIN successfully undertook new digital tools for improving the delivery of care with an emphasis on multi-partner integration and commitment to access and continuity of care. Over 21 different programs are in progress, including virtual home care, urgent care, surgical transitions, remote home care monitoring and the more recent central wait list management.

In an effort to help contain the spread of COVID-19 in the north region, North West LHIN used funding provided by the Ontario Health Virtual Health Secretariat to provide virtual care services through remote care monitoring, surgical transitions and virtual urgent care. In 2020/21, 1,600 patients in the North region accessed these virtual supports.

Other virtual care projects launched by North West LHIN include:

- Virtual critical care
- COVID-19 remote care monitoring
- Surgical transitions
- Virtual urgent care
- Virtual care in home and community care

Community Engagement

Community engagement is built into every part of the planning, delivery and evaluation of LHIN work. Serving communities across the province responsibly and responsively relies on ongoing dialogue with those who use health services and those who deliver them. LHINs actively engaged with communities, residents, health service providers, provincial associations, local government leaders and many other organizations and individuals on how to improve and enhance Ontario's public health system.

In this last year, LHINs continued to engage with priority populations, including Francophone and Indigenous communities and other health system partners to identify potential risks and implement targeted interventions to improve access to appropriate and culturally sensitive care. As might be expected, many engagements in 2020/21 focused on ensuring support for these populations through the pandemic.

Engagement with Francophone Communities

Access to quality French language health services directly impacts the health of Franco-Ontarians. LHINs are committed to engaging with the Francophone community to inform planning and integration of these services in accordance with the *French Language Services Act*. Strong working partnerships have been established with French Language Health Services Planning Entities (les Entités) across the province to support engagement with Francophone stakeholders, as the following examples demonstrate.

Champlain LHIN, in collaboration with Le Réseau des services de santé de l'Est de l'Ontario (Le Réseau), continued to support health service providers seeking their official designation under the French Language Services Act, including the Foyer St-Jacques and Renfrew Victoria Hospital. Champlain LHIN also worked with Le Réseau to increase Francophone capacity in long-term care in the region.

In collaboration with Entité 4, North Simcoe Muskoka LHIN developed a comprehensive webinar module on active offering of French language services, which was adopted by area hospitals.

The Francophones and Cultural and Linguistic Sensitive Care online training was launched to home and community care and Ontario Health West staff in Erie St. Clair and South West. This training encouraged participants to reflect on how their own beliefs, biases and assumptions about the Francophone community shape their behaviours.

Toronto Central LHIN and Entité 3 worked in partnership to provide advice and support for the final steps of the designation process for Women's College Hospital. This resulted in the official designation of Women's College Hospital in May 2021.

South West LHIN had a total of 17 community engagements sessions for the francophone community, which were organized and held in collaboration with the French Language Health Planning Entity.

North West LHIN, in partnership with the Réseau, worked with health service providers to increase awareness and provide support to implement active offer within their practices. The Réseau participated in various committees to provide the Francophone perspective on issues such as senior care, palliative care and rehab care.

North East LHIN worked closely with the Réseau to enhance care coordination, improve the patient experience, increase access to services in French, reduce inequities, and strengthen the sustainability of French Language Services across the North. During this pandemic year, engagement was focused primarily with health service providers.

South East LHIN, in collaboration with the Réseau, continued working towards establishing French Language Services designation, with Ontario Health East approval, for Kingston Community Health Centres.

Engagement with Indigenous Communities

In 2020/21, LHINs continued to focus on establishing trust and strengthening relationships with Indigenous partners and communities to better understand and address the needs of Indigenous populations. Continuing to build mutually respectful relationships and engage with Indigenous communities, leadership and health service partners, LHINs were better equipped to facilitate new partnerships, particularly in response to the pandemic, to ensure culturally safe care, access to testing, PPE supplies, and Indigenous-specific messaging.

The Hamilton Niagara Haldimand Brant Indigenous Health Network, in partnership with the Hamilton Niagara Haldimand Brant LHIN, facilitated a unified vision for pandemic care that supported Indigenous people through creating space to identify and respond to the needs of the Indigenous community and embracing wellness. This included redeploying staff to support vulnerable Indigenous members of the community, distributing essential items such as food reserves and PPE, and developing and implementing strategies to address vaccine hesitancy and support culturally safe and trauma-informed approaches to vaccination.

Waterloo Wellington LHIN continued to work in partnership with local Indigenous communities to improve access to culturally safe care, COVID-19 testing and vaccination clinics. More than 200 LHIN staff (including front-line staff), providers and community members participated in an online Indigenous Cultural Safety Training course.

Central LHIN staff continued to work with Georgina Island Health Services Office, Barrie Area Native Advisory Circle, Canadian Mental Health Association York Region, as well as other Indigenous and non-Indigenous partners by participating in the 11th Annual Indigenous Health Forum hosted by the Simcoe Muskoka York Indigenous Health Circle. The event built on prior year co-design planning to identify needs, considerations and culturally appropriate programs and services.

Toronto Central LHIN worked with Anishnawbe Health Toronto to convene the Toronto Region Indigenous Table to help better understand and meet the needs of Toronto's Urban Indigenous population. The LHIN also engaged with a number of Indigenous community leaders on a virtual event discussing real First Nations, Inuit, Métis and urban Indigenous experiences in the health care system which advised on a number of ways to address anti-Indigenous racism.

Mississauga Halton LHIN and the other LHINs in Central Region quickly mobilized a Central Region Indigenous Specific Response in partnership with the Indigenous Health Circle of North Simcoe Muskoka. Indigenous representation was at the Emergency Operations Command table. The development of a Central Region Indigenous Specific Strategy for COVID-19 was the main priority and

led to activities which included frequently connecting with stakeholders so all First Nations and urban Indigenous communities felt supported during the pandemic. To align with regional integration, the NSM Indigenous Health Circle extended an invitation to Central LHINs' First Nation Community Chippewas of Georgina Island and The Indigenous Network to participate in critical discussions focusing on the pandemic. As a result, the Indigenous Health Circle established an Indigenous Leadership COVID-19 Response Table where the five First Nations and Indigenous providers strategize, share information and support on COVID 19 response and recovery with topics including PPE allocation and supplies, testing, contact tracing and communication.

In an effort to keep communication lines open, the South West LHIN and Ontario Health West maintained regular contact with one-on-one meetings with Indigenous partners to address needs and offer ongoing support. The LHIN facilitated discussions between the Western Ontario Health Team and the Indigenous Health Committee (IHC) to discuss how Indigenous communities/agencies may wish to participate and support Ontario Health Team developments to ensure planning and provision of services is influenced by Indigenous voices.

Central East LHIN held weekly touch-base meetings with First Nation, Métis, Inuit and urban Indigenous agencies during the pandemic. This enabled local response to PPE needs, provision of advice on overcoming challenges related to testing, assessment and vaccine access for urban Indigenous peoples. Central East Health Advisory Circles worked with the touch-base group to invest their annual Indigenous community engagement budget to directly support COVID-19 response, including cultural supports and essential supplies for those in need.

North East and North West LHINs engaged extensively with Northern Indigenous partners and people this pandemic year. In April 2020, North East LHIN created a COVID-19 Response Indigenous Working Group, which includes Northern First Nation Health Directors (109 First Nations in the North), Tribal Councils, health authorities, and federal and provincial partners. The working group focused on mental health and addictions, PPE and critical supplies, communications and engagement, connectivity and testing.

North East LHIN co-led the provincial roll out of rapid access testing to First Nations communities, Indigenous health service providers, and health partners across the North. All 109 First Nations communities were engaged either directly or through Tribal Councils or Indigenous health partners.

Engagement with Other Communities and Populations

Throughout the year, engagement activities with Patient and Family Advisory Committees (PFACs) across the LHINs continued, albeit it virtually due to restrictions on in-person meetings. Many PFACs pivoted their meetings to focus on pandemic issues. Membership of these committees is diverse and encompasses Ontarians with a broad range of lived experiences, including home care patients, caregivers, palliative caregivers and those with mental health and addiction issues.

Engaging with underserved populations supports the LHINs' efforts to inform strategies that improve the quality of care and the patient experience. Through community engagement, LHINs are able to address care needs through a more local lens, which was vital in supporting these vulnerable populations through the pandemic.

Toronto Central LHIN launched the Toronto Region Anti-Racism Steering Committee, composed of leaders from Black and Indigenous communities, alongside other health system leaders and allies, in response to the heightened sense of urgency to address anti-Black and anti-Indigenous racism. A critical step was to engage with Black communities to understand how a truly anti-racist health system would look, feel and be experienced. To address health inequities for Black communities that were amplified by COVID-19, Toronto Central LHIN led the High Priority Community Testing strategy, partnered with other system allies to support the Black Health Strategy, and through our partners, supported the COVID-19 Vaccine Sprint Strategy which took an equity lens to vaccine provision and rollout.

North Simcoe Muskoka was one of four LHINs in the Central Ontario region that came together to host a meeting in which Ontario's late Patient Ombudsman, Cathy Fooks, spoke about "Honoring the Voices and Experiences of Long-Term Care Home Residents, Caregivers and Staff During the First Wave of COVID-19 in Ontario." Participants included members of LHIN Patient and Family Advisory Committees, advisors for area hospitals and regional Ontario Health Teams, as well as patient experience and relations staff from LHINs and area hospitals.

Erie St. Clair LHIN engaged with Southwestern Ontario Local Immigration Partnership to help bring the We Speak interpretation strategy to health care providers within their memberships. This tool was used at COVID-19 testing centres, in mobile units as well as in vaccine clinics. The LHIN worked with the international agricultural workers community to help connect system-level and community-level COVID-19 initiatives, and general health and wellness resources, including language supports via We Speak.

Waterloo Wellington LHIN came alongside the shelter system when they began to experience multiple travel outbreaks and partnered to provide additional nursing resources to homeless patients in isolation units, including palliative care, and increased the number of isolation units overall.

Champlain LHIN worked to increase access to gender-affirming care for transgender, two-spirit, intersex, non-binary and gender-diverse communities. The LHIN provided base funding to support the ongoing work of the Regional Planning Table on Trans, Two-Spirit, Intersex, Non-Binary and Gender Diverse Health, whose work plan focused on the development of strategies to increase primary care capacity and strengthen care pathways between primary care providers and transition-related mental health supports.

Health System Performance

In 2020/21 LHINs defined their ability to adapt and innovate during the COVID-19 pandemic while driving system integration, supporting the needs of home and community care patients in their region.

Throughout the year, LHINs were at the frontline of the province's pandemic response whether it be providing care in patients' home, being redeployed into long-term care homes or developing new services and supports for patients' when hospital or community care was halted due to ensuring the health and safety of staff and Ontarians, and the ramp down of non-urgent or emergent care.

The pressures across the entire health care system because of the pandemic resulted in several provincial performance indicators not being met. Based on provincial averages, LHINs met or achieved the provincial target for one performance indicator: *Percentage of home care clients who received their nursing visit within five (5) days of the date they were authorized for nursing services*. Individually, the majority of LHINs exceeded the provincial target for at least one indicator.

Indicator	Provincial target	Provincial						
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1. Performance Indicators								
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%	87.80%	86.69%	85.63%	86.12%
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%	96.25%	95.87%	95.66%	94.43%
90th Percentile Wait Time from community for Home Care Services -	21 days	29.00	29.00	30.00	29.00	28.00	27.00	24.00

Application from Community Setting to first Home Care Service (excluding case management)*								
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	8.00	9.00
90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	10.87	10.87	10.88
90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.62	4.95	4.43
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%	79.58%	80.20%	64.00%
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%	75.12%	76.67%	60.00%
Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.70%	16.62%	19.50%	17.83%
ALC rate	12.70%	13.70%	13.98%	15.19%	15.68%	15.35%	16.30%	16.76%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	21.60%	21.91%	21.62%	23.18%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.80%	33.75%	34.38%	34.81%

Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.57%	16.63%	16.40%	16.96%
2. Monitoring Indicators								
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	85.56%	85.44%	71.00%
Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	70.58%	65.91%	70.00%
Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18%	82.11%	84.73%	84.20%	80.40%	80.00%
Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00
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	7.00	7.00	7.00
Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	16.82	14.26	12.51	4.31
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	335.22	332.68	325.89	179.64
Percentage of acute care patients who had a follow-up with	NA	46.09%	46.61%	47.43%	46.71%	46.17%	44.76%	29.69%

a physician within 7 days of discharge**								

Challenges

The pandemic placed an unprecedented pressure on the health care service resulting in the ramp down of elective or non-emergent care, and redeployment of health care staff to support COVID-19 patients or critical care services over the 12 months. As a result of service closures, the redirection of human resources, and multiple waves of the pandemic, several provincial indicators were not met despite the tremendous work undertaken by the LHINs.

It is anticipated that focus for 2021/22 will be health system recovery, and the LHINs have identified several pressures and opportunities to increase activities levels so that outcomes are more closely aligned to provincial indicators and targets in subsequent years.

ALC Rate

As a result of COVID-19, there was a need for a system-wide approach to improve flow of ALC patients out of acute and post-acute care settings. The ministries and Ontario Health supported broad system changes with directives that eliminated barriers to flow and enabled collaboration to drive fast-acting processes to improve patient flow. The health care system shifted to prioritize placement for those in greater need and to optimize all available LTC beds and increase admissions of ALC patients to long-term care.

Toronto Central LHIN, one of the hardest hit LHINs, leveraged a series of existing models and ALC initiatives to continue to drive flow of ALC patients to the next appropriate place of care. (i.e., integrated transitional services, service resolution tables, short-term transitional models).

Hospitalization rate for ambulatory care sensitive conditions.

Historically, in the North Simcoe Muskoka LHIN the outcomes for this indicator have been significantly higher than provincial performance, indicating a reliance on hospital-based services to provide regular and routine care. Over the past year, this indicator declined substantially. This was in part due to COVID-19 restrictions, but also relates to increased usage of virtual platforms and e-health initiatives that ensured a degree of continued access to primary care. Historical investments in e-health and virtual care are beginning to demonstrate outcomes, as the COVID-19 situation encouraged the population to engage with virtual health options rather than relying on hospitals.

Appointees

Board Members for Ontario	Initial Appointment Date	Current Term Expires
Bill Hatanaka (Chair)	March 8, 2019	March 6, 2022
Elyse Allan (Vice Chair)	March 8, 2019	March 6, 2022
Jay Aspin	March 8, 2019	March 6, 2023
Andrea Barrack	March 8, 2019	March 6, 2022
Alexander Barron	March 8, 2019	March 6, 2022
Adalsteinn Brown	March 8, 2019	March 6, 2022
Robert Devitt	March 8, 2019	Resigned January 9, 2021
Garry Foster	March 8, 2019	March 6, 2022
Shelly Jamieson	March 8, 2019	March 6, 2022
Jacqueline Moss	March 8, 2019	March 6, 2023
Paul Tsaparis	March 8, 2019	March 6, 2022
Anju Virmani	March 8, 2019	March 6, 2023

Total remuneration paid to members of the Board of Directors by Ontario Health during the 2020/21 period amounted to $150,000.

Financial Analysis

Local Health Integration Networks (LHINs) were established as Crown Agencies under the *Local Health System Integration Act, 2006*. LHINs are funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement (MLAA), which describes budgetary arrangements established by the Ministry of Health and the approved funding arrangements reflected in the Financial Statements.

In accordance with the MLAA, LHINs are required to be in a balanced position at year end. Funding directed toward home and community care may be reallocated from one LHIN to another for shared programming and resources, and to help address in-year funding pressures, pending ministry approval. Any funding received in excess of expenses incurred is required to be returned to the Ministry of Health. Detailed finances can be found in the attached Audited Financial Statements.

Central LHIN
Central LHIN delivered on its objective within the Ministry of Health funding allotment of $2.97 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $2.58 billion represented transfer payments to health service providers, while $394 million was related to LHIN operations including the delivery of home and community care.

Central East LHIN
Central East LHIN delivered on its objective within the Ministry of Health funding allotment of $2.88 billion (based on ministry funding schedules) for the full fiscal year 2020-21. Of that amount, $2.51 billion represented transfer payments to health service providers, while $368.8 million was related to LHIN operations including the delivery of home and community care. During the year, Central East LHIN reallocated $5.7 million to other LHINs and Ontario Health to assist with in-year funding pressures.

Central West LHIN
Central West LHIN - Central West LHIN delivered on its objective within the Ministry of Health funding allotment of $1.28 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.12 billion represented transfer payments to health service providers, while $163 million was related to LHIN operations including the delivery of home and community care.

Champlain LHIN
Champlain LHIN delivered on its objective within the Ministry of Health funding allotment of $3.47 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $3.18 billion represented transfer payments to health service providers, while $291.6 million was related to LHIN operations including the delivery of home and community care. During the year, Champlain LHIN reallocated $9.3 million to other LHINs and Ontario Health to assist with in-year funding pressures.

Erie St Clair LHIN
Erie St. Clair LHIN delivered on its objective within the Ministry of Health funding allotment of $1.48 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.31 billion represented transfer payments to health service providers, while $169 million was related to LHIN operations including the delivery of home and community care.

Hamilton Niagara Haldimand Brant LHIN
Hamilton Niagara Haldimand Brant LHIN delivered on its objective within the Ministry of Health funding allotment of $3.89 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $3.5 billion represented transfer payments to health service providers, while $394 million was related to LHIN operations including the delivery of home and community care.

Mississauga Halton LHIN
Mississauga Halton LHIN - Mississauga Halton LHIN delivered on its objective within the Ministry of Health funding allotment of $2.12 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.89 billion represented transfer payments to health service providers, while $229 million was related to LHIN operations including the delivery of home and community care.

North East LHIN
The North East LHIN delivered on its objective within the Ministry of Health funding allotment of $1.91 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.75 billion represented transfer payments to health service providers, while $166 million was related to LHIN operations including the delivery of home and community care.

North Simcoe Muskoka LHIN
North Simcoe Muskoka LHIN delivered on its objective within the Ministry of Health funding allotment of $1.19 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.07 billion represented transfer payments to health service providers, while $125.7 million was related to LHIN operations including the delivery of home and community care.

North West LHIN
North West LHIN delivered on its objective within the Ministry of Health funding allotment of $875 million (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $812 million represented transfer payments to health service providers, while $63 million was related to LHIN operations including the delivery of home and community care.

South East LHIN
South East LHIN delivered on its objective within the Ministry of Health funding allotment of $1.43 billion (based on ministry funding schedules) for the full fiscal year 2020-21. Of that amount, $1.30 billion represented transfer payments to health service providers, while $136.7 million was related to LHIN operations including the delivery of home and community care. During the year, South East LHIN reallocated $12.0 million to other LHINs and Ontario Health to assist with in-year funding pressures.

South West LHIN
South West LHIN delivered on its objective within the Ministry of Health funding allotment of $2.8 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $2.57 billion represented transfer payments to health service providers, while $239 million was related to LHIN operations including the delivery of home and community care.

Toronto Central
Toronto Central LHIN delivered on its objective within the Ministry of Health funding allotment of $7.76 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $7.48 billion represented transfer payments to health service providers, while $278 million was related to LHIN operations including the delivery of home and community care.

Waterloo Wellington LHIN
Waterloo Wellington LHIN delivered on its objective within the Ministry of Health funding allotment of $1.47 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, $1.3 billion represented transfer payments to health service providers, while $172 million was related to LHIN operations including the delivery of home and community care.

Audited Financial Statements

<TO BE INSERTED AFTER BOARD SIGN-OFF>

Appendix One – LHIN Populations Profiles

LHIN	Population Profile		Health Service Providers*
Erie St. Clair	Area (km^2):	7,324	· 5 Hospitals · 36 Long-Term Care Homes · 29 Community Services · 20 Mental Health Agencies · 4 Residential Hospices · 5 Community Health Centres
	Total Population:	666,890	
	% of Ontario Population:	4.58%	
	Population Age 65+:	19.69%	
	Population Growth Rate:	1.16%	
	Population Density:	85.7	
	Rural Population:	22.50%	
	Indigenous Population:	3.40%	
	Francophone Population:	3.30%	
	Low Income Population	3.30%	
South West	Area (km^2):	1,886,389	· 19 Hospitals · 78 Long-Term Care Homes · 53 Community Services · 31 Mental Health Agencies · 5 Residential Hospices · 5 Community Health Centres
	Total Population:	1,038,957	
	% of Ontario Population:	7.13%	
	Population Age 65+:	19.38%	
	Population Growth Rate:	1.87%	
	Population Density	45.6	
	Rural Population	39.80%	
	Indigenous Population	2.40%	
	Francophone Population	1.40%	
	Low Income Population	15.00%	

Waterloo Wellington	Area (km^2):	4,751	· 8 Hospitals · 36 Long-Term Care Homes · 24 Community Services · 13 Mental Health Agencies · 4 Residential Hospices · 4 Community Health Centres
	Total Population:	845,582	
	% of Ontario Population:	5.80%	
	Population Age 65+:	15.21%	
	Population Growth Rate:	2.40%	
	Population Density:	161.2	
	Rural Population:	14.00%	
	Indigenous Population:	1.70%	
	Francophone Population:	1.60%	
	Low Income Population:	11.60%	
Hamilton Niagara Haldimand Brant	Area (km^2):	6,474	· 9 Hospitals · 86 Long-Term Care Homes · 59 Community Services · 38 Mental Health Agencies · 7 Residential Hospices · 7 Community Health Centres
	Total Population:	1,499,117	
	% of Ontario Population:	10.29%	
	Population Age 65+:	19.58%	
	Population Growth Rate:	1.25%	
	Population Density:	216.1	
	Rural Population:	13.80%	
	Indigenous Population:	2.70%	
	Francophone Population:	2.30%	
	Low Income Population:	13.50%	
Central West	Area (km^2):	2,591	· 2 Hospitals · 23 Long-Term Care Homes · 19 Community Services · 8 Mental Health Agencies · 1 Residential Hospices · 2 Community Health Centres
	Total Population:	1,056,893	
	% of Ontario Population:	7.26%	
	Population Age 65+:	12.78%	

	Population Growth Rate:	3.74%	
	Population Density	355.9	
	Rural Population	6.10%	
	Indigenous Population	0.80%	
	Francophone Population	1.50%	
	Low Income Population	12.40%	
Mississauga Halton	Area (km^2):	1,054	· 2 Hospitals · 28 Long-Term Care Homes · 31 Community Services · 9 Mental Health Agencies · 3 Residential Hospices · 2 Community Health Centres
	Total Population:	1,260,695	
	% of Ontario Population:	8.65%	
	Population Age 65+:	14.31%	
	Population Growth Rate:	1.84%	
	Population Density	1104.6	
	Rural Population	1.60%	
	Indigenous Population	0.70%	
	Francophone Population	2.30%	
	Low Income Population	12.40%	
Toronto Central	Area (km^2):	192	· 18 Hospitals · 36 Long-Term Care Homes · 65 Community Services · 82 Mental Health Agencies · 3 Residential Hospices · 16 Community Health Centres
	Total Population:	1,337,884	
	% of Ontario Population:	9.18%	
	Population Age 65+:	15.61%	
	Population Growth Rate:	1.57%	
	Population Density	6412.6	
	Rural Population	0.00%	
	Indigenous Population	1.10%	

	Francophone Population	2.90%	
	Low Income Population	19.00%	
Central	Area (km^2):	2,731	· 9 Hospitals · 46 Long-Term Care Homes · 33 Community Services · 24 Mental Health Agencies · 3 Residential Hospices · 2 Community Health Centres
	Total Population:	1,954,258	
	% of Ontario Population:	13.42%	
	Population Age 65+:	15.78%	
	Population Growth Rate:	1.68%	
	Population Density	663.9	
	Rural Population	3.70%	
	Indigenous Population	0.60%	
	Francophone Population	1.70%	
	Low Income Population	15.80%	
Central East	Area (km^2):	15,395	· 8 Hospitals · 68 Long-Term Care Homes · 43 Community Services · 24 Mental Health Agencies · 2 Residential Hospices · 7 Community Health Centres
	Total Population:	1,672,971	
	% of Ontario Population:	11.49%	
	Population Age 65+:	17.35%	
	Population Growth Rate:	1.47%	
	Population Density	100.7	
	Rural Population	14.60%	
	Indigenous Population	1.80%	
	Francophone Population	1.80%	
	Low Income Population	15.00%	
South East	Area (km^2):	18,253	· 6 Hospitals · 37 Long-Term Care Homes · 20 Community Services
	Total Population:	511,938	

	% of Ontario Population:	3.51%	· 11 Mental Health Agencies · 5 Residential Hospices · 5 Community Health Centres
	Population Age 65+:	23.30%	
	Population Growth Rate:	1.10%	
	Population Density	26.4	
	Rural Population	55.80%	
	Indigenous Population	4.70%	
	Francophone Population	3.10%	
	Low Income Population	14.60%	
Champlain	Area (km^2):	17,723	· 20 Hospitals · 60 Long-Term Care Homes · 46 Community Services · 34 Mental Health Agencies · 7 Residential Hospices · 11 Community Health Centres
	Total Population:	1,406,174	
	% of Ontario Population:	9.65%	
	Population Age 65+:	17.24%	
	Population Growth Rate:	1.96%	
	Population Density	72.9	
	Rural Population	21.50%	
	Indigenous Population	3.20%	
	Francophone Population	19.80%	
	Low Income Population	12.80%	
North Simcoe Muskoka	Area (km^2):	8,449	· 6 Hospitals · 26 Long-Term Care Homes · 29 Community Services · 14 Mental Health Agencies · 5 Residential Hospices · 3 Community Health Centres
	Total Population:	503,783	
	% of Ontario Population:	3.46%	
	Population Age 65+:	20.27%	
	Population Growth Rate:	1.87%	
	Population Density	54.9	

	Rural Population	41.50%	
	Indigenous Population	5.00%	
	Francophone Population	2.70%	
	Low Income Population	12.20%	
North East	Area (km^2):	395,920	· 25 Hospitals · 45 Long-Term Care Homes · 70 Community Services · 44 Mental Health Agencies · 3 Residential Hospices · 6 Community Health Centres
	Total Population:	571,768	
	% of Ontario Population:	3.93%	
	Population Age 65+:	21.56%	
	Population Growth Rate:	0.38%	
	Population Density	1.4	
	Rural Population	47.30%	
	Indigenous Population	13.40%	
	Francophone Population	22.50%	
	Low Income Population	14.90%	
North West	Area (km^2):	406,926	· 12 Hospitals · 12 Long-Term Care Homes · 59 Community Services · 33 Mental Health Agencies · 6 Residential Hospices · 2 Community Health Centres
	Total Population:	239,637	
	% of Ontario Population:	1.65%	
	Population Age 65+:	18.87%	
	Population Growth Rate:	0.40%	
	Population Density	0.6	
	Rural Population	54.20%	
	Indigenous Population	24.80%	
	Francophone Population	3.10%	
	Low Income Population	13.20%	

Appendix Two- LHIN Performance Data

ONTARIO MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	87.80 %	86.69 %	85.63 %	86.12 %
2	Percentage of home care clients who received	95.00%	93.71 %	94.00 %	96.07 %	96.25 %	95.87 %	95.66 %	94.43 %

	their nursing visit within 5 days of the date they were authorized for nursing services*								
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	28.00	27.00	24.00
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	8.00	9.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	10.87	10.87	10.88
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.62	4.95	4.43
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 %	79.58 %	80.20 %	64.00 %
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 %	75.12 %	76.67 %	60.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35 %	14.50 %	15.69 %	15.70 %	16.62 %	19.50 %	17.83 %
10	ALC rate	12.70%	13.70 %	13.98 %	15.19 %	15.68 %	15.35 %	16.30 %	16.76 %

11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62 %	20.19 %	20.67 %	21.60 %	21.91 %	21.62 %	23.18 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34 %	33.01 %	32.50 %	32.80 %	33.75 %	34.38 %	34.81 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.60 %	16.65 %	16.74 %	16.57 %	16.63 %	16.40 %	16.96 %
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 %	85.56 %	85.44 %	71.00 %
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 %	70.58 %	65.91 %	70.00 %
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 %	84.20 %	80.40 %	80.00 %
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	13.00	13.00	12.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00

	acute-care setting**								
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	16.82	14.26	12.51	4.31
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	335.22	332.68	325.89	179.64
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 %	46.71 %	46.17 %	44.76 %	29.69 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

ERIE ST CLAIR LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	92.45 %	90.54 %	93.46 %	95.51 %	92.35 %	88.52 %	89.99 %
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%	95.04 %	95.03 %	95.88 %	96.46 %	96.01 %	95.10 %	95.42 %
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	18.00	19.00	26.00	27.00	28.00	21.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.87	9.67	9.55	9.78	9.92	10.13	9.83
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.00	3.98	4.22	4.45	4.85	5.10	4.67
7	Percent of priority 2, 3 and 4 cases	90.00%	83.85 %	80.24 %	87.90 %	88.22 %	84.09 %	80.71 %	59.00 %

	completed within access target for hip replacement								
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	75.26 %	75.94 %	72.62 %	67.56 %	72.51 %	71.54 %	49.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	18.07 %	15.97 %	14.96 %	10.46 %	11.56 %	6.74%	9.30%
10	ALC rate	12.70%	19.58 %	19.50 %	15.24 %	13.28 %	12.36 %	10.62 %	9.73%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	17.05 %	17.80 %	19.10 %	18.00 %	18.68 %	19.04 %	19.89 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.04 %	23.99 %	30.92 %	32.70 %	30.59 %	34.45 %	33.16 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.51 %	14.66 %	15.57 %	16.02 %	15.00 %	15.72 %	15.12 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	94.40 %	84.60 %	90.62 %	85.61 %	85.33 %	82.81 %	82.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	88.50 %	84.85 %	84.03 %	70.29 %	77.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	94.22 %	94.40 %	94.18 %	89.06 %	88.00 %
17 (a)	Wait times from application to eligibility determination for	NA	10.00	10.00	11.00	9.00	11.00	9.00	14.00

	long-term care home placements: from community setting**								
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	5.00	4.00	3.00	3.00	2.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	30.57	28.04	22.49	18.38	14.38	12.08	3.66
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	384.49	404.45	389.65	417.71	395.71	450.61	228.47
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	44.12 %	44.30 %	45.41 %	45.85 %	45.66 %	42.77 %	26.29 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

SOUTH WEST LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	90.87 %	88.95 %	91.99 %	88.90 %	84.74 %	79.87 %	83.89 %
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 %	92.59 %	93.10 %	93.69 %	94.01 %	93.16 %	92.79 %	90.42 %
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	21.00	21.00	22.00	30.00	25.00	26.00	25.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	9.00	10.00	12.00	15.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.37	7.73	7.73	8.45	8.40	8.23	8.05
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.62	3.62	3.60	3.90	4.03	4.28	3.80
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	76.53 %	68.39 %	50.35 %	47.44 %	52.30 %	52.86 %	37.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	76.83 %	68.86 %	47.56 %	44.16 %	51.83 %	50.52 %	35.00 %

9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	8.39%	9.24%	10.46 %	9.66%	10.48 %	14.68 %	12.44 %
10	ALC rate	12.70 %	9.65%	11.05 %	11.68 %	11.64 %	11.98 %	13.38 %	14.74 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	17.64 %	18.00 %	18.37 %	18.40 %	20.42 %	0.00%	20.83 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	21.08 %	23.06 %	24.52 %	27.00 %	26.87 %	27.90 %	27.95 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	17.34 %	17.19 %	17.12 %	17.17 %	17.11 %	16.82 %	17.14 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	88.52 %	91.27 %	83.57 %	81.47 %	84.71 %	87.29 %	77.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	0.00%	0.00%	66.49 %	65.75 %	69.49 %	58.83 %	60.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	0.00%	0.00%	84.57 %	82.41 %	81.82 %	82.16 %	82.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	9.00	7.00	8.00	8.00	7.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	4.00	4.00	3.00	3.00	3.00	3.00	4.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	46.03	42.56	41.76	42.79	37.55	27.97	8.94
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	389.32	397.79	414.67	423.36	405.24	396.21	230.83

20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	40.80 %	42.37 %	42.61 %	41.51 %	40.27 %	40.46 %	27.39 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

WATERLOO WELLINGTON LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	84.50 %	85.66 %	92.90 %	95.32 %	97.21 %	95.57 %	89.13 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00 %	94.77 %	93.97 %	95.98 %	97.00 %	96.11 %	96.57 %	94.71 %
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	12.00	13.00	13.00	14.00	14.00	15.00	19.00

4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	7.62	7.73	7.48	8.63	9.17	9.32	7.78
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.23	4.42	4.32	5.10	5.30	5.40	4.28
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	84.88 %	63.44 %	43.62 %	58.79 %	62.34 %	57.95 %	51.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	81.80 %	61.75 %	41.72 %	52.74 %	54.34 %	51.45 %	39.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	13.20 %	11.94 %	12.00 %	14.92 %	14.95 %	19.19 %	14.81 %
10	ALC rate	12.70 %	9.96 %	9.33 %	9.44 %	12.88 %	13.19 %	14.66 %	17.06 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	15.20 %	17.08 %	17.98 %	18.90 %	18.93 %	17.95 %	19.42 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	24.36 %	24.01 %	27.42 %	26.50 %	26.99 %	27.33 %	30.73 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	15.84 %	14.95 %	15.72 %	15.52 %	15.60 %	15.41 %	15.59 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	95.13 %	73.77 %	70.05 %	68.36 %	67.51 %	67.47 %	37.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	0.00 %	0.00 %	72.97 %	93.27 %	81.06 %	63.37 %	68.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	0.00 %	0.00 %	86.52 %	91.52 %	92.49 %	79.91 %	77.00 %
17 (a)	Wait times from application to eligibility determination	NA	12.00	11.00	9.00	10.00	11.00	9.00	11.00

	for long-term care home placements: from community setting**								
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	4.00	5.00	5.00	5.00	5.00	6.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	13.24	12.44	11.13	11.28	11.06	9.99	3.45
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	299.64	293.40	302.40	324.61	315.65	302.17	167.87
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	44.14 %	44.51 %	46.44 %	45.56 %	44.62 %	41.99 %	25.93 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

HAMILTON NIAGARA HALDIMAND BRANT LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1. Performance Indicators									
1	Percentage of home care clients with complex needs who received their personal support visit within 5	95.00%	89.37 %	90.28 %	89.92 %	88.63 %	85.05 %	86.03 %	87.84 %

	days of the date that they were authorized for personal support services*								
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%	92.67 %	93.69 %	95.97 %	95.89 %	95.79 %	95.32 %	94.14 %
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	23.00	25.00	28.00	28.00	28.00	34.00	33.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	6.00	6.00	6.00	7.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	13.28	12.83	14.53	15.97	16.02	15.12	14.87
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.50	4.55	4.57	5.08	5.43	5.37	4.85
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	75.06 %	79.22 %	73.88 %	66.32 %	70.10 %	73.32 %	58.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	72.25 %	75.32 %	66.34 %	63.41 %	65.05 %	68.20 %	50.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	18.23 %	16.21 %	16.27 %	16.51 %	17.48 %	17.13 %	17.03 %
10	ALC rate	12.70%	15.78 %	13.61 %	14.31 %	15.91 %	14.90 %	16.14 %	15.60 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	18.59 %	18.78 %	20.40 %	20.80 %	21.28 %	21.54 %	24.27 %

12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.11 %	30.10 %	29.57 %	30.90 %	30.10 %	31.89 %	32.60 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.50 %	16.60 %	16.97 %	16.31 %	16.52 %	16.17 %	17.72 %
2. Monitorinh Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	84.78 %	85.21 %	84.90 %	88.76 %	93.81 %	96.20 %	77.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	61.45 %	70.24 %	66.40 %	64.84 %	66.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	71.75 %	78.18 %	78.03 %	76.46 %	75.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	9.00	8.00	8.00	9.00	10.00	10.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	5.00	6.00	8.00	8.00	8.00	8.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	22.27	20.06	19.61	18.36	13.99	12.81	4.55
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	389.33	397.01	411.62	415.92	426.03	413.97	224.16
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	47.71 %	48.07 %	48.25 %	47.93 %	46.03 %	45.03 %	28.70 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

CENTRAL WEST LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	92.23 %	88.97 %	85.31 %	82.61 %	85.93 %	82.73 %	88.15 %
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%	96.52 %	95.43 %	95.17 %	95.69 %	96.48 %	96.05 %	95.81 %
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	19.00	21.00	24.00	30.00	29.00	36.00	21.00

4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	8.00	9.00	9.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.85	10.57	11.23	9.72	9.10	9.23	11.12
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.50	3.68	3.85	3.63	3.83	3.73	3.25
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	47.47 %	67.50 %	75.90 %	68.81 %	71.75 %	63.24 %	47.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	47.88 %	72.19 %	64.65 %	53.70 %	54.70 %	51.92 %	54.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	7.14%	6.38%	8.12%	9.35%	9.43%	16.35 %	12.72 %
10	ALC rate	12.70%	6.26%	5.53%	6.44%	8.11%	7.27%	8.94%	10.54 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	24.74 %	24.84 %	24.37 %	26.90 %	26.29 %	26.29 %	25.83 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.59 %	31.89 %	33.78 %	36.10 %	38.81 %	33.41 %	35.16 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.90 %	15.91 %	16.20 %	16.76 %	16.08 %	14.85 %	16.01 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within	90.00%	89.21 %	87.08 %	92.63 %	96.74 %	96.68 %	94.62 %	81.00 %

	access target for cataract surgery								
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	NA***	NA***	NA***	NA***	80.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	95.41 %	97.53 %	94.83 %	92.50 %	88.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	18.00	20.00	21.00	19.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	12.00	13.00	11.00	14.00	14.00	13.00	13.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	5.25	4.93	4.17	5.60	5.51	5.53	3.16
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	279.11	273.16	272.23	280.86	251.58	256.68	132.22
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	55.41 %	56.52 %	56.65 %	56.34 %	56.84 %	55.53 %	38.25 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

MISSISSAUGA HALTON LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	92.07 %	91.48 %	92.63 %	90.81 %	90.99 %	90.91 %	91.59 %
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%	95.22 %	95.58 %	96.69 %	96.60 %	95.99 %	95.61 %	94.50 %
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	27.00	28.00	34.00	27.00	24.00	23.00	24.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	11.00	9.00	10.00	11.00	14.00
5	90th percentile emergency department (ED)	8 hours	9.15	9.62	10.47	10.82	11.18	11.13	12.57

	length of stay for complex patients								
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.58	3.70	3.72	3.82	4.05	4.30	4.43
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	89.36 %	69.10 %	57.02 %	49.42 %	53.74 %	59.55 %	58.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	76.51 %	53.48 %	46.16 %	42.06 %	43.49 %	53.33 %	46.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	12.62 %	14.05 %	15.18 %	17.29 %	16.19 %	16.26 %	14.30 %
10	ALC rate	12.70%	9.60%	11.35 %	14.05 %	14.70 %	13.38 %	11.86 %	10.83 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	17.23 %	17.30 %	16.69 %	17.40 %	17.79 %	17.71 %	18.83 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.50 %	25.48 %	27.21 %	27.20 %	30.22 %	28.80 %	27.61 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.09 %	15.52 %	15.80 %	15.60 %	14.81 %	15.18 %	16.31 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	95.74 %	77.31 %	73.06 %	64.05 %	68.75 %	65.71 %	71.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	79.68 %	83.44 %	83.21 %	81.16 %	81.00 %

16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	79.58 %	81.01 %	81.24 %	77.73 %	78.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	15.00	12.00	12.00	15.00	16.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	17.00	11.00	12.00	15.00	10.50	12.00	13.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.36	6.00	5.17	5.39	4.92	4.30	1.41
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	205.67	192.44	199.39	202.72	219.79	192.19	107.39
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	52.99 %	53.46 %	54.28 %	54.75 %	54.02 %	53.21 %	34.56 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

TORONTO CENTRAL LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal	2016/17 Fiscal	2017/18 Fiscal	2018/19 Fiscal	2019/20 Fiscal	2020/21 Fiscal Year

				Year Result	Year Result	Year Result	Year Result	Year Result	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%	85.47 %	85.03 %	93.95 %	95.57 %	95.54 %	96.40 %	96.41 %
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%	93.64 %	93.50 %	96.19 %	96.06 %	96.46 %	95.77 %	95.91 %
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	25.00	26.00	26.00	26.00	28.00	27.00	20.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	8.00	9.00	10.00	10.00	12.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	12.17	12.18	12.85	13.08	13.62	13.47	14.70
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.47	4.50	4.58	4.65	4.82	5.05	4.80

7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	85.53 %	80.19 %	90.28 %	91.75 %	94.57 %	91.97 %	81.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	85.61 %	84.05 %	90.89 %	91.85 %	93.46 %	92.62 %	76.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	9.79%	10.46 %	12.86 %	11.25 %	11.70 %	13.27 %	13.16 %
10	ALC rate	12.70%	10.33 %	11.97 %	12.58 %	11.49 %	11.75 %	12.92 %	12.73 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	26.59 %	28.54 %	27.90 %	28.40 %	28.69 %	26.49 %	28.84 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	40.84 %	43.17 %	41.95 %	39.00 %	41.15 %	41.50 %	42.88 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	17.89 %	18.13 %	17.72 %	17.99 %	18.19 %	18.24 %	18.35 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	88.43 %	86.55 %	80.12 %	79.36 %	79.47 %	74.11 %	69.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	52.48 %	50.43 %	47.95 %	55.23 %	59.82 %	54.55 %	60.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	65.24 %	67.68 %	69.15 %	75.61 %	72.79 %	67.31 %	73.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home	NA	3.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***

	placements: from community setting**								
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.90	6.73	6.32	5.70	4.12	4.10	1.71
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	259.37	244.27	250.57	272.35	268.57	261.79	148.05
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	49.89 %	50.52 %	51.59 %	50.26 %	49.27 %	48.59 %	29.80 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

CENTRAL LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	84.35 %	83.68 %	92.39 %	93.03 %	94.12 %	93.81 %	94.54 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00 %	94.13 %	94.23 %	96.65 %	96.41 %	95.93 %	96.09 %	96.04 %
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	31.00	33.00	33.00	22.00	22.00	20.00	17.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	6.00	6.00	5.00	6.00	5.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.28	9.80	10.20	10.35	10.67	10.05	10.42
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.43	3.33	3.50	3.80	4.18	4.28	3.73
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	95.63 %	97.46 %	97.90 %	97.40 %	94.94 %	93.31 %	72.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	93.88 %	96.20 %	96.41 %	95.31 %	93.36 %	89.75 %	71.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.34 %	14.36 %	15.95 %	16.65 %	18.24 %	23.06 %	20.11 %
10	ALC rate	12.70 %	13.23 %	13.87 %	15.72 %	15.14 %	12.32 %	11.47 %	11.77 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	18.25 %	18.99 %	19.28 %	20.70 %	20.64 %	19.75 %	20.61 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	23.68 %	26.02 %	25.12 %	25.70 %	27.59 %	27.33 %	29.12 %

13	Readmission within 30 days for selected HIG conditions**	15.50 %	15.90 %	15.92 %	15.94 %	15.52 %	16.37 %	15.72 %	16.43 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	99.71 %	98.46 %	96.69 %	99.68 %	99.41 %	97.77 %	73.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	62.78 %	67.66 %	69.42 %	67.87 %	79.99 %	78.74 %	78.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	84.92 %	83.75 %	82.66 %	83.87 %	87.63 %	86.18 %	83.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	17.00	22.00	19.00	21.00	21.00	20.00	22.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	6.00	4.00	5.00	4.00	3.00	4.50
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.53	6.87	6.41	6.07	5.33	5.06	1.91
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	190.85	177.72	177.24	198.25	207.16	197.32	108.72
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	53.32 %	54.31 %	54.83 %	53.80 %	53.43 %	52.19 %	36.24 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

CENTRAL EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	87.88 %	88.69 %	90.64 %	90.10 %	87.75 %	88.48 %	89.13 %
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 %	95.67 %	95.84 %	96.83 %	96.51 %	95.99 %	96.27 %	94.71 %
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	23.00	30.00	49.00	41.00	39.00	31.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	13.00	10.00	9.00	9.00	10.00	12.00	13.00

5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.62	9.47	10.33	11.00	11.28	10.75	11.07
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.02	3.92	4.08	4.33	4.70	4.75	4.28
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	95.63 %	94.27 %	91.86 %	91.97 %	92.71 %	94.47 %	83.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	94.03 %	90.70 %	88.67 %	86.52 %	88.43 %	93.82 %	81.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	16.84 %	15.22 %	18.40 %	20.83 %	20.78 %	24.94 %	24.42 %
10	ALC rate	12.70 %	18.13 %	17.79 %	23.62 %	23.96 %	21.51 %	24.14 %	22.68 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	19.63 %	19.58 %	21.45 %	23.80 %	22.39 %	23.09 %	24.06 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	25.18 %	26.03 %	27.30 %	29.20 %	27.83 %	28.94 %	30.99 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	16.69 %	17.33 %	16.95 %	16.78 %	17.25 %	16.43 %	16.88 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	98.03 %	95.10 %	95.53 %	96.71 %	98.60 %	97.96 %	86.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	67.95 %	74.31 %	80.98 %	84.67 %	92.81 %	92.07 %	92.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	84.62 %	88.04 %	95.10 %	97.78 %	98.79 %	98.03 %	95.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	21.00	20.00	17.00	20.00	20.00	16.00	24.00

17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	10.00	10.00	8.00	8.00	9.00	8.00	12.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	14.85	14.52	12.82	12.19	9.50	8.37	3.02
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	322.50	317.86	308.07	317.42	314.57	300.93	167.74
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	47.54 %	47.32 %	48.17 %	47.94 %	47.57 %	46.64 %	31.17 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

SOUTH EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	86.84 %	84.62 %	90.72 %	88.12 %	87.37 %	80.26 %	72.78 %
2	Percentage of home care clients who	95.00%	92.70 %	91.90 %	96.14 %	96.28 %	95.04 %	93.64 %	90.04 %

	received their nursing visit within 5 days of the date they were authorized for nursing services*								
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	23.00	21.00	22.00	21.00	20.00	22.00	21.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	7.00	7.00	7.00	7.00	7.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.47	8.90	9.18	8.87	8.98	9.18	9.05
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.28	4.35	4.48	4.43	4.58	4.67	4.45
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	55.82 %	60.17 %	66.78 %	80.63 %	77.31 %	85.29 %	76.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	61.35 %	66.27 %	74.55 %	78.17 %	76.42 %	86.40 %	70.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	15.40 %	15.24 %	17.21 %	17.74 %	16.80 %	20.47 %	18.93 %
10	ALC rate	12.70%	17.11 %	19.19 %	17.74 %	19.30 %	20.66 %	21.32 %	18.78 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	21.94 %	21.79 %	20.12 %	22.40 %	22.28 %	20.81 %	25.23 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	24.86 %	28.14 %	22.84 %	25.80 %	26.46 %	26.37 %	28.75 %

13	Readmission within 30 days for selected HIG conditions**	15.50%	16.23 %	17.01 %	17.64 %	17.34 %	17.59 %	17.02 %	17.86 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	90.95 %	84.43 %	65.34 %	67.53 %	66.01 %	75.78 %	53.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	60.94 %	67.79 %	67.55 %	64.70 %	76.61 %	77.75 %	79.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	84.87 %	78.20 %	78.63 %	83.82 %	80.37 %	81.71 %	80.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	15.00	14.00	13.00	13.00	13.00	7.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.50	8.00	11.00	11.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	41.11	39.92	37.54	38.21	31.62	27.85	9.71
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	460.80	506.16	498.43	549.67	542.45	539.66	293.52
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	42.72 %	42.50 %	43.04 %	41.00 %	40.30 %	38.34 %	26.72 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

CHAMPLAIN LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	78.86 %	77.03 %	77.33 %	71.39 %	68.16 %	66.12 %	63.24 %
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%	91.70 %	93.48 %	96.04 %	96.08 %	95.29 %	95.25 %	93.35 %
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	62.00	55.00	34.00	50.00	45.00	40.00	40.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	8.00	11.00	9.50	9.00
5	90th percentile emergency department (ED)	8 hours	10.68	10.38	11.22	11.68	11.53	13.03	12.02

	length of stay for complex patients								
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.52	4.58	4.77	5.03	5.42	6.53	5.47
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.96 %	85.27 %	90.84 %	89.76 %	90.25 %	91.55 %	59.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	85.02 %	88.02 %	86.19 %	89.16 %	93.14 %	95.66 %	63.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	12.10 %	12.70 %	14.20 %	14.32 %	15.40 %	19.90 %	16.63 %
10	ALC rate	12.70%	12.13 %	12.64 %	13.94 %	14.47 %	14.65 %	16.73 %	21.25 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	18.02 %	17.72 %	18.19 %	18.50 %	19.60 %	19.32 %	19.85 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.02 %	27.41 %	25.02 %	25.70 %	26.29 %	28.47 %	28.41 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.11 %	16.84 %	16.35 %	15.59 %	16.10 %	16.00 %	16.38 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	89.84 %	88.91 %	85.86 %	81.70 %	84.00 %	81.75 %	65.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	52.32 %	56.84 %	77.55 %	73.60 %	67.06 %	60.61 %	68.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	81.30 %	75.52 %	83.28 %	83.18 %	84.13 %	76.99 %	79.00 %

17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	24.00	24.00	23.00	13.00	20.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	10.00	9.00	13.00	16.00	N/R***	N/R***
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	21.94	20.23	18.66	19.25	17.01	15.22	5.11
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	297.25	305.79	303.84	304.59	305.52	319.34	173.27
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	42.31 %	42.08 %	43.03 %	41.59 %	41.37 %	38.84 %	24.78 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

NORTH SIMCOE MUSKOKA LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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%	69.53 %	77.19 %	89.20 %	87.03 %	86.56 %	86.89 %	87.68 %
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%	91.52 %	93.08 %	95.79 %	97.62 %	98.13 %	97.75 %	97.17 %
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	69.00	67.00	51.00	41.00	32.00	27.00	27.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	8.00	6.00	8.00	9.00	12.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.95	9.03	9.10	10.38	10.23	9.52	9.48
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.95	4.37	4.25	4.37	4.35	4.62	4.32
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	90.62 %	81.32 %	77.26 %	83.08 %	73.05 %	71.01 %	54.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	88.66 %	84.52 %	75.69 %	77.35 %	69.44 %	69.20 %	52.00 %

9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	21.02 %	23.83 %	21.13 %	20.24 %	22.69 %	26.83 %	23.50 %
10	ALC rate	12.70%	15.04 %	15.81 %	14.47 %	17.03 %	18.67 %	19.37 %	18.78 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	16.08 %	17.18 %	17.01 %	17.00 %	17.58 %	18.48 %	18.22 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.00 %	21.12 %	23.96 %	22.30 %	22.11 %	25.59 %	25.04 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.17 %	16.81 %	16.60 %	17.25 %	16.40 %	17.54 %	17.67 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	94.39 %	81.36 %	68.41 %	50.82 %	62.92 %	78.39 %	69.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	51.19 %	52.98 %	57.35 %	63.96 %	59.92 %	54.64 %	60.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	87.85 %	82.11 %	81.97 %	85.20 %	83.28 %	85.56 %	76.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	19.50	15.00	15.00	14.00	13.00	14.00	4.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	13.00	15.00	24.00	28.00	34.00	29.00	19.00
18	Rate of emergency visits for conditions best managed	NA	31.64	28.48	26.46	26.38	22.50	18.22	6.35

	elsewhere per 1,000 population*								
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	392.71	401.63	389.40	403.15	449.36	432.00	238.71
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	40.80 %	42.83 %	43.65 %	41.13 %	42.39 %	39.53 %	27.11 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

NORTH EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	86.06 %	83.70 %	96.05 %	87.65 %	85.99 %	83.10 %	80.96 %
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 %	93.61 %	94.09 %	98.20 %	98.49 %	98.25 %	98.50 %	96.41 %

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	70.00	48.00	39.00	31.00	28.00	24.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	11.00	9.00	7.00	7.00	8.00	7.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.20	8.47	8.60	8.43	8.62	8.93	8.55
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.95	3.92	4.05	4.10	4.25	4.57	4.33
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	72.26 %	87.08 %	82.28 %	76.67 %	81.78 %	88.60 %	78.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	71.13 %	84.16 %	81.84 %	74.45 %	70.07 %	82.92 %	72.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	23.17 %	27.64 %	26.31 %	25.05 %	29.33 %	33.65 %	30.69 %
10	ALC rate	12.70 %	21.03 %	19.45 %	22.47 %	24.95 %	24.77 %	26.20 %	27.90 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	17.56 %	17.95 %	18.84 %	18.60 %	18.96 %	20.58 %	21.88 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	31.29 %	32.76 %	27.34 %	28.90 %	32.68 %	30.40 %	32.86 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	17.84 %	17.32 %	17.47 %	17.09 %	17.10 %	16.62 %	16.56 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	90.52 %	91.90 %	93.72 %	93.61 %	86.89 %	86.87 %	70.00 %

15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	68.71 %	69.40 %	71.21 %	71.99 %	69.36 %	63.68 %	69.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	83.66 %	84.77 %	85.90 %	83.25 %	85.09 %	81.84 %	80.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	8.00	7.00	7.00	7.00	7.00	13.50
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00	11.00	9.00	9.00	8.00	7.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	55.29	54.49	52.87	55.03	46.11	46.24	14.28
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	626.00	627.01	598.97	632.37	607.54	582.59	324.81
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	36.41 %	37.03 %	38.99 %	37.50 %	37.55 %	34.82 %	24.95 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

NORTH WEST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year 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 %	76.43 %	78.52 %	83.92 %	83.46 %	85.23 %	93.59 %	94.44 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00 %	89.31 %	88.32 %	95.86 %	96.09 %	95.73 %	97.38 %	98.20 %
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	35.00	28.00	30.00	26.00	23.00	22.00	18.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	5.00	5.00	5.00	5.00	5.00	6.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.73	9.33	9.58	10.30	10.38	10.93	10.57
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.88	3.93	4.18	4.67	4.98	5.32	4.87
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	73.04 %	83.08 %	78.65 %	76.65 %	88.47 %	82.62 %	71.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	64.66 %	71.85 %	76.61 %	74.49 %	78.27 %	73.56 %	77.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	21.72 %	21.27 %	26.07 %	24.00 %	27.09 %	33.26 %	31.03 %
10	ALC rate	12.70 %	27.60 %	27.76 %	30.58 %	33.98 %	33.99 %	33.59 %	35.69 %
11	Repeat Unscheduled Emergency Visits within 30	16.30 %	16.32 %	16.98 %	18.12 %	20.70 %	22.43 %	22.55 %	24.30 %

	Days for Mental Health Conditions*								
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	43.22 %	46.24 %	43.76 %	43.00 %	46.76 %	47.54 %	47.23 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	16.64 %	16.45 %	17.75 %	17.27 %	17.40 %	17.04 %	18.35 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	93.87 %	91.51 %	89.21 %	82.73 %	93.32 %	87.09 %	74.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	89.65 %	88.88 %	83.38 %	77.61 %	64.41 %	64.99 %	80.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	80.58 %	59.46 %	89.42 %	88.29 %	82.85 %	68.93 %	69.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	35.00	34.50	32.00	27.00	36.00	16.00	8.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	15.00	12.00	14.00	11.00	12.00	10.00	8.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	42.67	42.62	39.71	35.19	32.37	34.38	10.87
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	519.59	564.67	600.65	619.81	559.38	608.50	388.27
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	36.98 %	36.89 %	38.65 %	39.72 %	36.97 %	36.49 %	28.63 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)
**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)