Chapter 3
Section
3.08

LHINs—Local Health Integration Networks

1.0 Background

1.1 Overview of Local Health Integration Networks

1.1.1 Purpose of Local Health Integration Networks

Ontario's 14 Local Health Integration Networks (LHINs) were established by the *Local Health System Integration Act, 2006* (Act) to achieve an integrated health system and enable local communities to make decisions about their local health systems. The purpose of the Act is "to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province, and effective and efficient management of the health system at the local level." (See **Section 1.2.3** for more information on what an "integrated health system" means.)

1.1.2 History of Local Health Integration Networks

The Ministry of Health and Long-Term Care (Ministry) announced the creation of the 14 LHINs in September 2004 and the Act came into force in March 2006. In April 2007, all LHINs began assuming their role in managing local health services, starting with the hospital sector. By July 2010, the LHINs had fully assumed their role over all six health sectors (see **Section 1.3.1**). Prior to April 2007, the Ministry's seven regional offices were responsible for funding and monitoring health service providers, and 16 district health councils (advisory, health-planning organizations funded by the Ministry) were responsible for planning the health system and engaging communities. The district health councils were closed in March 2005 and the regional offices were closed in April 2007.

1.1.3 Comparison with the Rest of Canada

All provinces and territories in Canada use a regional approach to health care. Outside of Ontario, the bodies doing the work of administering and/or delivering health care to each region's residents are called health authorities. Ontario was the last province in Canada to adopt a regional model.

In moving toward a regional model, Ontario took a somewhat different path than that of some other provinces. The most significant difference between the LHIN model in Ontario and the regional health systems in other parts of Canada is that, in Ontario, LHINs neither directly govern nor provide health services: all of the health-care providers, such as hospitals and long-term-care

homes, still maintain their own boards of directors. In contrast, in Alberta and Manitoba where all or most of the local boards of the individual health-care providers were dissolved, the regional health authorities themselves directly employ health-care workers, and directly provide health services, sometimes including primary care.

1.1.4 Structure and Governance of Local Health Integration Networks

Each LHIN is a not-for-profit Crown agency covering a distinct region of Ontario (see **Figure 1**) that varies in size, population health profile, service delivery issues and health service providers.

Each LHIN is governed by a board of directors. Each board consists of no more than nine members who are appointed by the Lieutenant Governor in Council with the advice of the Cabinet. The chair of a LHIN board is accountable to the Minister of Health and Long-Term Care for the goals, objectives and performance of the local health system.

Each LHIN also has a Chief Executive Officer (CEO), who is responsible for managing the LHIN and its staff.

On average, each LHIN employs about 40 staff. As of March 31, 2015, the 14 LHINs together employed approximately 600 full-time staff, compared to about 470 full-time staff employed by district health councils and ministry regional offices prior to the establishment of LHINs.

1.1.5 Operational Expenditures of Local Health Integration Networks

In the year ending March 31, 2015, the total operational expenditures of all 14 LHINs combined were $90 million. About 0.4%, or 40 cents on each $100 of the Ministry's LHIN funding (including payments destined to health service providers such as hospitals and long-term-care homes) were spent on LHIN operational expenditures. In that year, LHINs spent about half of their operational expenditures on salaries and benefits; one-third on one-time, LHIN-led initiatives for specific projects, such as those on diabetes, emergency departments and critical care; and the remainder primarily on administrative expenses such as rent, consulting services, and supplies and equipment.

Figure 1: Locations of Ontario's 14 Local Health Integration Networks
Source of data: Ministry of Health and Long-Term Care

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

1.2 Functions of Local Health Integration Networks

The Act sets out every LHIN's obligation to plan, fund and integrate its local health system into 14 specific responsibilities that it calls "objects," which are listed in **Appendix 1**. They include, for example, developing strategies to improve the integration of the provincial and local health systems, and making the delivery of health services more economically efficient toward a more sustainable health system. Further details of the LHINs' three functions—planning, funding, and integrating—are provided below.

1.2.1 Planning

Planning at the four LHINs we visited generally involves these steps:

- holding community engagements to seek input from community members (such as associations representing specific health sectors—for instance, the Ontario Hospital Association and the Ontario Association of Community Care Access Centres), patients, and health service providers on ways to identify local priorities and improve health care in the region;
- defining the current needs of the local health system, considering the demographics, socio-demographic characteristics, and health status of its residents, as well as the health practices and preventive care taken by its residents;
- defining the current state of performance of the local health system, taking into account how residents use these health services (for example, by studying wait times); and
- determining and prioritizing the health service gaps that need to be addressed.

After each LHIN conducts the above activities, it develops an Integrated Health Service Plan that outlines plans and priorities for the local health system. (LHINs can also conduct these planning activities for reasons other than to develop their Integrated Health Service Plans, such as to inform LHIN decisions on system planning throughout the year.) The Act requires that these plans, which are completed every three years, be made public. The Ministry reviews these plans to identify possible policy implications in the plans' proposals and whether the contents are consistent with directions set out in the overall provincial health-care action plan—both the original 2012 plan and the updated 2015 iteration—that sets out the government's commitment to put patients at the centre of the system.

1.2.2 Funding

According to the Act and the accountability agreement between the Ministry and each LHIN, LHINs can, with certain exemptions, allocate funds as they choose among and between health service providers and health sectors. For example, a LHIN can choose to transfer funds from assisted-living services to addiction services, or from a hospital to a community-based agency, subject to various conditions, such as ensuring they reallocate unused funding dedicated to a health sector to another sector with Ministry approval. LHINs have less discretion over funding in the long-term-care homes sector because that is based on per-diem rates set by the Ministry.

Before 2012, the Ministry used to fund hospitals and CCACs on the basis of how much they had received in the previous year. Starting April 1, 2012, the Ministry began to reform the funding methodology to these two sectors so that some funding would be based on forecasted population growth, past usage of health services, the number of people cared for and the services they provide. As a result, LHINs today can only reallocate funding in these two sectors on amounts that are not subject to the reform. In the year ending March 31, 2015, funding from the reformed methodology represented about 50% of funding in hospitals and 30% of funding in CCACs.

In 2007/08, the LHINs received a combined total of $50 million to establish the Urgent Priorities Fund. This fund has been part of the LHINs' overall annual funding since then. LHINs can spend this

Figure 2: Local Health System Integration—Meanings and Examples

Sources of data: *Local Health System Integration Act, 2006*; Local Health Integration Networks

Meaning of Integration in the *Local Health System Integration Act, 2006*	Examples from the Four LHINs We Visited
To co-ordinate services and interaction between different persons and entities	• developed a system to co-ordinate referrals across hospitals • integrated central assessment records for community agencies and long-term-care homes • developed central access and crisis line for palliative care • co-ordinated provision of different health services, such as hospital, family doctor, long-term-care home and community organizations, to work as a team to develop health-care plans for patients with complex needs
To partner with another person or entity in providing services or in operating	• partnered with a health-service provider to provide language interpretation services for all patients within the LHIN requiring interpretation • partnered with a hospital to purchase telemedicine units for long-term-care homes • partnered with a hospital to provide mobile support for seniors with high needs
To transfer, merge or amalgamate services, operations, persons or entities	• merged different health-service providers (such as merging the Toronto Rehabilitation Institute with the University Health Network) • amalgamated transportation services among community agencies • transferred a seniors program from a community agency to a long-term-care home • transferred acute stroke services from one hospital to another
To start or cease providing services	• introduced a new model of assisted living for high-risk seniors • created a new model of congregate care for adults with disabilities at a community agency • introduced a new addiction support service for pregnant mothers with addictions at a community health centre • stopped providing funding for a specific service at a health-service provider
To cease to operate or to dissolve or wind up the operations of a person or entity	• stopped providing funding to a health-service provider

fund on projects submitted by health service providers to address urgent local health-care priorities. Each LHIN has authority to allocate its share of this fund as it chooses to, provided the funding is used to provide direct health services (as opposed to paying for consultants, planning, research or staffing costs).

1.2.3 Integration

The Act sets out various definitions of the term "integration." **Figure 2** outlines these different definitions and provides specific examples of integration activities we noted at the four LHINs we visited.

LHINs' authority to integrate only extends to the health service providers in the six health sectors that they fund. LHINs can integrate the local health system in three ways:

- by providing or changing funding to a health service provider;
- by facilitating and negotiating the integration of health service providers; and
- by instructing a health service provider to either proceed with or stop integration.

1.3 Parties Involved in Delivering, Overseeing, and Reporting on Health Care

1.3.1 Six Health Sectors Managed by LHINs

Planning, funding and integrating the local health system involves each LHIN managing the following six health sectors:

- public and private hospitals;
- long-term-care homes;
- community care access centres (CCACs);
- community mental health and addiction agencies;
- community support service agencies; and
- community health centres.

In the year ending March 31, 2015, LHINs provided a total of about $25 billion in funding to health-care organizations within these six sectors, representing slightly over half of the provincial health-care budget for that year, as shown in **Figure 3**. (The remaining budgeted funding went to areas LHINs are not responsible for, as well as health capital costs.)

LHINs are not responsible for the following elements of the health-care system: primary care, with the exception of community health centres (includes family physicians, nurse practitioners and others who serve as the first and ongoing point of contact for patients), public health, laboratory services, the Ontario Health Insurance Plan (OHIP), emergency medical services (ambulance services), programs providing assistive devices and drug programs, to name a few.

1.3.2 The Ministry of Health and Long-Term Care

The Ministry of Health and Long-Term Care (Ministry) is ultimately responsible for monitoring and reporting on the health system as a whole. The Ministry's role is to provide overall direction and leadership for the health system, focusing on developing legislation, standards and policies to support its strategic directions, and ensuring that the LHINs fulfil the Ministry's expectations. Those expectations are outlined in two agreements it established with each of the 14 LHINs: the Ministry–LHIN Memorandum of Understanding, and the Ministry–LHIN Performance Agreement (accountability agreement).

The Ministry also manages provincial programs that are not managed by LHINs (refer to **Section 1.3.1**).

Figure 3: Expenditures of LHINs and Health Sectors Managed by LHINs for Fiscal Year Ending March 31, 2015
Source of data: Ministry of Finance

	Expenditures ($ million)	% of Overall Provincial Health Expenditures
LHIN Operational Expenditures	90	0.2
Health Sectors Managed by LHINs		
Hospitals	16,942	33.8
Long-Term Care Homes	3,545	7.1
Community Care Access Centres	2,495	5.0
Community Mental Health and Addiction Agencies	936	1.9
Community Support Services Agencies	834	1.6
Community Health Centres	378	0.8
Other LHIN Expenditures (for electronic health records)	7	<0.1
Total Health Funding Managed by LHINs, including LHIN Operational Expenditures	**25,227**	**50.4**
Health Funding Not Managed by LHINs	24,786	49.6
Total Provincial Health Expenditures	**50,013**	**100.0**

Appendix 2 shows the relationships among the Ministry, LHINs and health service providers.

How the Ministry Measures the Effectiveness of LHINs

The Ministry has selected 15 areas of performance for measuring the effectiveness of LHINs. The 15 areas, which are set out in the Ministry–LHIN accountability agreement that was effective in 2014/15, are shown in **Figure 4**.

For 11 of those areas (areas 1–11 in **Figure 4**), the Ministry has set both a provincial target and separate LHIN-specific targets. For three of these areas that relate to surgery wait times, the provincial target and LHIN-specific target are the same. The provincial target represents the ideal level of performance. The LHIN-specific targets are negotiated between the Ministry and the LHIN, taking into account past performance and local challenges, with the intent to move the LHIN's performance closer to provincial targets.

For the remaining four areas (areas 12–15 in **Figure 4**), the Ministry has set only LHIN-specific targets, which differ from one LHIN to the next.

Figure 4: Indicators Used by the Ministry of Health and Long-Term Care to Measure Performance of Local Health Integration Networks

Source of data: Ministry of Health and Long-Term Care

Access to Health Services	
1	90th percentile emergency room length of stay for admitted patients
2	90th percentile emergency room length of stay for non-admitted complex patients with a CTAS score of 1 to 3
3	90th percentile emergency room length of stay for non-admitted uncomplicated patients with a CTAS score of 4 to 5
4	% of Priority 4 cases completed within access target of 84 days for cancer surgery
5	% of Priority 4 cases completed within access target of 90 days for cardiac by-pass procedures
6	% of Priority 4 cases completed within access target of 182 days for cataract surgery
7	% of Priority 4 cases completed within access target of 182 days for hip replacement
8	% of Priority 4 cases completed within access target of 182 days for knee replacement
9	% of Priority 4 cases completed within access target of 28 days for MRI scan
10	% of Priority 4 cases completed within access target of 28 days for diagnostic CT scan
Co-ordinated Health Care	
11	% of Alternate Level of Care (ALC) days
12	90th percentile wait time from community for CCAC in-home services (application from community setting to first CCAC service, excluding case management)
High-quality Health Services	
13	Readmissions within 30 days for selected CMGs
14	Repeat unscheduled emergency visits within 30 days for mental health conditions
15	Repeat unscheduled emergency visits within 30 days for substance abuse conditions

Explanatory Notes:

90th percentile wait time in emergency room—number of hours that nine out of 10 patients stayed in the emergency room.

ALC: Alternate Level of Care – measures how often a patient who could be treated elsewhere occupies a hospital bed.

CCAC: Community Care Access Centre

CT: computer tomography – produces cross-sectional images of body parts such as the head and the abdomen.

CTAS: Canadian Triage and Acuity Scale – categorizes patients by both injury and physiological findings, ranking them by severity from 1 (being the highest) to 5.

CMG: Case Mix Groups – acute-care inpatients with similar clinical and resource-utilization characteristics, including the following seven conditions: stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac and gastro-intestinal disorders.

Length of stay: describes the duration of a single episode of hospitalization.

MRI: Magnetic resonance imaging – uses radiology to investigate the anatomy and physiology of the body.

Priority 4: patients who are waiting for a scheduled follow-up appointment at a specific interval to meet their clinical needs; the lowest of four priority levels (priority 1 would be immediate.)

1.3.3 Health Service Providers

Health-care organizations within the six health sectors that LHINs manage are called health service providers. A health service provider could be a hospital, a CCAC, a mental health and addiction agency, a community health centre, a community support services agency, or a long-term care home. Health service providers provide health services to Ontarians according to the terms and conditions spelled out in formal agreements with LHINs called service accountability agreements. In the year ending March 31, 2015, the 14 LHINs together managed about 1,700 such agreements with about 1,300 health service providers. (Some service providers operate multiple health services and therefore have multiple service accountability agreements with the LHINs.) **Figure 5** shows the number of unique health service providers by LHIN as at March 31, 2015.

How LHINs and the Ministry Oversee Health Service Providers

Health service providers report on their own performance against targets set out in the contract they negotiate with the LHIN, using a data entry tool. When health service providers perform below expectations, depending on the severity of the issue, the LHINs and sometimes the Ministry can intervene in different ways, including requesting operational reviews and peer reviews. The Ministry can also choose to appoint supervisors.

1.3.4 Health Quality Ontario

Health Quality Ontario is an independent government agency created in September 2005 that is responsible for monitoring and reporting on the state of the health system in Ontario.

Figure 5: Number of Unique Health Service Providers in the Six Health Sectors Funded by LHINs as at March 31, 2015

Source of data: Ministry of Health and Long-Term Care

LHIN	Hospitals	Long-term Care Homes	Community Care Access Centres	Community Health Centres	Community Support Services Agencies	Mental Health and Addiction Agencies	Total
Toronto Central	18	37	1	17	70	82	**225**
Hamilton Niagara Haldimand Brant	9	87	1	7	64	40	**208**
Champlain	21	61	1	11	60	44	**198**
North East	25	40	1	6	75	47	**194**
South West	20	80	1	5	49	33	**188**
Central	9	77	1	2	39	23	**151**
North West	13	14	1	2	64	35	**129**
Central East	9	46	1	7	44	21	**128**
South East	7	37	1	5	33	22	**105**
Erie St. Clair	7	38	1	5	34	16	**101**
Waterloo Wellington	8	36	1	4	27	14	**90**
North Simcoe Muskoka	7	27	1	3	31	11	**80**
Mississauga Halton	2	28	1	1	33	12	**77**
Central West	2	23	1	2	18	9	**55**
Total	**157**[1]	**631**	**14**	**77**[1]	**641**[1]	**409**[1]	**1,929**[2]

1. Total number of unique agencies by sector is greater than the sector's total number of agencies reported in Appendix 2 because some agencies provide services in multiple sectors and in multiple LHINs.
2. There are about 1,300 unique health service providers across Ontario.

2.0 Audit Objective and Scope

Our audit objective was to assess whether Local Health Integration Networks (LHINs), in conjunction with the Ministry of Health and Long-Term Care (Ministry), have effective systems and procedures in place to facilitate the provision of the right care at the right time in the right place for Ontarians. Senior ministry management reviewed and agreed to our audit objective and associated audit criteria.

Our audit work was conducted between December 2014 and June 2015, primarily at four selected LHINs—Central, Hamilton Niagara Haldimand Brant, North East, and Toronto Central. Their combined expenditures in the year ending March 31, 2015, were $11 billion, or 44% of the overall provincial funding for LHINs that year. We also conducted other work at the Ministry's offices in Toronto.

In conducting our audit, we reviewed relevant documents, legislation and ministry guidelines; analyzed information; interviewed ministry staff, the Chief Executive Officer (CEO) and staff from each of the four LHINs we visited; reviewed relevant information and research on regionalized health system models from other provinces and territories; and attended one community engagement event and one board of directors meeting at each of the four LHINs we visited. We also interviewed senior officials from Health Quality Ontario and Cancer Care Ontario to understand how these organizations work with LHINs. As part of our planning for this audit, we reviewed a number of the Ministry's internal audit reports on LHINs and considered them in determining the scope of our audit.

To obtain perspectives from those who manage and govern the LHINs as well as those overseen by LHINs, we also conducted a survey of all current and former CEOs and board members of the 14 LHINs for whom we have contact information (70% of those contacted responded to our survey), and the current senior officials (usually the CEOs) at about 1,300 health service providers that are funded by the 14 LHINs for whom we have contact information (57% of those contacted responded to our survey). In addition, we met with senior representatives from associations that represent all six health sectors that LHINs oversee. They include: Addictions and Mental Health Ontario, the Association of Ontario Health Centres, the Ontario Association of Community Care Access Centres, the Ontario Community Support Association, the Ontario Hospital Association, and the Ontario Long Term Care Association.

3.0 Summary

Since 2007, the 14 Local Health Integration Networks (LHINs) in Ontario have been responsible for planning, funding and integrating health services in six sectors, including hospitals, long-term-care homes and community-based health services such as Community Care Access Centres, as shown in **Appendix 2**. The LHINs have a significant task: to provide for an integrated health system in Ontario. According to the legislation that created them, such a health system would be efficient and effectively managed through the provision of accessible and high-quality health services, so that Ontarians will experience better health and better co-ordinated care across health sectors, locally and throughout the province.

The formation of LHINs has allowed health service providers, such as hospitals, and the home and community sector to better work together to find solutions to common health system issues, as a number of working groups and committees have been established to address common priority areas such as mental health and palliative care. However, to fully realize the value of LHINs, both the Ministry of Health and Long-Term Care (Ministry) and the LHINs themselves need to better ensure that LHINs are meeting their mandate.

Our audit found that the Ministry has not clearly determined what would constitute a "fully integrated

health system," or by when it is to be achieved, nor has it yet developed ways of measuring how effectively LHINs are performing specifically as planners, funders and integrators of health care.

If achieving the LHINs' mandate means meeting all expected performance levels measured (as shown in **Figure 4**), then LHINs have not achieved their mandate of providing the right care at the right time in the right place consistently throughout the health system. While province-wide performance in six of the 15 areas measured has improved between the time the LHINs were created and 2015, in the remaining nine areas, performance has either stayed relatively consistent or deteriorated since 2010 or earlier, as shown in **Figure 6**. For instance, a greater percentage of inpatient days were used by patients who did not need acute care in a hospital setting for the year ending March 31, 2015, as compared to when LHINs started to operate in 2007.

Most LHINs performed below expected levels in the year ending March 31, 2015. In that year, LHINs on average achieved their respective local targets for six of the 15 performance areas; the best-performing LHIN met local targets in 10 areas and the worst-performing LHINs (there were four) met only four, as shown in **Figure 10**. Based on the provincial results that include all 14 LHINs, only four of the 11 provincial targets that measure long-term goals for LHINs were met. The Ministry has not set any timelines for when all 14 LHINs are expected to meet the 11 provincial targets. In four areas such as those concerning home care, mental health, and substance abuse, the Ministry did not set any long-term goals, as shown in **Figure 7**.

We also found that the performance gap among LHINs has widened over time in 10 of the 15 performance areas. For instance, patients in the worst-performing LHIN waited 194 days, or five times longer than the best-performing LHIN, to receive semi-urgent cataract surgery in 2012. Three years later, this performance gap widened from five times to 31 times. The Ministry needs to better

Figure 6: Province-wide Performance Trend in 15 LHIN Measurement Areas

Sources of data: Cancer Care Ontario, Cardiac Care Network of Ontario, Ministry of Health and Long-Term Care

Performance declined between 2007 (or 2010 when earliest comparable data available) and 2015	
1	Readmissions within 30 days for selected CMGs
2	% of Alternate Level of Care days
3	Repeat unplanned emergency visits for patients with mental health conditions
4	Repeat unplanned emergency visits for patients with substance abuse conditions
Performance remained consistent between 2007 and 2015	
5	Cardiac by-pass procedures provided within 90 days
Performance improved between 2007 and 2010 but plateaued or worsened since 2010	
6	Cataract surgery provided within 182 days
7	Hip replacement provided within 182 days
8	Knee replacement provided within 182 days
9	Diagnostic CT scan provided within 28 days
Performance improved since 2007 (or 2009 when earliest comparable data available)	
10	Length of emergency room stay for admitted patients
11	Length of emergency room stay for complex patients not admitted to hospital
12	Length of emergency room stay for non-complex patients not admitted to hospital
13	MRI scan provided within 28 days
14	Cancer surgery provided within 84 days
15	Wait time for CCAC in-home services

Note: Appendix 3 provides detailed statistics on trend performance for each of the measured areas.

Figure 7: Comparison of Best- and Worst-performing LHINs in 15 Performance Areas, Year Ending March 31, 2015

Source of data: Ministry of Health and Long-Term Care

		Actual Performance						
Performance Area [1]		Best-performing LHIN	Worst-performing LHIN	Provincial Results	LHIN-specific Target (Low to High)	# of LHINs that Did Not Meet Their Respective LHIN-specific Target	Provincial Target	# of LHINs that Did Not Meet the Provincial Target
1	Length of ER stay for admitted patients	17.5 hours	34.7 hours	29.5 hours	8 hours–30.6 hours	14	8 hours	14
2	Length of ER stay for complex patients not admitted	5.6 hours	7.8 hours	6.8 hours	6.25 hours–8 hours	4	8 hours	0
3	Length of ER stay for non-complex patients not admitted	3.4 hours	4.5 hours	4.03 hours	3.7 hours–4.5 hours	6	4 hours	6
4	Cancer surgery provided within 84 days	99.8%	86.9%	94.7%	90%	2	90%	2
5	Cardiac by-pass provided within 90 days [2]	100.0%	78.0%	98.0%	90%	1	90%	1
6	Cataract surgery provided within 182 days	99.7%	85.4%	92.5%	90%	4	90%	4
7	Hip replacement provided within 182 days	97.0%	49.1%	86.3%	80%–90%	9	90%	10
8	Knee replacement provided within 182 days	95.3%	44.3%	84.2%	75%–90%	10	90%	11
9	MRI scan provided within 28 days	55.0%	11.1%	37.6%	30%–90%	12	90%	14
10	Diagnostic CT scan provided within 28 days	96.2%	51.4%	77.9%	70%–90%	9	90%	11
11	ALC days [3]	6.9%	22.6%	14.0%	9.46%–22%	9	9.46%	12
12	Wait time for CCAC in-home services	12 days	82 days	28 days	17 days–66 days	5	Not established	n/a [4]
13	Readmissions of select CMGs [5] within 30 days	15.3%	18.8%	16.7%	12.8%–18%	12	Not established	n/a [4]
14	Repeat unscheduled emergency visits within 30 days for patients with mental health conditions	15.1%	27.2%	19.6%	13.2%–23%	12	Not established	n/a [4]
15	Repeat unscheduled emergency visits within 30 days for patients with substance abuse conditions	19.6%	40.7%	30.4%	18.1%–33%	13	Not established	n/a [4]

1. Figure 4 gives detailed information on these performance areas.
2. Nine of the 14 LHINs provide cardiac by-pass procedures within their geographic areas.
3. The number of days that patients who do not require hospital care stay in hospital because they cannot obtain care elsewhere or have not been able to be discharged from the hospital.
4. Not applicable because the Ministry has not established a provincial target for this area.
5. CMGs are Case Mix Groups—acute-care inpatients with similar clinical and resource utilization characteristics, including the following seven groups of conditions: stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac and gastro-intestinal disorders.

understand the reasons for the widening gap and implement changes to narrow that gap if it wants to achieve its goal of ensuring health-service levels do not vary significantly across the province.

In addition, these 15 areas of performance are intended to measure the performance of the local health system rather than the LHINs themselves. While the Ministry has ongoing engagement with the LHINs to understand and monitor their performance, it did not have performance indicators to measure how effectively LHINs are performing as planners, funders and integrators of health care. For the most part, the performance indicators measure the effectiveness of hospitals, so the Ministry has limited knowledge of how LHINs ensure health services are delivered satisfactorily in non-hospital sectors.

Our other specific observations in this audit include:

- **LHINs have not been consistently assessing whether their planning and integration activities were effective in providing a more efficient and integrated health system, and determining how much cost savings have been reinvested into direct patient care as a result of integration**—Only one in five health service providers who responded to our survey felt that LHINs are on track to achieving the goals in their strategic plans, compared to almost 80% of the current and former LHIN board members and CEOs. We found that three of the four LHINs we visited did not establish any quantifiable targets or performance measures on their goals and strategies in the integrated health service plans to assess whether their planned work has helped them progress toward a fully integrated local health system.
- **Due to inconsistent and variable practices that still persist across the province, patients face inequities in accessing certain health services**—These variances mean that, depending on where they live, some people experienced better access to better integrated health care than others, and some people were not receiving health care in the setting that best meets their health needs and, sometimes, at a much higher cost than necessary. Moreover, because provincial standards or approaches to care are lacking in some areas, patients receive differing standards of care for the same health condition. We found that while processes are in place to enable collaboration among LHINs, much more can be done to enhance consistency.
- **The Ministry takes little action to hold the LHINs accountable to make changes when low performance continues year after year**—When LHINs do not meet their targets, the Ministry has seen its role as being "supportive" rather than "directive" in effecting improvement. While this might be advisable in some cases, in other instances this has contributed to performance issues persisting for years. For example, one of the four LHINs we visited did not meet the annual wait-time target for MRI scans in six of the eight years leading up to March 31, 2015. Another LHIN we visited did not meet its annual hip replacement wait-time target in seven out of the last eight years.
- **The Ministry responds differently to challenges faced by LHINs**—When an expected performance was not achieved in one year, for some LHINs the target became more lax; for other LHINs the target stayed the same or became more stringent. For instance, of the seven LHINs that could not meet their respective Alternate Level of Care (ALC) performance targets between 2011/12 and 2014/15, the Ministry lowered the target for five LHINs (for instance, from 17% to 22% ALC days in one LHIN), and either tightened or maintained the target for the remaining two. (ALC days refer to hospital inpatient days used by patients who no longer needed hospital care but were waiting for care elsewhere or to be discharged.) The Ministry indicated that it sets these

revised targets jointly with LHINs to account for local circumstances and challenges.

- **LHINs could do more to define system capacity**—Capacity refers to how service supply meets current and future demand for service. Concerns have been raised about insufficient capacity planning in the areas of palliative care, home- and community-care, and rehabilitative services.
- **LHINs need to better monitor health service providers' performance**—At the four LHINs we visited, we found that quality of health services is not consistently monitored, performance information submitted by health service providers (some of which contained errors) is not verified, and non-performing health service providers are not consistently dealt with in accordance with Ministry guidelines. Regarding the latter, we found that the four LHINs we visited predominantly discussed and shared information with health service providers even for issues that have persisted for years.
- **Tracking of patient complaints lacks rigour**—There is no common complaint-management process across LHINs, and LHINs did not always ensure that patient complaints are appropriately resolved. Across the province, three LHINs did not track complaints at all in 2014, or only partially tracked them.
- **Group purchasing and back-office integration were not consistently implemented or fully explored**—LHINs could not demonstrate that they have maximized economic efficiencies in the delivery of health services as per their mandate, because the use of group purchasing and "back-office integration" (that is, integrating or consolidating the administrative and business operations of LHINs and/or health service providers) differed across the four LHINs we visited. According to our survey results, more health service providers wanted LHINs to explore additional group purchases and back-office integration opportunities than did not. Also, while over 70% of the current and former LHIN board members and CEOs felt that LHINs have brought economic efficiencies to the delivery of health services, only a quarter of the health service providers who responded felt the same way.

This report contains 20 recommendations, consisting of 37 actions, to address the findings noted during this audit.

OVERALL MINISTRY RESPONSE

In 2006, the government established Local Health Integration Networks (LHINs) in recognition that a health system is best organized and managed at the local level. Under the LHIN model, the Ministry of Health and Long-Term Care (Ministry), LHINs and health service providers work collaboratively in planning, funding and integrating health-care services to improve access to care and better co-ordinate the delivery of services within LHINs' geographic areas.

LHINs are key partners working collaboratively with the Ministry in implementing the *Patients First: Action Plan for Health Care*, the government's blueprint for the next phase of health-care transformation. Patients First is designed to put people and patients first by improving their health-care experience and their health outcomes. With extensive knowledge and understanding of their local communities, LHINs are uniquely positioned to translate the provincial priorities identified in *Patients First* into local actions. With their in-depth knowledge and understanding of their local health-care systems and the needs of their population, LHINs have made substantial progress in ensuring that Ontarians have access to high-quality person-centred care.

Within a complex health-care system that includes over 1,800 health service providers across multiple sectors, the LHINs have worked locally to implement improvement initiatives

in communities across the province, many of which are focused on people with the highest needs. LHINs have been effective champions for the shift from acute care to community care so that we make the best use of our hospital resources and give people more options for care at home. LHINs have also demonstrated transparency and accountability by leading extensive community engagement activities, developing and publishing three-year Integrated Health Service Plans, Annual Business Plans and Annual Reports, and holding board meetings that are open to the public.

The Ministry appreciates the recommendations contained in the Auditor General's audit of the LHINs. The recommendations build upon the strong accountability and performance framework already in place between the Ministry, LHINs, and their health service providers, and support the ongoing work to improve patient care and access to health care across the province.

OVERALL LHINs' RESPONSE

The Local Health Integration Networks (LHINs) appreciate the opportunity to participate in this audit. The observations, insights and recommendations presented in the Auditor General's report will support our ongoing efforts and commitment to continuously improve Ontario's health system for the individuals and communities we serve. The audit report highlights key areas of focus for the LHINs' role in the broader health system—performance, accountability, integration and funding. The LHINs agree with these focus areas and will thoughtfully consider all of the input and recommendations provided.

The LHINs recognize their unique contribution to the performance of the health system. LHINs are system planners, funders, facilitators and leaders; LHINs are not direct care providers nor health service operators. As such, while the current indicators such as wait times, readmissions and alternate levels of care are important, they are only indirect measures of the LHINs' performance and achievement of their mandate. LHINs are engaged in the identification and development of more direct measures of LHIN performance.

The health system performance indicators have evolved during the 10 years that LHINs have been in existence, resulting in revised definitions, specifications, and/or data sources. Indicator evolution is important and positive; however, such changes limit the ability to draw conclusions about performance across time, and thus should be done cautiously. Comparisons of performance between LHINs based solely on select indicators should also be approached cautiously. The LHINs share the concern expressed by the Auditor General about the considerable variance between LHINs on performance indicators. It must be acknowledged, however, that contextual differences exist historically and currently in the LHINs that influence these results, including population demographics, health status, geography, levels of service and providers. Despite these challenges, the LHINs will continue to actively work together, in collaboration with health service providers and the Ministry, to improve health system performance as measured by the indicators outlined in their accountability agreements.

Under the *Local Health System Integration Act* (Act), the LHINs have a responsibility to plan, integrate and fund the care and service delivered in their communities by health service providers. One of the purposes of LHINs under the Act is to "…enable local communities to make decisions about their local health systems." LHINs engage with and seek input from their communities, represented by patients, health service providers, citizens, associations, municipalities and others. LHINs are best positioned to understand the strengths, challenges and needs of the population and providers within their geographic areas, which is key to building a robust and sustainable health system that puts

patients first. Through service accountability agreements and strong working relationships, LHINs hold health service providers accountable for the quality, quantity and value of the care and services they deliver. LHINs take these responsibilities very seriously and continually seek to improve on them.

LHINs welcome the input and feedback garnered through formal and informal community engagements, health service provider collaboration, and now the report of the Auditor General of Ontario. LHINs will work in collaboration with the Ministry of Health and Long-Term Care and others to address the recommendations as outlined in our responses below.

4.0 Detailed Audit Observations

4.1 Performance Improved Only in Limited Areas over Time and Varies from One LHIN to the Next; Variation Widens over Time for Two-thirds of Measured Areas

With the growing and aging population, continuous improvement of the health system is important so that patients can receive the best quality health care possible. Even though the province is divided into 14 parts for the purpose of planning, funding and integrating health services, patients should expect to receive fairly consistent quality of care on a timely basis no matter where they live. However, we found that the LHINs' performance has not significantly improved since inception and that their performance varies from one to the next. In addition, between 2012 and 2015, the performance gap among LHINs actually increased in two-thirds of the performance areas despite the fact that the Ministry has a goal of reducing this performance gap. As a result, patients' ability to receive consistent, good quality care across the province is limited.

We look at the above issues in detail in the following subsections.

4.1.1. No Notable Improvement in Performance Since Inception of LHINs

We compared the performance of all 14 LHINs between 2007 and 2015 to determine whether LHIN performance has improved over time. Overall, we found that in nine of the 15 performance areas, LHINs' performance has either stayed relatively consistent or deteriorated since 2010 or earlier, as shown in **Figure 6**. As a result, LHINs cannot demonstrate that they have effectively integrated the local health system and improved patient care and access to high quality health services.

Appendix 3 shows the performance trend of all 15 performance areas between 2007 and 2015.

Performance Declined in Areas that Measure Integrated Health Services

Four of the 15 performance areas measure LHINs' activities in integrating health services, because success in these areas requires LHINs to ensure services are delivered efficiently and effectively in both hospital and community health-care settings. These performance areas are:

- readmission of selected groups of acute hospital patients to any facility for inpatient care within 30 days of discharge;
- repeat unplanned emergency visits for patients with mental health issues;
- repeat unplanned emergency visits for patients with substance abuse conditions; and
- hospital inpatient days used by patients who no longer needed hospital care but were waiting for care elsewhere or to be discharged (referred to as Alternate Level of Care or ALC days)

On a provincial basis, performances have steadily declined in three of these four areas since the inception of LHINs. (In the case of ALC days, performance declined from the inception of LHINs

to 2010/11, then remained relatively constant from 2011/12 through 2014/15.) For example, in the year ending March 31, 2010 (the earliest comparative data available), about 26% of patients with substance abuse conditions in the province had to visit the emergency department within 30 days of their first emergency visits. In the year ending March 31, 2015, this increased to about 30%. These unplanned repeat emergency visits are not only problematic on their own, they can also impact related wait times. This trend indicates that LHINs could do more to plan and integrate health services to help patients' access community-based services.

Similarly, a greater number of hospital inpatient days were used by patients who no longer needed acute care in a hospital setting for the year ending March 31, 2015, as compared to when LHINs started to operate in 2007. In the year immediately prior to the first full year of LHIN operation, 12% of all hospital patient days were attributed to ALC patients. This has increased to 16% in 2011, then 14% between 2012 and 2015. This trend indicates that a significant number of patients were receiving care in a setting that was no longer appropriate for their care needs, which may potentially have a negative impact on the patient's health. As well, it is much more costly to keep patients in a hospital as opposed to a community setting.

We recognize that the aging population is one of the factors causing an increase in ALC days—the proportion of people aged 75 or more has steadily increased from 6.2% to 6.9% between 2006 and 2014. In recent years, the four LHINs we visited have all treated health services to senior adults as a priority service area, yet the Ministry and the LHINs could do more to better plan health services for senior adults so that these patients receive the care they need.

Overall Performance Declined or Not Significantly Changed Since 2010 for Certain Hospital Procedures

Although access to specific surgery (cataract, hip replacement, and knee replacement) and CT scans had improved between LHINs' inception and 2010, the overall performance had either plateaued or gotten worse. For instance, between 2007 and 2010, wait times for cataract surgeries had gone down, from 220 days to 108 days, for 90% of the patients in the province. This performance has worsened since 2010 and for the year ending March 31, 2015, the wait time climbed to 160 days, compared to a provincial target of 182 days.

The overall provincial wait time between 2007 and 2015 for all types of cardiac by-pass procedures (urgent, semi-urgent, and elective) has remained consistent at around 40 days.

According to our survey results, while 60% of the current and former LHIN board members and CEOs felt that the health system is performing as expected, given that LHINs have only been in operation since 2007, just a quarter of the health service providers felt the same way.

Certain LHINs Always Performed Worse than Provincial Average

Since the introduction of LHINs, three have consistently performed below others in at least five of the 15 performance areas. For example, between March 2007 and March 2015, one LHIN consistently performed worse than the overall provincial performance in the areas of: patients with mental health and substance abuse conditions needing to repeatedly visit emergency room within 30 days of first emergency visit; patients who are not ultimately admitted to hospital waiting longer in emergency rooms for care; and patients waiting longer to receive cancer surgeries. We discuss Ministry action on LHINs that do not perform at expected levels in **Section 4.2.3**.

4.1.2 Ontario Performs Better than the Canadian Average in Most Measured Areas Relating to LHINs; Still Has Room to Improve in Other Areas

Appendix 4 compares Ontario's performance to the rest of Canada on a number of health-system performance indicators reported by Health Quality Ontario and the Canadian Institute for Health Information (CIHI). Between 2010 and 2014, Ontario's performance was better than the Canadian average in most of the measured areas that relate to LHINs, such as access to radiation therapy and 30-day readmission for mental illness. Its performance was below average in other areas, however, such as access to cataract surgery and better informing patients discharged from hospitals on what to expect after they return home.

4.1.3 Performance Varies across LHINs

Ontarians on the whole do not have equitable access to health services due to various factors, including the performance variance among LHINs, not only in the 15 areas that the Ministry focuses on but also in areas that Health Quality Ontario and the Canadian Institute for Health Information (CIHI) report on. These at-times significant variances mean that, depending on where they live, some people experienced better access to more fully integrated health care than others and some did not receive health care in the most appropriate settings, sometimes at a much higher cost than necessary. As well, when a number of LHINs are responsible for a different geographical portion of a single large urban area, people may not have equal access to health services, even though the similar population size and health-care infrastructure in each LHIN would lead the public to expect similar experiences. For instance, five different LHINs oversee the health services available in the City of Toronto. While residents of East Toronto and Scarborough are geographically near each other and live in neighbourhoods that have much in common, the East Toronto resident is served by the Toronto Central LHIN and the Scarborough resident is served by the Central East LHIN. But residents in these LHINs experience significantly different wait times in accessing certain hospital procedures.

In response to our survey, half of the current and former LHIN board members and CEOs felt that the level of health care provided to Ontarians has become more equitable compared to before LHINs were created. Only one-third of the health service providers felt the same way. Further, when we asked whether they felt Ontarians can access an equitable set of health services regardless of where they live, over 60% of the health service providers and over 40% of the current and former LHIN board members and CEOs indicated no.

Ministry-measured Performance Indicators

As shown in **Figure 7**, for the year ending March 31, 2015, performance in the 15 areas varied among LHINs. The difference in performance between the best- and worst-performing LHIN could be as much as sevenfold. Some examples are as follows:

- Across Ontario, 14% of hospital inpatient days were used by patients who no longer needed hospital care, but were waiting in hospital until they could find care elsewhere or be discharged (also known as ALC days as explained in **Section 4.1.1**). Among the 14 LHINs, however, ALC days varied widely, from about 7% of inpatient days in one LHIN to about 23% in another—a more-than-triple difference. This inefficient use of hospital resources could reflect the lack of system integration and post-discharge service availability as well as inadequate discharge co-ordination processes as noted in our 2010 audit of discharge of hospital patients, causing delays in discharge arrangements.
- Province-wide, about 38% of patients who had the lowest-priority needs were able to access MRI scans within 28 days (although the Ministry, through Cancer Care Ontario, collects and reports MRI wait times for those patients with higher priority needs, such data was not

measured against targets and not included in the Ministry-LHIN accountability agreement at the time of our audit). The best-performing LHIN was able to provide access within 28 days to over half of its patients, compared to another LHIN that could only provide that prompt access to 11% of its patients.

- Across Ontario, 90% of the patients who were referred to CCACs by their family or primary-care physician (as opposed to being referred by a hospital after a hospital stay) received their first CCAC in-home service in 28 days. However, depending on where a person lives in the province, the wait time could be as short as 12 days to as long as 82 days, a difference of more than two months.

Health Quality Ontario Analysis

According to Health Quality Ontario's annual report on the health system's performance, released in November 2014, the gap between the best-performing and worst-performing LHIN could prove significant, as shown in **Figure 8**. The following examples demonstrate that in 2012/13 (the most recent fiscal year for which information was available at the time of our audit), Ontarians were not always receiving health care in the most appropriate setting:

- For every 100,000 people, there was an average of 246 cases of hospitalization for medical conditions that could be managed outside the hospitals where it would be less costly. The LHIN with the least frequent hospitalizations that year had 159 cases per 100,000 people, while the LHIN with the most frequent hospitalizations had almost three times as many cases (436 per 100,000 people).
- Ontarians waited 111 days, on average, to be admitted from their home in the community (such as their own home or supportive housing) to a long-term-care home. At one LHIN they waited an average of 53 days, while at another they waited four times as long, an average of 219 days. The long wait time can be affected by the size of the wait list and existing bed supply.
- Ontarians waited 65 days, on average, to be admitted from a hospital to a long-term-care home. But people in one LHIN only waited, on average, 33 days, while people in another LHIN waited almost five times as long, for an average of 152 days. Again, the long wait time can be affected by the size of the wait list and existing bed supply.

Canadian Institute for Health Information Analysis

According to CIHI's April 2015 report on wait times in Canada, there was "considerable variation" among the six LHINs that serve Toronto and its surrounding areas with respect to hip replacements and knee replacements in the period between April and September 2014. These examples show that the accessibility to similar health services varies from one LHIN to the next, even within a single large urban region with similar population sizes and health-care infrastructure.

We used the annual data for the period ending March 31, 2015 that we obtained from the Ministry, which produced the same variance pattern as observed in the CIHI six-month data from 2014:

- The best-performing LHIN in the Toronto area provided hip-replacement surgeries within the expected time frame of 182 days for 97% of its patients; the worst-performing LHIN met this expected time frame for only 49% of its hip-replacement patients.
- The best-performing LHIN in the Toronto area provided knee-replacement surgeries within the expected time frame of 182 days for 95% of its patients; the worst-performing LHIN met the target time frame for only 44% of its knee-replacement patients.

We expanded the CIHI observation to areas outside the Toronto area, and noted regional disparities in other neighbouring LHINs in the year ending March 31, 2015. For example:

Figure 8: Performance of Best- and Worst-performing LHINs According to Health Quality Ontario Indicators,* 2012/13 and 2013/14

Source of data: Health Quality Ontario

		Actual Performance		
Indicators Where Performance by LHIN Published	**Period Covered**	**Best-performing LHINs**	**Worst-performing LHINs**	**Provincial Results**
% of home-care patients with complex needs who received first personal support visit within 5 days of authorization to receive such services	2013/14 3rd quarter	94.5%	60.5%	84.0%
% of people able to see primary care provider on the same day or next day when they were sick	2013	54.2%	29.2%	45.3%
% of people reported difficult or somewhat difficult in getting access to care on evening or weekend without going to emergency department	2013	42.9%	68.2%	53.7%
Median number of days to admit to a long-term-care home from hospital	2012/13	33 days	152 days	65 days
Median number of days to admit to a long-term-care home from home	2012/13	53 days	219 days	111 days
Hospitalizations for medical conditions that can potentially be managed outside the hospitals per 100,000 people	2012/13	159	436	246
30-day readmission rates following hospitalization for medical diagnoses	2012/13	12.0%	14.5%	13.5%
30-day readmission rates following hospitalization for surgical diagnoses	2012/13	5.8%	8.0%	7.0%

* These performance indicators are different than those used by the Ministry of Health and Long-Term Care.

- In two neighbouring LHINs in the south, while 96% of patients living in one LHIN waited within the targeted 182 days for hip replacement surgery, patients living in the other LHIN were less fortunate—only 50% accessed hip replacement surgery within the targeted wait time (provincially, 86% of patients accessed hip replacement surgery within 182 days).
- 30% of repeat emergency visits were made by Ontarians with substance abuse conditions within 30 days of their first emergency visits. In two neighbouring LHINs in the north, patients in one LHIN experienced a similar return rate as the average Ontarian, but the return rate was higher in the other LHIN, at 40%.

4.1.4 Performance Gaps among LHINs Have Widened over Time

The Ministry has a goal of reducing the performance gap among LHINs over time so that the level of health service does not vary significantly across the province. However, the Ministry has not indicated what degree of variation it would consider acceptable in each of the performance areas, nor has it set timelines for bringing the performance gaps to acceptable levels.

We examined the performance gap among LHINs from the year ending March 31, 2012, through the year ending March 31, 2015, and found that the gap actually increased in 10 of the 15 performance areas, as shown in **Figure 9**. (We began measuring as of the 2011/12 fiscal year because seven of the 15 performance areas were introduced by the Ministry only in 2010/11.)

Figure 9: Areas Where Performance Gaps among LHINs Widened between 2011/12 and 2014/15

Sources of data: Cancer Care Ontario, Cardiac Care Network of Ontario, Ministry of Health and Long-Term Care

	Year Ending March 31, 2012			Year Ending March 31, 2015		
Performance Area	Worst-performing LHINs	Best-performing LHINs	Factor by Which the Best-performing LHIN Outperformed the Worst-performing LHIN	Worst-performing LHINs	Best-performing LHINs	Factor by Which the Best-performing LHIN Outperformed the Worst-performing LHIN
90th percentile wait time for cataract surgery—semi-urgent (days)	194	41	4.7	609	20	30.5
90th percentile wait time for cancer surgery—urgent (days)	45	14	3.2	108	14	7.7
90th percentile wait time for cardiac by-pass procedures—semi-urgent (days)	39	15	2.6	93	13	7.2
90th percentile wait time for CCAC in-home services (days)	64	20	3.2	82	12	6.8
90th percentile wait time for cardiac by-pass procedures—urgent (days)	15	5	3.0	20	5	4.0
90th percentile wait time for cardiac by-pass procedures—non-urgent (days)	58	23	2.5	117	29	4.0
90th percentile wait time for cataract sugery—urgent (days)	173	33	5.2	187	30	6.2
90th percentile wait time for CT scan—semi-urgent (days)	42	14	3.0	39	11	3.5
90th percentile wait time for CT scan—non-urgent (days)	68	28	2.4	66	20	3.3
90th percentile wait time for hip replacement surgery—non-urgent (days)	323	133	2.4	337	133	2.5
Alternate level of care (ALC) days during hospital stay (%)	27	10	2.7	23	7	3.3
90th percentile emergency room length of stay for admitted patients (hours)	45	24	1.8	35	17	2.0
90th percentile emergency room length of stay for non-admitted complex patients (hours)	8	7	1.3	8	6	1.4
Repeat unplanned emergency visits within 30 days for mental health conditions (%)	25	14	1.7	27	15	1.8

For instance, for the year ended March 31, 2012, patients in the worst-performing LHIN waited 194 days or five times that of the best-performing LHIN (41-day wait) to receive semi-urgent cataract surgery. Three years later, this performance gap widened from five times to 31 times.

The Ministry needs to better understand the reasons for the widening gap in the performance of LHINs so it can take appropriate action to reduce the gaps. If it is the case that better-performing LHINs are adopting better practices, they need to be identified and shared with other LHINs. If it is the case that poorly performing LHINs are experiencing growing obstacles to account for the worsening performance, those obstacles need to be identified and overcome. We discuss this further in **Section 4.2.3**.

RECOMMENDATION 1

To minimize the differences in health service performance among Local Health Integration Networks (LHINs) across the province, the Ministry of Health and Long-Term Care, in conjunction with the LHINs, should:

- analyze the reasons for the widening gap in the performance of LHINs in key performance areas;
- establish the degree of variation it would consider acceptable among LHINs' performance in each measured performance area; and
- set timelines for bringing the performance gaps among LHINs to acceptable levels.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will continue to work with the LHINs to understand performance issues across the province.

The LHIN performance indicators and targets are set out in the Ministry-LHIN Accountability Agreement. Through the agreement process, the Ministry and LHINs will determine the level of variation against the targets that would be acceptable and timelines to address performance gaps.

The Ministry and the LHINs have recently completed a refresh of performance indicators and targets to guide joint work in 2015-2018, with annual opportunities for updates. The Ministry and the LHINs expect to use quarterly reviews of performance indicator data to identify shared priorities for provincial strategies, investments and initiatives that would be of benefit to all patients in all LHINs.

4.2 None of the LHINs Were Able to Meet All Performance Targets and the Ministry Could Do More to Help LHINs Improve Their Performance

According to the Memorandum of Understanding between the Ministry and each of the 14 LHINs, in effect from 2012 to 2017, the Minister can take action, or direct LHINs to take action, to correct their administrative or operational weaknesses. Similarly, the Ministry–LHIN accountability agreement states that the Minister can propose remedies to help improve LHIN performance.

In practice, when LHINs do not perform according to expectations, the Ministry takes a collaborative approach, working with LHINs to identify issues and determine next steps to improve performance. Although there may be valid reasons for this approach, it has often resulted in performance shortfalls continuing year-after-year.

One factor contributing to LHINs' varying performance is that the Ministry has negotiated different targets for each LHIN to achieve in the 15 performance areas. We noted that while targets for selected health conditions were developed based on evidence, others are not. Instead, they are based on their previous-year's performance and local challenges.

Another hindrance is the fact that LHINs do not manage the primary-care sector. If primary care is not available or if the actions of primary-care providers such as family physicians do not align

with LHIN actions, LHINs may be hindered in their efforts to achieve ministry targets and expectations.

Further, neither the Ministry nor the legislation has a definition of what constitutes a fully integrated health system, making it unclear whether the integrated health service plans they develop every three years will help them achieve the end goal of providing that integrated health system.

We look at the above issues in detail in the following subsections.

4.2.1 LHINs Did Not Meet All Performance Indicator Targets

None of the 14 LHINs have ever met all of the targets and expectations in the 15 areas of performance for measuring the effectiveness of LHINs, as defined by the Ministry-LHIN accountability agreements. These areas include indicators that measure access to selected health services, co-ordinated health care and readmission patterns of patients with selected health conditions. The complete list of the 15 performance areas is in **Figure 4**.

In the year ending March 31, 2015, the best-performing LHIN met performance targets in 10 areas; the worst-performing LHINs (there were four) met four. LHINs on average achieved the targets for six of the 15 performance areas, as shown in **Figure 10**.

In that year, LHINs overall were performing well in the area of providing timely access to cancer surgeries and cardiac by-pass procedures. In all but two LHINs, at least 90% of their patients accessed cancer surgery within 84 days. In eight of the nine LHINs that offer cardiac by-pass procedures, almost all of their patients accessed these procedures within 90 days. However, it is Cancer Care Ontario, a provincial government agency, that is primarily responsible for planning and allocating resources for cancer surgery and works with health service providers in every LHIN to improve cancer care for the people they serve.

On the other hand, most LHINs were unable to meet expected levels of performance in the areas of too many readmissions to health facilities, too many emergency-room return visits, long wait times at the emergency room, and long wait times for MRI scans for certain patient populations. In the year ending March 31, 2015, at least 12 of the 14 LHINs performed below targeted levels in the following critical areas:

- *Repeat unscheduled emergency visits for patients with mental-health or substance abuse conditions within 30 days of a prior visit*. According to the Ministry, the main reason for these recurring emergency visits is lack of effective and available community-based services upon discharge.
- *Readmission to any health-care facility of select groups with similar clinical characteristics for non-elective inpatient care within 30 days of discharge*. Selected groups display one or more of the following seven conditions—stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac, and gastro-intestinal disorders. Many of the patients with these conditions were readmitted to hospitals but their conditions could have been managed elsewhere. According to the Ministry, readmission rates are important indicators of quality of inpatient and post-discharge care. Poor performance in this area demonstrates that discharge planning and post-discharge care need improvement, especially for frail patients and patients with complex, multiple diseases or conditions.
- *Patients who were ultimately admitted to hospital having stayed beyond a defined duration (ranging from 8 hours to 30.6 hours, depending on the LHIN) in the emergency room*. One reason for this occurrence is that patients with multiple, complex medical conditions often require higher-intensity assessments and diagnoses. Another reason is that patients who no longer require hospital care were not discharged quickly enough and were occupying hospital beds, as demonstrated by the higher-than-targeted ALC rate reported in the province.

Figure 10: Performance in Achieving LHIN-specific Targets for 15 Performance Areas, by LHIN, Year Ending March 31, 2015

Source of data: Ministry of Health and Long-Term Care

	Performance Area *															# of Indicators Where
Local Health Integration Network	1 (hours)	2 (hours)	3 (hours)	4 (%)	5 (%)	6 (%)	7 (%)	8 (%)	9 (%)	10 (%)	11 (%)	12 (days)	13 (%)	14 (%)	15 (%)	LHIN-specific Target Met
Central West	34.42	7.07	3.50	93.55	n/a	89.20	49.08	44.31	15.20	85.21	6.92	18	15.66	25.16	25.77	4
Hamilton Niagara Haldimand Brant	34.67	7.30	4.50	86.89	100	85.39	81.91	76.44	45.96	77.09	17.62	23	16.44	18.84	26.64	4
North East	32.22	5.57	3.95	87.43	99	91.11	76.14	71.52	47.34	71.27	22.56	76	18.74	17.24	29.42	4
North West	31.37	6.77	3.88	95.26	n/a	94.44	75.54	64.20	50.08	79.35	21.39	35	17.24	16.83	40.65	4
Erie St. Clair	24.37	6.88	4.00	96.98	n/a	97.10	84.91	78.93	27.31	96.17	18.22	16	16.28	17.24	23.50	5
North Simcoe Muskoka	27.20	6.20	3.95	98.38	n/a	94.10	91.64	88.65	11.10	59.65	21.25	82	15.97	15.33	23.43	5
Waterloo Wellington	17.45	6.33	4.23	98.41	100	95.11	89.34	86.46	37.75	70.41	12.47	12	16.05	15.05	23.20	5
Mississauga Halton	34.60	6.12	3.58	96.25	99	95.83	97.02	80.41	21.12	51.35	12.27	28	15.32	16.35	25.13	6
South East	27.22	6.70	4.28	96.71	99	93.54	50.00	78.97	51.47	94.71	13.97	23	16.69	22.20	25.00	6
South West	25.30	6.32	3.62	91.28	100	89.13	77.76	79.19	28.83	73.32	8.93	21	17.20	17.63	19.62	7
Toronto Central	26.60	7.75	4.47	94.40	99	90.09	88.17	94.25	41.32	59.09	9.63	25	18.79	27.18	40.60	7
Central East	31.30	6.08	4.02	97.22	n/a	98.13	96.57	95.28	55.00	91.54	15.75	23	16.22	19.78	23.97	8
Champlain	26.93	7.60	4.52	97.59	78	89.94	87.49	89.22	35.98	75.66	11.83	56	16.39	17.51	26.43	8
Central	32.70	6.53	3.43	99.75	99	99.69	96.42	95.32	38.50	88.71	14.40	28	15.50	17.60	23.62	10
Average																**6**
Total # of LHINs That Met Local Target	**0**	**10**	**8**	**12**	**8**	**10**	**5**	**4**	**2**	**5**	**5**	**9**	**2**	**2**	**1**	

* Refer to list of performance areas in Figure 4.

Grey-shaded boxes indicate LHINs met their respective local, LHIN-specific targets in the year ending March 31, 2015.

- *Patients having to wait for 28 days or more for a non-urgent MRI scan.* Most LHINs faced challenges in ensuring patients receive MRI scans within 28 days. The four LHINs we visited noted that they were unable to meet the increasing demand with the existing resources. We examined whether hospitals in these four LHINs met the targeted wait time for non-urgent MRI scans in 2014/15 (the Ministry did not measure LHINs' performance in wait time for urgent MRI scans in 2014/15), and noted that within individual LHINs, some hospitals could better meet the targeted wait times than others, indicating that there are opportunities for improvement for LHINs to better manage capacity and demand across the region.

4.2.2 Performance Issues Persist in Some LHINs

Some LHINs have had limited success in meeting expected levels of performance over long periods of time. Inability to meet performance targets on an ongoing basis means that patients in these LHINs are continuously short-changed when it comes to accessing quality health care in a timely manner. For instance, one of the four LHINs we visited did not meet the annual wait-time target for MRI scans in six of the eight years ending March 31, 2015. Another LHIN that we visited did not meet its annual hip-replacement wait-time target in seven out of the last eight years. In both cases, the initiatives that the LHINs implemented could not resolve the performance shortfall. The Ministry has a responsibility to hold LHINs accountable to their performance. When we asked the Ministry what it had done to ensure these LHINs perform better, it indicated that its role would be to continue monitoring the LHINs' performance, request updates on performance-improvement initiatives implemented by LHINs to address specific performance challenges, and work with LHINs to develop and implement strategies for improvement.

Underserved Rural and Northern Communities a Long-standing Performance Issue

In another example, we noted at one of the LHINs we visited that both the Ministry and the LHIN still have not acted on their previous commitments to address the long-standing challenges of providing health services in rural and northern communities.

Many studies have identified that health-care needs in the north and other rural areas are not adequately met. For instance:

- In December 2010, a Ministry-appointed panel on rural and northern health care noted that there was a lack of community-based health services available in rural areas. As a result, patients were admitted to hospital even for conditions that in urban areas would be cared for in "ambulatory settings" (where the patient is treated only as an outpatient at a hospital or at a clinic).
- In 2012 and again in 2015, the Ontario Hospital Association noted that rural and northern communities have insufficient home- and community-care services.

One LHIN we visited had identified in 2006 that the current and future role of its small community hospitals needs to be further defined to better meet the needs of residents. At the time of our audit, this LHIN was still in the process of developing a regional strategy to better support the delivery of services in its communities.

The Ministry noted in 2007 that it would develop a provincial plan on health-care needs in rural and northern communities to support improved access to health care in these areas. At the time of our audit, the Ministry still had not developed this plan but had, in the year ending March 31, 2013, established a four-year, $80-million fund for small and rural hospitals. Its aim is to strengthen linkages with community care and help hospitals and community care providers operate as integrated networks. By March 2015, a total of about $61 million was distributed by the Ministry to 65 rural hospitals, mostly towards technology projects, such as the establishment of

an information management system and facilitation of electronic health records. An external consultant completed a review of this fund in March 2015 and noted that some funded projects did not demonstrate any quantitative benefits. As such, the consultant suggested that the Ministry and participating LHINs standardize the reporting of these projects to capture information such as planned milestones, expected outcomes and project progress.

RECOMMENDATION 2

To help ensure that patients across the province receive targeted levels of care, the Local Health Integration Networks should better manage capacity and demand for community-based services and MRI scans within their individual regions.

RESPONSE FROM LHINs

LHINs acknowledge the need to be strong leaders in managing local resources, continuing to build capacity and strengthen system sustainability. However, the LHINs recognize they have limitations in managing demand for services. These are influenced by external factors outside of the LHINs' scope, such as demographic changes, population health needs, changing technologies and practices.

LHINs fully support the Ministry's vision of creating a patient-centred system of care, as articulated in *Patients First : Action Plan for Health Care* (February 2015) and *Patients First: A Road Map to Strengthen Home and Community Care* (May 2015). Currently, disparities exist across the province in the capacity of home and community providers, and the availability of health human resources to meet demands. Inequities and challenges need to be addressed by LHINs, which will work in partnership with the Ministry and their health service providers to better manage current and future demands on the system. With our aging population, demands on home and community care services, as well as demands on resources, will continue to grow.

LHINs endorse the need to ensure Ontarians who require MRIs receive timely access to this diagnostic service. LHINs have no ability to control the demand for MRIs; however, they have worked and will continue to work with hospitals to improve utilization and efficiency. LHINs will also continue to work closely with their hospitals and the Ministry in the efforts to implement best practices, as well as address geographic and other challenges associated with MRI access.

RECOMMENDATION 3

To help ensure that patients across the province receive consistent levels of care, the Ministry of Health and Long-Term Care should:

- ensure that capacity and demand for community-based services and MRI scans are managed province-wide with consideration to existing resources; and
- develop the provincial plan on health-care needs in rural and northern communities according to its commitment in 2007.

MINISTRY RESPONSE

The Ministry accepts this recommendation and is implementing strategies to manage capacity and demand for community-based services. For example, Access to Care at Cancer Care Ontario is developing an MRI capacity-planning tool designed to advise the Ministry on LHIN capacity and need for MRI services. The tool considers wait time, population growth and existing services and will be used to support MRI services based on provincial need.

The Ministry also recognizes the unique challenges faced by rural and northern health service providers and facilities. The Ministry is committed to ensuring that health-care needs in rural and northern communities are met through greater integration and locally governed services.

Hospitals in rural Ontario, in collaboration with the Ontario Hospital Association and the LHINs, have been working with the Ministry to assess opportunities to create rural health hubs. Rural health hubs would provide access to services across the care continuum for a defined population. In May 2015, the Minister announced the intent to pursue this model, and work is underway to identify early sites.

4.2.3 Ministry Needs Better Oversight of LHINs

Every quarter, the Ministry reviews performance data submitted by the LHINs and meets with representatives of three or four LHINs at a time to ensure it meets with all 14 LHINs once over a 12-month period. At these meetings, the LHINs present the initiatives they have taken or plan to take to address their performance gaps. The Ministry and the LHINs hold other meetings throughout the year for the purpose of sharing information and discussing various programs, rather than focusing on performance issues.

The Ministry indicated that it encourages LHINs to find their own solutions to performance problems. It has sometimes suggested that LHINs refer to best practices to find efficiencies. We found that while the Ministry has provided support to LHINs in searching for best practices, it could be more directive in its approach.

Such an approach could help prevent performance issues from persisting at some LHINs, as noted in **Section 4.2.2**.

For example, the best-performing LHIN that consistently provides timely access to cataract surgeries, established an internal committee in April 2007 to oversee and implement a plan for improving access to eye surgeries in the region. The Ministry recognized these positive steps but did not require other LHINs, particularly those underperforming, to adopt similar practices. One LHIN in which patients consistently experienced the least timely access to cataract surgeries did not plan and monitor access to these surgeries across the entire LHIN, limiting its efforts only to individual health facilities, until 2014 when it established an internal committee to oversee a vision-care plan that applies to the entire LHIN area to better meet cataract surgeries access expectations. Although this strategy has not appreciably improved the LHIN's cataract-surgery wait-time results so far, if the Ministry had requested the LHIN to refocus its strategic planning and had made it aware of the practices used by the other LHIN, a suitable solution to the performance gap could potentially have been identified sooner.

We found that while the four LHINs we visited used problem-solving approaches like root-cause analysis to help analyze the underlying cause of under-performance, these approaches were not used in all cases. Nor did the Ministry actively promote the use of such approaches.

The Ministry could do more to ensure underperforming LHINs set reasonable time frames to address underlying issues, and hold them accountable to those timelines.

Health service providers and current and former LHIN board members and CEOs we surveyed also felt that the Ministry could do more to hold LHINs accountable in their performance. Almost two-thirds of them felt that the Ministry needs to better address the underlying reasons for why LHINs could not meet their performance targets, identify and roll out best practices or leading models (we discuss this in **Section 4.4.3**), and develop service standards for common areas (we discuss this in **Section 4.4.4**). Further, only one-third of the health service providers felt that the Ministry is effective in setting the overall direction of the health system, compared to 55% of the current and former LHIN board members and CEOs who felt similarly.

RECOMMENDATION 4

To ensure Local Health Integration Networks (LHINs) perform at desired levels, the Ministry of Health and Long-Term Care, in conjunction with the LHINs, should:

- communicate best practices observed in well-performing LHINs to LHINs that need intervention so the latter can identify potential solutions to performance shortfalls;
- assist LHINs in analyzing the root causes of performance gaps and determining appropriate action to address ongoing issues; and
- require LHINs to establish reasonable timelines to address performance gaps and monitor their progress accordingly.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will continue to work with LHINs on performance, performance gaps and timelines.

The Ministry notes that LHINs have established and spread leading practices by identifying priorities and solutions that are important to their local communities and providers. Examples such as integrated lab systems, vision care strategies, centralized intake and assessment for orthopedics, stroke rehabilitation strategies and mental health integration have all been led by individual LHINs, with adoption by others. Against this backdrop is a strong history of provincial strategies, such as those led by Cancer Care Ontario, the Cardiac Care Network and the Ministry, including the palliative care and the diabetes strategies, all of which have been supported by LHINs and their providers for implementation. LHINs have collaborated to initiate common provincial strategies for shared priorities, such as the Rehabilitative Care Alliance. The Ministry is fully aware and supportive of these LHIN-led initiatives and actively identifies leading LHIN practices to other LHINs.

To assist the LHINs with analyzing root causes of performance gaps, the Ministry will continue to provide data, analytics and policy research to LHINs and regularly seek advice from them on provincial priorities and strategies to determine appropriate action to address ongoing issues. LHINs themselves meet regularly to collaborate on common challenges and solutions. LHIN performance data is fully available to all LHINs for review and collaboration.

The Ministry will continue to foster community of practice and will work with the LHINs to establish reasonable timelines to address performance gaps and monitor progress.

4.2.4 Some Performance Targets Not Evidence-based and Vary Significantly

While targets for selected health conditions were developed based on scientific literature, others are not evidence-based—that is, they are not based on known best practices. Instead, they are set according to results of previous years at the individual LHINs, and to local challenges. This practice has resulted in considerable differences among LHINs targets. **Figure 7** shows the range of LHIN-specific targets for all 15 performance areas in the year ending March 31, 2015. For example, targeted wait time for CCAC home care ranged from 17 days in one LHIN to 66 days in another, and targeted duration for a patient waiting in an emergency room who was ultimately admitted to hospital ranged from eight hours in one LHIN to 30.6 hours in another.

We also found that the response to challenges differed from one LHIN to the next. Specifically, when an expected performance was not achieved in one year, for some LHINs the target became more lax; for other LHINs, the target stayed the same or became more stringent. For instance, of the seven LHINs that could not meet their respective ALC performance targets between 2011/12 and 2014/15, the Ministry lowered the target for five LHINs (for instance, from 17% to 22% ALC days in one LHIN), and either tightened or maintained the target for the remaining two. The Ministry indicated that it sets these revised targets jointly with LHINs to account for local circumstances and challenges.

4.2.5 Ministry Revising and Establishing New Performance Measures to Evaluate LHIN Performance

The 15 performance areas for which LHINs are accountable measure, for the most part, hospital performance more than they measure the LHINs' performance as planners, funders and integrators of their local health systems. Both the Ministry and the LHINs have acknowledged this. **Figure 11** shows how performances in individual health sectors are attributed (and in some cases, not attributed) to LHINs' performance.

In December 2014, the Ministry directed an Indicators Advisory Group comprising representatives of the LHINs, the Ministry, and Health Quality Ontario to review current indicators and determine whether new indicators should be developed. These indicators, which the advisory group finalized in August 2015, were subsequently included in the 2015–2018 Ministry–LHIN accountability agreement. **Figure 12** shows the new indicators. Some of these indicators relate to the performance of non-hospital sectors and the co-ordination of health services in the local health system—these areas have never been measured before.

Figure 11: Health Performance Measurement and Accountability, from Health Service Providers to LHINs to the Ministry

Prepared by the Office of the Auditor General of Ontario based on information provided by the Ministry of Health and Long-Term Care

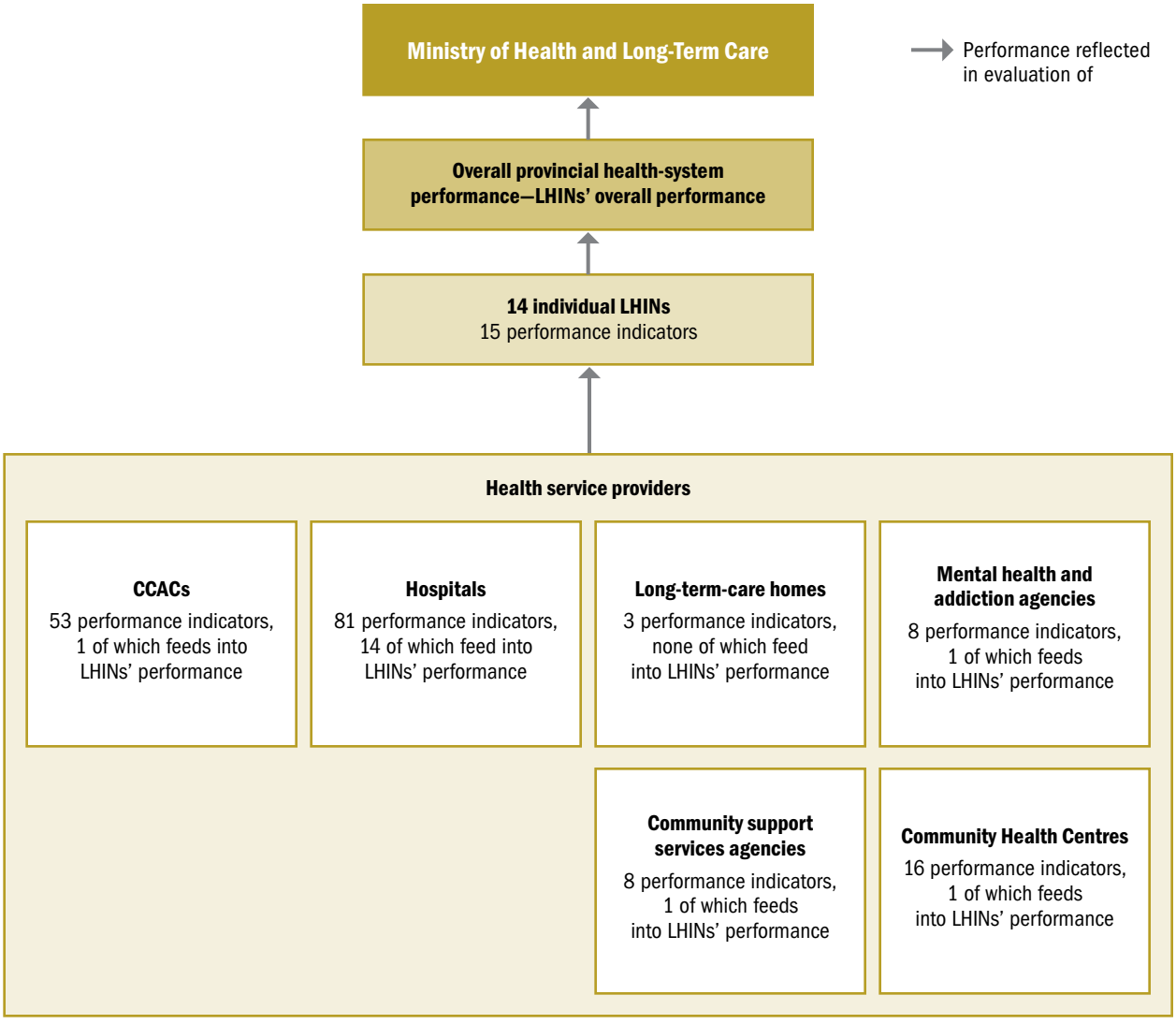


Figure 12: New Indicators Used to Measure LHINs' Performance, 2015–2018

Source of data: Ministry of Health and Long-Term Care

Indicators in the 2013–2015 Ministry–LHIN Performance Agreement	
1	% of Alternate Level of Care days
2	90th percentile wait time for CCAC in-home services—application from community setting to first CCAC service (excluding case management)
3	Repeat unscheduled emergency visits within 30 days for mental health conditions
4	Repeat unscheduled emergency visits within 30 days for substance abuse conditions
Expansion of the Current Indicators	
5	% of priority 2, 3 and 4 cases completed within access target for cancer surgery
6	% of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery
7	% of priority 2, 3 and 4 cases completed within access target for cataract surgery
8	% of priority 2, 3 and 4 cases completed within access target for hip replacement
9	% of priority 2, 3 and 4 cases completed within access target for knee replacement
10	% of priority 2, 3 and 4 cases completed within access target for MRI scans
11	% of priority 2, 3 and 4 cases completed within access target for CT scans
12	Readmission within 30 days for selected HBAM inpatient group (HIG) conditions*
New Indicators	
13	% of acute-care patients who have had a follow-up with a physician within 7 days of discharge
14	% 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
15	% of home-care clients who received their first nursing visit within 5 days of the date they were authorized for nursing services
16	% of palliative-care patients discharged from hospital with home support
17	90th percentile emergency department length of stay for complex patients
18	90th percentile emergency department length of stay for minor/uncomplicated patients
19	Alternate Level of Care rate
20	CCAC wait times from application to eligibility determination for long-term-care home placement (from community setting and from acute-care setting)
21	Hospitalization rate for ambulatory care sensitive conditions
22	Overall satisfaction with health care in the community
23	Rate of emergency visits for conditions best managed elsewhere

* Health Based Allocation Model (HBAM) inpatient group (HIG) conditions include acute myocardial infarction, cardiac conditions, congestive heart failure, chronic obstructive pulmonary disease, pneumonia, diabetes, stroke and gastrointestinal disease.

Some of the new indicators are also measured by the Canadian Institute for Health Information, and some are similar to those used to evaluate the performance of regional health authorities in other countries and selected Canadian provinces. However, we also identified additional indicators used in those jurisdictions that Ontario has not yet proposed. For instance, one British Columbia health authority measures the proportion of those aged 75 years or more who receive home-care services to assess whether it is meeting the goal of keeping people at home for as long as appropriately and safely possible. As well, the single health authority in Alberta measures whether people access supportive living or long-term care within 30 days of the date they were assessed and approved for placement.

Further, the Ministry noted in a 2004 submission to Cabinet that it expects LHINs to achieve a number of outcomes and benefits in four years,

including reducing health costs, integrating and co-ordinating programs and services to emphasize disease prevention and health promotion, and distributing health services equitably across the province. However, the Ministry had not measured any of these anticipated outcomes.

Fully measuring LHINs' performance in all their mandated activities and expected outcomes, and setting evidence-based targets for these performance areas, can help the Ministry better measure whether each of the 14 LHINs has been effective in providing for an integrated local health system.

RECOMMENDATION 5

To ensure that Local Health Integration Networks (LHINs) are assessed objectively and comprehensively on their operational effectiveness and for all health sectors that they manage, the Ministry of Health and Long-Term Care should:

- develop LHIN-specific performance targets that reflect current evidence-based benchmarks; and
- examine the appropriateness of including additional performance indicators not currently in those recommended by the Indicators Advisory Group and finalize the implementation of the performance indicators that measure non-hospital-sector performance as well as co-ordination of health services.

MINISTRY RESPONSE

The Ministry supports this recommendation. As part of the 2015–18 Ministry–LHIN Accountability Agreement, which was developed collaboratively between the Ministry and the LHINs, provincial performance targets have been set for all performance indicators; there are no longer LHIN-specific performance targets. Evidence-based targets have been set, where possible. LHINs are expected to demonstrate progress toward achieving the targets by the end of the three-year term of the agreement. Where provincial targets are not based on evidence, the Ministry will work toward identifying targets that are based on known best practices.

During the course of the Auditor General's audit, as part of the Ministry's regular review, a number of non-hospital indicators were added to the list of indicators (including home and community care, palliative care, patient satisfaction and primary care). The Ministry, in partnership with the LHINs, will review indicators on a yearly basis and modify as appropriate. The Ministry and LHINs will also evaluate the addition or creation of new indicators to reflect emerging priorities.

4.2.6 LHINs' Performance Is Also Influenced by Factors Not within LHIN Control

The LHINs we visited told us that sometimes they can do little to improve performance in certain areas because they cannot control patients' preferences and physicians' practices.

For instance, patients will experience longer wait times if they are referred to health service providers that other physicians habitually refer patients to or whom patients simply prefer. In light of this reality, there is little a LHIN can do to improve its wait-time performance.

Under the Act, LHINs do not oversee primary care (that is, the day-to-day health care provided most commonly by family physicians). The lack of control in this area is impacting their performance in areas such as the three emergency room length-of-stay indicators (areas 1, 2 and 3 in **Figure 4**). If a patient's family physician is not available on the weekend or cannot see a patient within one or two days of the patient trying to book an appointment, the patient is more likely to seek help in an emergency room or walk-in clinic.

Some external advisers to the government have recommended that primary care be included in the LHINs' mandate. For example, in March 2015, a report from a government expert group on home

and community care, *Bringing Care Home*, noted that primary care is still somewhat disconnected from other dimensions of home and community care, particularly in remote and rural communities. The report indicated that unless primary care and home and community care are well aligned, the latter will be unable to transition to a high-performing system. According to the report, one key way of achieving this transformation is for LHINs to manage the delivery of primary care. Similarly, in 2012, the report of the *Commission on the Reform of Ontario's Public Services* (commonly known as the Drummond Report) recommended that all health services in a region, including primary-care physician services, be integrated under the LHINs.

According to our survey results, a greater proportion of current and former LHIN board members and CEOs felt that LHINs can still be effective managers even without having responsibility over primary care versus those that felt the opposite. Their opinions were in stark contrast to those of the health service providers—a greater proportion of them felt that LHINs cannot be effective managers even without having responsibility of primary care versus those who felt the opposite.

The Ministry noted that it is considering various reports regarding provision of primary care, and is working with all partners to improve how primary care is provided in Ontario.

RECOMMENDATION 6

To better meet Local Health Integration Networks (LHINs)' mandate of integrating local health systems, the Ministry of Health and Long-Term Care should determine how best LHINs can manage the primary-care sector.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will examine ways the LHIN role in primary care can be strengthened as part of ongoing efforts to support the government's vision for an integrated health system.

4.2.7 "Integrated Health System" Remains Undefined and No Timeline Set to Achieve It

The Act mandates that each LHIN is responsible to "provide an integrated health system," and LHINs develop three-year strategic plans to that end. However, neither the *Local Health System Integration Act, 2006* nor the Ministry has provided a clear definition of what would constitute a fully integrated health system, or when it is to be achieved. Over half of the health service providers and 44% of the current and former LHIN board members and CEOs who responded to our survey felt that the Ministry has not defined what an "end-state" integrated health system will look like. As well, over half of all respondents noted that the Ministry had not specified when a fully integrated health system is to be achieved.

LHINs develop three-year strategic plans called Integrated Health Service Plans that outline proposals and priorities for their local health system, toward providing an integrated health system. But without a clear picture of what that system looks like, it's difficult for LHINs to know whether implementing their proposed initiatives will in fact lead to that result. The Ministry is also unable to determine to what extent individual LHINs and LHINs as a whole are progressing toward providing an integrated health system.

Until the concept of a fully integrated health system is clearly defined, the Ministry can assess LHINs' progress in meeting the provincial targets it has established for 11 of the 15 performance areas. As shown in **Figure 7**, these targets represent long-term performance goals, and differ from the unique LHIN-specific targets discussed in **Section 4.2.4**. However, as noted in **Section 1.3.2**, there are no provincial targets set for four performance areas. Of the 11 areas that do have provincial targets, using overall provincial results in the year ending March 31, 2015, the targets were achieved in only four areas.

We discuss these issues in the following subsections.

Progress Made in LHINs' Three-year Strategic Plans Not Always Assessed

The LHINs we visited did not assess if the goals described in their three-year strategic plans were effective in bringing them closer to a fully integrated health system. The Memorandum of Understanding between the Ministry and LHINs states that the LHIN boards are responsible for developing measures to monitor and assess the performance of LHINs. However, three of the four LHINs did not establish any quantifiable targets or performance measures for their stated goals and strategies, so there is no formal assessment on how their work helps them progress toward a fully integrated local health system. For example, one LHIN had a goal of reducing the percentage of palliative patients dying in acute care beds. But it did not specify how much the reduction should be and when the reduction should be realized. The LHIN uses other methods to demonstrate progress, including presenting success stories in its annual reports. The fourth LHIN only developed performance measures for its strategies, with targets to meet, in its most recent three-year plan covering 2013 to 2016.

The lack of quantifiable targets in integrated health service plans may explain the following survey result: only one in five health service providers who responded to our survey felt that LHINs are on track to achieving the goals in their strategic plans, compared to almost 80% of the current and former LHIN board members and CEOs.

Provincial Targets Serve as Longer-term Goals for LHINs to Work Towards

For 11 of the 15 performance areas, the Ministry has established what it calls "provincial targets" that serve as long-term goals for LHINs to work towards (see **Figure 7**). In most cases, these targets are more stringent than the targets the Ministry has negotiated for individual LHINs to meet. For example, the Ministry's provincial target for ALC days is 9.46%, meaning no more than 9.46% of the total days a patient spent in hospital should have been due to them waiting for care elsewhere or to be discharged. Only two LHINs had this specific target to meet. The other 12 LHINs were held to targets that were less challenging than the provincial target for ALC days. Using the overall provincial performance in the year ending March 31, 2015, only four of the 11 provincial targets were met that year. Further, the Ministry has not set any timelines for when all 14 LHINs are expected to meet the 11 provincial targets.

RECOMMENDATION 7

To ensure Ontario benefits from a fully integrated health system in the foreseeable future, the Ministry of Health and Long-Term Care should:

- establish a clear picture of what a fully integrated health system looks like, its milestones and final targets, and timelines for when LHINs should achieve those targets; and
- require that LHINs develop performance measures and targets to meet the goals they propose in their three-year strategic plans, and report on their results.

MINISTRY RESPONSE

The government has articulated its vision for an integrated health system through the *Patients First: (Ontario's) Action Plan for Health Care*; this plan sets out health system priorities including access, equity and quality of care. The Ministry is reviewing input from a variety of sources about options to support and further the government's vision for an integrated health system.

LHINs identify and detail the strategies they will implement to deliver on the government's priorities through their Integrated Health Service Plans (IHSPs). The LHINs' Annual Business Plans build on their IHSPs, as this is where the LHINs are required to demonstrate how they will deliver on the commitments made in their IHSPs, including the identification of performance measures and targets. In addition, LHINs

develop Annual Reports that contain a report on the progress of their local health system and performance results to date. Together, these public documents articulate the LHINs' strategic priorities, key initiatives and performance commitments.

The Ministry will work with the LHINs to adopt performance measures and targets to meet the goals they propose in their three-year strategic plans, and report on their results.

4.3 LHINs' Oversight of Health Service Providers Needs Strengthening

LHINs have a responsibility to monitor the performance of hospitals, CCACs, long-term-care homes, community health centres, mental health and addiction agencies, and community support services agencies to ensure patients receive quality health care. To do so, LHINs contract with these health service providers and require them to meet certain performance expectations. We examined how LHINs monitor health service providers and what LHINs do when performance is below expectation. We also reviewed how LHINs ensure complaints about health services are handled and resolved appropriately. At the four LHINs we visited, we found that quality of health services is not consistently monitored, performance information submitted by health service providers is not verified—some of which contained errors—and non-performing health service providers are not always dealt with in accordance with Ministry guidelines. As well, we found that there is no common complaint-management process across LHINs, and LHINs did not always ensure that patient complaints are appropriately resolved.

We look at the above issues in detail in the following subsections.

4.3.1 Service Providers Mainly Report Output Measures Rather than Measures of Services Quality

The service accountability agreements between LHINs and health service providers in the six health sectors generally focus on output volumes such as number of cases, number of visits and number of surgeries. The agreements with hospitals often focus on wait time measures (because a number of the performance areas to which the Ministry holds LHINs accountable relate to wait times). Although LHINs are required to undertake strategies to improve patient care, the quality of health services is seldom measured.

Two of the LHINs we visited took steps in this direction. One required all its health service providers to report on client satisfaction starting in April 2014. The other required all health-service providers in its region to conduct patient satisfaction surveys starting in April 2015. As well, this second LHIN in 2013 required its mental health and addiction agencies and community support service agencies to develop quality improvement plans and submit them to the LHIN. (Health Quality Ontario's requirement for preparing quality improvement plans only applies to all hospitals, long-term-care homes, CCACs, and inter-professional primary care organizations, which include community health centres.) The quality improvement plans document how each health service provider intends to meet its long-term improvement priorities such as patient access to services and patient safety. The other three LHINs we visited followed the Health Quality Ontario requirement and had not expanded the quality improvement plans requirement to the other two sectors. However, we noted that neither LHINs nor Health Quality Ontario ensure that health service providers implement the actions identified in the submitted quality improvement plans.

RECOMMENDATION 8

To help improve patient care and quality of health services, Local Health Integration Networks, in collaboration with Health Quality Ontario, should:

- assess patients' satisfaction with their health service providers and the extent to which they feel they are receiving quality services;
- assess whether a quality improvement plan should be required of all health service providers; and
- ensure health service providers implement the actions contained in the quality improvement plans.

RESPONSE FROM LHINs

In September 2014, the 14 Ontario LHINs and Health Quality Ontario (HQO) signed a *Commitment to Collaboration*, which defines a collaborative relationship between the Crown agencies to promote alignment efforts and accelerate advancement of a high-performing health-care system. Significant work has already been initiated by the LHINs and HQO, and the progress and activities on priority areas are reviewed quarterly by the HQO/ LHIN Partnership Table.

A Patient Experience Measurement Committee, co-chaired by the LHIN CEO Quality Lead and HQO, is developing an inclusive plan to support patient experience measurement for the purposes of quality improvement, public reporting and research, within and across all sectors in Ontario. The secondary goal of the Committee is to make recommendations to HQO and other health system stakeholders about what approaches might be used to develop standards for patient experience measurements in Ontario.

LHINs and HQO are also working together to create an aligned, integrated Provincial Quality Improvement strategy aimed at strengthening the impact of the Quality Improvement Plans and advising on future directions for the Quality Improvement Plans required under the *Excellent Care for All Act*. The opportunities identified within this recommendation will be considered as the work plan is further developed.

4.3.2 Performance Data Submitted by Health Service Providers Not Verified

Neither the Ministry nor the LHINs routinely verify that the information health service providers submit to them is accurate and reliable. Without such verification, the Ministry and the LHINs cannot be certain that health services are being provided as expected, nor can they be assured that significant errors in reporting has not occurred.

The Ministry's Health Data Branch and Health Analytics Branch collect information as reported by health service providers and make it available to the LHINs by uploading it to databases they access. The LHINs we visited said they expected the Ministry had confirmed the information's reliability before making it available to them. But the Ministry told us that LHINs are themselves responsible for ensuring accurate information.

Upon examining the documents that define the roles and responsibilities of the Ministry and the LHINs, we found they both have some role to play in data reporting. According to the accountability agreement between the Ministry and each LHIN:

- the Ministry is to inform health service providers of any data-quality issues; and
- each LHIN is to work with its health service providers to ensure they improve data quality.

However, the agreement does not clearly define who is responsible for ensuring data accuracy. The LHINs we visited noted that the health service providers are obligated under their agreements with the LHINs to report accurate data. Neither the Ministry nor the four LHINs we visited do any verification in this regard.

All four LHINs we visited analyzed data submitted by service providers to identify variances

and outliers, and routinely followed up with the respective health service provider regarding any anomalies. However, none of them had visited the health service providers' premises to review even a sample of source documents to ensure submitted data was accurate.

We selected a sample of the performance data that health service providers had submitted to the four LHINs we visited, and verified the information with the health service providers directly. We found that in almost half of the cases, the information submitted by health service providers to the LHINs were not accurate, with some results being exaggerated. For instance, a community support service provider over-reported on the volume in one service area so that it looked like it achieved 84% of the LHIN expected volume when in fact it only achieved 41%. The discrepancies highlight the importance for LHINs to verify the information reported by health service providers.

4.3.3 Long-standing Performance Issues Not Always Resolved at Health Service Providers

When performance issues persist at health service providers, LHINs do not consistently ensure they are resolved. These performance issues are wide-ranging, from clinical (for example, a hospital's readmission numbers are high), to operational (for example, the number of clients served by a clinic at a community health centre repeatedly falls short of the performance target or markedly decreases), to financial (for example, a health service provider experiences chronic deficits). As a result, patients may not be receiving the best possible quality of care at these providers.

We found that the four LHINs visited did not consistently intervene to review or investigate performance issues, some of which have persisted for years. In June 2011 and August 2012, the Ministry released two guidelines for audits and reviews, one for hospitals and the other for community health service providers, to help LHINs respond effectively and consistently to health-service-provider issues. Both guidelines state that if a performance issue persists after the LHIN has held discussions and shared information with health service providers, the LHIN should intervene in other ways. These include:

- conducting a root-cause analysis to identify the source of the problem; and
- conducting an in-depth analysis of the health service provider's operations (or, in the case of a hospital, request another hospital to conduct a peer review).

The four LHINs we visited predominantly discussed and shared information with health service providers even for long-standing performance issues. Our review of a sample of health-service-provider performance reports found that 60% of community-sector and 80% of hospital-sector service providers failed to meet at least one performance target consistently over the three years leading up to March 31, 2014. For example, at one LHIN, we found that a CCAC did not meet five of its performance targets consistently over this three-year period. These performance shortcomings include not serving the expected number of individuals for in-home nursing, personal support services, and residential hospice services. This LHIN explained that the consistent underperformance was due to this CCAC shifting its resources to other priority areas, and providing more hours of care to clients with more complex needs, resulting in fewer clients being served. Although the four LHINs we visited had ordered peer reviews (the next level of intervention after discussions and information sharing), this intervention was used in a limited way—primarily for hospitals that faced deficits. As well, in the files we sampled, only one LHIN we visited applied intervention strategies with the community-sector health service providers that had failed to meet performance targets over the three years; the other three didn't. We made a similar observation in our audit of the Long-term-care Home Quality Inspection Program in **Section 3.09** of Chapter 3 of this Annual Report.

The Ministry can intervene for the most serious performance issues at health service providers by, for example, appointing a supervisor at a hospital or a CCAC. Over the past five years leading up to March 31, 2015, the Ministry had appointed a supervisor to oversee hospitals in three instances and a CCAC in one instance for issues such as concerns with the governance and management of a health-care organization, and disagreement over where to locate certain clinical services in a multi-site hospital.

The LHINs we visited explained that they choose discussions and information sharing over intervention strategies because they want to maintain a positive working relationship with their health service providers, who are not directly governed by the LHINs, and to work with them to identify solutions. The LHINs noted that other escalation strategies such as decisions to reduce funding are only reserved for situations warranted, as delivery of patient care may be affected as a result of these actions.

4.3.4 LHINs Do Not Always Ensure Corrective Actions Have Been Taken

All four LHINs we visited identified when health service providers did not meet performance targets, but they did not consistently follow up to ensure they implemented corrective actions to help them meet their targets in the future.

Our review of a sample of health-service-provider performance reports from March 31, 2014 (so we could assess LHIN follow-up activities the year after), found that about 30% of the service providers that performed below targeted levels did not provide explanations as required, and 45% did not prepare an action plan to describe how they would address the performance shortfall. Moreover, less than half of the health service providers that provided an action plan included timelines for completion. In the next reporting period, when we expected to see LHINs following up with the non-performing health service providers, we found that one LHIN had appropriately followed up on these cases while the other three had not. At these three LHINs, there was no documented evidence that follow-up actions were taken in over 70% of the sampled cases.

RECOMMENDATION 9

To ensure that performance issues of health service providers are addressed in an appropriate and timely manner, Local Health Integration Networks (LHINs) should:

- clarify with the Ministry of Health and Long-Term Care whose responsibility it is to verify data submitted by health service providers; if it is the LHINs' responsibility, verify on a sample basis information submitted by health service providers;
- take appropriate remedial action according to the severity and persistence of performance issues; and
- follow up with health service providers to ensure they provide explanations of performance shortfalls and take effective corrective actions to resolve issues according to a committed timeline.

RESPONSE FROM LHINs

The LHINs and Ministry acknowledge the importance of high-quality data for decision making. Accountability for reporting accurate and timely data lies with the health service providers. This obligation is embedded in the service accountability agreements for all sectors. The LHINs support health service providers to successfully meet their reporting accountabilities. The LHINs are not resourced or mandated to perform data audits and cannot assume that function. In order to increase confidence in the performance information submitted by health service providers, LHINs will develop or maintain a practice of regularly reviewing data submissions for consistency and reasonableness. LHINs will address concerns with health service

providers and identify data quality as a performance issue as appropriate.

LHINs have a responsibility to identify and respond to serious and/or persistent performance issues demonstrated by health service providers as outlined in the service accountability agreements. Given the large number of health service providers and numerous services and programs offered by those providers, it is important that LHINs utilize a risk stratified approach to reviewing, prioritizing and resolving performance issues. Each LHIN will adopt or maintain a performance management framework and/or performance accountability policy.

The frameworks and policies will outline the risk management approach and an escalating set of interventions to be employed by LHINs in response to serious or persistent performance issues.

4.3.5 Weaknesses in Complaint Management

Consistent Complaint-management Process Lacking

We found that LHINs do not handle complaints in a consistent way. Effectively managing patient complaints and using a consistent process is important to ensuring quality health services are delivered consistently across the province.

The Act requires LHINs to ensure that appropriate processes within the local health system are in place to respond to concerns that people raise about the services they receive. However, there is no standardized patient complaint-management system for all LHINs. In 2014, the then-Minister of Health and Long-Term Care proposed that such a system be established. At that time, all LHIN CEOs agreed that LHINs should manage patient complaints consistently. However, at the time of our audit, a common complaint-management system had not yet been established. The LHINs we visited felt that their existing processes were meeting their needs and therefore do not intend to implement a common complaint-management system. In our view, the lack of consistency in handling complaints poses risks that patient concerns may not be appropriately addressed.

We analyzed the complaints for the year 2014 for 11 LHINs to identify the most common types of complaints. (Three LHINs did not track complaints at all or only partially tracked complaints in that year.) We found that access to health services (including accessing equitable services and service availability) was the most common area of concern. The second most common area of concern relates to health service quality (including concerns with health-care worker competency). These two types of concerns combined accounted for over 60% of all complaints received by these LHINs in the year 2014. **Figure 13** shows the types of complaints each LHIN received in the year 2014.

In December 2014, the government passed a bill, which, once proclaimed, will amend the *Excellent Care for All Act, 2010* to establish the province's first Patient Ombudsman, who will respond to complaints from hospital patients, long-term-care home residents, and CCAC clients and their caregivers that cannot be resolved through existing complaint processes. At the time of our audit, the government was conducting public consultation on the qualifications of the Patient Ombudsman. One LHIN we visited informed us that the reporting and working relationships between LHINs and the Patient Ombudsman are yet to be determined.

LHINs Do Not Actively Inform Public of Complaint Processes

Although each of the four LHINs we visited has its own policy for dealing with the complaints it receives, none of them has a mechanism for informing the public on how to register a complaint about health services when resolution at the health service provider is not achieved. For the most part, LHINs rely on the Ministry, health service providers and Members of Provincial Parliament to forward patient complaints to them. LHINs also noted to

Figure 13: Total Number of Complaints Received by LHINs, 2014

Sources of data: 14 Local Health Integration Networks

	Total Number of Complaints Received Relating to:							
LHIN	**Access [1]**	**Quality of Service [2]**	**Wait Time [3]**	**Integration and Co-ordination of Services [4]**	**Funding [5]**	**Community Engagement [6]**	**Others [7]**	**Total**
Erie St. Clair	35	21	8	2	3	1	14	**84**
Hamilton Niagara Haldimand Brant	18	18	10	3	3	0	12	**64**
Champlain	23	16	7	4	3	0	11	**64**
Toronto Central	14	15	9	3	1	0	21	**63**
North East	24	19	4	1	2	2	10	**62**
Central	16	14	6	1	0	2	19	**58**
Central East	18	11	2	1	1	0	3	**36**
Mississauga Halton	5	8	1	2	0	0	4	**20**
South West	4	9	5	0	0	0	1	**19**
North West	10	5	1	0	0	0	2	**18**
Waterloo Wellington	5	3	1	0	2	0	2	**13**
Central West [8]	not available — not tracked by LHIN until mid-2014							
North Simcoe Muskoka [9]	not available							
South East [9]	not available							
Total	**172**	**139**	**54**	**17**	**15**	**5**	**99**	**501**
% of Total Number of Complaints	**34**	**28**	**11**	**3**	**3**	**1**	**20**	

1. Examples of complaints included health service availability, capacity, closure, service gaps and service inequality. Complaints on service wait times are not included.
2. Examples of complaints included handling of services by health service providers and staff competency at health service providers.
3. The most common complaint was an overly long wait time.
4. Examples of complaints included the LHIN's integration strategies or initiatives and the LHIN's failure to co-ordinate services.
5. The most common complaint was insufficient funding for the health service provider to provide services.
6. Examples of complaints included health service providers' engagement with the stakeholder and the LHIN's community engagement.
7. Examples of complaints included complaints about other sectors not managed by the LHIN, such as primary care and ambulance service; and administrative matters, such as the LHIN, or a health service provider's governance, staff, and handling of complaints.
8. This LHIN began tracking complaints in mid-2014.
9. These LHINs do not have a formal complaint-tracking system in place.

us that patients can reach them via the contact information on their websites. The LHINs we visited have not considered other methods of informing patients about their complaint processes, such as including their contact information in pamphlets available at the offices of health service providers. Two-thirds of the health service providers who responded to our survey believe that the public is not well aware of the process in place to raise complaints to the LHINs; about a third of the current and former LHIN board members and CEOs felt the same way.

LHINs Do Not Ensure Health Service Providers Manage Complaints Well

We found that only two of the four LHINs have processes for ensuring that their health service providers resolve patient complaints. The other two LHINs keep too little information on patient complaints to show whether health service providers have satisfactorily resolved complaints, and one of them does not keep any original documents on patient complaints at all.

RECOMMENDATION 10

To ensure patients receive quality health services, and to facilitate collaboration between Local Health Integration Networks (LHINs) and the Patient Ombudsman, LHINs should:

- establish a common complaint-management process that, among other things, clearly defines the methods for informing the public on how to register complaints;
- implement processes to determine whether health service providers have established policies and procedures to address and satisfactorily resolve patient complaints; and
- clarify the working relationship between LHINs and the incoming Patient Ombudsman.

RESPONSE FROM LHINs

The LHINs fully support the core promise of the Ministry to build a health system that puts patients first. This means understanding what is important to patients and listening when they have concerns. LHINs are currently working on website messaging that explains and outlines the complaint process to citizens, health service providers and other key stakeholders. LHINs will adopt and/or maintain a patient-complaints management protocol.

Health service providers are accountable to establish and implement patient relations and complaints policies and procedures under the *Excellent Care for All Act* and/or their service accountability agreement. LHINs will ensure a process exists whereby health service providers demonstrate compliance with these accountabilities.

LHINs will continue to work closely with the Ministry as it implements the role of Patient Ombudsman. Following the Patient Ombudsman's appointment, the Ministry and LHINs will meet with the Patient Ombudsman to define the working relationship and expectations of each party. The Ministry will need to communicate to LHINs how the reporting and communication flow will occur between the Patient Ombudsman and the LHINs. Timelines will be contingent on work by the Ministry and the appointment of the Patient Ombudsman.

4.4 Processes Used to Plan and Integrate the Health System Need Improvement

LHINs' responsibilities include planning for the provision of health services in their regions for the six health sectors they manage and integrating these services.

Planning requires LHINs to engage with the community. All four LHINs visited were doing so, but only one consistently evaluated the success of the activities it undertook to engage with the community. Planning also requires LHINs to determine, among other things, their capacity to meet health service needs. While LHINs have begun working

toward defining their capacity to meet health needs in the areas of rehabilitative services, palliative care, and home and community care, such work was not completed at the time of our audit.

LHINs are also expected to ensure consistencies among themselves and to develop joint strategies to improve patient care. While common approaches have been developed in some health areas to ensure patients receive reasonably similar care regardless of where they live, in the remaining health areas it is unclear whether the Ministry or the LHINs are responsible for developing consistent standards. As well, projects and initiatives undertaken are not always evaluated to determine whether they are worth sharing with other LHINs.

Good integration practices include group purchasing and "back-office integration" (that is, integrating or consolidating the administrative and business operations of LHINs and/or health service providers). However, these practices were not consistently used in the LHINs we visited, and more health service providers indicated to us via survey response that they wanted LHINs to explore additional group purchases and back-office integration opportunities than those that did not.

We also found that LHINs were not consistently measuring their planning and integration projects to determine if they met intended outcomes. As well, LHINs were not effectively sharing successes from these projects with each other.

We look at the above issues in detail in the following subsections.

4.4.1 Effectiveness of Community Participation Not Assessed

The Act requires all LHINs to engage the community about the local health system on an ongoing basis while setting priorities. The Ministry's *LHIN Community Engagement Guidelines and Toolkit* (Guidelines) defines community engagement as "the methods by which LHINs and health service providers interact, share and gather information from and with their stakeholders" ("individuals, communities, political entities or organizations that have a vested interest in the outcomes" of LHIN projects and initiatives). Ways in which LHINs can engage with the community include public consultations, communication and education.

The Guidelines state that LHINs are to evaluate the success of their engagement activities. Specifically:

- Was the activity useful?
- Did participants feel the session gave them an opportunity to share relevant experience and recommendations?
- Did the activity allow LHINs to identify areas for improvement?

We reviewed a sample of community engagements carried out at the four LHINs we visited over the three years leading up to March 31, 2015, to determine if community-engagement activities were evaluated. We found that only one LHIN consistently did so. The other three LHINs had not evaluated more than 90% of these engagements. So, although all four LHINs incorporated input from their community-engagement events into their strategic plans, the lack of evaluation by those three LHINs may make it harder for them to tell whether their engagements were effective in identifying areas of concerns for planning and priority-setting purposes.

4.4.2 Processes for Determining System Capacity Lacking

Each of the four LHINs we visited has a process to define health system needs. The processes vary—some LHINs obtain input from patients directly, while others receive information from their health service providers. However, LHINs could do more to define system capacity (that is, how service supply meets current and future demand for service).

Concerns have been raised about insufficient capacity planning in the areas of palliative care, home and community care, and rehabilitative services. As we noted in our 2014 audit of Palliative Care, LHINs did not have system-wide information

on available resources. The March 2015 report of the Expert Group on Home and Community Care, *Bringing Care Home*, recommended that each LHIN should "submit to the Ministry of Health and Long-Term Care an evidence-informed capacity plan for its region indicating where there are shortfalls and how any gaps in home care and community services will be addressed." Similarly, the March 2015 report issued by Rehabilitative Care Alliance (a province-wide collaborative established in April 2013 by all 14 LHINs) recommended that LHINs use a capacity planning framework to define existing rehabilitative care resources. In addition, one of the LHINs we visited acknowledged in its 2013/14 annual business plan that it did not know whether there were service gaps in the delivery of community health services in its region.

According to our survey results, while more than 80% of the current and former LHIN board members and CEOs felt that LHINs have a good understanding of the local health system capacity and needs and are effective health system planners, only about 40% of the health service providers who responded to our survey felt the same.

RECOMMENDATION 11

To best meet the patients' health-care needs, Local Health Integration Networks should:

- assess the effectiveness of each community engagement activity as required by the *LHIN Community Engagement Guidelines and Toolkit* issued by the Ministry of Health and Long-Term Care;
- begin to collect, over a reasonable time period, the data needed to determine the existing capacity of all health services in their regions; and
- develop and implement action plans with timelines to address the service gaps identified.

RESPONSE FROM LHINs

A key component of the LHINs' mandate is to engage with and seek input from their local communities. This includes patients, families, health service providers, residents, professional associations, municipalities and others. The LHINs, in collaboration with the Ministry, are currently in the process of refreshing the *LHIN Community Engagement Guidelines and Toolkit*. The Guidelines and Toolkit refresh will continue to be aligned with the *Local Health Systems Integration Act, 2006* (Act) while reflecting the changing landscape of community and patient engagement, new and emerging technologies, and the maturation of LHIN processes that have now structurally incorporated engagement into routine planning. Direction about what type of community engagement activity lends itself to formal evaluation will be included in the refreshed Guidelines and Toolkit.

Work is under way to establish capacity plans in rehabilitative service, palliative care, and home and community care. The LHINs will continue to engage with the Ministry, health service providers, subject matter experts and other stakeholders in capacity assessment at a provincial level.

4.4.3 Sharing of Best Practices Needs Improvement

LHINs Have Collaboration Processes

Overall, we found that LHINs have processes in place to collaborate with each other on initiatives for meeting patient needs.

Both the Act and the accountability agreement between the Ministry and the LHINs require that LHINs ensure consistency and collaboration to improve patient care and to ensure a uniform approach to common issues and services.

We noted a number of working groups and committees involving all the LHINs are established to share information in different areas, such as

Aboriginal health, cancer programs, and mental health and addiction services. The LHIN CEOs also hold monthly meetings to discuss, among other things, potential LHIN initiatives involving all the LHINs. As well, the Local Health Integration Networks Collaborative, a division of the LHINs that the Ministry and the LHINs jointly fund, created a web-based forum for LHINs to share information on specific health topics such as home care and palliative care.

Some Best Practices Are Not Identified and Shared

LHINs undertake different projects and initiatives as defined under their three-year strategic plans to help improve their local health systems. But the LHINs we visited do not have a process in place to identify if their projects result in best practices and are therefore worth sharing with other LHINs. LHIN CEOs and Board Chairs agreed in 2014 that LHINs should have a framework to identify best practices and share successes. However, at the time of our audit, this framework had not been established.

A process for identifying best practices would involve defining the intended outcomes and formulating performance targets for each project that, if met, would indicate outcomes were achieved and best practices worth sharing.

We found that, in all the projects we sampled, only one LHIN we visited had established performance measures with targets to assess the success of its projects. Over 40% of a sample of projects we examined at the other three LHINs did not have any performance targets at all. For example, one LHIN we visited set up a geriatric program but did not have any measure to assess whether it reduced emergency department visits for the elderly. Doing so can help identify if the program is working as intended and is worth sharing with other LHINs.

In the four LHINs where projects did have performance targets, about half of them measured mainly outputs. For example, one LHIN we visited developed a handout for patients discharged from hospital on how to care for themselves once they return home. This program was in response to a November 2011 report by a provincial expert panel on avoidable hospitalization that found discharge instructions are often poorly communicated. However, instead of measuring the success of this initiative in reducing readmissions to hospitals, the LHIN only measured the number of hospitals that participated in this initiative.

One LHIN we visited hired an organization that is part of a research centre within a hospital to train its staff in the fall of 2015 on how to design projects so they can be evaluated. Given that over 40% of projects we reviewed at three of the four LHINs did not have any targets, it would be prudent to ensure that all LHIN staff receive such training.

According to our survey results, only about 30% of the health service providers who responded to our survey felt that LHINs collaborate well with each other to improve different aspects of health services including quality of care, access to care and continuity of care, and to identify best approaches to plan and monitor the health system. In contrast, about 60% of the current and former LHIN board members and CEOs felt similarly.

RECOMMENDATION 12

To ensure that best practices are effectively identified and shared, Local Health Integration Networks should:

- develop guidelines and training to evaluate whether projects result in best practices; and
- establish a protocol to use for sharing best practices.

RESPONSE FROM LHINs

LHINs agree that sharing best practices is key to leveraging successes across the system in order to respond to population health needs. This is evident in the adoption of best practices across LHINs such as the Joint Assessment Centres. In order to drive innovative and sustainable service delivery, LHINs have initiated work in

three priority areas to share best practices and minimize duplication of effort.

The Local Health Integration Network Collaborative, a division of LHINs jointly funded by the Ministry to co-ordinate and implement pan-LHIN initiatives, is working with the 14 LHINs in Mental Health & Addictions, Home & Community Care, and End of Life Care using this approach. Leveraging the learnings from these initiatives underway, the LHINs will continue to work toward developing guidelines and training for evaluation of best practices and establishing a protocol for sharing these across LHINs, recognizing the diverse geographies and unique populations that they serve.

4.4.4 Consistent Approaches to Delivering Certain Health Services Lacking

Certain health services can be delivered in consistent ways to ensure that patients receive the same level of service regardless of where in Ontario they live. Collaboration among LHINs is essential for this to happen.

The accountability agreement between the Ministry and the LHINs specifies that the Ministry is to identify common issues and services for which a consistent approach across LHINs is required, and to provide standards, directives and guidelines for LHINs or health service providers to follow. But because health care is such a vast and complex field, leaving it up to the Ministry alone to develop consistent approaches to every health service would not be efficient. More could be achieved if the Ministry and LHINs share in the task of developing consistent ways of delivering care in different areas. However, there is a lack of clarity in terms of who—the Ministry or the LHINs—is meant to lead the initiative, and when a consistent approach is necessary. About half of the current and former LHIN board members and CEOs—yet only a quarter of the health service providers—who responded to our survey, were clear on whether the Ministry or LHIN would take on the responsibility of developing standardized responses to common issues and services, indicating that this role should be clarified.

In practice, the responsibility has been shared between the Ministry and the LHINs, as noted in the following examples:

- The Ministry in 2013 began to establish standard clinical handbooks for 10 health procedures and conditions, including cancer surgery, coronary artery disease and pneumonia. These evidence-based handbooks look at how to improve the quality of care and achieve system efficiencies.
- The 14 LHINs in April 2013 formed an alliance with a goal to improve the delivery of rehabilitative care and develop a common approach to care for patients who require rehabilitative care across health sectors.

Yet, LHINs use inconsistent approaches for the same areas of other health services because standardized approaches are lacking, as noted in the following examples:

- Neither the Ministry nor the LHINs had defined a standard set of available addiction services, despite the fact that the Minister's Advisory Group on the 10-Year Mental Health and Addiction Strategy in December 2010 recommended that the Ministry establish a common basket of core services and provincial standards for mental health and addiction services. Given the absence of a standard set of services provincially, one LHIN we visited established its own set of core addiction services in 2014. Finally in May 2015, five years after the recommendation, all LHINs decided to begin working on identifying a core set of addiction services for the whole province. The Ministry noted that it had begun working toward identification of core services.
- Two of the four LHINs we visited used a best practice that involves identifying conditions for which common clinical approaches should be used and ensuring that health service providers follow them, so that all patients

have equitable access to similar treatment and quality care. One LHIN uses this approach for a broad range of medical conditions including gastroenterology, cancer, vascular surgery and ophthalmology. Another LHIN uses this approach for a smaller range of medical conditions—complex continuing care, stroke, and total joint replacement. The first LHIN followed this approach at the recommendation of an external consulting firm it engaged in 2012, following a review of leading practice strategies of 10 international jurisdictions with the best overall health in their populations.

RECOMMENDATION 13

To reduce the variation in the experiences of patients, the Ministry of Health and Long-Term Care should clarify under what circumstances it, as opposed to the Local Health Integration Networks, is responsible for establishing common approaches to delivering health services.

MINISTRY RESPONSE

The Ministry accepts this recommendation and is committed to continue to strengthen relationships with the LHINs, and to clarify, where required, responsibilities regarding the planning and delivery of health services. These discussions will occur through a variety of forums, including the monthly meetings between the Ministry's senior management committee and the LHIN CEOs.

Early and ongoing engagement between the Ministry, LHINs and health service providers on provincial strategies, working groups and expert panels has been and will continue to be a common business practice. In some instances, such as the work to develop standardized processes in rehabilitative care, the LHINs will take a leadership role with ministry engagement and support. In other cases, such as the development of quality-based procedures to reduce practice variation for select clinical procedures, the Ministry will provide the provincial direction with input and participation from the LHINs.

4.4.5 Group Purchases and Back-office Integration Not Fully Explored

The use of group purchasing and "back-office integration" (that is, integrating or consolidating the administrative and business operations of LHINs and/or health service providers) differed across the four LHINs we visited. As a result, LHINs could not demonstrate that they have maximized economic efficiencies in the delivery of health services as per their mandate.

Nine shared-services organizations have been established to help hospitals obtain better prices for goods and services through group purchasing and back-office services such as contract management (seven were established prior to creation of LHINs, and two after). Hospitals in three of the four LHINs we visited used services offered by one or more of these shared-services organizations. Some of these LHINs also co-ordinated for their hospitals additional group purchases and back-office integration services such as accounts payable services. As well, these LHINs co-ordinated group purchases on goods such as vehicles and computer equipment and arranged for translation services for their community-based health agencies. In comparison, the fourth LHIN did not use group purchasing, and its hospitals generally do not obtain services from any of the pre-existing shared-services organizations. Instead, one of the larger hospitals in this region has arranged for shared services on payroll and information technology with other hospitals. In 2013, an external consultant identified potential savings of $2.2 million over seven years if hospitals in this LHIN eliminated duplicated administrative work that each hospital will have to undertake in purchasing, and tried to arrange for volume discounts. However, this LHIN had not acted on this at the time of our audit, nor had it considered helping its community-based health service providers achieve similar cost savings.

We also found that only one LHIN we visited had plans to centralize the back-office support for all its integrated clinical programs including those for high-risk seniors, stroke and oncology programs across the LHIN so that they share common information management, human resources and financial support. The other three do not have such an initiative.

According to our survey results, more health service providers wanted LHINs to explore additional group purchases and back-office integration opportunities than those that did not. Also, while over 70% of the current and former LHIN board members and CEOs felt that LHINs have brought economic efficiencies to the delivery of health services, only a quarter of the health service providers who responded felt the same way.

RECOMMENDATION 14

To ensure that health services across Ontario are delivered as cost efficiently as possible, Local Health Integration Networks should identify further group-purchasing and back-office integration opportunities in the various health sectors, and implement these cost-saving practices.

RESPONSE FROM LHINs

The LHINs will support their health service providers to implement group-purchasing and back-office integration initiatives where a case exists to achieve significant value (i.e., realized cost savings, improved quality, improved internal controls and increased capacity). Consistent with the LHIN mandate, LHINs will continue to lead and focus on service integration (i.e., the integration of service delivery to patients, clients and residents) for the benefit of residents.

4.4.6 Outcomes of Integration Initiatives Not Always Measured

When LHINs implement initiatives to help integrate the health system, we found that they do not always measure cost savings achieved by these initiatives. It is, therefore, unclear whether these initiatives actually helped improve the local health systems and how much cost savings have been reinvested into direct patient care as a result. On average, the four LHINs we visited each initiated five to 26 integration projects in each of the 2013/14 and 2014/15 fiscal years. These projects included mergers of health-care providers and partnership with a health service provider to provide interpretation services for all patients in the region (see **Figure 2** for additional examples).

According to our survey results, 45% of the health service providers noted that LHINs have not fully explored integration opportunities in the different health sectors. A greater number of health service providers felt that LHINs' integration efforts mainly focused on hospitals than those who felt that the efforts focused on the entire health system. Also, LHIN management and health service providers did not have a consistent view on integration—90% of current and former LHIN board members and CEOs felt that their LHINs understand that integration is more than just reducing the number of health service providers in the region, while only half of the health service providers felt this way.

Only one of the four LHINs we visited tracked the cost savings that resulted from its integration projects, and then only on merger-type projects. This LHIN expected that once its integration projects are fully implemented, it will achieve annual cost savings of $1 million across its community health sector and $8.8 million across its hospital sector. At the time of our audit, two-thirds of the expected cost savings have been achieved; the LHIN expects to achieve the remaining cost savings by 2017. The fact that the impact of each integration initiative was not quantified may explain the following survey result—while over 80% of LHIN management felt that integration initiatives in their LHINs have resulted in better access to patient care and better quality care, only 40% of health service providers felt the same way.

LHINs we visited indicated that integration initiatives can also improve continuity of care, enhance the patient experience, and increase system capacity; these impacts may be tracked through other measures such as output or outcome measures. However, as we noted in **Section 4.4.3**, LHINs need to improve how they measure their integration projects, including developing performance targets and establishing outcome measures to assess the success of all integration projects.

RECOMMENDATION 15

To ensure integration initiatives improve local health systems and to help identify the most effective types of approaches to integration, Local Health Integration Networks should measure the impact that each integration initiative has on LHIN service levels and costs.

RESPONSE FROM LHINs

LHINs fully support measurement of the impact that each integration has on LHIN service levels and costs. The LHINs recognize the complexity associated with these evaluations. LHINs will work toward developing a standard framework in which to identify and measure the impact of these integrations demonstrating overall value for service providers, patients and the system. This work will be informed by the Ministry in partnership with health service providers and evaluation specialists in order to ensure an effective and aligned approach.

4.5 Funding Process Needs Improvement to Better Meet Patient Needs

LHINs are responsible for more than half of the provincial health-care budget for the year ending March 31, 2015. LHINs can, with certain exemptions, allocate funds among and between health service providers and health sectors as they choose to. We found that the four LHINs we visited did not consistently understand their funding authority as it relates to reallocating funds within and among health sectors, thereby limiting the opportunities to fully integrate the health services in their regions. We also found that LHINs are not notified of funding changes on a timely basis, and in turn do not in due course notify the health service providers they fund, resulting in cases where funding originally earmarked for health service providers is returned to the Ministry. As well, one LHIN we visited used a different tool than the common assessment framework to evaluate projects submitted by health service providers for the Urgent Priorities Fund, but that tool did not incorporate all assessment areas required in the common framework. As a result, there was no assurance that projects selected in that region were fairly meeting local urgent needs.

We look at the above issues in detail in the following subsections.

4.5.1 LHINs' Authority to Fund Health Sectors Needs to Be Clarified

Some LHINs might not have fully pursued certain integration opportunities because they had a different understanding than the Ministry of their authority over health-sector funding. The four LHINs we visited had a different perception of their funding authority from that of the Ministry.

The Ministry indicated that LHINs have the flexibility to allocate and reallocate much of their funds, provided that the LHIN's funding decision is made in accordance with the expectations stated in the accountability agreement and within the legislative framework. LHINs have less discretion over protected funding, such as long-term-care home sector funding (as explained in **Section 1.2.2**). However, the four LHINs we visited believe the Ministry still maintains authority and control over funding, as the Ministry can intervene in a LHIN's funding decision even if it has been approved by the LHIN Board. The Ministry noted that it would only intervene in a LHIN funding decision where the decision was contrary to the terms and conditions of the funding.

Also, the LHINs we visited have indicated that they cannot move new funding that the Ministry has specified to be spent on a specific health sector to another health sector if the LHIN considers that the other sector would better benefit from the new funding. For example, the four LHINs we visited indicated that they cannot use the funding increase that the Ministry earmarked for the community-based health sectors for hospital-based community services to spend on related services such as tele-homecare for chronic disease patients and a chronic disease prevention clinic. But the Ministry actually allows LHINs to negotiate with it if the LHINs want to use the funding for a purpose different than that specified by the Ministry. The lack of clarity on funding authority between the Ministry and LHINs may result in LHINs not being able to direct funds to facilitate areas of health care to address their local needs, including the need to integrate health-care services.

RECOMMENDATION 16

To ensure that Local Health Integration Networks (LHINs) appropriately facilitate areas of health care to address local needs, the Ministry of Health and Long-Term Care (the Ministry) should clarify with the LHINs what authority they have to reallocate funding among health service providers, and inform them that they can negotiate the use of dedicated funding with the Ministry.

MINISTRY RESPONSE

The Ministry supports this recommendation and will take appropriate steps to ensure that all LHINs have a consistent understanding of their funding authority, including the ability to reallocate funds.

4.5.2 Ministry Finalizes Annual Funding Late in the Year and Health Service Providers Receive Funding Late from LHINs

Health service providers need to know how much funding is available to them in order to effectively plan health services for the year and ensure they do not run deficits. However, LHINs do not confirm their final funding until well into the fiscal year.

With the exception of funding for reforms of hospitals and CCACs, health service providers are generally funded based on the amount they received the year before. But annual funding is subject to changes depending on the Ministry's and LHIN's funding decisions during the year. In the two years leading up to March 31, 2015, the Ministry finalized funding to the four LHINs we visited well into the fiscal year. These delays resulted in these LHINs not informing the health service providers about their funding decisions until six months before the fiscal year end that first year and three months before the fiscal year end the second year. At all four LHINs we visited, health service providers were notified of funding changes as late as the last month of the fiscal year in the year ending March 31, 2015. These delays made it difficult for health service providers to provide the intended services for the period, and to meet their service volume target. As a result, some service providers had to return the money to the LHINs. The LHINs, in turn, needed to reallocate the surpluses to other providers, and returned the residual amount to the Ministry, defeating the purpose of providing funding to those health service providers in the first place.

RECOMMENDATION 17

To ensure health service providers can properly plan to meet patient-care needs, the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks, should finalize the annual funding each health service provider will receive before the fiscal year begins or as early in the current fiscal year as possible.

MINISTRY RESPONSE

The Ministry supports this recommendation. The majority of LHIN funding is a base budget that continues from one year to the next. The Ministry is working with sector partners to review its funding processes to identify opportunities to finalize allocations earlier, and will work with the LHINs to confirm funding amounts as early as possible.

4.5.3 Urgent Priorities Fund Allocated to LHINs Based on Outdated Population Information

The Ministry has not reviewed whether the existing allocation and amount of the Urgent Priorities Fund (Fund) are still appropriate. The purpose of the Fund is to address urgent local health-care priorities for projects submitted by health service providers. Examples of funded projects include increased funding to alleviate wait times for accessing MRI and CT scans at hospitals, and increased funding to a mobile mental health crisis team.

While the Fund has remained constant at $50 million for all 14 LHINs since its inception, the amount of overall LHIN funding, including funding to health service providers, has increased by 29% between 2008 and 2015 (the inflation-adjusted increase is 12%). Between 2008 and 2015, LHINs on average distributed 97% of the Fund to health service providers.

Each LHIN's annual allocation from the Fund is based on the population information the Ministry had when the Fund was created in 2007, eight years ago (the Ministry cannot confirm the actual year from which the population data was derived). But population distribution has changed since then. For instance, between 2006 and 2011, the population of one of the LHINs we visited increased by 11%, twice the provincial increase of 5.6%. Moreover, this LHIN's population is expected to grow an additional 10% by 2016, and a further 10% by 2021. Residents of this LHIN could well be shortchanged with respect to their most urgent health-care needs because their share of the Fund is based on outdated population data.

RECOMMENDATION 18

To ensure that the share of the Urgent Priorities Fund allocated to each Local Health Integration Network reflects current patient needs, the Ministry of Health and Long-Term Care should:

- ensure the amount allocated to the Fund is appropriate considering overall funding increases over time; and
- regularly revise the allocation on the basis of current population and/or other relevant information.

MINISTRY RESPONSE

In 2007, the government announced a commitment to address urgent health-care priorities in local communities through the creation of a population-based $50 million annual fund. The funding was rolled out to the LHINs as base funding and it is reflected within their total annual allocation. As part of the guidelines for the fund, LHINs have the ability to designate all or a portion of their annual allocation to a health service provider's base budget. Since much of this funding is already committed by the LHINs to their health service providers for the purpose of addressing urgent local priorities, reallocating existing funding could have impacts on direct service delivery.

The Ministry supports the recommendation to allocate funding using population-based models and will work with the LHINs to equitably distribute new funding based on the latest population figures for each LHIN.

4.5.4 Urgent Priorities Fund Projects Assessed Using Different Selection Criteria

The Local Health Integration Networks Collaborative (discussed previously in **Section 4.4.3**)

developed a decision-making framework in November 2010 to help LHINs make consistent decisions on projects, including funding proposals they receive for the Urgent Priorities Fund. But, while LHINs are expected to use this framework—which includes project-assessment criteria such as value to the health system and impact on system performance and population health—they are not consistently doing so.

Three of the four LHINs we visited did use the framework and assigned specific weighting to each of the framework categories in order to ensure that funding supports their local strategic priorities. One of the LHINs we visited, however, uses a different tool to assess proposed projects, but this tool does not incorporate all assessment areas that are required in the common framework, such as potential impact on service quality and population health outcomes. Also unlike the common framework, this tool does not assign scores to its assessment criteria. As a result, there is no assurance that the projects selected by this LHIN are the most appropriate to serve its urgent needs at that time.

4.5.5 Urgent Priorities Fund Used for Purposes Not Allowed

We tested a sample of projects that used the Urgent Priorities Fund in the four LHINs we visited to ensure funding was going exclusively to direct patient services, as the Fund requires. Most of the funded projects we reviewed were for direct patient services such as increasing hospital beds, increasing long-term-care beds, and funding more hours for MRI or CT scans. We found two instances where the Fund was used for other purposes than direct patient services. In one case, a LHIN allocated $861,000 to a health service organization so it could develop business application software to make patient information available to hospitals and a local CCAC. The LHIN did not use the common assessment framework and explained that the software has allowed hospitals to easily identify patients with high needs. In another case, a LHIN in 2013 allocated $130,000 toward the severance payment of an outgoing CEO of a former mental health agency.

RECOMMENDATION 19

To ensure health service providers spend funding from the Urgent Priorities Fund only on patient services, as the Fund requires, Local Health Integration Networks should follow a consistent decision-making process and approve applications only on the basis of established criteria.

RESPONSE FROM LHINs

Many LHINs adopted the decision-making framework developed in 2010 by the Local Health Integration Networks Collaborative to help make consistent decisions on funding projects, programs and services. All LHINs will use the revised framework for decision-making about the allocation of discretionary funds.

4.6 LHIN Boundaries Need Revisiting

Ever since the Ministry divided the province into 14 LHINs in 2006, it has not reviewed whether the division is still appropriately meeting the health-care needs of the changing population. In creating those divisions, the Ministry considered the patterns of how people accessed hospital services. Specifically, the postal codes of patients at each hospital were analyzed and mapped into unique areas, ultimately becoming the 14 LHINs as they exist today. As a result, the division of the province differs from already-established divisions such as municipal boundaries or electoral districts.

Health service providers who responded to our survey expressed concerns that because the LHIN boundaries do not always conform to municipal boundaries, it is difficult to leverage existing partnerships for health-care planning and to provide consistent patient care with adjoining LHINs. A greater number of respondents indicated that there are too many LHINs than those who found there were not enough.

RECOMMENDATION 20

To ensure the division of the Local Health Integration Networks (LHINs) is conducive to effective planning and integrating of local health-care services, the Ministry of Health and Long-Term Care should review existing LHIN boundaries.

MINISTRY RESPONSE

The Ministry will review the existing LHIN boundaries to determine whether changes may be required.

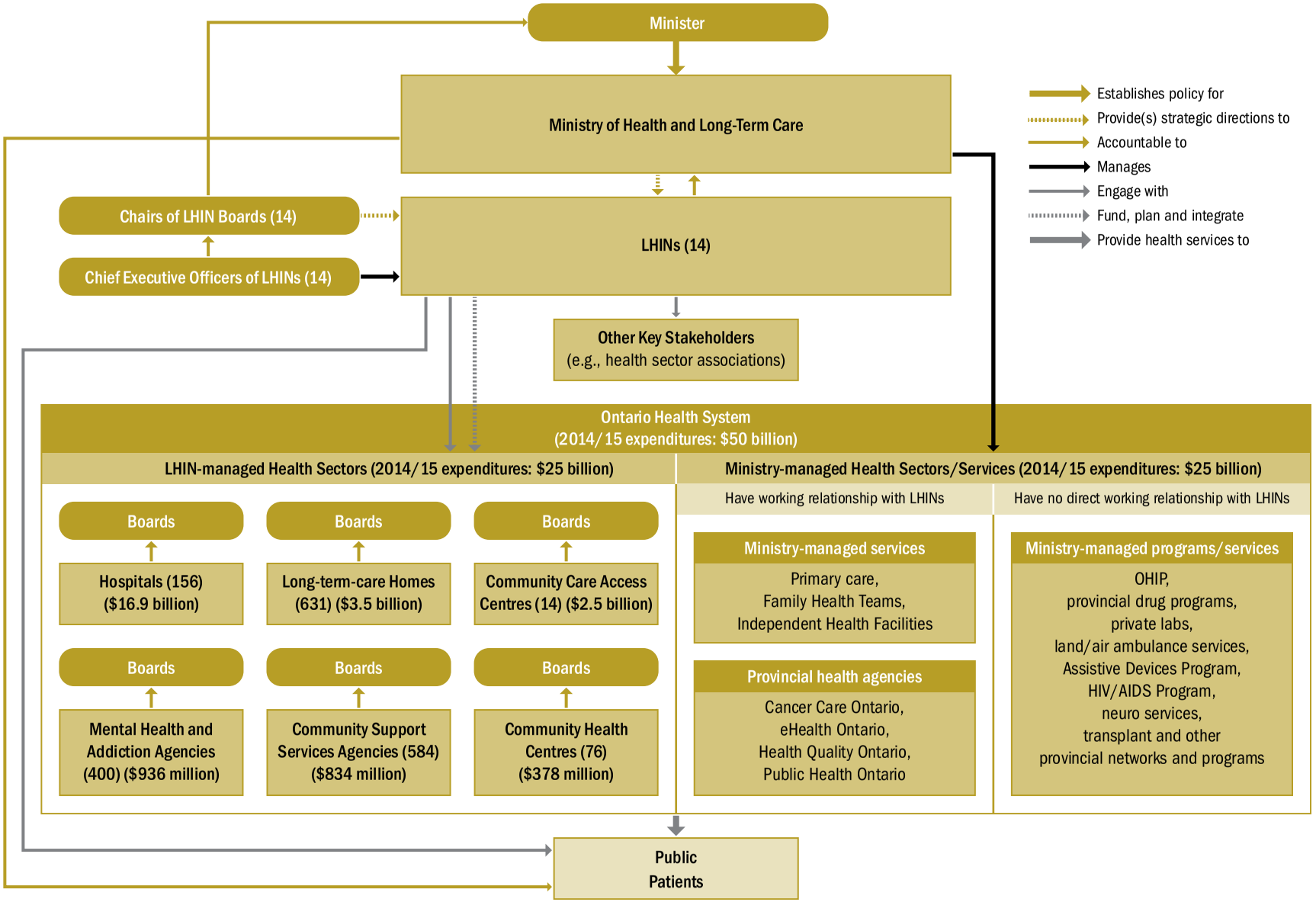
Appendix 1—Objects of a Local Health Integration Network

Source of data: *Local Health System Integration Act, 2006*

1	To promote the integration of the local health system to provide appropriate, co-ordinated, effective and efficient health services.
2	To identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the Minister about that system, including capital funding needs for it.
3	To engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation.
4	To ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive.
5	To evaluate, monitor and report on and be accountable to the Minister for the performance of the local health system and its health services, including access to services and the utilization, co-ordination, integration and cost-effectiveness of services.
6	To participate and co-operate in the development by the Minister of the provincial strategic plan and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services.
7	To develop strategies and to co-operate with health service providers, including academic health science centres, other local health integration networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services.
8	To undertake and participate in joint strategies with other local health integration networks to improve patient care and access to high-quality health services and to enhance continuity of health care across local health systems and across the province.
9	To disseminate information on best practices and to promote knowledge transfer among local health integration networks and health service providers.
10	To bring economic efficiencies to the delivery of health services and to make the health system more sustainable.
11	To allocate and provide funding to health service providers, in accordance with provincial priorities, so that they can provide health services and equipment.
12	To enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network.
13	To ensure the effective and efficient management of the human, material and financial resources of the network and to account to the Minister for the use of the resources.
14	To carry out the other objects that the Minister specifies by regulation made under this Act. 2006, c. 4, s. 5.

Appendix 2—Overview of the Ontario Health System

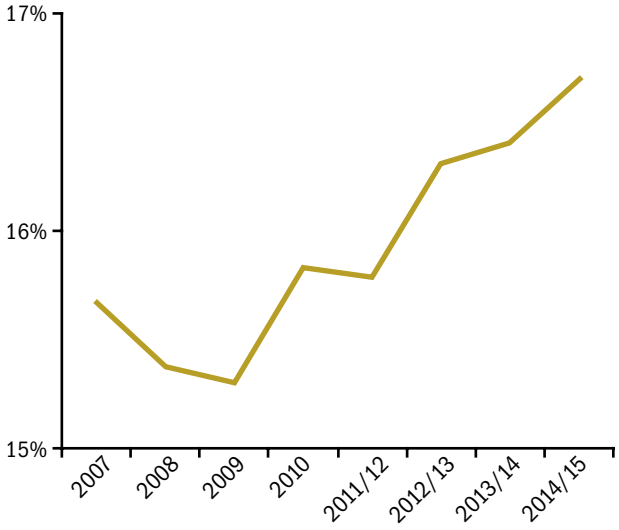
Prepared by the Office of the Auditor General of Ontario based on information provided by the Ministry of Health and Long-Term Care and the Ministry of Finance



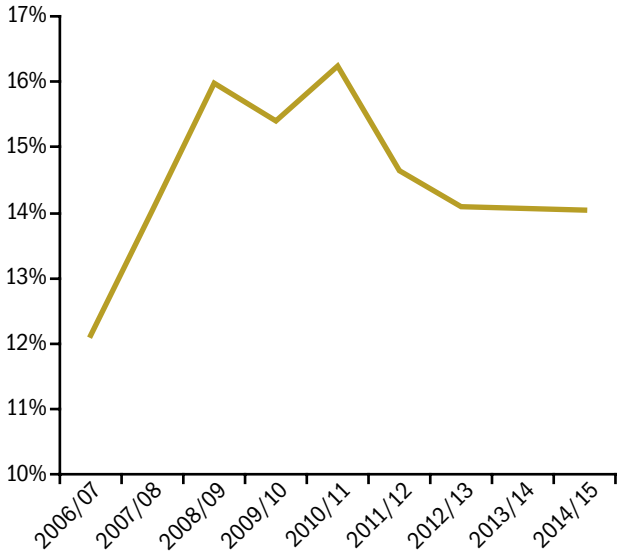
Appendix 3—Summary Statistics on Province-wide Performance for 15 LHIN Measurement Areas

Sources of data: Cancer Care Ontario, Cardiac Care Network of Ontario, Ministry of Health and Long-Term Care

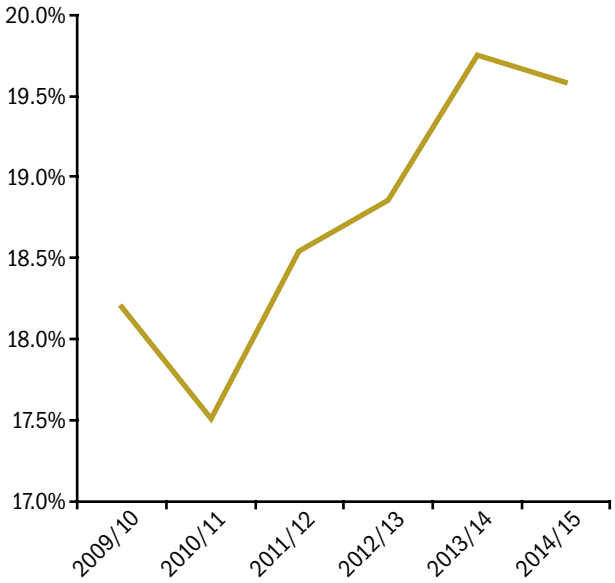
Readmissions within 30 Days for Selected CMGs[1]



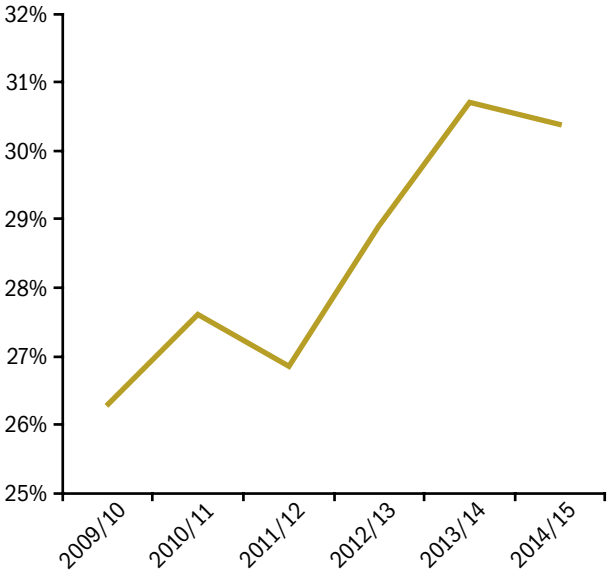
Percentage of Alternate Level of Care (ALC) Days



Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions[2]

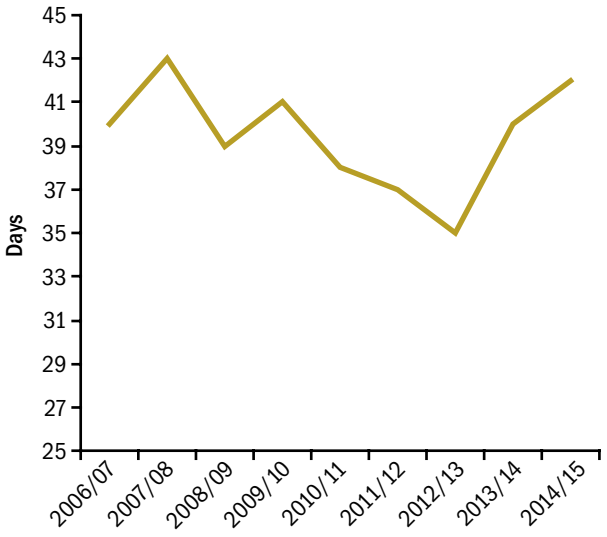


Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions[2]

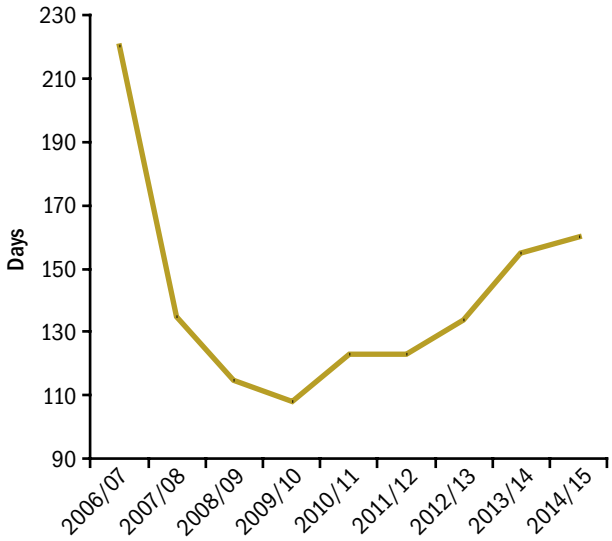


1. Data prior to the fiscal year ending March 31, 2012 is only available for the calendar year.
2. Comparative data is only available from the fiscal year ending March 31, 2010, onwards.

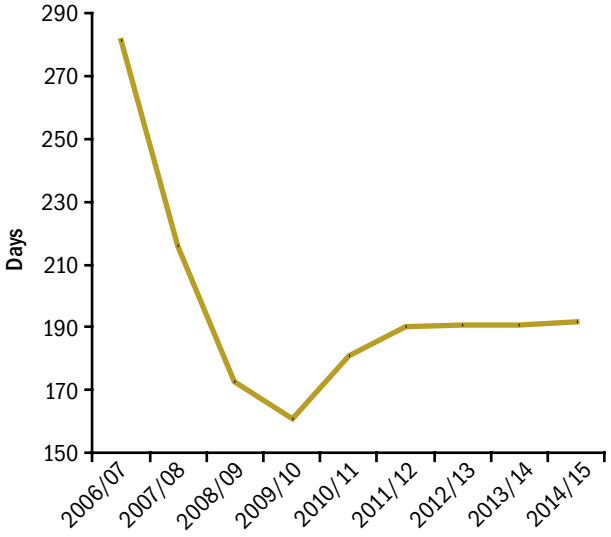
90th Percentile Wait Time—Cardiac By-pass Procedures



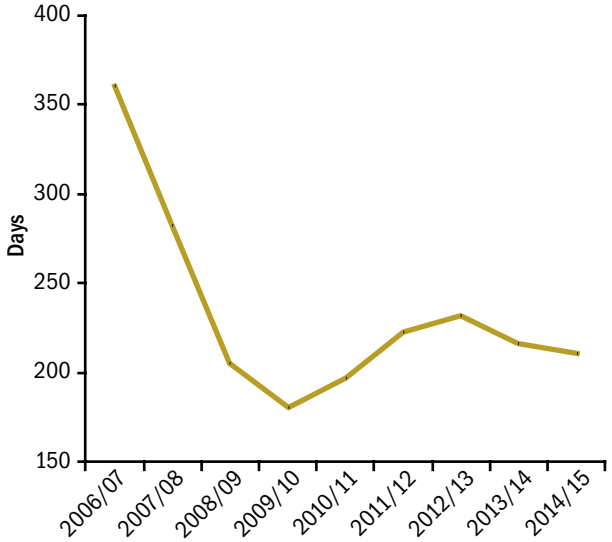
90th Percentile Wait Time—Cataract Surgery



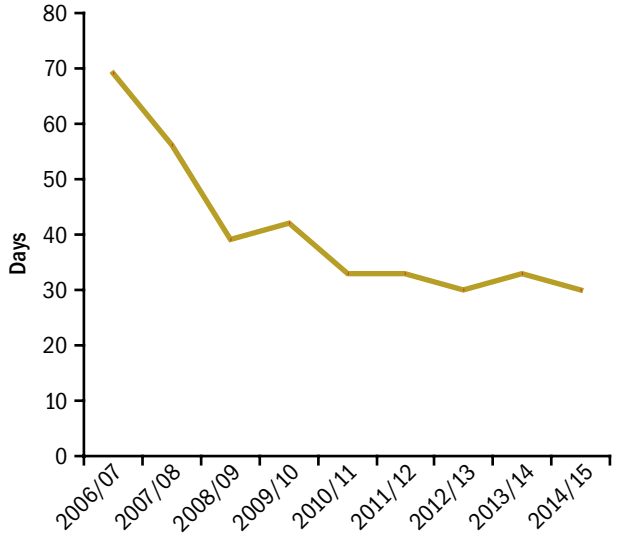
90th Percentile Wait Time—Hip Replacement



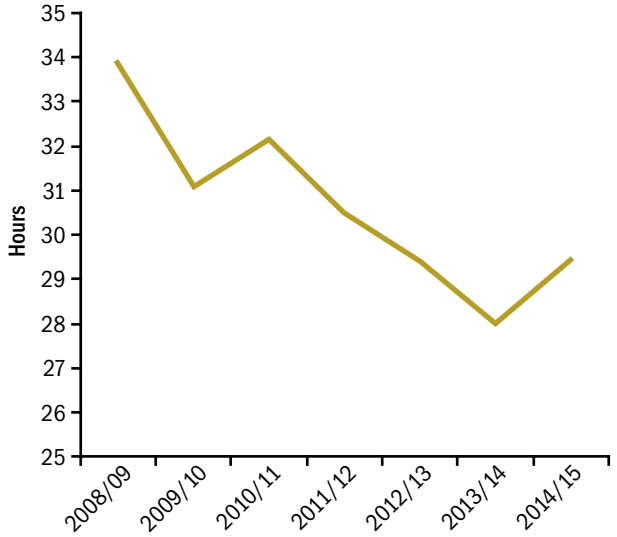
90th Percentile Wait Time—Knee Replacement



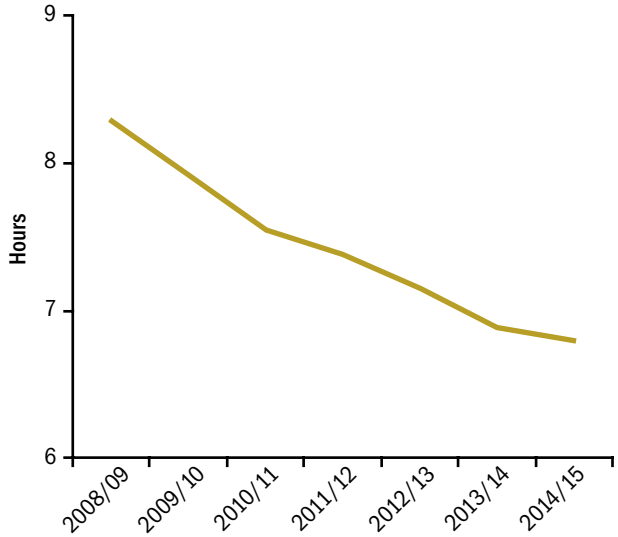
90th Percentile Wait Time—Diagnostic CT Scan



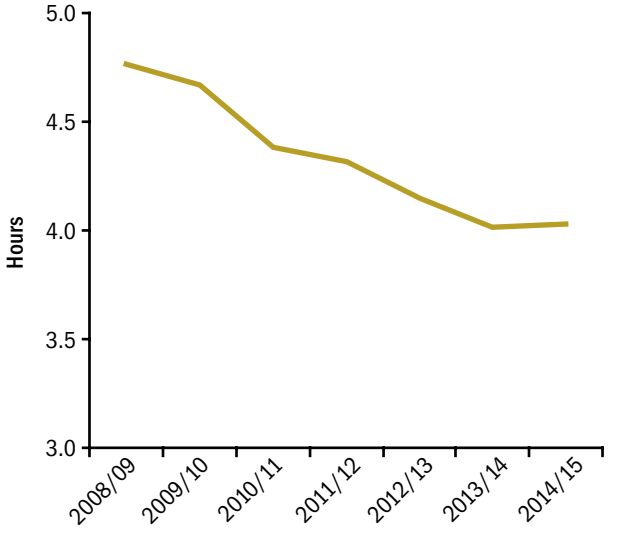
90th Percentile Emergency Room Length of Stay—Admitted Patients



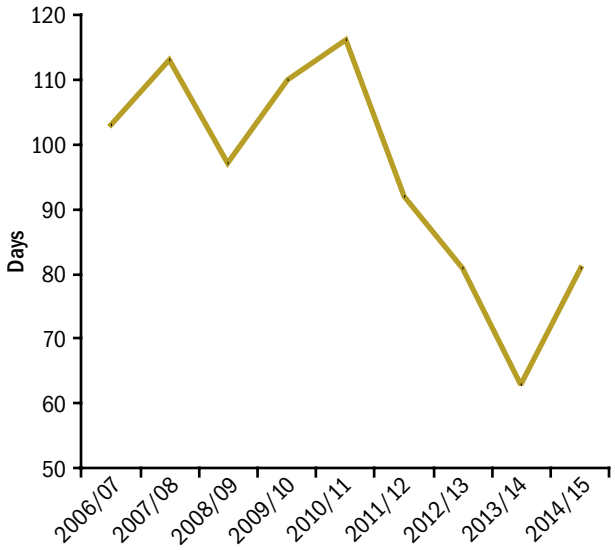
90th Percentile Emergency Room Length of Stay—Non-admitted Complex Patients



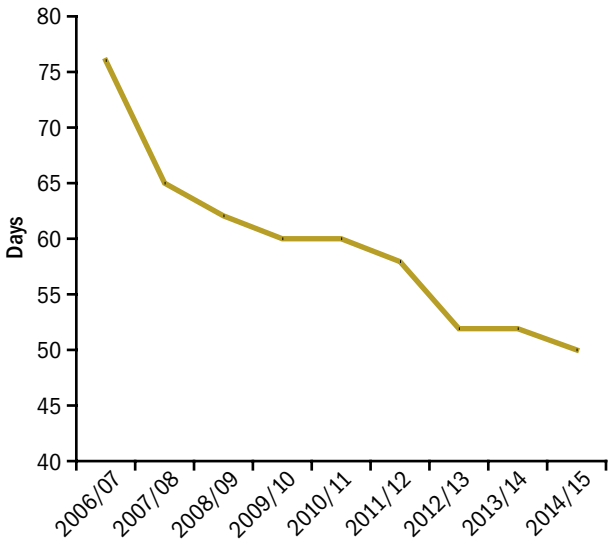
90th Percentile Emergency Room Length of Stay—Non-admitted Uncomplicated Patients



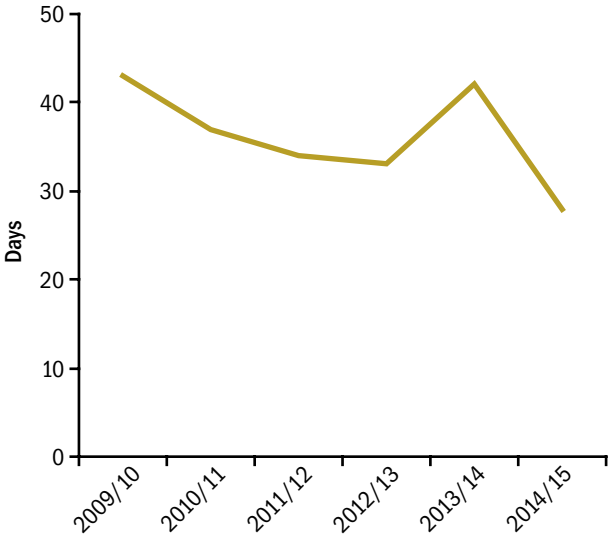
90th Percentile Wait Time—MRI Scan



90th Percentile Wait Time—Cancer Surgery



90th Percentile Wait Time from Community for CCAC In-home Services[2]



2. Comparative data is only available from the fiscal year ending March 31, 2010, onwards.

Appendix 4—Health System Performance, Ontario and Other Canadian Jurisdictions, 2010–2014

Sources of data: Health Quality Ontario, Canadian Institute for Health Information

Indicators	Period Covered	Results of the Best-performing Province	Results of the Second-best-performing Province	Results of the Third-best-performing Province	Ontario's Performance (If Not within Top 3)	Canada Average
Indicators Currently Measured in the 15 Areas (either identical or similar)						
% of hip replacement procedures provided within patient wait time of 182 days	2014	Newfoundland and Labrador, 96%	Saskatchewan, 93%	**Ontario, 88%**		83%
% of knee replacement procedures provided within patient wait time of 182 days	2014	Newfoundland and Labrador, 92%	Saskatchewan, 89%	**Ontario, 86%**		79%
30-day readmission rates following hospitalization	2010/11	Alberta and Nova Scotia, 8.2%	Quebec, 8.3%	**Ontario** and New Brunswick, **8.4%**		8.5%
30-day readmission for mental illness	2012	Manitoba, 9.2%	Alberta, 9.8%	Saskatchewan, 10.5%	**Ontario, 11.3%** (5th)	11.5%
% of cataract surgery procedures provided within patient wait time of 112 days	2014	Newfoundland and Labrador, 96%	New Brunswick, 89%	Saskatchewan and Quebec, 88%	**Ontario, 81%** (5th)	80%
Indicators in the Proposed 23 Areas (either identical or similar)						
Hospitalizations for medical conditions that can potentially be managed outside the hospitals per 100,000 people	2011/12	British Columbia, 254	**Ontario, 269**	Quebec, 275		290
% of people who stayed overnight in hospital in the past 2 years and when left, hospital made arrangements or made sure that follow-up care with a doctor or other health-care professional was provided	2014	Newfoundland and Labrador, 88%	Prince Edward Island, 82%	**Ontario, 81%**		78%
Other Indicators						
% of radiation therapy procedures provided within patient wait time of 28 days	2014	Manitoba, 100%	**Ontario** and Quebec, **99%**	Newfoundland and Labrador, 95%		98%
% of people reported difficult or somewhat difficult in getting access to care on evening or weekend without going to emergency department	2013	British Columbia, 54%	**Ontario, 56%**	New Brunswick and Prince Edward Island, 61%		60%
% of people able to see primary care provider on the same day or next day when they were sick	2013	British Columbia, 45%	Saskatchewan and Prince Edward Island, 41%	**Ontario, 40%**		38%

Indicators	Period Covered	Results of the Best-performing Province	Results of the Second-best-performing Province	Results of the Third-best-performing Province	Ontario's Performance (If Not within Top 3)	Canada Average
% of hip fracture repair procedures provided within patient wait time of 48 hours	2014	Manitoba, 91%	British Columbia, 89%	**Ontario, 84%**		84%
% of people who stayed overnight in hospital in the past 2 years and when left, knew whom to contact if there was a question about their condition or treatment	2014	Prince Edward Island, Saskatchewan, 95%	British Columbia, 94%	Manitoba, 93%	**Ontario, 90%** (5th)	88%
% of people who stayed overnight in hospital in the past 2 years and when left, received written information on what to do when they returned home and what symptoms to watch for	2014	Newfoundland and Labrador, 84%	Saskatchewan, 82%	Alberta, Manitoba, 81%	**Ontario, 75%** (tied for 6th with New Brunswick)	73%
% of people who stayed overnight in hospital in the past 2 years and when left, doctors or staff at the place where individual usually received medical care seemed informed and up to date about the care received in the hospital	2014	Prince Edward Island, 92%	Manitoba, 89%	British Columbia, 87%	**Ontario, 77%** (tied for 7th with Newfoundland and Labrador)	80%