

Transforming the health care system, together

2012 / 13 Annual Report



Transforming the health care system, together

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the provincial government through the *Local Health System Integration Act (LHSIA)*, 2006, to plan, coordinate, integrate and fund health services at the local level.

LHINs reflect the idea that communities know their own health needs and priorities best. They bring together health care partners from sectors such as hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care to develop innovative, collaborative solutions so that people in our communities have more timely access to high-quality services.

LHINs are key partners in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.

LHINs have already brought about significant and positive change in the way health services are delivered, and will continue to build upon that work. Populations are growing and aging, the rates of chronic conditions are rising and current fiscal realities have resulted in challenges that need to be addressed.

But transformation requires a collective call to action. Everyone has an important role to play in making healthy change happen, including health service providers, LHINs, community leaders and the public.

Visit www.lhins.on.ca for more information on how LHINs are making a difference in Ontario's health care system.



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Message from the Chair and CEO

As a funder, planner and manager of the local health system, Central LHIN's goal is to improve the health care system and make it better for all of us who live, work and receive health care in our region. Central LHIN also has a key role in enabling and maintaining the sustainability of Ontario's health care system, in integrating care so that it reflects the needs of patients, and in implementing provincial priorities at the local level. All of this is done with robust input from our key stakeholders and the community.

Central LHIN strongly believes that *together, we are better*. This philosophy is the foundation of what we do, at a system level, to advance change and improve quality. We believe that we must work together to achieve the highest quality of care for our patients, clients and residents. And by quality care, we mean that the *right care* is provided in the *right place* at the *right time*. As the only LHIN in Ontario to achieve each of the Ministry's 15 performance targets for 2012/13, we continue to demonstrate that together we are indeed better.

In 2012/13, Central LHIN continued to guide its activities according to the Integrated Health Service Plan for 2010-2013 (IHSP) and made significant progress in the four key planning priorities: Emergency Department and Alternate Level of Care, Chronic Disease Management and Prevention, Mental Health and Addictions, and Health Equity. Highlights include:

- Increasing support for community services by \$14.3 million to provide more seniors with care at home, reduce unnecessary emergency room visits and increase local addiction services;
- Leading through innovation by working across ministries to fund a new model of assisted living for young adults with complex medical needs. This innovative cluster care model addresses the needs of those who wish to reside in a setting appropriate to their age group while incorporating a high level of intensive care support;
- Reducing wait times for cancer and cardiac surgeries, and diagnostic MRI and CT scans;
- Creating new capacity through transitional care beds to assist people who are discharged from hospital to long-term care to help decrease the number of patients waiting for alternate levels of care; and
- Providing leadership in regional palliative care by appointing the Central Community Care Access Centre (CCAC) to lead the development of a Regional Palliative Hospice Care Program in the Central LHIN. This program brings together all palliative care providers in

our LHIN with the goal of providing standardized, best practice care and integrated services to patients.

Engagement of primary care providers in our regional quality agenda continues to be a key focus for Central LHIN. In 2012/13, these partnerships resulted in collaborative initiatives, such as: being a leader in improving access to primary care services for unattached patients; supporting the implementation of avoidable hospitalizations; holding our second annual Quality Forum - *Quality Improvement in Primary Care* – in partnership with the University of Toronto; and other quality of care initiatives such as Health Links.

Health Links is about improving the coordination of care for high-needs patients – such as seniors and people with complex conditions – by wrapping services around them in a way that hasn't been done before. With two early adopter Health Links in our LHIN, this innovative approach is a cornerstone for transforming the health system in Central LHIN.

Our success in advancing change over the course of the 2010-2013 Integrated Health Service Plan (IHSP) demonstrated that Central LHIN health service providers understand and support the need for health system transformation. Our next IHSP focuses that need through a quality improvement lens that advances our four system directions – appropriateness, access, integration and person-centredness. These quality-based system directions will guide the Central LHIN's activities, engagement plans and investments in the local health system over the next three years as we work together to help transform the local health care system in a way that matters most to the people it serves.

As always, we thank our health service providers, our Board of Directors and our staff for their hard work and dedication to transforming the health care system and advancing quality health care for our communities.



John Langs

Chairman of the
Board of Directors



Kim Baker

Chief Executive
Officer

Our Board of Directors

LHINs operate as not-for-profit crown agencies governed by an appointed Board of Directors and are bound by a Ministry-LHIN Performance Agreement and Memorandum of Understanding with the Ministry of Health and Long-Term Care. Board members are appointed by an Order-in-Council for a term of one to three years, subject to a maximum of two terms (up to six years).

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



John M. Langs – Chairman
Sept. 24, 2008 – Sept. 23, 2011
June 2, 2011 – June 1, 2014
Toronto



Maneesh Mehta
June 17, 2010 – March 27, 2013
Unionville



Dr. Uzo Anucha
June 2, 2011 – June 1, 2014
Richmond Hill



Stephen E. Quinlan
June 23, 2011 – June 22, 2014
Sharon



Judy Cameron
June 2, 2011 – June 1, 2016
Keswick



John Rogers
Mar. 10, 2010 – Mar. 9, 2013
Mar. 19, 2013 – Mar. 18, 2016
Keswick



Albert Liang
May 17, 2011 – May 16, 2014
Markham



Brenda Urbanski
April 8, 2011 – April 7, 2014
Beeton

More information on the Central LHIN Board of Directors can be found at www.centrallhin.on.ca.

About Central LHIN

Central LHIN's mandate is to plan, coordinate, integrate and fund health services at the local level. In 2012/13, Central LHIN's budget of \$1.8 billion was allocated across a range of health programs through 110 Service Accountability Agreements delivered by our health service providers, including:

- Six public and three private hospitals;
- 46 long-term care homes;
- 37 community support service providers;
- 21 mental health and addictions service providers;
- One community care access centre (CCAC); and
- Two community health centres.

Some health service providers deliver care and services in multiple sectors.

Population

With a population of over 1.8 million*, Central LHIN has the most residents, is among the most diverse and is one of the fastest growing of all LHINs.

The population trends that will have significant impact on planning and delivery of health services in Central LHIN are growth, aging and diversity. A key challenge is to meet the increasing demand for care and services as our population continues to grow and age at a rate above the provincial average.

Growth

Central LHIN's population is growing. Between 2011 and 2016, our population will increase by 10.1 per cent*. By 2021, the population will have grown by 20.3 per cent* since 2011 – one of the highest projected growth rates among the LHINs (provincial population growth rate projected between 2011 and 2021: 12.7 per cent*).

Aging

Central LHIN will experience greater-than-average population aging over the next 10 years. Currently, 12.5 per cent* of residents in the LHIN – or 214,670* people – are seniors aged 65 or higher. This puts Central among the top three LHINs in terms of absolute numbers of seniors. By 2021, seniors will comprise 16.1 per cent* of all residents – or 342,538* people. This means that in 2021, Central LHIN will be home to 127,868 more seniors than we have today.



Diversity

Central has the largest proportion of immigrants (48 per cent* of residents) among the LHINs, and the second highest visible minority population (42 per cent* of residents). We also have the highest proportion of residents who report no knowledge of either official language (4.5 per cent*). In 2006, just over half of the LHIN's population reported English as their mother tongue (the lowest rate among the LHINs) and only 1.2 per cent* included French as their mother tongue (the second lowest percentage in Ontario).

Aboriginal and Francophone communities

Central LHIN has a relatively small Aboriginal/First Nations population – 0.4 per cent of our population, or about 8,600 people. While a portion of this population lives on Georgina Island, the majority of First Nations people in Central LHIN are living off reserve, primarily in semi-rural and smaller communities in South Simcoe County.

Just over three per cent of the people who live in the Central LHIN – about 56,000 people – are considered Francophone under the new provincial definition (adopted in 2009).

Geography

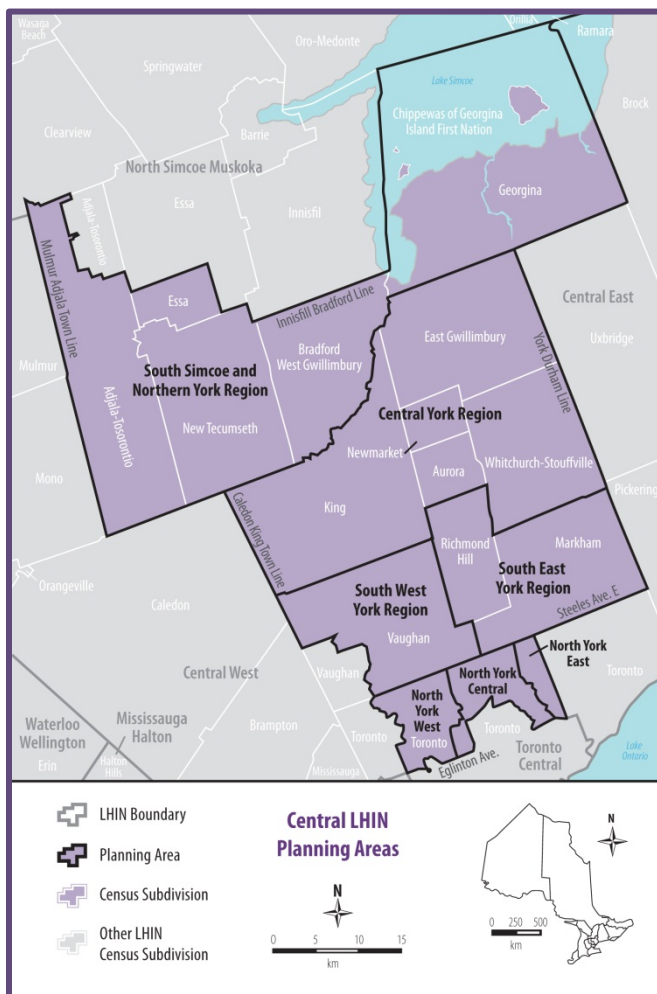
Central LHIN is geographically varied and comprises sections of northern Toronto, all of York Region and South Simcoe County. Covering an area of 2,730 square kilometres, Central is one of the smallest LHINs geographically. Although Central LHIN is primarily urban, there is a significant rural area in the north, which can present challenges to residents when accessing services close to home in those areas.

*Source: IHSP 2013-2016 Environmental Scan, Ministry of Health and Long-Term Care Health Analytics Branch analysis of Census Canada.

Central LHIN's planning areas

Central LHIN is divided into seven geographical planning areas, as illustrated by the map below. Each planning area has varying populations, age structures, economic conditions, and health and social characteristics, requiring targeted approaches to respond to its own unique challenges and needs when planning at a system level.

LHIN boundaries are intended for planning purposes only. Our borders allow us to look at the specific needs of our region but are not to impact referral patterns for services. This means that people should receive care from the service provider of their choice, even if that means traveling outside the LHIN.



by identifying populations that would benefit from focused initiatives.

Generally, our residents have a significantly lower incidence of heart disease, arthritis and multiple chronic conditions than that of Ontario as a whole, and rank among the lowest across the LHINs.

However, social determinants of health such as unemployment, education levels and risk behaviours – such as smoking, obesity and inactivity – have all been shown to affect how healthy people are.

Within our planning areas there are variations in health status due to the differences in these characteristics. South Simcoe/Northern York Region and North York West are two planning areas that have been identified as high risk** from a population health standpoint. A higher number of residents in these two planning areas face serious chronic diseases and obstacles to accessing primary care, compared to other planning areas in the LHIN.

The growing health needs of our aging population will significantly impact Central LHIN over the next five to 10 years and beyond. The prevalence of multiple chronic conditions increases dramatically with age. Nearly 40 per cent* of current Central LHIN residents aged 65-74 and 56 per cent of those aged 75 plus have two or more chronic conditions. These conditions account for six out of 10 deaths*, 20 per cent* of acute hospital discharges, and 25 per cent* of acute hospital days for our residents.

Central LHIN residents have the highest life expectancy at birth of 83.6 years* and the second highest life expectancy at age 65* in Ontario.

Health profile

Analyzing Central LHIN's health profile helps us work towards our goal of reducing health disparities and ensuring equitable access to quality health care in our communities

*Ministry of Health and Long-Term Care Health Analytics Branch analysis of Census of Canada (Statistics Canada) 2006 and 2011 data; Ministry of Finance population estimates and projections.

**According to the Canadian Institutes of Health Research, high risk populations are groups of people that share characteristics – such as homelessness, single women living in poverty or lone-parent families – associated with high risk of adverse health outcomes.

Central LHIN population factors by planning areas

Community	South Simcoe and Northern York Region	Central York Region	South East York Region	South West York Region	North York West Region	North York Central Region	North York East Region	Central LHIN (total)	Ontario
Population*	117,774	217,181	496,319	245,400	241,829	316,368	124,103	1,758,974	13,210,671
Largest municipality (by population)	Georgina (York Region)	Newmarket (York Region)	Markham (York Region)	Vaughan (York Region)	North York (Toronto)	North York (Toronto)	North York (Toronto)	York Region	Toronto
Profile	Immigrant:	14%	21%	47%	45%	57%	57%	63%	48%
	Senior:	13%	12%	12%	10%	15%	17%	16%	13%
	Francophone:	2%	2%	0.8%	1%	0.7%	1%	2%	1%
	Aboriginal*:	1%	0.8%	0.1%	0.1%	0.4%	0.2%	0.2%	0.4%

Source: IHSP 2013-2016 Environmental Scan, Ministry of Health and Long-Term Care Health Analytics Branch analysis of Census Canada.

*The population demographic data was obtained from the 2011 Census

**The Francophone and Aboriginal demographic data were obtained from the 2006 Census

Central LHIN's role as a health system funder

Central LHIN is committed to transparent, responsive and accountable health spending. We work with our stakeholders to plan investments that put local health dollars where they are most needed to improve the accessibility, coordination, quality and efficiency of our local health system for patients and their families.



Health Service Provider funding allocation

In 2012/13, Central LHIN authorized transfer payments of \$1,839,520,964 (2011/12 - \$1,824,986,446) to the following sectors, which represents an increase of 0.9 per cent over the previous year:

Sector	2012-2013	2011-2012
Hospitals	\$1,127,771,450	\$1,135,136,035
Long-term Care Homes	\$317,942,980	\$311,945,250
Community Care Access Centre	\$240,775,825	\$229,474,894
Community Support Services	\$72,281,825	\$71,997,394
Community Health Centres	\$8,810,116	\$8,500,437
Community Mental Health and Addictions Agencies	\$71,939,565	\$67,932,436
TOTAL	\$1,839,520,964	\$1,824,986,446

Health system accountability

Through the development and execution of Service Accountability Agreements (SAAs) with our health service providers, and through the Ministry-LHIN Performance Agreements with the Ministry of Health and Long-Term Care, LHINs enhance system accountability for public funds. These agreements set out funding and performance deliverables for local services that are aligned with LHIN and Ministry of Health and Long-Term Care priorities.

In 2012/13, Central LHIN had 110 current SAAs across all sectors and providers. Ultimately, these agreements support system collaboration to enhance stability and accountability in the health system. They also help us to build a better local health care system that emphasizes quality care for people and their families that is delivered within available resources.

Timely access to care is critical, and receiving care in the most appropriate setting allows faster access to care when needed. That is why wait times remain both a provincial and Central LHIN priority. Over the 2012/13 fiscal year, Central LHIN has taken an integrated approach to making the best use of our local resources and capacity. The Ministry of Health and Long-Term Care, Central LHIN and local hospitals have been working together to continue to shorten wait times.

When comparing 2012/13 annual results to last year's annual results, wait times for a number of procedures improved, including cancer and cardiac by-pass surgeries, hip and knee replacement procedures, and diagnostic MRI and CT scans.

Wait times were also shortened for people who were treated in the emergency department despite an increasing number of very sick individuals coming to the emergency department.

Central LHIN had the second best* year-over-year results in the province at 3.65 hours for the 90th percentile** emergency room (ER) length of stay for non-admitted, minor uncomplicated patients. Central LHIN hospitals also improved the ER wait time for patients waiting for an inpatient bed by over eight hours compared to 2011/12.

In 2012/13, major progress was made in discharging patients with very long stays in acute care hospitals. This was achieved through new physical bed capacity created through the Transitional Home Ventilation Service, behavioral support unit, transitional care bed program, and community alternatives to long-term care

such as the Home First philosophy. Improving access in the emergency department depends in part on a hospital's ability to either admit patients to its acute care beds, to discharge patients to other appropriate care settings, or to safely send them home with the assistance of home-based care, if needed.

Central LHIN and its health service providers are focused on improving emergency department efficiency and capacity, reducing the time spent in acute care beds waiting for alternate levels of care, and building capacity in the community. Reducing the time people spend waiting in a hospital emergency department for care is a complex issue that is both a provincial and Central LHIN priority.

* Tied for second place with Central West LHIN

**The maximum length of time in which nine out of 10 patients have completed their emergency room visit. This is the default metric for public reporting of total time spent in the emergency room.

Wait time improvements

(2012/13 Annual Results)

- ✓ Non-admitted patients visiting Central LHIN's emergency departments are being seen within 3.65 hours – that's the second fastest result in Ontario*
- ✓ Wait times for Admitted patients in Central LHIN's emergency departments decreased by 22%
- ✓ Cancer surgery wait times decreased by 10%
- ✓ Cardiac by-pass procedure wait times decreased by 18%
- ✓ Hip Replacement surgery wait times decreased by 1%
- ✓ Knee Replacement surgery wait times decreased by 4%
- ✓ Diagnostic MRI scan wait times decreased by 42%
- ✓ Diagnostic CT scan wait times decreased by 7%

Central LHIN performance and targets as defined by the Province of Ontario

2012/13 Performance Indicators	Starting point	Performance Target	Most Recent Quarter	Annual Result
Emergency Room / Alternate Level of Care				
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	15.64%	15.00%	16.68%	16.27%
90th Percentile ER Length of Stay for Admitted Patients	40.75	36.00	34.13	32.27
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.42	7.00	7.02	7.15
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	3.73	4.00	3.60	3.65
Surgical Wait Times				
90th Percentile Wait Times for Cancer Surgery	41	47	39	37
90th Percentile Wait Times for Cardiac By-Pass Procedures	55	63	37	45
90th Percentile Wait Times for Cataract Surgery	80	100	89	85
90th Percentile Wait Times for Hip Replacement	141	139	145	140
90th Percentile Wait Times for Knee Replacement	160	154	152	153
Diagnostic Wait Times				
90th Percentile Wait Times for Diagnostic MRI Scan	102	90	61	59
90th Percentile Wait Times for Diagnostic CT Scan	30	30	35	28
Excellent Care for All / Quality				
Readmission within 30 Days for Selected CMGs**	15.13%	15.00%	16.83%	15.82%
Mental Health and Substance Abuse				
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	17.11%	17.00%	18.69%	17.59%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	18.88%	18.70%	21.31%	20.44%
Access to Community Care				
90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	25	27	24	23

* FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 – Q3 2012/13) due to availability

** FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 – Q2 2012/13) due to availability

Enhancing emergency room capacity

In 2012/13, Central LHIN participated in provincial emergency room (ER) programs designed to help meet the following ER provincial targets:

- Reduce 90th Percentile ER Length of Stay for Admitted Patients;
- Reduce 90th Percentile ER Length of Stay for Non-Admitted, High Acuity Patients;
- Reduce 90th Percentile ER Length of Stay for Non-Admitted, Low Acuity Patients;
- Reduce 90th Percentile Time to Physician Initial Assessment; and
- Reduce 90th Percentile Time to an Inpatient Bed.

Shorter emergency department visits

(2012/13 Annual Results)

- ✓ 90th Percentile ER Wait Times for high acuity admitted patients improved by 22%
- ✓ 90th Percentile ER Wait Times for non-admitted high acuity patients treated improved by 3.6%
- ✓ 90th Percentile ER Wait Times for non-admitted low acuity patients improved by 2.1%

Rapid Response Nurses Program

The Rapid Response Nurses program's main goal is to reduce re-hospitalization and avoidable emergency department visits by improving the quality of transitions from acute care to home care.

Targeted patients are usually complex, frail and in need of dedicated nursing care. The role of the nurse is to ensure: medications are taken as instructed; doctor's visits are made and kept; and patients understand how to manage their symptoms of disease. The Rapid Response Nurse will remain involved for two to three weeks until transitional goals are met. Patients in the Rapid Response program may also receive nursing care from a contracted nursing provider for specific treatments. In 2012/13, eight nurses were hired for the Rapid Response Nurses program.

Emergency Department Pay for Results (Year 5)

In 2012/13, Central LHIN was assigned \$9.8 million of the \$93 million provincial investment in the Emergency Department Pay for Results funding allocation. This allocation is determined based on performance against peer hospitals on all five 90th percentile ER provincial targets listed at the left.

Pay for Results funding was directed toward initiatives to help reduce emergency department length of stay and to improve patient satisfaction. In 2012/13, Central LHIN hospitals reported that 82% of patients surveyed gave a positive rating when asked about how they would rate the care they received in the emergency department.

All six Central LHIN acute care hospitals – Humber River Hospital, Markham Stouffville Hospital, Mackenzie Health, North York General Hospital, Southlake Regional Health Centre and Stevenson Memorial Hospital – participated in the program.

The Pay for Results Year 5 program resulted in significant improvements compared to the baseline (2011/12). For example, the emergency department wait times for admitted patients improved by 21 per cent, or 8.5 hours (2012/13 annual results). The emergency department wait times for non-admitted patients with complex and minor uncomplicated conditions both improved by more than 5.3 per cent (2012/13 third quarter results).

This accomplishment was achieved despite the fact that Central LHIN's number of emergency department visits increased by 5.9 per cent and admitted patients increased by 7.8 per cent compared to the previous year.

Investing in additional procedures

In 2012/13, Central LHIN worked with our local hospitals to invest \$13.6 million to perform:

- ✓ 14,315 MRI hours
- ✓ 6,230 CT hours
- ✓ 716 cancer surgeries
- ✓ 601 cataract surgeries
- ✓ 358 general surgeries
- ✓ 270 joint replacement surgeries
- ✓ 144 paediatric surgeries

Integrated Health Service Plan (IHSP) priorities

In 2012/13, Central LHIN continued to direct available resources towards making progress in the priorities identified in our IHSP 2010-2013. This fiscal year was the last operation period for IHSP 2010-2013. As defined in the plan, Central LHIN's key areas of focus were:



Emergency Department / Alternate Level of Care (ED/ALC)

In the past fiscal year, Central LHIN continued to develop a **more sustainable health system for seniors** by:

- Appointing a physician ED Care Lead to support the implementation of various ED strategies and other system improvements.
- Supporting provincial priorities to reduce emergency department wait times and ALC pressures;
- Leveraging Aging at Home to support IHSP priorities;
- Building service capacity;
- Addressing gaps in seniors care;
- Strengthening linkages between our health service providers and community leaders outside the traditional health sector;
- Supporting disadvantaged and underserved groups;
- Targeting opportunities that support our Accountability Agreement indicators and Ministry priorities;
- Advancing emergency department quality enhancement efforts with knowledge exchange forums on *Improving Flow in the Emergency Department for Mental Health and Addiction Services*;
- Implementing the first phase of the Senior Friendly Hospitals Strategy to enable seniors to maintain optimal health and function while they are hospitalized so they can transition successfully home or to the next level of care.

Continuing to Reduce Alternate Level of Care (ALC) Pressures

When patients no longer need acute care in our hospitals, they often remain in acute care beds while waiting to be discharged or transferred. They need an “alternate level of care” such as home care, rehabilitation or long-term care. Central LHIN has worked with our health services providers and the Ministry of Health and Long-Term Care to build capacity in our local system to reduce ALC pressures and ensure people get the care they need at the right time and right place. Highlights include:

- Creating 145 **new transitional care beds** across the hospital, long-term care and community support services sectors to assist with people who are discharged from the hospital to long-term care and are waiting for the Central CCAC to facilitate the care management plan;
- Developing **There's No Place Like Home**, a planning initiative that all Central LHIN hospitals, together with the Central Community Care Access Centre (CCAC), have undertaken to help ensure that people are well aware of viable options for care, at home or in the community, after discharge. A hospital-focused initiative, *There's No Place Like Home* aligns with the province's Home First philosophy, which is shifting the focus to discharging elderly patients to their home after an acute episode in the hospital when appropriate, rather than assuming that a long-term care home is the only destination;
- Continuing to support the **Transitional Home Ventilation Service** at West Park Healthcare Centre, which admitted a total of 18 clients from Central and surrounding LHINs from April 2012 to March 2013. Seventeen clients have been successfully transitioned out of hospital to now live successfully in the community. Through this service, 3,429 alternate level of care days in acute care were avoided which freed up Intensive Care Unit beds to provide critical care;
- Continuing with “**assess and restore**” programs aimed at restoring and reactivating an elderly patient's level of functioning and creating opportunities for them to be transferred home from the hospital with appropriate ongoing supports;
- Continuing to implement the **Senior Friendly Hospital (SFH) strategy**, an initiative aimed to improve the health, wellbeing and experience of

seniors in Ontario hospitals, helping them get back home sooner and healthier.

In an effort to promote an organization-wide approach to service planning and care for seniors, a Senior Friendly Hospital Toolkit (a collection of resources organized under the domains of the Senior Friendly Hospital framework) was released in 2012/13.

Also in 2012/13, a report of the Senior Friendly Hospital Indicators Working Group was approved by the 14 LHINs. The report summarizes the work of the working group, which was tasked with identifying metrics for ongoing monitoring and evaluation of delirium and functional decline practices, and identifies two accountability indicators - one process and one outcome. A sub-working group, co-chaired by the Regional Geriatric Program of Toronto and Baycrest, is planning a pilot for implementation testing of these indicators;

- A **hospital-led system-wide initiative** was completed in 2012/13 to address patients waiting in acute care for rehabilitation services and the adoption of best practices for certain high-volume patient populations, such as total joint replacements (TJR).

Through this work, hospitals, working together with the LHIN, have implemented a LHIN-wide care pathway for TJR and a standardized patient letter for all prospective TJR patients. The work of this initiative will be used as the LHIN moves forward in improving hip fracture and stroke services to continue to reduce alternate level of care days associated with inpatient rehabilitation.

The Home First philosophy has served 2,243 clients since its implementation in September 2009 to March 2013. On average, nearly 64 per cent of Home First clients remain in the community after receiving enhanced care, thus reducing the need for long-term care.

Home First diverted 34,952 Alternate Level of Care (ALC) days from hospitals, and 47 per cent of active Home First clients received Medication Management Support Services while on the program since April 2012 to March 2013.

Chronic Disease Management and Prevention

Chronic diseases such as diabetes, chronic kidney disease, congestive heart failure, arthritis and stroke have significant personal, social and economic impacts. Treatment of chronic diseases and their complications places significant demand on our acute care system and community-based services – a demand that is expected to increase with the aging of our population and as the LHIN becomes more diverse.

Central LHIN is committed to improving access to diabetes, renal and stroke care by supporting the implementation of the Ontario Diabetes Strategy, the Ontario Renal Plan and the Ontario Stroke Network Strategic Plan, streamlining the delivery system, focusing on primary care and putting a plan in place to support self-management.

Successes in this area in 2012/13 included:

- Supporting the **Central LHIN Regional Renal Steering Committee** to plan, coordinate and support quality improvement for the delivery of renal services across our LHIN, as one of the first quality based procedures;
- Expanding the five **stroke prevention clinics** to include integration with cardiovascular rehabilitation services targeting underserved areas in Central LHIN. The program was included as part of Mackenzie Health's successful Stroke Services Distinction survey through Accreditation Canada;
- Assuming the operational responsibility and funding for the function of the **Diabetes Regional Coordination Centre** to the Central LHIN with a focus on using local resources and existing expertise to develop and maintain an integrated, coordinated system for the prevention and management of diabetes;
- Funding for **clinical training** was provided to hospitals to help them improve discharge planning practices and to reduce unplanned return trips to the hospital or emergency department;
- Supporting collaboration across our hospitals to develop an **action plan around enhancing timely access** to rehabilitation services to improve outcomes for stroke patients across our LHIN;

Additionally:

- The **Ontario Diabetes Strategy** (ODS) implemented the Self-Management Initiative across Central LHIN providing over 350 patients with training on how to self-manage their chronic disease to prevent hospital readmissions, as well as provide training for approximately 180 health care professionals on self-management tools and strategies for patients;
- In March 2012, under the ODS, North York General Hospital became a **Centre for Complex Diabetes Care (CCDC)** – a place where patients receive specialized services from an inter-professional team;
- Southlake Regional Health Centre and Markham Stouffville Hospital implemented **telemedicine** nurses to enhance access to experts across the province via the Ontario Telemedicine Network;
- The Central LHIN **Primary Care Lead** has been meeting with hospital administrators to better understand discharge protocols to inform the development of a standard discharge protocols, and a request for proposals was awarded in early 2013 for an initiative focused on integrated discharge planning;
- Southlake Regional Health Centre **Heart Function Clinic** developed a process to flag patients registered with the clinic when they visit the emergency department. The Clinic is notified via email and it follows-up directly with the patient via telephone and offers an 'urgent' visit to the clinic to divert repeat visits to the emergency department.



Mental Health and Addictions

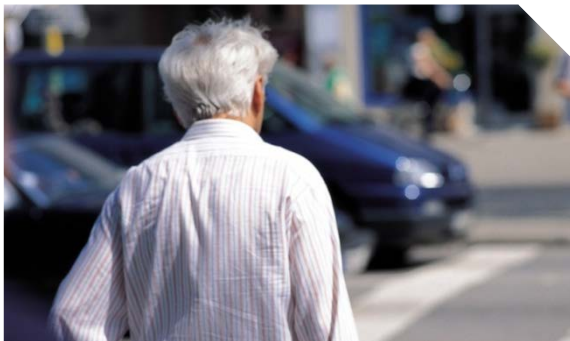
Helping people with mental illness and addictions access the supports they need is an ongoing challenge. Central LHIN continues to focus resources where they make the greatest impact – coordinating care, bridging gaps in the system, reducing wait times for assessment and services, and enhancing community supports.

Central LHIN's goals and priorities are consistent with the provincial government's Comprehensive Mental Health and Addictions Strategy that includes supporting programs and initiatives that improve the health and well-being of all Ontarians, reduce the incidence of mental illness and addictions, identify mental health and addictions early, and intervene appropriately.

2012/13 successes in this area included:

- Hosting a **Quality Collaborative** focused on improving quality in emergency department for patients living with mental health and addictions by enhancing flow which led to the development of a model for medical clearance guidelines;
- Expanding the **Ontario Telemedicine Network** programs at the Canadian Mental Health Association (CMHA), York Region and Toronto branches, with the implementation of telemedicine nurses to deliver clinical mental health and addictions care to enhance access to community-based services and experts across the province;
- Implementing the Central Community Care Access Centre (CCAC) **mental health and addictions nurses in District School Boards** to improve transitions from hospital to the community (began in January 2013);
- Investing in the establishment of a **Community Opioid Treatment Clinic** and enhanced programs for community services for pregnant and parenting women with addictions;
- Supporting the implementation of **10 new supportive housing units** in Stouffville led by LOFT Community Services, and a transitional housing program across York Region through CMHA-York Region;

- Supporting LOFT Community Services to establish a new **Assisted Living Program** to 50 seniors with mental health and addictions challenges in Bradford;
- Continuing the **Emergency Department Diversion Program** at North York General Hospital and Humber River Hospital, an initiative which focuses on improving the coordination of care delivery between acute care and community-based supports for mental health clients;
- Expanding the **community mental health eating disorders programs**, including the addition of three new nurse practitioners, more paediatric inpatient beds and enhanced adult outpatient services across Central LHIN;
- Expanding the **community mental health early psychosis intervention programs** in Central LHIN to increase access for children and youth;
- Continuing the **Centralized Access Program** – through York Support Services Network and Toronto North Support Services – to coordinate case management services and assertive community treatment teams, assessment and triage, system navigation, peer support, match coordination and centralized waitlist management;
- Supporting the **Behavioural Supports Ontario** project to enhance services for people with behaviours associated with complex and challenging mental health, dementia or other neurological conditions;
- Supporting the Addiction Services for York Region to develop a partnership with Community Head Injury Resource Services (CHIRS) to provide a **program for complex clients** with cognitive, neurobehavioural impairments and problematic substance use.



Behavioural Supports Ontario (BSO) Project

Central LHIN's population is aging and the number of people with cognitive impairment is growing. BSO exists to enhance services for people with challenging and complex behaviours wherever they live – at home, in long-term care, or elsewhere -- and help with much needed support for families, healthcare professionals, and the health system.

Through the development and implementation of new models designed to focus on quality of care and quality of life for this vulnerable population, a \$40 million provincial BSO investment, \$3.97 million of which has been allocated to Central LHIN, allows local health service providers to hire new staff – nurses, personal support workers and other health care providers – and to train them in the specialized skills necessary to provide quality care to these individuals.

Specific investments include enhancing a specialized behavioural unit in long-term care, as well as building on local behavioural services and expertise to establish interdisciplinary Behavioural Support Teams across Central LHIN.

BSO accomplishments in 2012/13 included:

- Mobile Teams in Central LHIN collaborated with long-term care home staff, caregivers in the community and the clients themselves, on creative approaches to reducing challenging behaviours. Team members modeled care plans for over 1,200 long-term care home staff and caregivers to follow, and they improved over 438 residents' quality of life.
- Over 1200 staff members participated in structured learning events across the Central LHIN to enhance their skills and consider ways in which new knowledge could be adapted and applied within their own practice environments.
- In September 2012, the Central LHIN's Cumber Lodge gained eight beds as a Ministry-designated Behavioural Supports Unit for a total of 16 beds.

Health Equity

Central LHIN's health equity priority aims to reduce health service inequities and improve access to care within certain population groups in key planning areas identified as having higher-than-average incidence of serious health conditions and challenges in accessing primary care.

The priority includes the objective of collaborative planning with other ministries, such as the Ministry of Community and Social Services and the Ministry of Children and Youth Services. Over the past year, key successes achieved in support of the health equity priority included:

- Developing a **Joint Action Plan** in collaboration with the Entité de planification des services de santé en français #4 Centre Sud-Ouest (Entité 4), and North Simcoe Muskoka and Central East LHINs. The 2012/13 fiscal year marked the first full year of collaboration between the partners and, consistent with the Accountability Agreement, Entité 4 submitted its Final Advisory Report for 2012 to the three LHINs in February 2013. The Report showed that more than 90 per cent of mutual objectives that were spelled out in the Joint Action Plan 2012-2013 were achieved;
- Hosting several meetings with the Administrator for the Health Centre on Georgina Island to discuss how to **improve diabetes services for First Nation people** living on the island, together with the Diabetes Regional Coordination Centre in Central LHIN, Southlake Regional Health Care and the Ontario Telemedicine Network (OTN) Regional Manager. The Diabetes Education Program at Southlake agreed to host programs out of the Chippewas of Georgina First Nation Nurse Practitioner Clinic and the Health Centre agreed to recruit at risk clients. In addition, exploration of establishing OTN on the island continues;
- Participating in the second annual **Provincial Aboriginal Planning Session**. This two-day assembly, which involved LHIN Chief Executive Officers and Aboriginal Planning Leads, provided additional cultural awareness training and offered a forum for LHINs to share information about current Aboriginal health planning and community engagement within their communities. The session also identified areas for continued collaboration in 2012/13, including opportunities related to the development of the LHINs' Integrated Health Service Plan 2013-2016 and primary care engagement. A key next step is to develop a pan-LHIN engagement plan, which will be undertaken by the LHIN Aboriginal Network, of which Central LHIN is a member;
- Holding a **consultation session with community leaders**, including representatives from Canadian Association of Retired Persons (CARP), Tertece Enterprises Inc., The Centre for Israel & Jewish Affairs, Parya Trillium Foundation and Richmond Hill Chamber of Commerce in November 2012. The session was part of the engagement activities undertaken for the development of Central LHIN's Integrated Health Service Plan 2013-2016, to obtain feedback on our strategic direction.
- Establishing a **multidisciplinary Newcomers Settlement Planning Group** to provide recommendation on addressing the needs of our culturally diverse communities.



Community investments that better support seniors and other Ontarians

Through the current transformation of Ontario's health system, we are witnessing greater cross-sectoral collaboration, and a shift to more person-centred care.



As we see the benefits of moving more care from hospitals into the community, we understand the importance of paying attention to the health needs of particular groups of residents, such as our growing populations of seniors, newcomers, and people living in poverty, as well as those with complex medical needs. We know we must find better ways to support these individuals and to help them remain in the community and avoid unnecessary hospitalization.

Here are a few highlights of how Central LHIN supported seniors and other Ontarians in 2012/13:

CCAC Expanded Role

To support the vision of Ontarians receiving the right care, at the right time and in the right place, the Central Community Care Access Centre (CCAC), along with CCACs across the province, are working toward facilitating smooth transitions to adult day programs, assisted living, supportive housing, complex care beds and rehabilitation beds. In partnership with health service providers, CCACs will support clients in receiving integrated, coordinated and client-centred care, focusing on the complex needs of an aging population.

In 2012/13, the Central CCAC engaged local stakeholders and developed plans and processes for the expanded CCAC system navigator and care connector roles for adult day programs and assisted living services across the Central LHIN.

Palliative Care

Following the release of the *Declaration of Partnership and Commitment to Action**, both an expression of interest and a request for proposals were posted for an Operational Lead Agency to lead Central LHIN's Regional Palliative Hospice Care Program and leverage the work completed by the Central Hospice Palliative Care Network to build a regional hospice palliative program.

Central CCAC was identified as the successful proponent to lead the development of a Regional Palliative Hospice Care Program in the Central LHIN by March 31, 2015.



* The *Declaration of Partnership and Commitment to Action* is a document that outlines the common consensus on a vision for palliative care in Ontario and outlines the steps we need to take together to make that vision a reality, including the need to restructure services to reflect a regional palliative program, where resources are standardized and coordinated at the regional level.

Central Adult Day Programs

With the major milestones associated with the expanded role project now complete, Central CCAC is the single point of access for assessment, eligibility and waitlist management for the 18 LHIN-funded Adult Day Programs (ADP). As a result, individuals and families are benefiting from this person-centered, streamlined approach to accessing these programs.

Capitalizing on the concurrent implementation of other provincial initiatives, including the provincial implementation of the interRAI Community Health Assessment (interRAI CHA) tools in the community sector, community stakeholders have worked together to streamline the assessment process and establish guidelines for sharing information, thereby reducing the number of times clients must tell their story. Over a two month period, 60 clients were able to avoid undergoing duplicate assessments prior to admission to an ADP.

Thanks to the collaborative development of a transparent Central LHIN ADP waitlist and collection of performance indicators, Central CCAC can now provide up-to-date information on the full range of ADP programs and their waitlists, and applications to ADPs with vacancies are processed by the Central CCAC within 24 hours.

Central LHIN funded new model of assisted living for young adults with complex medical needs

Young adults with complex medical needs residing in the Central Local Health Integration Network (LHIN) now have additional options for care – and a greater degree of independence. A new model of complex care assisted living was identified as a targeted area for the community sector funding investment announced in November 2012.

With this initiative, Central LHIN is supporting the Ontario March of Dimes to manage around-the-clock services for seven young adults residing in a cluster/congregate care setting. The services provided include nursing, personal support and other health services, and significant care coordination. The initial location for the cluster care units is the Reena Community Residence on the Lebovic Jewish Community Campus in Vaughan. The Central Community Care Access Centre (CCAC) provides the nursing component of care.

Transportation (dialysis)

As of January 6, 2013, Toronto Transit Commission (TTC) Wheel-Trans services were discontinued for individuals who attend dialysis treatments in the Toronto area but do not use a mobility device. To support the transition for these clients, Central LHIN staff worked with Community Support Service agency transportation providers to find a solution. Eight Central LHIN Community Support agencies that currently provide transportation services to this population were approved by the LHIN for one-time funding, to provide the required transportation services to about 80 affected clients from Central LHIN (5,980 rides) from January 6 to March 31, 2013.

The service delivery model aimed to ensure all identified clients were matched to a Central LHIN transportation provider and that a coordinating mechanism existed between the providers.



Assisted living/supportive housing services

In 2012/13, Central LHIN funded community service providers to expand on existing services to address the following targeted priorities:

- assisted living services for high risk seniors;
- transitional/short-term assisted living services for individuals with mental illness and addictions; and
- cluster / congregate care for younger adults with complex medical needs.

Community Engagement

The 2012-2013 Community Engagement Plan had six priority areas in support of our IHSP and the 2012-2013 Annual Business Plan (ABP). These areas were:

1. Advancing Health System Quality
2. Strengthening Integrated Health Care to Improve Transitions
3. Advancing Physician and Primary Care Engagement
4. Collaboration with Francophone and Aboriginal Populations
5. Enhancing Cross Ministry / LHIN engagement
6. Supporting the development of IHSP3

In each of the priority areas, Central LHIN staff engaged stakeholders, committees, working groups and others in the ongoing development of each priority area. Key engagement activities in 2012-2013 included:

- Engaging stakeholders in the development of a **regional palliative care program**;
- Hosting the LHIN's **2nd Annual Quality Forum – Quality Improvement in Primary Care**;
- Supporting the Primary Care Physician Lead's **engagement of primary care physicians** LHIN-wide;
- Reconstituting the **Health Professionals Advisory Committee**;
- Identifying **health system key informants** to provide systems-level input on cross-sector discussions;
- Engaging stakeholders in the **formation of Health Links** in Central LHIN;
- Continuing engagement with the **French Language Planning Entity**;
- Engaging the community in the development of **IHSP3**;
- Hosting a stakeholder engagement day to gain input into our **ABP priorities**;
- Engaging stakeholders in developing a **congregate care model** for young adults;
- Supporting quality improvement initiatives in the **Mental Health and Addictions** sector;
- Engaging stakeholders in the implementation of the **CCAC expanded role**.

Our targeted engagements were instrumental in the development of LHIN priorities for this year. Our upcoming plan, which is embedded in our ABP Plan and

aligned with our IHSP 2013-16, will support our quality improvement approach to advancing our four system directions: appropriateness, access, integration and person-centredness.

Aboriginal First Nation (AFN) Strategy

Central LHIN has conducted a review of the current environment with respect to AFN people in our LHIN. The goal is to develop a comprehensive long-term strategy that addresses the First Nation, rural and urban communities concurrently. Our strategy is predicated on trust and mutual respect being essential for any effective engagement between AFN populations and the LHIN.

The strategy has two objectives. The first is to establish a strong relationship with AFN peoples and their representatives so that we may hear the health needs of AFN peoples, as they understand them. The second is to do what we can now to align the local health system to address understood health issues among AFN populations.

A first step in alignment with the provincial Trilateral First Nations Senior Officials Committee's health priorities is to ensure that prescription drug abuse treatment initiatives incorporate the provision of services to the AFN population. In 2012, this was accomplished in Central LHIN through an RFP process that awarded the establishment of an Opioid Treatment Clinic that treats clients who identify themselves as AFN.

Collaborating with our Francophone Community

In 2012/2013, Central LHIN engaged with the Francophone population and collaborated with key stakeholders to determine the health needs and improve health outcomes for this population. Key areas of success include:

- Conducting the **Health Service providers' Report on French Language Services for 2012**. The Report helps monitor the capacity of service providers and assesses their compliance with French language service requirements. Three providers are identified to build capacity to provide services in French, and five others have developed strategies and the capacity necessary to provide French services to their francophone clientele;

- Receiving the French Language Health Planning Entity #4 (Entité 4) **Final Advisory Report** for 2012 for the Central, Central East and North Simcoe Muskoka LHINs. The Report showed that more than 90 per cent of mutual objectives that identified in the Joint Action Plan 2012-2013 were achieved;
- Seeking the input of the Entité 4 for the engagement of the Francophone community for the development of the **Strategic Framework for the Integrated Health Service Plan (IHSP) 2013-2016**. Entité 4 further provided feedback on the Health Service Provider French Language Services Report (2012) template and participated on the Annual Business Plan Planning Day;
- Collaborating with other LHINs, local health management programs and Entité 4 to facilitate the provision of the **French self-management of chronic diseases**. This has led to the development of workshops at the local level with members of the Francophone community who are at risk of contracting a chronic condition;
- Together with the Central CCAC, supporting Entité 4 to identify opportunities and develop strategies to improve **bed occupancy at Pavillon Omer Deslaurier at Bendale Acres Long-Term Care Home** (Bendale Acres). The bed occupancy strategy further aims to set up a Memory Centre at the same facility to detect and manage cognitive impairments at their early stage and maintain Francophone seniors in their homes and community;
- Together with Central East and North Simcoe Muskoka LHINs and Entité 4, Central LHIN adopted a **Joint Action Plan for 2013/14**. The plan aligns with the priority areas of the IHSP 2013-2016 and will guide the activities and initiatives that will be jointly carried out over the next fiscal year. The general objective of the Plan is to improve awareness of and access to the right French language care, at the right place and at the right time for Francophones within the priority sectors: of seniors care, patients with chronic conditions, mental health and addictions, and primary care. Implementing this

objective will help improve the quality and safety of care, improve the patient experience, and reduce the detrimental impact of linguistic and cultural barriers on health system performance.



Engaging local governments

Good governance is fundamental and key for organizations operating in today's complex health care environment. Central LHIN is committed to promoting and supporting our health service provider boards to share best practices and learn from one another.

In 2012/13, Central LHIN hosted our annual MPP Breakfast and Annual Municipal Forum. These sessions gave Central LHIN's Chief Executive Officer and Board of Directors the opportunity to meet with and update local government representatives about our current activities and priorities, foster stronger relationships, and continue our ongoing dialogue on local health issues and our shared commitment to transforming the local health system.

In 2012/13, Central LHIN held four Governance Council meetings at various locations throughout the LHIN, all geared to fostering governance-level relationships amongst health service providers. These sessions inform health service provider Board Chairs about Central LHIN's actions and investments, and enable participants to discuss governance-level priorities and opportunities for collaboration.

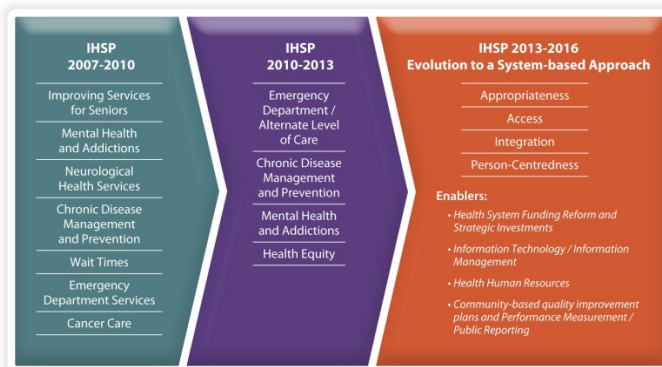
Advancing Excellence in Local Health Care *Together*

Across the province, LHINs have been working with their local stakeholders on the development of their third Integrated Health Service Plans (IHSPs). In February 2013, Central LHIN launched its IHSP 2013-2016, a roadmap to move us toward achieving our vision of *Caring Communities – Healthier People* by supporting a local health system that is there for our residents when they need it, now and in the future.

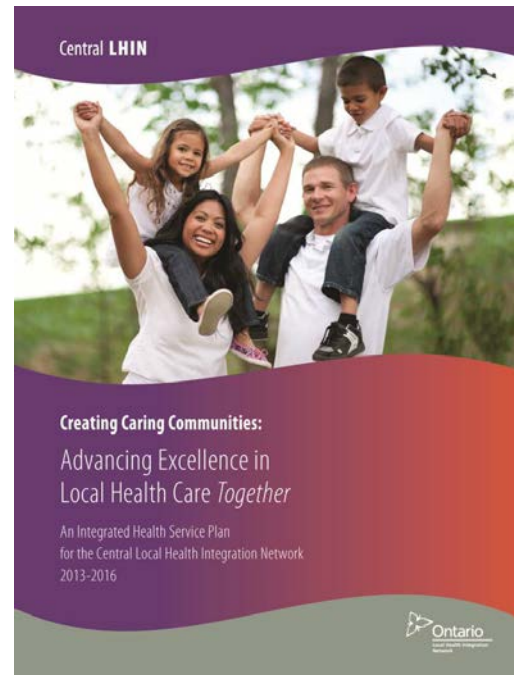
Four quality-based system directions

IHSP 2013-2016 has four quality-based system directions that will guide Central LHIN's activities and investments in the local health system over the next three years. They are:

- **Appropriateness** – Improve the delivery of safe, effective and timely care in the right setting;
- **Access** – Continue to improve access to hospital, community and primary care services;
- **Integration** – Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care; and
- **Person-Centredness** – Improve equity in how people experience health care and service delivery.



The strategic plan aligns with provincial strategies, such as *Ontario's Action Plan for Health Care*, and has adopted provincial frameworks, including Health Quality Ontario's quality framework and design attributes for a high-performing health system.



The plan was developed in consultation with patient representatives, local health service providers, and input from community leaders and the general public. The IHSP 2013-2016 builds on the achievements of our two previous IHSPs (2007-2010 and 2010-2013) and was informed by an Environmental Scan provided by the Ministry of Health and Long-Term Care, as well as population estimates and projections from the Ministry of Finance. This information enabled us to build on the comprehensive Service Needs Assessment and Gap Analysis completed in 2008.

Central LHIN residents and health system users benefit every year from the investments made in the local health system. Working together with our health care providers, we are committed to ensuring that our residents receive the right care, at the right time, and in the right place. We are counting on our local partners to join with us and collectively bring our new strategic plan to life.

For more information, please see the full Integrated Health Service Plan 2013-2016 report, which is available in electronic format at www.centrallhin.on.ca, and in hard copy upon request.

Integration

Pursuing service integration provides the opportunity for Central LHIN and its health service providers to build partnerships and improve system responsiveness and quality. Integrated models provide coordinated, accessible and high-quality health care that improves patient care and makes service delivery more efficient.

Local health system integrations are informed by the priorities of Central LHIN and its communities. Central LHIN is making progress to improve the sustainability of the health system by encouraging integrated service delivery and care models across sectors.

In July 2012, following the completion of the due diligence process and the approval from both the Central and Toronto Central LHINs and the Ministry of Health and Long-Term Care, **St. John's Rehab Hospital** and **Sunnybrook Health Sciences** amalgamated. Under the Amalgamation Agreement, Sunnybrook Health Sciences has assumed accountability for St. John's obligations.

Also in July 2012, following completion of the due diligence process and approval from the Central LHIN Board of Directors, **Hospital Special Needs Inc.** transferred its transportation programs and related funding to **Ontario March of Dimes**. The voluntary merger builds capacity for the delivery of transportation services to seniors and people with disabilities in Central LHIN.

Central LHIN regularly monitors outcomes and the status of all health system integrations undertaken per the Local Health System Integration Act (LHSIA) by requiring health service providers to report on their integration progress. Health service providers are requested to provide both qualitative results on progress to date, as well as a quantitative analysis based on available data and any efficiency gains achieved.



eHealth

Central LHIN's Integrated Health Service Plan (IHSP) 2010-2013 identified eHealth as a key enabler for achieving LHIN, Ministry and health service provider priorities.

We believe strategic investments in information technology and information management (IT/IM) will provide secure and integrated access to clinical information and will support the delivery of high quality health care to people in our communities. These include:

Resource Matching and Referral (RM&R)

Thanks to the LHIN-wide RM&R system, patient referrals between acute care hospitals, St. John's Rehab and Central CCAC are now being managed electronically. This means people are being served faster, smarter and safer.

The deployment of RM&R is part of the province's commitment to create electronic health records for all Ontarians by 2015, and represents the next generation of the health care referral processes.

In 2012/2013, Carefirst and Alliston Family Health Teams implemented the RM&R system, designating them as the first set of primary care providers in Ontario to implement an e-Referral solution.



Connecting GTA (cGTA)

cGTA is a partnership of the six GTA LHINs, with a goal to improve the patient and clinician experience by providing point-of-care access to electronic patient information from across the continuum of care.

In 2012/2013, the Central LHIN's Resource Matching and Referral (RM&R) system was chosen to be integrated into cGTA as a clinical system viewer, allowing RM&R users to have access to the information in the cGTA repository.

The Alternate Level of Care Resource Matching and Referral Business Transformation Initiative

Central LHIN participates in the Provincial RM&R project as part of Cluster 2. In 2012/2013, Central LHIN participated in the development of the referral forms for the following in scope pathways:

- Acute (medical and surgical inpatient) to Rehabilitation
- Acute (medical and surgical inpatient) to Complex Continuing Care;
- Acute (medical and surgical inpatient) to Long Term Care; and
- Acute (medical and surgical inpatient) to CCAC in-home services.

These forms will be piloted at Central LHIN in 2013/2014.

Hospital Report Manager (HRM)

Central LHIN, along with eHealth Ontario, is working to advance the deployment of HRM. Currently, Markham Stouffville Hospital is using HRM since they were identified as a pilot site in 2011/12. Once implemented, this tool will allow physicians to receive their patients' hospital discharge reports electronically into their electronic medical record (EMR) in a timely manner.

Hospital Report Manager aims to eliminate the paper processes (mail, fax and scanning) that are currently required to receive these reports. It allows for the integration of information from the various hospital reports into EMR systems and reduce the time it takes for information to reach physicians. Central LHIN submitted the Hospital Report Manager proposal and was accepted by eHealth Ontario in 2011/12. The project charter is now complete and work is underway to connect all Central LHIN hospitals and affiliated physicians by March 2014.

Hospital Diagnostic Imaging Repository Services (HDIRS)

The HDIRS is a project with 23 member hospitals. The goal of the project is to develop, implement and operate a shared diagnostic imaging repository, and contribute to the development of an Electronic Health Record for all Canadians. All Central LHIN community hospitals are members of HDIRS with the exception of Humber River Regional Hospital, which is a member of a similar project called GTA West DI-r.

Community Care Information Management (CCIM) – Integrated Assessment Record (IAR)

A number of Central LHIN health service providers have implemented the IAR and many more are scheduled for 2013/2014. IAR is an application that allows electronic assessment information to move with the client from one health service provider to another. It also enables health service providers to view timely client assessment information electronically, securely and accurately – reducing the number of assessments required. In 2012/2013, over 50 health service providers from various sectors of the continuum of care implemented the IAR as well as the appropriate assessment based on the programs of that health service provider.



Advancing Quality

In 2011/13, Central LHIN continues to make progress with respect to our *Patients First: An Action Plan to Improve Quality in the Transitions of Care* report. The report carved out three areas of focus to advance our collective quality direction: strengthening relationships to support a culture of quality improvement through Health Service Provider Quality Collaboratives; standardizing hospital discharge processes; and developing indicators for transitions of care. The three over-arching strategic goals underpinning the Quality Action Plan include improving patient outcomes and overall quality of care; improving access to care; and improving system performance (with a particular focus on Alternate Level of Care).

On April 1, 2012, hospitals across Ontario submitted their 2012/13 Quality Improvement Plans to the MOHLTC and Health Quality Ontario. A new requirement this year was the inclusion of an “integration” dimension designed to encourage system-wide initiatives focused on continuity of care and care transitions. A review of Central LHIN hospitals’ plans confirmed several common areas of focus including patient

experience, falls prevention, emergency department length of stay for admitted patients and hand hygiene compliance. Central LHIN will be meeting with hospital to review their plans and discuss challenges and opportunities from their first year of implementation.

In June 2012, Central LHIN held its third Quality Collaborative, *Improving Flow in the Emergency Department for Mental Health and Addiction Services* at North York General Hospital.

The Collaborative was attended by over 65 front-line and administrative professionals from health service agencies and first responders. Presentations focused on enhancing the implementation of best practices to improve the flow of patients seeking care for mental illness or substance abuse in Central LHIN emergency departments. Presenters shared their own experiences in implementing changes that have resulted in: reduced wait-times, enhanced continuity of care and patient flow between the emergency and other hospital departments, lower hospital admission rates and more efficient use of resources resulting in cost savings.



Shown from left to right:
Dr. Rakesh Kumar, Central LHIN Emergency Department Lead; Kim Baker, Chief Executive Officer, Central LHIN; and Police Constable Mark Kowalchuk, York Regional Police.

In December 2012, the Ministry of Health and Long-Term Care launched Health Links, a collaborative of health care providers, to improve delivery and coordination of care for “high-needs” users of the system including seniors and others with complex conditions. In the first phase of the provincial implementation, two early adopter Health Links in Central LHIN were identified – the North York Central Health Link in the southern part of the LHIN and the South Simcoe Northern York Region Health Link in the northern part of the LHIN. In the early adoption stage, local providers in each Health Link include hospitals, specialists, primary care providers, Central Community Care Access Centre, home and community care providers, mental health and addictions providers, long-term care providers and Emergency Medical Services (EMS).

In March 2013, Central LHIN held its second Annual Quality Symposium - *Quality Improvement in Primary Care*. The symposium was aligned with the Ontario Action Plan and recognized that primary care doctors play a vital role in helping to ensure that the patient is getting proactive, preventative care that will help keep them out of the hospital or long-term care. By providing family physicians with the tools to implement Quality Improvement in their practices and link across the continuum, they will be better positioned to contribute to system change in alignment with Central LHIN’s Integrated Health Service Plan 2013-2016 focus of using evidence-based integrated health service provider communities that work together to improve care and are accountable to the system.

Health Links

Health Links will encourage greater collaboration and co-ordination between a patient’s different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly-knit team of providers.

Each Health Link will measure results and develop plans to:

- Improve access to family care for seniors and patients with complex conditions;
- Reduce avoidable emergency room visits;
- Reduce unnecessary re-admission to hospitals shortly after discharge;
- Reduce time for referral from primary care doctor to specialist appointment; and
- Improve the patient’s experience during their journey through the health care system.

Together, We’re Better.

LHINs reflect the idea that communities know their own health needs and priorities best. They bring together health care partners from sectors such as hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care to develop innovative, collaborative solutions leading to achieve more timely access to high quality services for the people in our communities.

By supporting these important partnerships, LHINs work to enable Ontarians to have access to an effective and efficient health care system that delivers improved health care results and a better patient experience. Because of the LHINs:

- Providers in the local health care system are working together to improve access to quality care for Ontario residents;
- The health care needs of people in the local community are being identified, co-ordinated and addressed as a truly integrated system. This means we are working toward people receiving the right care, at the right time, in the right place, and greater access to care;
- Local decisions are being made at the Board level to respond to local health care needs; and
- Health service providers are being held accountable for the taxpayer dollars they are given. LHINs enable this through Service Accountability Agreements with each health service provider, and in turn are accountable to the Ministry of Health and Long-Term Care through Ministry-LHIN Performance Agreements.

Visit www.centrallhin.on.ca for more information on how LHINs are making a difference.

Financial statements of

**Central Local Health
Integration Network**

March 31, 2013

Central Local Health Integration Network

March 31, 2013

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Independent Auditor's Report

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

We have audited the accompanying financial statements of the Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2013, and the statements of operations, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2013, and the results of its operations, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in cursive script that reads "Deloitte LLP".

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 28, 2013

Central Local Health Integration Network

Statement of financial position as at March 31, 2013

	2013	2012
	\$	\$
Financial assets		
Cash	827,473	783,009
Due from Ministry of Health and Long-Term Care ("MOHLTC")	3,746,803	1,864,300
Accounts receivable	154,169	31,412
	4,728,445	2,678,721
Liabilities		
Accounts payable and accrued liabilities	425,042	290,049
Due to Health Service Providers ("HSPs")	3,746,803	1,864,300
Due to Ministry of Health and Long-Term Care ("MOHLTC") (Note 3)	589,608	445,234
Due to the LHIN Shared Services Office (Note 4)	-	98,795
Deferred capital contributions (Note 5)	188,172	167,740
	4,949,625	2,866,118
Net debt	(221,180)	(187,397)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	33,008	19,657
Tangible capital assets (Note 7)	188,172	167,740
	221,180	187,397
Accumulated surplus	-	-

Approved by the Board

Director



Director

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

Central Local Health Integration Network

Statement of financial activities year ended March 31, 2013

	2013		2012
	Budget (Note 8)	Actual	Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,807,421,300	1,839,520,964	1,824,986,446
LHIN Operations and Programs			
General and administrative	4,189,100	4,077,803	4,107,734
Emergency Room/Alternative Level of Care ("ER - ALC") Funding (Note 10a)	100,000	100,000	100,000
Primary Care Lead (Note 10b)	75,000	75,000	15,625
Aboriginal Initiative (Note 10c)	10,000	345	728
Behavioral Supports Ontario (Note 10d)	-	-	31,373
Emergency Department Lead (Note 10e)	75,000	72,000	72,000
French Language Health Services (Note 10f)	106,000	96,354	93,321
Critical Care Lead (Note 10g)	75,000	63,000	72,229
Enabling Technologies for Integration			
Project Management Office (Note 10h)	-	199,501	338,122
Diabetes Strategy (Note 10i)	-	5,689	-
Amortization of deferred capital contributions (Note 5)	81,600	73,756	81,541
Total LHIN Operations and Programs	4,711,700	4,763,448	4,912,673
	1,812,133,000	1,844,284,412	1,829,899,119
Expenses			
Transfer payments to HSPs (Note 9)	1,807,421,300	1,839,520,964	1,824,986,446
Operations			
General and administrative (Note 11)	4,189,100	4,077,803	4,107,734
ER - ALC funding (Note 10a)	100,000	100,000	100,000
Primary Care Lead (Note 10b)	75,000	75,000	15,625
Aboriginal Initiative (Note 10c)	10,000	345	728
Behavioral Supports Ontario (Note 10d)	-	-	31,373
Emergency Department Lead (Note 10e)	75,000	72,000	72,000
French Language Health Services (Note 10f)	106,000	96,354	93,321
Critical Care Lead (Note 10g)	75,000	63,000	72,229
Enabling Technologies for Integration			
Project Management Office (Note 10h)	-	199,501	338,122
Diabetes Strategy (Note 10i)	-	5,689	-
Amortization of capital assets (Note 9)	81,600	73,756	81,541
	1,812,133,000	1,844,284,412	1,829,899,119
Annual surplus	-	-	-
Accumulated surplus, beginning of year	-	-	-
Accumulated surplus, end of year	-	-	-
	-	-	-

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

Central Local Health Integration Network

Statement of change in net debt year ended March 31, 2013

		2013	2012
	Budget (Note 8)	Actual	Actual
	\$	\$	\$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	94,188	45,969
Amortization of tangible capital assets	-	(73,756)	(81,541)
Change in other non-financial assets	-	13,351	(21,799)
Increase (decrease) in net debt	-	33,783	(57,371)
Net debt, beginning of year	-	187,397	244,768
Net debt, end of year	-	221,180	187,397

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

Central Local Health Integration Network

Statement of cash flows year ended March 31, 2013

	2013	2012
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	(73,756)	(81,541)
Amortization of deferred capital contributions (Note 5)	73,756	81,541
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from MOHLTC	(1,882,503)	3,183,935
Increase in accounts receivable	(122,757)	(5,438)
Increase (decrease) in accounts payable and accrued liabilities	134,993	(200,918)
Increase in due to the MOHLTC	144,374	96,205
Increase (decrease) in due to HSPs	1,882,503	(3,183,935)
(Decrease) increase in due to the LHIN Shared Services Office	(98,795)	96,643
(Increase) decrease in prepaid expenses	(13,351)	21,799
	44,464	8,291
Capital transaction		
Acquisition of tangible capital assets	(94,188)	(45,969)
Financing transaction		
Deferred capital contributions received (Note 5)	94,188	45,969
Net increase in cash	44,464	8,291
Cash, beginning of year	783,009	774,718
Cash, end of year	827,473	783,009

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

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

1. Description of business

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

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

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

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

Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers have flowed through the LHIN's financial statements. Throughout the years, funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues and expenses in the fiscal year that the events giving rise to the revenues or expenses occur, and the revenues and expenses are earned or incurred and measurable. Through the accrual basis of accounting expenses include non-cash items, such as the amortization of tangible capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

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

Effective April 1, 2007, the LHIN assumed responsibility to authorize transfer payments to Health Service Providers. The transfer payment amounts are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

LHIN Financial Statements do not include funds that are not included in the MLPA, under which the Health Service Provider is directly accountable to the MOHLTC.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

2. Significant accounting policies (continued)

Government transfers

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the transfer is authorized and all eligibility criteria have been met, except when and to the extent that the transfer gives rise to an obligation and a liability is recorded.

Transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work.

Deferred capital contributions

Amounts received that are used to fund capital asset purchases are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset. The amount recorded as revenue in the Statement of Financial Activities is consistent with the amortization expense of the related capital asset.

Tangible Capital assets

Tangible capital assets are recorded at cost. Cost includes the purchase price of the asset and other acquisition costs such as design, construction, and duties. Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of Financial Statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the Financial Statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook Section PS 1201, "Financial Statement Presentation", Section PS 2601 "Foreign Currency Translation", PS 3410 "Government Transfers" and Section PS 3450, "Financial Instruments". There was no impact of the adoption of these new standards on the financial statements.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Revenue has only been recognized to the extent that eligible expenditures have been incurred. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

Funding repayable to the MOHLTC and eHealth is as follows:

			2013	2012
	Funding received	Revenue recognized	Repayable	Repayable
	\$	\$	\$	\$
Transfer payments to HSPs	1,839,520,964	1,839,520,964	-	-
LHIN operations	4,092,798	4,077,803	14,995	301,882
Enabling Technologies	580,000	199,501	380,499	61,878
Special program funding	606,503	412,389	194,114	81,474
	1,844,800,265	1,844,210,657	589,608	445,234

In the previous fiscal year (2011-12) the LHIN was funded by MOHLTC through the MLPA and eHealth Ontario directly in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect the one time funding arrangement for comparative purposes. In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, was required to be returned to the eHealth Ontario. In the current fiscal year (2012-13) the funding for eHealth Initiatives with respect to Enabling Technologies for Integration are incorporated as part of the budget arrangements of the MLPA.

4. Related party transactions

In accordance with the Memorandum of Understanding between the MOHLTC and the LHIN, LHINs are required to centrally source and share services for Legal Services, Audit Services, HR Services, IM & IT Infrastructure Development and Management and Management of Recorded Information. The LHINs accordingly formed the LHIN Shared Services Office ("LSSO") as a division of the Toronto Central LHIN. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LSSO operating under paid by the LHIN at year end is recorded as a payable to the LSSO.

The LHIN Collaborative (LHINC) was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LHINC operating costs overpaid (or under paid) by the LHINs at year end, are recorded as a receivable (payable) from (to) the LHINC.

During the year, the LHIN made payments to LSSO and LHINC of \$390,710 (2012 - \$501,995).

5. Deferred capital contributions

	2013	2012
	\$	\$
Balance, beginning of year	167,740	203,312
Capital contributions received during the year	94,188	45,969
Amortization for the year	(73,756)	(81,541)
Balance, end of year	188,172	167,740

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	\$	\$	\$
2014	271,687	7,633	279,320
2015	280,620	-	280,620
2016	326,924	-	326,924
2017	326,924	-	326,924
2018 and after	303,025	-	303,025

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

7. Tangible capital assets

			2013	2012
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	421,300	272,817	148,483	99,446
Computer equipment	20,030	17,217	2,813	24,455
Leasehold improvements	66,553	29,677	36,876	43,839
	507,883	319,711	188,172	167,740

8. Budget figures

Budget amounts have been reported in the Statement of Operations to comply with PSAB reporting requirements and reflect the initial budget at April 1, 2012. The budgets were approved by the Government of Ontario.

	2013	2012
	\$	\$
LHIN total budget	1,812,133,000	1,735,375,499
Less Health Service Provider		
Budget (a)	(1,807,421,300)	(1,730,059,133)
LHIN operating budget (b)	4,711,700	5,316,366

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

8. Budget figures (continued)

a) Health Service Provider Budget

\$

Initial HSP Budget	1,807,421,300
Adjustments due to announcements made during the year	36,710,100
	<u>1,844,131,400</u>

The total budget by sector is as follows:

Hospitals	1,129,748,000
Long Term Care Homes	319,067,700
Community Care Access Centres	240,999,500
Community Support Services	72,369,800
Community Health Centres	8,865,400
Community Mental Health and Addictions	72,731,700
Initiatives	349,300
Total budget	<u>1,844,131,400</u>

b) LHIN Operating Budget

\$

Initial budget as reported on the statement of operations	4,711,700
Additional funding received in-year	641,357
Funding for capital asset purchased transferred to deferred capital contributions	94,187
Closing budget	<u>5,447,244</u>

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of \$1,839,520,964 (2012 - \$1,824,986,446) to the following sectors:

	2013	2012
	\$	\$
Hospitals	1,127,771,450	1,135,136,035
Long Term Care Homes	317,942,980	311,945,250
Community Care Access Centres	240,775,028	229,474,894
Community Support Services	72,281,825	71,997,394
Community Health Centres	8,810,116	8,500,437
Community Mental Health and Addictions	71,939,565	67,932,436
	<u>1,839,520,964</u>	<u>1,824,986,446</u>

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

10. Operations of LHIN

a) *Emergency Response - Alternate Level of Care (ER-ALC)*

The LHIN received funding of \$100,000 (2012 - \$100,000) for the Emergency Response - Alternate Level of Care project. The following are the expense details:

	2013	2012
	\$	\$
Salaries and benefits	98,834	98,130
Accommodation and administration	-	599
Supplies and other	1,166	1,271
	100,000	100,000

b) *Primary Care LHIN Lead*

The LHIN received one time funding of \$75,000 (2012 - \$43,750) to support Primary Care LHIN Lead. Expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Professional services	75,000	15,625

c) *Aboriginal initiative*

The LHIN received net funding of \$345 (2012 - \$728) related to the Aboriginal Planning initiative. Expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Supplies and other	345	728

d) *Behavioural Supports Ontario*

The LHIN received one time funding of \$nil (2012 - \$31,373) to support the Behavioural Supports Ontario program. Expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Salaries and benefits	-	26,265
Accommodation and administration	-	5,108
	-	31,373

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

10. Operations of LHIN (continued)

e) *Emergency department (ED) lead project*

The LHIN received funding of \$72,000 (2012 - \$72,000) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Professional services	72,000	72,000

f) *French Language Health Services*

The LHIN received funding of \$96,354 (2012 - \$93,321) to support the implementation of French Language Health Services. Expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Salaries and benefits	94,555	91,421
Accommodation and administration	1,799	1,900
	96,354	93,321

g) *Critical Care LHIN Lead*

The LHIN received one time funding of 63,000 (2012 - \$72,229) to support Critical Care LHIN Lead. Expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Professional services	63,000	72,000
Accommodation and administration	-	229
	63,000	72,229

h) *Enabling Technologies for Integration Project Management Office (formerly eHealth)*

The LHIN received funding of \$199,501 (2012 - \$338,122) to support the adoption and implementation of eHealth initiatives. eHealth expenses incurred during the year are as follows

	2013	2012
	\$	\$
Salaries and benefits	104,906	306,702
Consulting services	-	19,320
Accommodation and administration	-	4,555
Centralized Services (COEHSC)	92,508	7,545
Supplies and other	2,087	-
	199,501	338,122

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

10. Operations of LHIN (continued)

i) Diabetes Strategy

The LHIN received funding of \$5,689 (2012 - nil) related to the Diabetes Strategy. Diabetes Strategy project expenses incurred during the year are as follows:

	2013	2012
	\$	\$
Accommodation and administration	5,689	-

11. General and administrative expenses

The Statement of Operations presents the expenses by function. The following table classifies the general and administrative expenses by object:

	2013	2012
	\$	\$
Salaries and benefits	2,875,270	3,010,986
Occupancy	253,332	187,505
Shared services	390,710	501,995
Public relations	71,956	54,548
Professional Services	28,822	33,996
Supplies	97,219	70,770
Board expenses (see below)	91,720	94,441
Mail, courier and telecommunications	42,836	45,368
Other	225,938	108,125
	4,077,803	4,107,734

Board expenses included in general operating expenses above include per diem costs and other Board expenses as follows:

	Budget 2013	Actual 2013	Actual 2012
	\$	\$	\$
Board Chair per diem expense	36,000	29,900	40,100
Other Board members per diem expense	40,000	21,200	22,800
Governance costs and travel	49,600	40,620	31,541
	125,600	91,720	94,441

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 28 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was \$230,724 (2012 - \$274,515) for current service costs and is included as an expense in the 2013 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2012. At that time, the plan was fully funded.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2013

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative numbers have been reclassified to conform to the current year presentation.