Central **LHIN**

A Journey of Deliberate Steps

2013 / 14 Annual Report

Ontario
Local Health Integration Network

A Journey of Deliberate Steps

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 work with local health service providers and communities to design real-life solutions that improve access to care, better coordinate services and improve people's experience with the health care system. Together we are building a better health care system by removing obstacles that prevent coordination and providing better value for taxpayer dollars.

Bringing together health care providers from sectors such as hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care as well as collaborating with primary care providers, LHINs work locally to achieve meaningful system improvements – results that could only be achieved at a local level based on a thorough understanding of our local health care needs and established relationships.

LHINs have already brought about significant and positive change making the health care system work more like a system, improving value for money and access to care, and promoting health equity. We continue to build upon that work to develop innovative, collaborative solutions leading to more timely access to high-quality health care for residents.

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 we continue our journey – one of deliberate steps towards transformation, improvement and sustainability – our focus remains on providing the communities and residents we serve in Central LHIN with the best possible health care system.

Helping others live life well, receive quality care when they need it and design a person-centred, integrated health care system has always been at the heart of what we do. As a funder, planner and manager of the local health system, Central LHIN works to identify priorities, allocate resources and plan for appropriate services to improve the health care system for everyone, all the while making sure it remains sustainable for future generations.

Each year, our focused plans and actions propel the health care system forward. Achieving our goals depends on working with our health service providers so that people in our diverse communities receive the best possible care from prevention through to end of life.

And we continue to gain momentum. In line with our 2013-2016 Integrated Health Service Plan and guided by our four strategic system directions – appropriateness, access, integration and person-centredness – the 2013/14 year showed significant progress. Impacts included:

- Over $27.5 million in new annual funding to support home care for more seniors and for expanded community health care services, including mental health supports and crisis services in Central LHIN.
- The realization of a new congregate care model at the Reena Community Residence in Vaughan where housing, health care, significant care coordination and support services come together to offer a new way of life for young adults with complex medical needs.
- Two Health Links that are up and running, putting patients at the centre of the health care system by creating communities of health service providers that more effectively coordinate local health care services for people who need them the most. Over the next few years, the LHIN will continue to work towards implementing up to five Health Links in Central LHIN.
- Commencing the development of a regional vision and plan for palliative care in collaboration with the Central LHIN Regional Hospice Palliative Care Program Council and the Central CCAC.
- Implementing a system that provides equitable access to exercise and falls prevention classes to keep our seniors healthy and in their homes.
- The formation of a Citizens Health Advisory Panel, made up of people with "lived experience" in the health care system, who are sharing their experiences with us to help make our system more responsive.
- Beginning a journey focused on patient experience to understand what patients value, to strengthen patient empowerment and participation and support the creation of a consumer scorecard – a tool that will help us understand the experience patients are having with our health care system.

Our successes continue to make our health care system stronger. The LHINs are in the unique position to transform the system, to adapt to changing needs and to respond to the needs of our local populations. And this is exactly what we are doing. Through relationship development, accountability, and system-level focus across transitions of care, the Central LHIN continues to make a meaningful impact.

Central LHIN's philosophy is that *together, we are better*. This philosophy lays the groundwork, at a system level, to advance change and improve quality. Through the hard work and dedication of our health service providers, our Board of Directors, our staff and partners, we continue to make significant progress towards the creation of a high-quality, person-centred health care system*, together*.

John Langs

Chairman of the Board of Directors

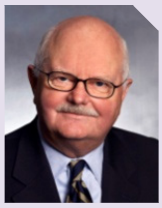
Kim Baker

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
September 24, 2008 – June 1, 2014
Toronto

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

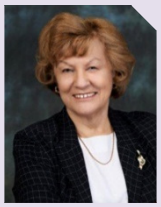
Judy Cameron
June 2, 2011 – June 1, 2016
Keswick

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

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

John Rogers
March 10, 2010 – March 18, 2016
Keswick

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



Aldous (Sally) Young
October 23, 2013 – October 22, 2016
Gormley

Audrey Wubbenhorst
October 23, 2013 – October 22, 2016
Toronto

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 2013/14, Central LHIN's budget of $1.9 billion was allocated across a range of health programs through 112 Service Accountability Agreements delivered by our health service providers, including:

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

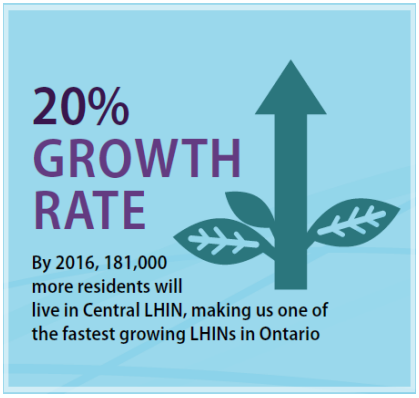
Note that some health service providers deliver care and services in multiple sectors.

Population

With a population of over 1.8 million[1], 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[1]. By 2021, the population will have grown by 20.3 per cent[1] 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[1]).

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

Aging

Central LHIN is experiencing greater-than-average population aging (2011-2021). Currently, 12.5 per cent[1] of residents in the LHIN – or 221,068[1] 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[1] of all residents – or 342,538[1] people. This means that in 2021, Central LHIN will be home to 121,470 more seniors than we have today.

Diversity

Central has the largest proportion of immigrants (48 per cent[1] of residents) among the LHINs, and the second highest visible minority population (42 per cent[1] of residents). We also have the highest proportion of residents who report no knowledge of either official language (4.5 per cent[1]). 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[1] included French as their mother tongue (the second lowest percentage in Ontario).

Aboriginal and Francophone Communities

Central LHIN has a relatively small Aboriginal population – 0.4 per cent[3] of our population, or about 7,000 people. The majority of the Aboriginal population in Central LHIN are living off-reserve. The Chippewas of Georgina Island, comprised of approximately 200 residents, are Central LHIN's only First Nations and on-reserve community.

Just over 1.9 per cent of the people who live in the Central LHIN – about 31,725 people[2] – are considered francophone under the provincial definition (adopted in 2009).

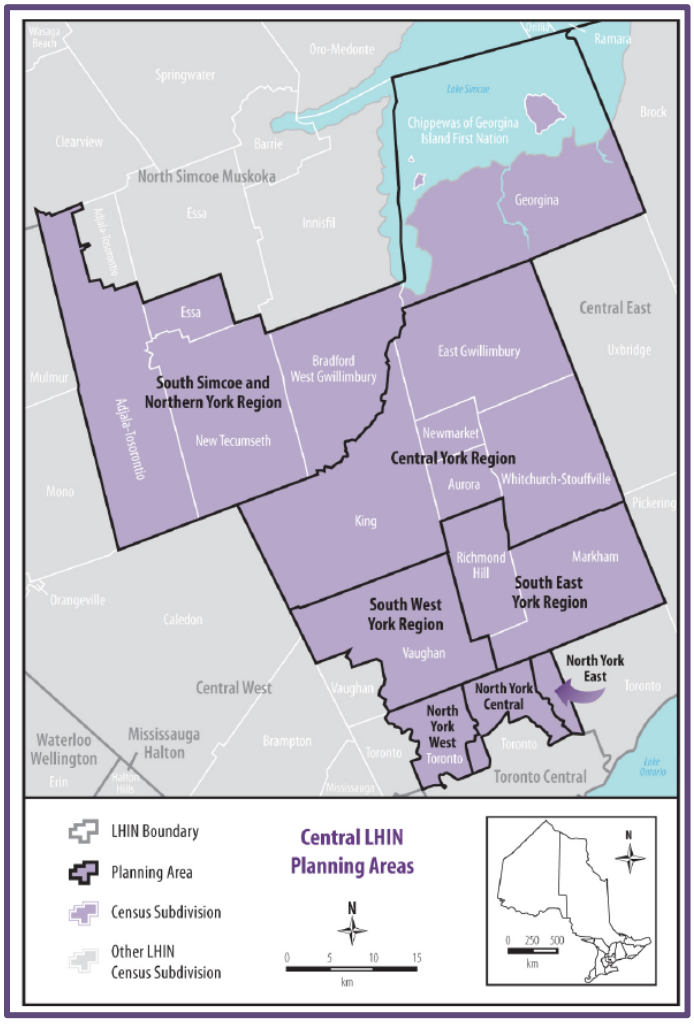
[2] Ministry of Health and Long-Term Care Health Analytics Branch analysis of 2011 Census of Canada; 2011 Census IDF by Census Subdivision (Office of Francophone Affairs).

Geography

Central LHIN is geographically varied covering an area of 2,730 square kilometres and comprises sections of northern Toronto, a portion of Etobicoke, most of York Region and south Simcoe County. 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.

Central LHIN's Planning Areas

For planning purposes, 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. When planning at a system level, targeted approaches are taken to respond to the unique challenges and needs of each planning area.

It's important to note that LHIN boundaries are intended for planning purposes only. Our borders allow us to look at the specific needs of our region but should not 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.

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 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. Central LHIN residents have the highest life expectancy at birth of 83.6 years[3] and the second highest life expectancy at age 65[3] in Ontario.

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[4] 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[3] 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[3], 20 per cent[3] of acute hospital discharges, and 25 per cent[3] of acute hospital days for our residents.

[3] 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.

[4] 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

Central LHIN Planning Area		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*		114,075	213,185	487,250	257,790	238,410	274,705	118,220	1,703,635	12,851,825
Largest municipality within planning area (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%	55%	45%	57%	57%	63%	48%	28%
	Senior*:	13%	12%	12%	10%	15%	17%	16%	13%	15%
	French (mother tongue)**:	2%	2%	0.9%	1%	0.7%	1%	2%	1%	4%
	Aboriginal**:	1%	0.8%	0.2%	0.1%	0.4%	0.2%	0.2%	0.4%	2%

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

*Census 2011 data

**Census 2006 data

Creating a Sustainable Health Care System: Funding, Accountability and Performance

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 everyone that receives health care in our region. Central LHIN is committed to transparent, responsive and accountable health spending.

Health Service Provider Funding Allocation

In 2013/14, Central LHIN authorized transfer payments of $ 1,886,989,082 (2012/13 - $1,839,520,964) to the following sectors, which represents an increase of 0.9 per cent over the previous year:

Sector	2013/14	2012/13
Hospitals	$1,128,142,640	$1,127,771,450
Long-Term Care Homes	$330,282,084	$317,942,980
Community Care Access Centre	$258,379,710	$240,775,028
Community Support Services	$80,252,415	$72,281,825
Community Mental Health and Addictions Agencies	$78,343,289	$71,939,565
Community Health Centres	$11,588,944	$8,810,116
TOTAL	**1,886,989,082**	**$1,839,520,964**

Health System Accountability

Through the development and execution of Service Accountability Agreements 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 2013/14, Central LHIN had 112 current Service Accountability Agreements 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 – one that emphasizes quality care for people and their families and is delivered within available resources.

Meeting our Performance Goals

Timely access to care is critical, so receiving care in the most appropriate setting allows faster access to care when needed. That is why access to health care services and wait times remain both a provincial and Central LHIN priority.

Over the 2013/14 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 improve access and shorten wait times.

The table entitled: *Central LHIN Performance and Targets as Defined by the Province of Ontario, pg. 9* provides results from the latest quarter and 2013/14 annual results. What we are doing to achieve these targets is outlined below:

Access to Health Care Services

Performance Indicators 1-3

Wait times for patients in Emergency Departments (ED).

In the most recent quarter, Central LHIN did not meet the LHIN target of 30.0 hours for 90th percentile ER length of stay for admitted patients. This is partly due to high volumes experienced by hospitals during winter months. Central LHIN has consistently performed better than the target for the previous three quarters as well as annually for 2013/14. Improvement initiatives such as Kaizen process improvement events, Medical Assessment Consultation Unit, increased diagnostic imaging (DI) services, Rapid Assessment Zones, as well as increased human resources to facilitate admissions, patient flow and discharge are ongoing.

Central LHIN continues to perform better than the LHIN target of 7.0 hours for 90th percentile ER length of stay for non-admitted complex patients, as indicated by the quarterly and annual results. Initiatives related to facilitating patient flow in ED, increasing DI services, and enhancing Physician Initial Assessment continue to drive improvements.

Similarly, Central LHIN's performance for 90th percentile ER length of stay for non-admitted minor/uncomplicated patients has consistently exceeded the LHIN performance target of 4.0 hours this past quarter and annually. Initiatives that focus on expediting initial assessment by the physician (e.g. Fast Track Zones, physician assistants), and enhancing care coordination in the community (e.g. Health Links, Geriatric Emergency Management nurses, discharge planning nurse) have all helped to sustain improvements for this indicator.

Central LHIN continues to closely monitor ED performance, work collaboratively with hospitals to provide recommendations and opportunities to discuss strategies and improve and enhance learning from each other.

Performance Indicators 4-10

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

In 2013/14, Central LHIN surpassed the provincial targets for cataract, cardiac by-pass, cancer, hip replacement and knee replacement surgeries. These successes were due in part to innovative Central LHIN initiatives such as the two Centres of Excellence for Ophthalmology. Central LHIN also invested funding for additional hip and knee replacement surgeries during 2013/14.

The percentage of patients receiving their diagnostic (MRI and CT) procedure within the Ministry of Health and Long-Term Care's provincial target was a challenge for Central LHIN in 2013/14. Increased demand from regional programs caused longer waits for these services. Central LHIN invested funding in additional MRI and CT hours to improve performance in the fourth quarter of the year.

Access to health care services

(2013/14 Annual Results)

The percentage of cases* completed within the provincial target:

- ✓ **100%** of Cardiac By-Pass Procedures
- ✓ **100%** of Cataract Surgeries
- ✓ **99%** of Cancer Surgeries
- ✓ **97%** of Hip Replacement Surgeries
- ✓ **94%** of Knee Replacement Surgeries

Wait time improvements

(2013/14 Annual Results)

- ✓ Non-admitted minor uncomplicated patients visiting Central LHIN's emergency departments are being seen within **3.55 hours** – that's the **second fastest result in Ontario***
- ✓ Wait times for **Admitted patients in Central LHIN's emergency departments** decreased by 9%

* Percentage of cases refers to priority

Integration and Coordination of Care

Performance Indicator 11

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

In 2013/14, Central LHIN saw progressive improvements with an annual result of 14.1 per cent as compared to the Central LHIN target of 15.0 per cent. In the most recent quarter (Q3 2013/14), Central LHIN's percentage of ALC days was at 12.6 per cent.

This continued improvement is a result of collaboration on numerous initiatives between the Central LHIN, hospitals, Central Community Care Access Centre and community partners that aim at enhancing access to care and delivering care in the most appropriate setting. More details of initiatives targeted at improving emergency department and ALC indicators are described under: *Improving Emergency Department Efficiency and Capacity, pg. 10*.

Performance Indicator 12

Wait times for CCAC in-home services - application from community setting to first CCAC service (excluding case management).

Central LHIN's performance did not meet the target in quarter three as well as for fiscal year 2013/14 as a whole. Wait times for this indicator were significantly impacted by the influx of physiotherapy reform patients who entered the system in summer 2013.

Due to the large volume of patients, many first visits occurred in quarter three and as a result, the wait time results were significantly higher than expected. However, Central LHIN has improved its performance by eight days since quarter two 2013/14 and is now on track to move towards the Central LHIN target by reducing patients on the waiting list.

Quality and Improved Health Outcomes

Performance Indicator 13

Percentage of repeat unscheduled emergency visits within 30 days for selected case mix groups (CMGs).

In 2013/14, for quarters one and two, Central LHIN saw a slight increase in the percentage of repeat visits from 14.6 per cent to 14.8 per cent with an annual result of 15.04 per cent. Initiatives to improve performance are in place and include Health Links, rapid response nursing program, hospital based Telemedicine nurses and the implementation of quality based procedures.

Performance Indicators 14-15

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

In 2013/14, for quarters one-three, Central LHIN saw improvements in the percentage of repeat visits for substance abuse conditions. This improvement may be due to investments in community substance abuse services across the Central LHIN.

For the same time period, Central LHIN's performance for the percentage of repeat visits for mental health conditions has not improved, however, an investment of $1.5 million has been made to address waitlists for case management services and the LHIN has implemented peer navigators in two emergency departments. More details of initiatives targeted at improving performance are described under: *Mental Health and Addictions, pg.14*.

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

PI No.	2013/14 Performance Indicators	Starting Point	Central LHIN Performance Target	Most Recent Quarter	Annual Result
1: Access to healthcare services					
1	90th percentile ER length of stay for admitted patients	32.27	30.00	35.98	29.28
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	7.15	7.00	6.75	6.70
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	3.65	4.00	3.52	3.55
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	100%	90.00%	98.73%	98.98%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	96.50%	90.00%	100.00%	99.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	100%	90.00%	99.82%	99.78%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	96.00%	90.00%	98.02%	96.87%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	95.00%	90.00%	92.65%	93.65%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	48.00%	55.00%	32.92%	32.98%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	84.00%	85.00%	74.39%	69.61%
2: Integration and coordination of care					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	16.27%	15.00%	12.62%	14.10%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	23.00	28.00	48.00	49.00
3: Quality and improved health outcomes					
13	Readmission within 30 Days for Selected CMGs**	15.82%	15.00%	14.84%	15.04%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	17.60%	17.00%	18.56%	19.14%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	20.70%	20.70%	20.88%	23.46%

*FY 2013/14 is based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability
**FY 2013/14 is based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability
Note: Green = indicator met the Central LHIN target; Red = indicator did not meet the Central LHIN target

Advancing Excellence in Local Health Care *Together*

In 2013/14, Central LHIN began building on the priorities identified in our Integrated Health Service Plan (IHSP) 2013-2016 launched in February 2013.

The IHSP 2013-2016 is our road map, moving us towards achieving our vision of *Caring Communities – Healthier People*. The IHSP 2013-2016 builds on the achievements of two previous IHSPs (2007-2010 and 2010-2013).

The IHSP 2013-2016 outlines four quality-based system directions that are guiding Central LHIN's activities and investments in the local health system. 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.
- **Integration** – Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care.
- **Person-Centredness** – Improve equity in how people experience health care and service delivery.

Working together with our health service providers, we are committed to ensuring that our residents receive the right care, at the right time, and in the right place.

Here are a few highlights of the progress and results achieved in the 2013/14 year:

Appropriateness

Improve the delivery of safe, effective and timely care in the right setting.

Improving Emergency Department Efficiency and Capacity

Improving access to care and delivering care in the most appropriate setting are continued priorities of the province and Central LHIN. We are committed to reducing the time people spend waiting in a hospital emergency department (ED) by strengthening the capacity of our local health care system.

Reducing Emergency Department / Alternate Level of Care Pressures

2013/14 initiatives geared towards reducing the amount of time people spend waiting in their local ED and getting people discharged from the hospital faster and into a more appropriate setting of care include:

- Facilitating an **ED working group** with representation from all Central LHIN hospitals, the Central Community Care Access Centre and Toronto and York EMS, to provide a collaborative forum to communicate and exchange knowledge and ideas on ED strategies and system improvements.
- Facilitating an **Alternate Level of Care (ALC)**[5] **working group** to bring together experts and stakeholders from different areas of the health system to develop strategies to reduce ALC days and transition patients to their appropriate care destinations in a time-effective manner.
- Continuing to invest in **Home First**, an enhanced care service that is offered in partnership with Central LHIN hospitals and the Central Community Care Access Centre. The Home First philosophy helps older adults return home with the necessary post-hospital supports to safely continue healing when their acute care hospital treatment is complete. In addition, Home First provides adults who may be facing a decision to move to a long-term care home with the time they need to make an informed and

[5] When patients no longer need acute care in hospitals, they often remain in acute care beds while waiting to be discharged or transferred. They need an alternate level of care such as an appropriate community care setting or home care.

thoughtful choice from the dignity and comfort of their home.

The **Home First philosophy** has served 3,300 clients since its implementation in September 2009 to March 2014. In fiscal year 2013-14, Central LHIN funded a total of 200 Home First spots to support 1,343 clients to safely return home after their hospital stay. 72% of Home First clients remained in the community after receiving enhanced care, thus reducing the need for long-term care.

- Continuing to fund **103 transitional care beds**, which are temporary beds created to assist people who are discharged from the hospital to transition more quickly out of an acute care setting and into a more appropriate level of care.
- Continuing the investment to support **Geriatric Emergency Management (GEM) nurses** across Central LHIN hospitals, to identify high-risk seniors at the ED, assess the patient and facilitate access to the appropriate community supports and keep the individual living in the community.
- Supporting the provincial physiotherapy reform, implementing strategies to **expand physiotherapy services for seniors** in the community, thereby helping seniors to stay healthy, physically active and independent (see also: *Expanding Physiotherapy for Seniors and Patients, pg. 13*).
- Supporting the expansion of **Nurse-Led Long-Term Care Outreach Teams (NLOT)** to enhance nursing care at long-term care homes, to enable long-term care residents to have better access to timely, high quality care in their homes, and to minimize avoidable transfers to EDs and hospital admissions.
- Strengthening linkages between health service providers and community service providers through **Health Links** implementation (see also: *Health Links, pg. 15*).
- Continuing to implement the **Senior Friendly Hospital** strategy, aimed to improve seniors' health and well-being, and prevent their physical and mental decline in the hospital.
- Supporting the implementation of the provincial **Assisted Living for High Risk Seniors Policy**, so that Assisted Living services will be more equitable and accessible by eligible seniors (see also: *Implementing the Assisted Living for High Risk Seniors Policy, pg. 13*).

"Central LHIN's emergency rooms have continued to see improvements in reducing wait times and treating more patients. This is a direct result of the planning efforts the LHIN and our hospitals have undertaken, and I am confident in the sustainability of our endeavours."

– Dr. Rakesh Kumar, Central LHIN Emergency Department Lead

Emergency Department Pay for Results (Year 6)

The provincial Emergency Department Pay for Results program is designed to improve emergency room performance. For 2013/14, Central LHIN was funded $10.6 million in one-time funding out of the $93 million provincial investment to support the Emergency Department Pay for Results program. This funding focused on initiatives used to enhance emergency room (ER) capacity, reduce ER length of stay and improve patient satisfaction.

Some of the key initiatives aimed at reducing ER wait times in FY 2013/14 included:

- Increasing diagnostic imaging services
- Increasing capacity in the medical/surgical clinics
- Short-stay/express admission units
- Rapid Assessment Zones
- Physician Initial Assessment initiatives
- Additional human resources (e.g. patient flow navigators, physician assistants, admission and discharge nurses, etc.)

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 funding allocation was determined using the 2012 calendar year performance data (January 1, 2012 – December 31, 2012) and ranking amongst 74 peer hospitals on five provincial ED performance measures listed below:

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

Patient Satisfaction

Central LHIN hospitals reported that 81 per cent* of patients surveyed provided a positive rating when asked about how they would rate the care they received in the ED *(2% improvement since 2012/13)*.

*Quarterly Stocktake Report; May 2014

Transitioning the Diabetes Regional Coordination Centre to the LHIN

The successful provincial transition of diabetes programs to LHINs was completed throughout 2013/14. Central LHIN has assumed responsibility for the coordination and planning for five Diabetes Education Programs (DEPs) and two Paediatric Diabetes Programs located in five hospitals and two community health centres. A year-end report completed by the LHIN Chronic Disease Management and Prevention Community of Practice highlights some of the key accomplishments in Central LHIN and includes:

- **Bringing LHIN funded and non-funded DEPs together to improve alignment:** Central LHIN worked with DEP leaders and the LHIN's Primary Care Lead to align work reflecting Ontario Diabetes Strategy initiatives/priorities, the LHIN Integrated Health Service Plan and local needs. The Central LHIN Diabetes Advisory Committee includes patient representatives as active committee members.
- **Common referral:** Central LHIN DEPs have updated standardized and centralized referral forms. All referral forms and diabetes education program information and related resources have been migrated to the CCAC's Centralhealthline website: www.centralhealthline.ca.
- **Screening for diabetes:** Central LHIN has pursued partnerships with local pharmacies and welcome centres for new immigrants to provide diabetes screening and health promotion education to at-risk individuals.
- **Ontario Telemedicine Network (OTN) and accessing specialist care:** Central LHIN is expanding OTN not just for specialist care, but also to provide group DEP sessions in remote areas and long-term care homes.
- **Health Links:** Central LHIN DEPs have all been engaged with their local Health Links to support the needs of complex patients.

Expanding Physiotherapy for Seniors and Patients

On April 18, 2013, the Ministry of Health and Long-Term Care announced an expansion of physiotherapy service for Ontarians. Reforms to physiotherapy in Ontario will result in more than 200,000 additional seniors and patients across Ontario benefitting from improved access to high-quality physiotherapy, exercise and fall prevention classes.

Expanding physiotherapy is about ensuring seniors and their families have access to quality services and supports to lead healthy and independent lives. Central LHIN worked closely with health care providers so that those in our communities with the greatest need benefit from these improvements. The expansion has resulted in more equitable access for people throughout the province and in Central LHIN – in particular in northern York Region and south Simcoe where previously residents needed to travel further to access physiotherapy services.

- In 2013/14, Central LHIN was funded to provide 395 exercise and 247 falls prevention classes. These classes are available throughout the Central LHIN.

- Since August 2013, the Central CCAC has assessed 4,974 unique patients, providing in-home physiotherapy to 3,729 clients across the Central LHIN and further referred 2,551 patients into group exercise and falls prevention classes.

- All long-term care homes in Central LHIN have secured appropriate providers for one-on-one physiotherapy and group exercise classes.

- In late 2013/14, the Ministry of Health and Long-Term Care approved funding for 11 new Community Physiotherapy Clinics (CPCs) in Central LHIN, with a total of 26 CPCs now taking clients across the Central LHIN geography.

Access

Continue to improve access to hospital, community and primary care.

A New Model of Care for Young Adults with Complex Medical Needs

The new congregate model of care at the Reena Community Residence in Vaughan was developed so that seven young adults with complex medical conditions have the opportunity to live independently with their peers in a home setting. Central LHIN has funded the March of Dimes to manage around-the-clock services for these clients, and the Central Community Care Access Centre is providing the nursing component of care.

This made in Central LHIN solution was achieved by bringing together health care, housing, care coordination and support services to respond to a health care service gap that the LHIN recognized.

Central LHIN worked across multiple ministries and care providers to bring this model to life for the benefit of patients in the GTA. This model is now being explored by other GTA LHINs.

Implementing the Assisted Living for High Risk Seniors Policy

In 2013/14, the Central LHIN implemented the Assisted Living for High Risk Seniors Policy, including an investment of $5 million to serve an additional 625 seniors.

Assisted Living services are intended to support seniors with high needs who require services at a greater frequency or intensity than regular home care and include a combination of personal support worker care, homemaking and security checks provided 24/7 on both a scheduled and unscheduled basis.

Implementation of the policy means Assisted Living services will now be more equitable and accessible by high risk seniors regardless of where they live, and not be limited to those seniors living in supportive housing units.

Mental Health and Addictions

Helping people with mental illness and addictions access the supports they need is an ongoing challenge in Central LHIN and across Ontario. Central LHIN continues to focus resources where they make the greatest impact for people, so they can manage early symptoms of their health condition, access coordinated services along the continuum of care and obtain the care they need, where and when they need it.

Central LHIN's key goals for enhancing mental health and addictions services are in alignment with the provincial government's Comprehensive Mental Health and Addictions Strategy: Open Minds, Healthy Minds which outlines a 10-year plan to transform mental health and addictions services in Ontario, starting with children and youth services. Key areas of success in 2013/14 include:

- **Enhancing equitable access** to mental health and addictions services by expanding the existing centralized access models (Access 1 and Streamlined Access) to include additional services.

- Leading a **focused planning** process to discuss current and future needs for **mental health and addictions crisis services**, specifically focused on pre-charge diversion – which links people who are in contact with the police and/or criminal justice system to appropriate community or hospital-based services. The goal is to prevent incarceration or reduce the amount of time incarcerated and identify potential opportunities to improve access to services. This planning resulted in:

    - The expansion of peer support services including warm lines, peer navigators in the emergency department and Wellness Recovery Action Planning programs

    - Work towards standardizing the function of peer support across Central LHIN health service providers, in partnership with our Consumer Survivor Initiative

    - Investments in a new Mobile Crisis Team and expansion of a crisis line

- **Partnerships with primary care through the OTN:** Through the OTN nurses investment, the Canadian Mental Health Association – Toronto and York Region branches – have developed partnerships with primary care practitioners and psychiatrists to increase client access to screening and assessments while reducing stigma.

- Enhancing access to community mental health and addictions services across the LHIN by providing a **range of intensive case management service levels**. The program provides clients with psychiatric consultation and specialized knowledge (nurse, addiction specialist, etc.) at a service intensity level that is based on client needs, allowing clients to move to less intensive services without losing connection with the team. The service is delivered where the client resides (shelter, health services centre, hostel, rental unit and street).

- Expansion of **trauma-specific abuse services** for adults that are linked to mental health case management supports. Building capacity in **trauma-informed care** in community mental health and addictions providers.

Integration

Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care.

Palliative Care

Central LHIN is working with both our funded and non-funded health service providers to find new ways to strengthen palliative care for patients in our communities and to support more patients through the end of life period in their preferred locations.

Through ongoing collaboration, we are focused on implementing an equitable, efficient and sustainable model for hospice palliative care based on the advice and

guidance of our Regional Hospice Palliative Care Program Council.

Comprised of caregivers, family members, community representatives and health sector leaders representing palliative services, the Central Regional Hospice Palliative Care Program Council is focused on developing a comprehensive, integrated, regional program for hospice palliative care in Central LHIN. The Council is also responsible for providing the Central LHIN with service change recommendations, including opportunities for partnership and integration of service delivery.

The Council has created several working groups to move the palliative care agenda forward, including models of care, long-term care and process flow. A medical advisory committee also provides advice and suggestions to the Council. Other initiatives the Council has been involved with over the past year include Kaizen events to develop a desired future state of hospice palliative care in Central LHIN and process mapping. The Council also supported advanced care planning education for both health service providers and the general public.

The Central Community Care Access Centre is the operational lead agency for the Regional Hospice Palliative Care Program and is responsible to plan and implement the Regional Council/Program's identified action commitments – described in the Declaration of Partnership and Commitment to Action[6]. As operational lead, in 2013/14 the Central CCAC established the Central LHIN Regional Hospice Palliative Care Program Council formed through an expression of interest.

Health Links

Health Links is a model of care that makes it easier for people who rely on our system the most, such as seniors and people with complex chronic conditions, to access health care in Ontario.

Health Links are centred on one simple concept: physicians, specialists, hospitals, home care, long-term care and community services working together with patients and families to better coordinate care.

The goal of Health Links is to improve the patient experience and help health care providers stay connected each and every time a patient accesses health care. Working together with the patient, providers develop a coordinated care plan with clear goals, ensuring the right services and actions are matched to the patient's needs.

Over time, Health Links will make a difference by:

- Improving access to family health care for seniors and patients with complex conditions.
- Reducing avoidable emergency department visits.
- Reducing the need to go back to the hospital shortly after discharge.
- Reducing the time it takes to see a specialist once referred by the family doctor or nurse practitioner.
- Improving the patient's care and experience.

Central LHIN has launched two Health Links – North York Central Health Link, led by North York General Hospital, and South Simcoe and Northern York Region Health Link, led by Southlake Regional Health Centre. Three additional Health Links are in the planning phases.

[6] 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.

Person-Centredness

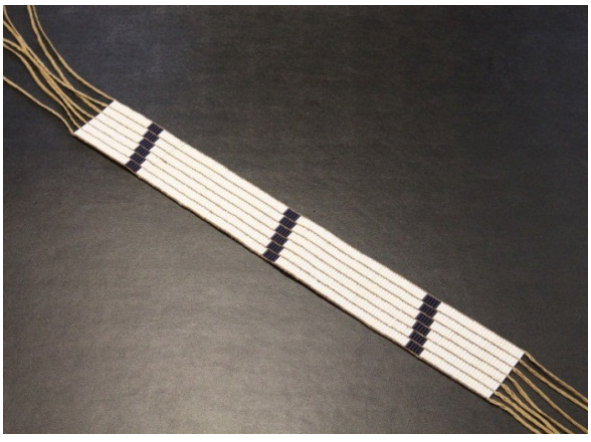
Improve equity in how people experience health care and service delivery.

Enhancing Collaboration with our Aboriginal Community

Central LHIN's Integrated Health Service Plan 2013-2016 re-affirmed the LHIN's commitment to collaborate and engage with its local Aboriginal population. The LHIN's Person-Centredness strategy identifies working with the community, including Aboriginal people, to promote holistic, cross-sectoral strategies to address social determinants of health in at-risk populations.

Central LHIN continues to work with the Ministry of Health and Long-Term Care, health service providers, the Provincial Aboriginal LHIN Network and off-reserve Aboriginal communities – at the local and regional level – to identify and begin to address access barriers to health and healing services, build a trust-based relationship and improve health outcomes for Aboriginals in Central LHIN. Key areas of success in 2013/14 include:

- **Aboriginal Cultural Competency Training for Central LHIN Board and staff.** Delivered by the Ontario Federation of Indian Friendship Centres, the training included a historical overview of Aboriginal people in Ontario, historical markers and a cultural competency framework for addressing different levels of cultural competence. The objectives of the training were to create an empathetic environment; instill better communication; and assist in building trustworthy relationships between Aboriginal populations, health service providers, health system planners and management.



- In 2013/14, Addiction Services for York Region was funded to establish a community satellite model of care for a community opioid treatment clinic. All satellite sites provide **culturally sensitive services, including those targeted at the Aboriginal population** living both on and off-reserve.

"Central LHIN is committed to developing relationships with our Aboriginal residents to learn more about their unique health care needs and challenges, and to work together towards building a more equitable health system. Ongoing dialogue, collaboration and consultation with members of the Aboriginal community are key steps to ensure we understand the unique health issues faced by this community."

– Kim Baker, CEO, Central LHIN

Enhancing Collaboration with Our Francophone Community

In 2013/14, Central LHIN collaborated with the Ministry of Health and Long-Term Care, health service providers, Entité 4 and francophone communities – at the local and regional level – to determine best approaches to improve: understanding of the health needs, health outcomes and access to services for francophone residents. Key areas of success in 2013/14 include:

- The **Forum on French Language Services** hosted by the Ministry of Health and Long-Term Care with participation from CEOs and Chairs of all 14 LHINs, members from the Entités, French Language Health Services Advisory Council and the Provincial Advisory Committee on Francophone Affairs. The forum provided an opportunity for collaboration and planning amongst all stakeholders regarding the evaluation of the Entité model and identification of next steps.

- **Central LHIN's collaboration with key stakeholders** which resulted in prioritization of francophone seniors eligible for long-term care placement at Pavillon Omer Deslauriers in Bendale Acres and the organization of a chronic disease self-management peer leadership training program (Train the Trainer) for francophone individuals living with or caring for patients with a chronic condition.

- **The Central CCAC, Central LHIN and Entité 4 collaboration** to enhance the French language services section of www.centralhealthline.ca, an information database on health services and health resources that is managed by the Central CCAC. Once complete, there will be an increase in the capacity to search and access French language services information and resources.

- **Collaborating with other LHINs and Entité 4** to support the development of French language services. Two workshops were organized to promote active offer of French language services, improve awareness of the French delivery models and equip health service providers with knowledge to actively provide services in French to improve the overall health outcomes and patient experience for francophone clients.

Citizens Health Advisory Panel

The Citizens Health Advisory Panel (CHAP) began meeting in early 2014 to bring a community perspective to Central LHIN's system planning.

This panel will serve as a forum for dialogue among community members with a focus around the LHIN's key initiatives. CHAP will provide advice on how to achieve person-centred health care within the local health system to assist the LHIN in carrying out activities.

Interpretation Services

Approximately 81,000 individuals with limited English proficiency live in the Central LHIN. This represents approximately 4.5 per cent of the Central LHIN population. In an effort to build community agency capacity to provide high-quality services adaptive to the language and culture needs of the diverse populations served, the Central LHIN provided the Vaughan Community Health Centre with funding to coordinate the provision of interpretation services for LHIN funded community agencies.

This new language and interpretation initiative for community agencies began in November 2013 and has served 872 clients between November 2013 and March 2014, offering a range of interpretation services, including face-to-face, telephone and video-conferencing. Currently, 26 health service providers have participated in training to implement the new Language Interpretation Services.

Executing the Annual Business Plan

Through our IHSP 2013-2016 and in conjunction with the execution of the 2013/14 Annual Business Plan, we have worked on advancing quality and excellence in the delivery of services and supports to our communities.

The chart below outlines the progress around the implementation of Central LHIN's Annual Business Plan 2013/14 by providing an update on the status and results to date with respect to priorities and strategies. As illustrated below, 88% of the 2013/14 ABP objectives met their target.

IHSP	Annual Business Plan		Project Management	
System Direction	**Action Plan #**	**Action Plan and Description**	**Target % to be Complete in 2013/14**	**% Complete as at Year End**
Appropriateness	1	Hospital and Community Health Centre Quality Improvement Plans (QIPs) aligned to LHIN performance	100%	**100%**
	2	Expand Telemedicine capacity LHIN-wide – includes increasing adoption of existing Telemedicine program and overseeing the implementation of Central LHIN's first Telehomecare program	25%	**25%**
	3	Improve and investigate expansion of eReferral across the health care continuum	50%	**35%**
	4	Transition Diabetes Education Programs (DEPs) to LHIN	100%	**100%**
	5	Establish hospice palliative care plan – to advance high quality and high value palliative care delivery in support of the Declaration of Partnership between LHINs, the Ministry and the Quality Hospital Palliative Care Coalition of Ontario	33%	**33%**
	6	Implement LHIN-wide discharge planning process and pilot for hospitals – for standardization of discharge processes across Central LHIN hospitals	100%	**75%**
	7	Implement evidence-based care pathways (Quality Based Procedures) beginning with Stroke, Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD)	33%	**33%**
Access	8	Embed Rapid Response Nursing Program into Health Links implementation – rapid response nurses are a part of the CCAC care team and provide transitional support to high need clients from hospital to home	50%	**50%**
	9	Expand residential congregate care model for young adults with complex needs – provides services to transitional aged youth and young adults with medical complexities and/or developmental disabilities	100%	**50%**
	10	Implementation of medical clearance best practices in Central LHIN emergency departments for people with mental health and addictions (MH&A) conditions – for faster treatment of the MH&A issue	50%	**50%**
	11	CCAC expanded role – implement system-wide process for managing and placing clients in assisted living and supportive housing	25%	**25%**
	12	Support the implementation and development of the provincial Life or Limb No Refusal Policy – for referring, accepting and repatriating clients with a life or limb threatening condition within Central LHIN hospitals and GTA hospitals	100%	**100%**

Integration	13	Implement up to five Health Links in Central LHIN – planned systems of collaborative health care providers working together to improve delivery and coordination of care	10%	**10%**
	14	Plan the implementation of a Mental Health and Addictions (MH&A) Service Collaborative in cooperation with the Centre for Addiction and Mental Health (CAMH)	10%	**10%**
	15	Reduce high risk utilization – facilitate implementation of LACE (Length of Stay, Acute Admission, Comorbidities, Emergency Visits) tool for discharge planning that identifies those at high risk of hospitalization	25%	**25%**
	16	Improve primary care providers' knowledge of local health service options; investigate creation of a single information resource for community services	75%	**75%**
	17	Implement community agency organizational health self-assessment – to evaluate the health level of community agencies so that improvement strategies can be developed by the agencies	100%	**100%**
	18	Optimize LHIN funded community based transportation services	50%	**50%**
Person-Centredness	19	Population health strategies – incorporate public health into Health Links implementation	100%	**100%**
	20	Implement the transition of the Diabetes Education Programs to the LHIN in alignment with the Ontario Diabetes Strategy (ODS)	100%	**100%**
	21	Leverage technology – pilot interpretation services to increase health service provider capacity to serve non-English speaking population	100%	**100%**
	22	Create and begin implementation of an Aboriginal community engagement strategy; begin to incorporate results of ongoing engagement in planning	15%	**15%**
	23	French Language Services – continue collaboration with Entité 4 including participation in the Joint Annual Action Plan	33%	**33%**
	24	Support the implementation of the Seniors Strategy/ Seniors First across the Central LHIN	25%	**25%**
	25	Explore the development of a maternal child strategy for Central LHIN – Central LHIN has the highest number of births of all the LHINs and a high proportion of children between the ages of 0-4 years (BORN Ontario, 2011)	100%	**100%**

Community Engagement

Community engagement is fundamental to enabling collaboration with partners across the system to improve access and services for residents in our communities. Throughout the 2013/14 year, Central LHIN continued to engage its diverse communities and stakeholders to support Central LHIN objectives, to inform our planning and decision making processes, and to maintain alignment with both the Annual Business Plan and the LHIN's Integrated Health Service Plan. Highlights from community engagement activities in Central LHIN 2013/14 are outlined below:

Join the Conversation about Health Services in your Community: Community Engagements

The purpose of these eight sessions was to invite the community to share feedback on their health care and service experiences with Central LHIN staff, and to share their perspectives on opportunities for health system improvements and enhancements. The engagements provided a better understanding of the needs and priorities of residents, and the results of the engagement have been incorporated into Central LHIN's Annual Business Plan for 2014/15. The full report, 2013 Community Engagement Sessions in Central LHIN, summarizes key themes which emerged from the sessions and is available at www.centrallhin.on.ca.

Experience Based Design

The objective of the session was to teach those involved in the planning and implementation of Health Links in Central LHIN about Experience Based Design (EBD), a simple yet effective methodology that empowers providers to meaningfully engage with patients and

families to improve the design of their programs to meet the needs of their patients from the perspective of the patient. Health care providers walked away with EBD techniques and the tools to help them understand, redesign and improve the health care experience of patients.

Health Links: Community Support Services and Mental Health and Addictions Engagements

These cross-sector engagements brought stakeholders together to identify objectives for system planning across the region, reduce system fragmentation and ultimately better serve clients. Strategies emerged for clients with mental health and addictions conditions and to address better coordinated and collaborative delivery of services for clients requiring community supports in the Central LHIN. These system-level strategies informed the development of future planning priorities for both sectors.

Francophone Community Engagement in Partnership with Central LHIN and Entité 4

This engagement provided an opportunity for community leaders – including Association des francophones de la région de York (AFRY) and Common Thoughts Initiative Corporation – and francophone immigrants to learn about the health care system, and share their health care needs, priorities and experiences as health service consumers. Central LHIN, Entité 4 and AFRY continue to work together to better capture the health care needs of francophone residents in York Region by considering the feedback received at this session.

eHealth Physician Engagement

Central LHIN and Ontario MD co-led the first combined Electronic Medical Records (EMR) Adoption and Optimization event in the province (see also: *Electronic Medical Record Adoption, pg. 22*).

Mental Health and Addictions Crisis Services Engagement

Sessions focused on planning around mental health and addictions crisis services with emergency management services professionals, police officers, health services providers and consumers. The group reviewed information on service demand, utilization and delivery to develop a service inventory of mental health and addiction crisis services across the Central LHIN. Advice, guidance and recommendations supported an additional $765,000 annual investment by the LHIN to enhance mental health and addictions crisis services.

Aboriginal Health and Healing Services Providers Engagement Session

A workshop with Aboriginal health and healing service providers helped identify barriers to accessing health care programs and services for the Aboriginal community, as well as services currently available and accessed by off-reserve Aboriginal people.

Off-Reserve Aboriginal Community Engagement

Community engagements helped to identify common themes including a need for: Aboriginal focused health service providers in York Region, improved access to preventive care services, system navigation, transportation, health information and patient advocacy.

Recognizing the need to engage in a culturally sensitive manner, Central LHIN engaged an Aboriginal consultant to support engagements by identifying community stakeholders and sites as well as facilitating and evaluating engagement sessions.

The results of the engagement sessions and a web-based survey have been incorporated into Central LHIN's Annual Business Plan for 2014/15.

Aboriginal Health Service Providers and the Central LHIN meet to discuss barriers to health care affecting local Aboriginal communities

Annual Business Plan 2014/15: Engagement Session

Local stakeholders were invited to provide feedback to validate the actions for consideration in the second year (2014/15) of the LHIN's three-year IHSP. Participants viewed and validated the draft action plan, identified gaps, enablers and risks/barriers to successful implementation of the plan. Feedback was used to prioritize the action plans and initiatives outlined in the Annual Business Plan for the 2014/15 year.

Annual Quality Symposium: Patient Experience

Central LHIN hosted its annual Quality Symposium: Reframing Quality through the Eyes of the Patient. With a constant focus on quality, this year's annual quality symposium focused on measuring and improving the patient experience in Central LHIN.

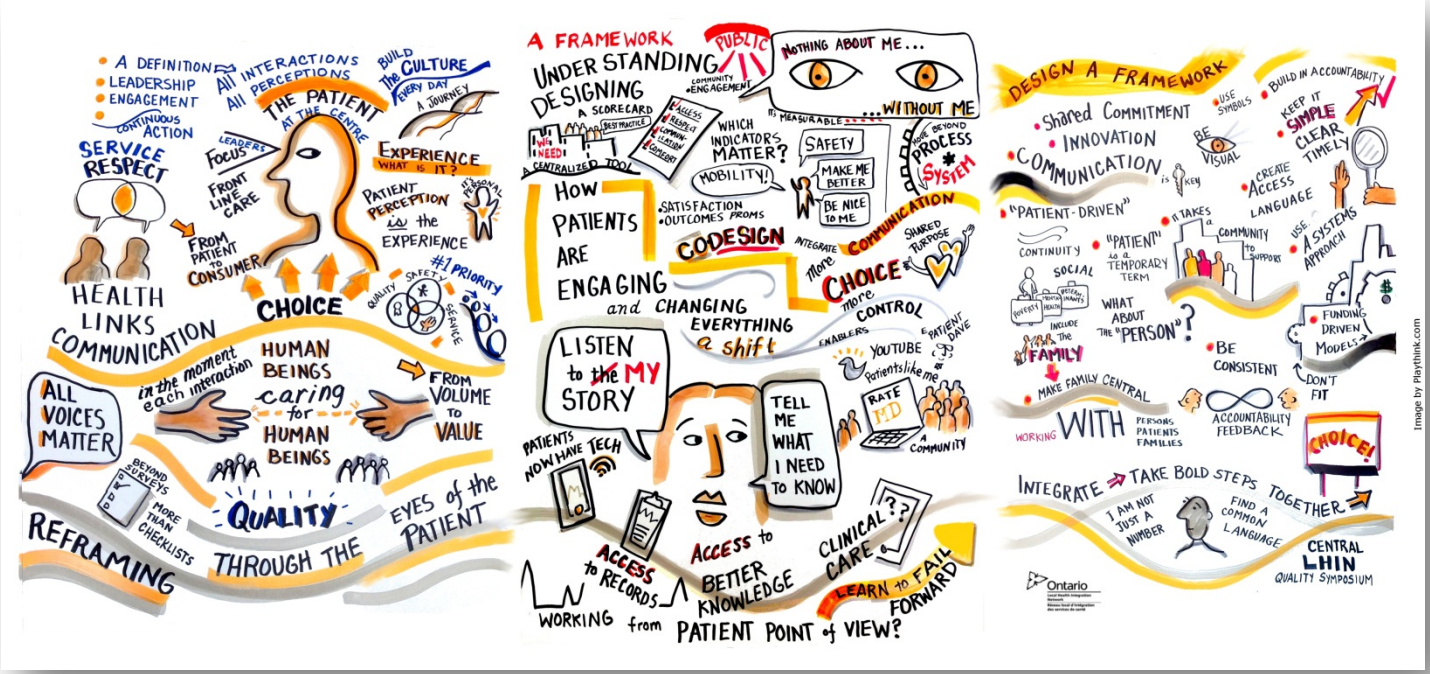
The symposium welcomed close to 200 guests representing health professionals, quality experts, patients and caregivers, including members from Central LHIN's newly formed Citizen's Health Advisory Panel. The feedback provided during the workshop, together with the insights provided by our speakers, helped us:

- Understand best practices related to integrating patient experience to transforming quality and health care delivery at the global, provincial and local level.
- Explore the potential of integrating patient experience in the quality and transformation agenda of the Central LHIN.
- Provide key input to elements of a patient experience framework and consumer scorecard.

"We are seeking to understand what patients value. The 2014 symposium represents the first step of a journey, a journey that we want to be on that will lead to the creation of a consumer scorecard – a tool that will help us understand the experience patients are having with our health care system."

– Kim Baker, CEO, Central LHIN

Some of the unique insights from the day were also captured by a visual note taker, as illustrated below:



Engaging Local Governance

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 2013/14, Central LHIN held four Governance Council meetings at various locations throughout the LHIN. 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.

Engaging Local Governments

In 2013/14, Central LHIN hosted our annual MPP Breakfast and Annual Municipal Forum. These sessions gave Central LHIN's Chief Executive Officer and Chairman, 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.

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.

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 2013-2016 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 – Continuous Improvement

The LHIN-wide Resource Matching and Referral (RM&R) system is a streamlined, consistent and reliable method of electronically transmitting thousands of patient referrals from acute care to inpatient rehabilitation and the Central CCAC. Referrals are now 28 per cent more complete, which means people are being served faster, smarter and safer.

Central LHIN and the RM&R operational lead continue to work with front line users to improve the system. Over the past year, we have focused on streamlining the forms and processes within RM&R. The LHIN also incorporated new provincial standards – for referral from hospitals to CCAC – ensuring information captured and processed in our LHIN aligns with processes across the province. The LHIN invested in the integration of the RM&R tool with hospital information systems in order to improve data flow across systems making the referral process faster and more accurate.

Central LHIN has also adopted a new tool for reporting and analytics to support continuous improvement and a better understanding of the patient journey.

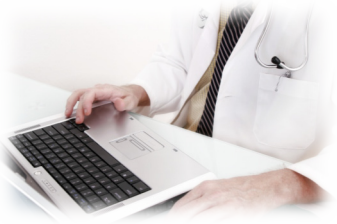
Connecting GTA

Connecting GTA (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.

The cGTA Clinical Data Repository (CDR) now contains data from over 70 per cent of provincial laboratories and 15 early adopter organizations including two Central LHIN health service providers – North York General Hospital and Central CCAC. The early adopters also got the benefit of the cGTA viewer portal which launched in March 2013. The viewer portal allows users quick and easy access to their patient's information through a simple, easy-to-use web interface.

Electronic Medical Record Adoption

Electronic Medical Records (EMRs) are used to document and receive patient health information, most often in a primary care setting.



In September 2013, Central LHIN and Ontario MD co-led the first combined EMR Adoption and Optimization event in the province to share best practices and better understand the benefits of EMRs.

As a result of the physician engagement session, Central LHIN experienced a significant improvement in the Electronic Medical Record adoption rate, and as of March 31, 2014, adoption increased to over 70 per cent.

"My EMR travels with me to house calls and palliative care visits, which gives me real-time access to all the documents I have that impact their care, including recent hospital discharge summaries, specialist notes and nursing reports. This assists the flow and accuracy of our visit, and at the end, medication changes and refills can be generated and sent directly to their pharmacy of choice."

– Dr. Darren Larsen, Lead Physician of Thornhill Village Family Health Organization, describes the benefits of EMRs for both himself and his patients

Hospital Report Manager

Central LHIN, along with eHealth Ontario, is working to advance the deployment of Hospital Report Manager (HRM). Markham Stouffville Hospital has been using HRM since they were identified as a pilot site in 2011/12. This tool allows primary care providers to receive their patients' hospital discharge, medical and diagnostic imaging reports electronically into their EMR in a timely manner.

HRM 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 hospitals into EMR systems and reduces the time it takes for information to reach primary care providers.

Central LHIN's Hospital Report Manager proposal was accepted by eHealth Ontario in 2011/12. The work of implementing HRM by connecting many of the Central LHIN hospitals and affiliated primary care providers is well underway. To date, 61 primary care providers are enjoying the many benefits of HRM with another 290 primary care providers signing agreements and moving forward with adoption.

Telehomecare

Telehomecare (THC) uses technology to bring chronic disease patients the monitoring they need, right in their home. A critical client-centred approach in the delivery of efficient and effective care to people with two chronic diseases: Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure, it has demonstrated tangible benefits including:

- Improvements in client's ability to manage their health.
- Improved self-reported quality of life and health outcomes.
- Decreased hospital readmissions and use of emergency departments and walk-in clinics.

As part of Central LHIN's Health Links implementation, THC was identified as a technology solution to support high user clients who face transportation challenges and/or require daily support to successfully manage their care plan. In November 2013, the South Simcoe and Northern York Region Health Link went live with the THC program to support the overall goal of improving client outcomes by improving delivery and coordination of care for high needs patients including seniors and others with complex conditions.

In 2013/14, Central LHIN also engaged with the Central CCAC and the North York Central Health Link to begin expanding the Telehomecare program further in 2014/15.

Together, We're Better.

Financial statements of

Central Local Health Integration Network

March 31, 2014

Central Local Health Integration Network

March 31, 2014

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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, 2014, 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, 2014, 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.

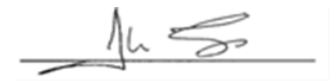
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 27, 2014

Central Local Health Integration Network

Statement of financial position
as at March 31, 2014

	2014	2013
	$	$
Financial assets		
Cash	**388,311**	827,473
Due from Ministry of Health and Long-Term Care ("MOHLTC")	**7,308,787**	3,746,803
Accounts receivable	**87,215**	154,169
	7,784,313	4,728,445
Liabilities		
Accounts payable and accrued liabilities	**393,418**	425,042
Due to Health Service Providers ("HSPs")	**7,308,787**	3,746,803
Due to Ministry of Health and Long-Term Care ("MOHLTC") (Note 3)	**135,006**	589,608
Due to Central West LHIN (Note 4)	**1,884**	-
Due to the LHIN Shared Services Office (Note 4)	**1,383**	-
Deferred capital contributions (Note 5)	**154,164**	188,172
	7,994,642	4,949,625
Net debt	**(210,329)**	(221,180)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**56,165**	33,008
Tangible capital assets (Note 7)	**154,164**	188,172
	210,329	221,180
Accumulated surplus	-	-

Approved by the Board



John Langs, Chairman of the Board of Directors

John Rogers, Director

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

Central Local Health Integration Network

Statement of operations
year ended March 31, 2014

	Budget (Note 8)	2014 Actual	2013 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,802,164,100**	**1,886,989,082**	1,839,520,964
LHIN Operations and Initiatives			
General and administrative	**4,189,100**	**4,188,182**	4,077,803
Emergency Room/Alternative Level of Care ("ER - ALC") Funding	**100,000**	**100,000**	100,000
Primary Care Lead	**-**	**75,000**	75,000
Aboriginal Initiative	**10,000**	**10,000**	345
Emergency Department Lead	**75,000**	**72,000**	72,000
French Language Health Services	**106,000**	**102,769**	96,354
Critical Care Lead	**75,000**	**72,000**	63,000
Enabling Technologies for Integration Project Management Office	**-**	**392,193**	199,501
Diabetes Strategy	**939,900**	**818,228**	5,689
Amortization of deferred capital contributions (Note 5)	**65,400**	**62,007**	73,756
Total LHIN Operations and Initiatives	**5,560,400**	**5,892,379**	4,763,448
	1,807,724,500	**1,892,881,461**	1,844,284,412
Expenses			
Transfer payments to HSPs (Note 9)	**1,802,164,100**	**1,886,989,082**	1,839,520,964
Operations			
General and administrative (Note 11)	**4,189,100**	**4,188,182**	4,077,803
ER - ALC funding (Note 10)	**100,000**	**100,000**	100,000
Primary Care Lead (Note 10)	**-**	**75,000**	75,000
Aboriginal Initiative (Note 10)	**10,000**	**10,000**	345
Emergency Department Lead (Note 10)	**75,000**	**72,000**	72,000
French Language Health Services (Note 10)	**106,000**	**102,769**	96,354
Critical Care Lead (Note 10)	**75,000**	**72,000**	63,000
Enabling Technologies for Integration Project Management Office (Note 10)	**-**	**392,193**	199,501
Diabetes Strategy (Note 10)	**939,900**	**818,228**	5,689
Amortization of tangible capital assets (Note 9)	**65,400**	**62,007**	73,756
	1,807,724,500	**1,892,881,461**	1,844,284,412
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, 2014

	2014 Actual	2013 Actual
	$	$
Annual surplus	**-**	-
Acquisition of tangible capital assets	**27,999**	94,188
Amortization of tangible capital assets	**(62,007)**	(73,756)
Change in other non-financial assets	**23,157**	13,351
(Decrease) increase in net debt	**(10,851)**	33,783
Net debt, beginning of year	**221,180**	187,397
Net debt, end of year	**210,329**	221,180

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, 2014

	2014	2013
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	(62,007)	(73,756)
Amortization of deferred capital contributions (Note 5)	62,007	73,756
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	(3,561,984)	(1,882,503)
Decrease (increase) in accounts receivable	66,954	(122,757)
(Decrease) increase in accounts payable and accrued liabilities	(31,624)	134,993
Increase in due to Central West LHIN	1,884	-
(Decrease) increase in due to the MOHLTC	(454,602)	144,374
Increase in due to HSPs	3,561,984	1,882,503
Increase (decrease) in due to the LHIN Shared Services Office	1,383	(98,795)
Increase in prepaid expenses	(23,157)	(13,351)
	(439,162)	44,464
Capital transaction		
Acquisition of tangible capital assets	(27,999)	(94,188)
Financing transaction		
Deferred capital contributions received (Note 5)	27,999	94,188
Net (decrease) increase in cash	(439,162)	44,464
Cash, beginning of year	827,473	783,009
Cash, end of year	388,311	827,473

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

1. Description of business

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

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

The mandate of the LHIN is 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.

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.

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

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Performance Agreement.

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.

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 Operations is consistent with the amortization expense of the related capital asset.

Tangible capital assets

Expenses greater than $3000 with a useful life longer than one year will be capitalized as assets and amortized. The value of the asset is determined on an individual basis, for example each software license, not on the total invoice value. 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 tangible capital asset are capitalized.

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. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. 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 Operations 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.

3. Funding repayable to the MOHLTC

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 expenses 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 is as follows:

			2014	2013
	Funding received	**Revenue recognized**	**Repayable**	Repayable
	$	**$**	**$**	$
Transfer payments to HSPs	**1,886,989,082**	**1,886,989,082**	**-**	-
LHIN operations	**4,188,467**	**4,188,182**	**285**	14,995
Special program funding	**1,380,909**	**1,249,997**	**130,912**	194,114
Enabling Technologies	**-**	**-**	**-**	380,499
Other recoveries	**-**	**-**	**3,809**	-
	1,892,558,458	**1,892,427,261**	**135,006**	589,608

4. Related party transactions

LHIN Shared Services Offices and LHIN Collaborative

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 $436,018 (2013 - $390,710)

Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, the LHIN entered into an agreement with Central, Central West, Central East, Toronto Central, Mississauga Halton and North Simcoe Muskoka (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from Central West LHIN of $392,193 (2013 - $Nil).

5. Deferred capital contributions

	2014	2013
	$	$
Balance, beginning of year	**188,172**	167,740
Capital contributions received during the year	**27,999**	94,188
Amortization for the year	**(62,007)**	(73,756)
	154,164	188,172

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	$	$	$
2015	291,912	2,413	294,325
2016	324,076	2,413	326,489
2017	307,960	1,005	308,965
2018	317,327	-	317,327
2019 and after	355,985	-	355,985

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

			2014	2013
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office furniture and fixtures	**449,299**	**317,634**	**131,665**	148,483
Computer equipment	**20,030**	**20,030**	**-**	2,813
Leasehold improvements	**66,553**	**44,054**	**22,499**	36,876
	535,882	**381,718**	**154,164**	188,172

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, 2013. The budgets were approved by the Government of Ontario.

	2014	2013
	$	$
LHIN total budget	**1,807,659,100**	1,812,133,000
Less Health Service Provider budget (a)	**(1,802,164,100)**	(1,807,421,300)
LHIN operating budget (b)	**5,495,000**	4,711,700

8. Budget figures (continued)

a) Health Service Provider budget

	$
Initial HSP budget	1,802,164,100
Adjustments due to accouncements made during the year	89,954,724
	1,892,118,824
The total budget by sector is as follows:	
Hospitals	1,129,402,800
Long Term Care Homes	331,258,800
Community Care Access Centres	258,423,700
Community Support Services	80,872,500
Community Health Centres	11,644,200
Community Mental Health and Addictions	80,212,100
Initiatives	304,724
Total budget	1,892,118,824

b) LHIN operating budget

	$
Initial budget as reported on the statement of operations	5,495,000
Additional funding received in-year	494,537
Funding for capital asset purchased transferred to deferred capital contributions	(27,999)
Closing budget	5,961,538

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of $1,886,989,082 (2013 - $1,839,520,964) to the following sectors:

	2014	2013
	$	$
Hospitals	**1,128,142,640**	1,127,771,450
Long Term Care Homes	**330,282,084**	317,942,980
Community Care Access Centres	**258,379,710**	240,775,028
Community Support Services	**80,252,415**	72,281,825
Community Mental Health and Addictions	**78,343,289**	71,939,565
Community Health Centres	**11,588,944**	8,810,116
	1,886,989,082	1,839,520,964

10. Operations of LHIN - Project Funds

The LHIN received funds for various initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2014	2013
	$	$
Salaries and benefits	**1,102,269**	390,803
Professional services	**294,000**	210,000
Shared services	**112,490**	-
Occupancy	**53,179**	5,689
Public relations and community engagement	**11,377**	2,493
Supplies	**10,126**	-
Mail, courier and telecommunications	**1,349**	1,240
Other	**57,400**	1,664
	1,642,190	611,889

Diabetes strategy operational expenses included in the project fund expenses above are as follows:

	Budget 2014	**Actual 2014**	Actual 2013
	$	**$**	$
Salaries and benefits	**677,500**	**635,702**	-
Others	**262,400**	**182,526**	5,689
	939,900	**818,228**	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:

	2014	2013
	$	$
Salaries and benefits	**2,940,484**	2,875,270
Shared services	**413,218**	390,710
Occupancy	**230,484**	253,332
Supplies	**118,140**	97,219
Board expenses (see below)	**91,180**	91,720
Public relations and community engagement	**77,933**	71,956
Professional services	**61,897**	28,822
Consulting services	**43,325**	-
Mail, courier and telecommunications	**33,656**	42,836
Other	**177,865**	225,938
	4,188,182	4,077,803

11. General and administrative expenses (continued)

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

	Budget 2014	**Actual 2014**	Actual 2013
	$	**$**	$
Board Chair per diem expense	**27,300**	**31,500**	29,900
Other Board members per diem expense	**38,400**	**22,700**	21,200
Governance costs and travel	**25,500**	**36,980**	40,620
	91,200	**91,180**	91,720

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 29 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 2014 was $313,872 (2013 - $230,724) for current service costs and is included as an expense in the 2014 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2013. At that time, the plan was fully funded.

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.

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