Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Quality care in community hands. Planning for the future.

2009-2010 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Local Health Integration Networks - Right Care, Right Place, Right Time

With the Ontario launch of Local Health Integration Networks in 2005 a wave of change in health care began. No longer would our health care system be centrally managed. Today, 14 Local Health Integration Networks (LHINs) are responsible for planning, integrating and funding the health services for community support services, long-term care homes, community health centres, mental health and addictions services and hospitals.

The benefits of the LHIN model are many. Health care planning and decision making are taking place close to home so that local needs can be identified and addressed. LHINs enable continuous and meaningful engagement with the communities they serve and the health service providers that deliver the care. They allow for flexible solutions to meet community needs.

The work of the LHINs is guided by an Integrated Health Service Plan (IHSP), a blueprint for health improvement priorities. In December, 2009 HNHB LHIN board approved its second IHSP, *Improving Our Health Care Experience: Integrated Health Service Plan 2010-2013*, which outlines local priorities and will help to guide funding and integration decisions over the next three years. The LHIN Board and staff will carry out the directions of this plan in concert with health service providers and community members.

On April 1, 2007, LHINs across the province received funding authority and responsibility for local community support services, community mental health and addictions agencies, community health centres, and community care access centres (CCACs). On March 31, 2009, the HNHB LHIN signed its first accountability agreements with community agencies. The Multi-Sector Service Accountability Agreements (M-SAAs) are two-year agreements that not only included funding allocations but also performance accountability.

The Hamilton Niagara Haldimand Brant LHIN

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need to access local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real conversation

Message from the Board Chair – Juanita G. Gledhill

On behalf of the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN), I am pleased to submit our 2009-2010 Annual Report. This report is another opportunity to share with our communities the work and accomplishments of our LHIN and its health service providers.

Since being established in 2005, the LHIN vision – a health care system that helps keep people healthy, takes good care of them when they are sick and is there for our children and grandchildren – has guided and been an integral piece of our work and decision-making process. As governors, it has been our responsibility (and privilege) to work with our health service provider counterparts to ensure that this vision is being carried out across our communities. Healthy people and healthy communities are a shared responsibility.

The LHIN vision guided the work of the Clinical Services Plan Steering Committee which worked tirelessly throughout 2009 to present its Plan to our board in November. I would like to thank Richard Woodcock for chairing the Steering Committee and guiding the Plan's development as well as all those who participated in the process – individual residents, health service providers, community agencies and our various health institutions. The outcome of their hard work and dedication is a three-plus year strategy map to reduce illness, improve health outcomes, and transform people's experience in the health system.

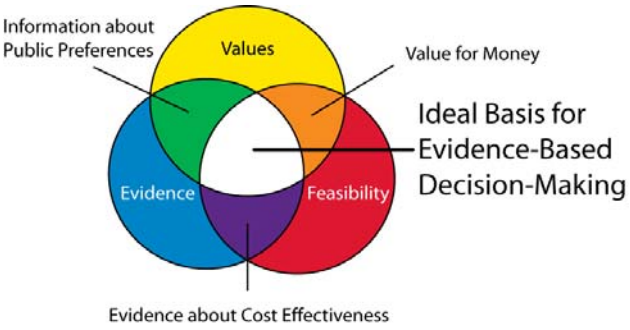
In 2006, the HNHB LHIN released its first Integrated Health Service Plan (IHSP) and in December 2009 the board approved the second IHSP. This IHSP is a road map for health system change for the next three years, 2010-2013. Now, and over the next ten years, the challenges for health care are enormous. Our population is aging, illness burden is high, resources are scarce, our ability to measure benefits of investments is poor, and, the economy is flat. Change is inevitable. Change is necessary and tough decisions will need to be made to ensure quality of health care and appropriate access to the right health services for all of us living in our LHIN.

Community engagement was a key component in the development of these action plans. In addition to 18 planning advisory groups, 11 reference groups and networks, multiple stakeholder consultations at key milestones, and four primary care engagement sessions, more than 1,000 people attended one of 12 Open Houses held in October 2009. The Open Houses provided an opportunity for LHIN Board members and senior staff to meet citizens of our LHIN and hear what they had to say about their health system. Almost every person met one or more Board member or staff member to share their comments on the health issues of the day and their aspirations for the future. All of the conversations, deliberations, input, feedback and diligence helped to identify and shape the strategies for improved health care.

I would be remiss if I did not acknowledge the investigation undertaken by the Ontario Ombudsman. On March 24, 2009, I was notified of the Ombudsman's intent to "…investigate the HNHB LHIN's decision-making process, including its approach to "community engagement" when it deals with proposals for the restructuring of health services." We cooperated fully with the Ombudsman and his team throughout the investigation and as of this writing (May, 2010) we have received neither the Ombudsman's report nor his recommendations. I am confident in the decision-making processes of our board and look forward to release of the final report.

In the end, we all want equal access to quality health care services whenever and if ever we need them. As not only the Board Chair, but also as a resident of the Hamilton Niagara Haldimand Brant LHIN, I truly

believe we are making substantial progress in achieving a health system that keeps people healthy, gets them good care when they are sick, and is there for our children and grandchildren. We acknowledge that as we make decisions to bring us closer to this vision, those decisions bring changes and change can be very difficult and challenging for some in our communities. Our board makes its decisions based on the values, attitudes and preferences of communities, a sound understanding of the readiness and resources, and knowledge and data and information to support practices, models and approaches that have demonstrated a positive impact. We are responsible for helping everyone understand the necessity and future benefits of the outcomes of our decisions.



Continuing to bring our vision to life takes hands, hearts and heads working together. Our continued accomplishments and positive changes are testament to the participation of our residents, health service providers and stakeholders. It has not always been an easy, straight-forward road and I am sincerely grateful for and appreciative of your enthusiastic involvement and support.

I would particularly like to acknowledge and thank my Board colleagues, for their commitment to improving the health care experience and to local decision making; CEO Pat Mandy, for her leadership and dedication to our vision and for her leadership of our organization; and her team, whose tireless efforts result in real, positive outcomes for the people in our communities. Thank you for joining me in exploring the possibilities that local health care system planning and decision making affords us.

It continues to be an honour and a privilege to serve the citizens of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk as Chair of our LHIN Board.

Juanita G. Gledhill

The HNHB LHIN Board of Directors

Juanita G. Gledhill, Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"Our Clinical Services Plan was a significant undertaking. Thanks to the considerable efforts of many, many health professionals and citizens who engaged in this process, the roadmap for improved accessibility to quality care has been approved and is becoming a reality."

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Jack Brewer, Vice-Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"The current recession has sent shock waves to all those providing services to the public and makes clear the pressure which will be placed on funding in the future. With this in mind, we face difficult challenges to provide ever improving health care services, and at the same time, to ensure the costs of health care can be met, not just for today but into the future. A quality and sustainable health care system will be the expectation of future generations and this must be a commitment we all work to achieve. 2009-2010 saw us moving closer to being able to better use the resources in health care to deliver care close to home and to ensure our tax dollars are being maximized in service delivery."

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Douglas Archibald, Member

Appointed: May 9, 2007 • Term: 2 years
Re-appointed: May 9, 2009 • Term: 3 years

"2009 was a signal year for our LHIN, culminating in the development and production of the Clinical Services Plan (CSP) which roadmaps the future of healthcare delivery in our LHIN. The CSP was approved by the LHIN Board on November 24 2009. I would encourage all residents within our LHIN to access the CSP on our website to familiarize themselves with the plan. The highlight of the year, for me, were the Open Houses held by the LHIN, which provided myself and fellow Board members with opportunities to meet many of our neighbours, community members and LHIN residents. The 12 Open Houses, held throughout the LHIN, also provided the opportunity to inform and answer questions on the CSP. I look forward to my participation as a Board member to witnessing the fruition of our endeavours."

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Ruby Jacobs, Member

Appointed: March 3, 2010 • Term: 3 years

"I have followed the development of regionalization in Ontario since its inception. The reorganization of the health care system is long overdue. What we are seeing now - an increase in accessible, quality health services and a reduction in the fragmentation of those services - is a process that, at times, has required very difficult decision-making and compromise from all parties. The streamlining and striving for accountable, state-of-the-art, health services continues to be a challenge and it is a challenge I am willing to take on to the best of my ability."

Bob Lawler, Member

Appointed: October 29, 2008 • Term: 3 years

"This was my first full year on the board and as I look back on what we did as a LHIN we continue to shape the delivery of health care services with the finite resources that are available to us. I believe we made the decisions in the best interests of all the people in our LHIN. Not all of these decisions were popular but they are decisions that have to be made now to ensure there is a health care system in the future."

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Bill McLean, Member

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years

"Our board has worked diligently to enhance the governance to governance relationships between the LHIN Board and health service provider boards. A successful example of this co-operative governance relationship happened this year with St. Catharines-Thorold Meals on Wheels. This organization was experiencing a number of problems and was close to ceasing operations completely. After several meetings between LHIN board members and board members of Meals on Wheels, assistance and advice was given to the Meals on Wheels Board and they went on to make some changes to their organization. They are now flourishing and providing a tremendous service to their communities."

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Bill Millar, Member

Appointed: March 7, 2007 • Term: 2 years
Re-appointed: March 7, 2009 • Term: 3 years

"It is clear that collaboration among all of the partners in the delivery of health care is the key to its quality, effectiveness and sustainability. Over this past year, through a combination of the LHIN's work and the commitment of all health care providers, we have seen that collaboration solidify and magnify. It is becoming the way of doing things in our LHIN and will serve us well as we move forward."

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Janice Mills, Member

Appointed: May 17, 2006 • Term: 13 months
Re-appointed: June 17, 2007 • Term: 3 years

"Achieving an approved Clinical Services Plan has been a major accomplishment for our LHIN. I was particularly impressed with the cooperation and enthusiasm from our health service providers Boards. This reaffirms that we are moving in the right direction. Belief in the CSP from leadership from health service providers across care sectors will help ensure we work through the implementation of the plan's directions together. I'm confident that unity and collaboration will result in a better health system for our LHIN."

Carolyn King, Member

Appointed: January 5, 2006 • Term: 13 months
Re-appointed: February 5, 2007 • Term: 3 years
Term Completed: February 5 2010

"In a statement about this past year, it is also my last statement as a LHIN Board member - 2006-2010. I have been fortunate to be part of the early building of the LHIN model, to help make decisions at the start and to see them being implemented such as this year, with the 2nd round roll out of the Aging at Home strategy, the planning and completion of the Clinical Services Plan, support new models of delivery and new collaborative ways to address our LHIN's health needs. These measures will help guide the future years with even more ways and means to enhance the LHIN model of community based decision-making and help reach the ultimate goal of improving the quality of health for all of the citizens in LHIN 4. I wish my colleagues all the best today and in the future."

Message from the CEO – Pat Mandy

As an organization, the Hamilton Niagara Haldimand Brant LHIN has continued to make significant strides over the last year. We continue to seek to understand our communities, address community health issues, and move our local health system toward one that offers better coordination of services, better value for money, and better personal health care experiences.

Over the course of the past year, staff has worked with residents, peers, health service providers and various organizations in a concerted effort to improve the health care experience for those who live and receive health services in Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk.

We engaged community members at Open Houses to understand what the communities want and need for better experiences with the health care system. We engaged health service providers in the development of the Clinical Services Plan to develop strategies to provide optimal patient care. We worked with professional associations to ensure equitable access to high quality care across our LHIN communities through the implementation of best practice guidelines. We worked with educational institutions and research institutes to promote and foster a culture of learning, sharing and collaboration.

Highlights include:

- In October 2009, we held 12 open houses across our communities to have real conversations with our residents about how to make the local health care system better.

- In consultation with health service providers from across the LHIN, we developed a Clinical Services Plan. Once fully implemented, residents will benefit from: a smoother transition between health services; common standards of care in all communities; a team-based approach to care; and, electronic access to personal health information.

- The HNHB LHIN was given the opportunity by the Registered Nurses Association of Ontario (RNAO) to become a Best Practice Spotlight Organization (Candidate). In collaboration with 10 hospitals, the HNHB Community Care Access Centre, and Niagara Region Public Health, we are focusing on implementation of best practice guidelines for falls, pressure ulcers and cultural competency.

- In partnership with McMaster University, primary care providers, public health, academia and clinical experts, we held a Continuing Health Sciences Education Event for health care providers. The goals were to raise awareness of chronic disease prevention and management (CDPM), demonstrate how evidence-based care can be incorporated into routine practice, and promote practical collaborative approaches to CDPM that facilitate seamless transition across care settings.

Our values as an organization are what propel us in our journey to improve the resident experience with the health care system. The Freedom of Information and Privacy Protection Act (FIPPA) gives the public the right to access records held by public bodies. Over the past year, the HNHB LHIN received four FIPPA requests. As an organization that values transparency and accountability, we welcomed these requests and believe our full cooperation demonstrates our commitment to our values and to providing value for money for our residents.

I would like to take this opportunity to thank our Board Chair, for her unrelenting commitment to and passion for improving our local health care system; the Board members for their discernment and leadership; our staff for their tireless efforts and dedication; and of course, our residents: the very reason we do what we do.

We are all on this journey toward a health system where the right care is available in the right place, at the right time. I look forward to taking the next steps together.

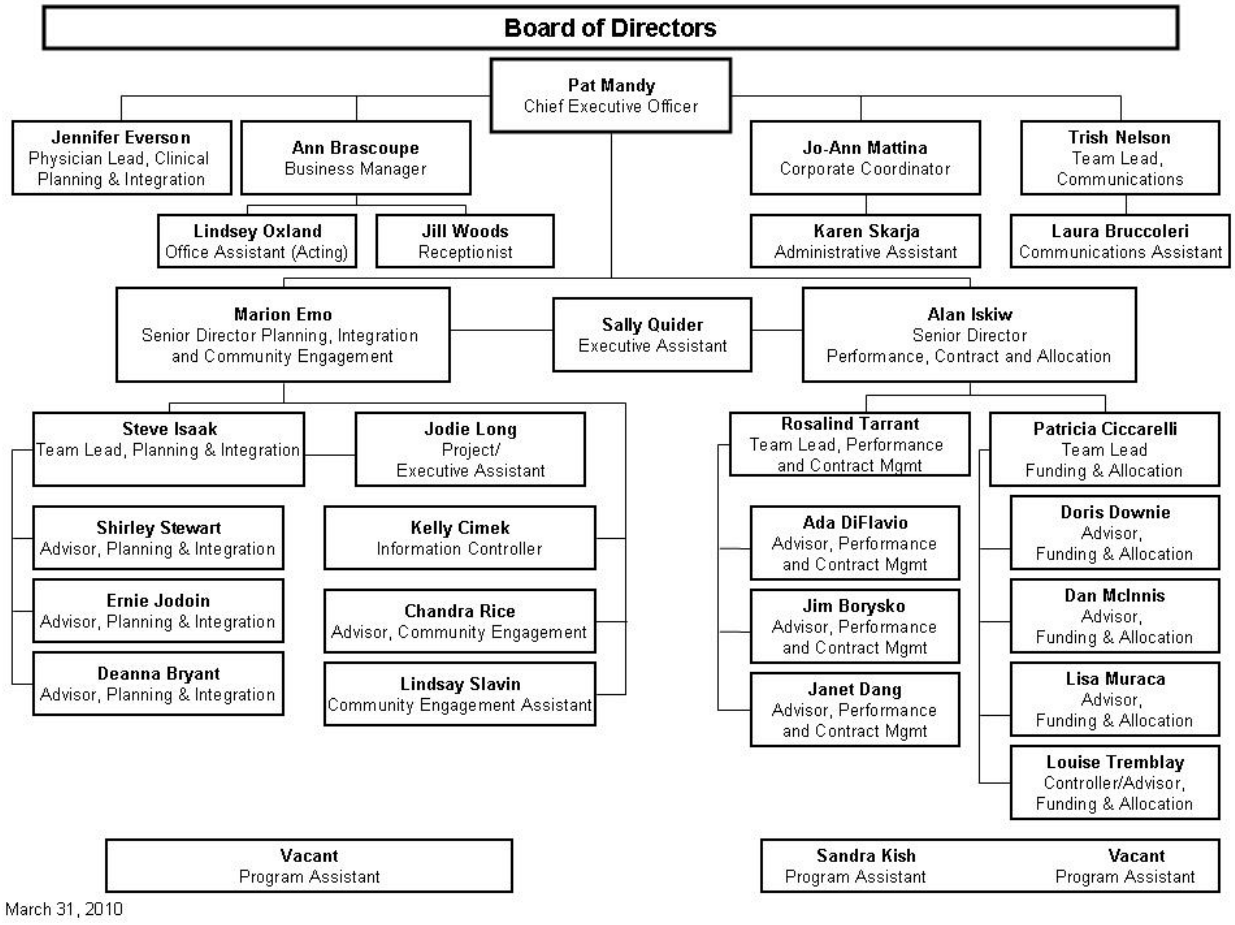
Pat Mandy

Continued Evolution of the HNHB LHIN

Our Organization

Staff

The HNHB LHIN staff complement is complete. Our organization continued to grow to expand on and complement the wealth of skills within the LHIN office. We have a greater range of skills, knowledge and experience in health and human services planning, funding and coordination, capacity development, epidemiology, performance measurement, project management, accounting, public health and communications. Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.



Board Members

In 2009-2010 there were two changes to our Board of Directors.

Leaving the Board

Carolyn King completed her term with the Board of Directors February 5 2010.

Joining the Board

On March 3, 2010, Ruby Jacobs joined the HNHB LHIN Board of Directors. Ruby, a lifelong community member of Six Nations of the Grand River Territory, is a registered nurse who served 13 years as the Director of Health Services for the Six Nations Elected Council. She retired from that role in 2007. Her education journey began in 1965 with a Registered Nursing Diploma from Hamilton's St. Joseph's School of Nursing. She went on to receive a Diploma Nursing Education (1968) from the University of Ottawa, a Bachelor of Arts in Sociology (1985) from McMaster University, and finally in 2005 received a Bachelor of Science in Nursing from McMaster University. She is currently engaged in consulting work and has completed Health Services accreditations for Accreditation Canada. Ruby is also a member of the Six Nations Health Foundation Inc. and serves part-time as administrative support for Six Nations Farmers Association.

Relationship between the Board and Senior Management

Our LHIN Senior Team includes the CEO, Senior Director – Performance, Contract and Allocation, and the Senior Director – Planning, Integration and Community Engagement.

Senior Team members attend the regular Board meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- Regular meetings
- Board committees
- Policy direction
- Performance appraisal

Snapshot of the Hamilton Niagara Haldimand Brant LHIN

HNHB LHIN Population

Demographics

The HNHB LHIN is home to nearly 1.4 million people -- about 11% of the population of Ontario. The HNHB LHIN population is estimated to grow 3.7% by 2014, and 8.4% by 2019 (Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).

While the total number of people 45-74 years old is growing the fastest, the largest changes will be among people ages 65-74 (growing by 43.8%) and over 84 (growing by 34.1%) over the next ten years. This change shows that the HNHB LHIN's population is aging.

As of 2009, more than 220,000 seniors live in the HNHB LHIN which is the largest number of seniors of all Ontario LHINs (Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).

Socio Demographic Characteristics

The HNHB LHIN has a diverse population. For 18% of HNHB residents, neither English nor French is their fist language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. But compared to Ontario, the HNHB LHIN has a lower percent of immigrants and visible minorities.

HNHB LHIN has a higher percent of lone parent families, and lower percent of adults with post secondary education than the Ontario average.

	HNHB LHIN	Ontario	Range for all 14 LHINs
Total Population (2009)*	1,392,343	13,062,794	236,598 - 1,708,896
Senior population, age 65+ (2009)*	15.9%	13.7%	9.6% - 17.7%
Population with English mother tongue	80.1%	69.8%	51.5% - 91.5%
Population with French mother tongue	2.2%	4.4%	1.0% - 23.9%
Population who are immigrants	20.3%	28.3%	6.3% - 47.9%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%	0.3% - 9.5%
Populations who are visible minorities	9.1%	22.8%	1.4% - 50.3%
Population of Aboriginal identity	1.7%	2.0%	0.4% - 19.0%
Labour force participation rate (age 15+)	65.7%	67.1%	60.1% - 71.5%
Unemployment rate (age 15+)	6.0%	6.4%	5.2% - 8.4%
Population in low income	13.7%	14.7%	9.6% - 24.0%
Families (with children) headed by a lone parent	26.1%	24.5%	20.0% - 30.9%
Population (age 25+) without certificate, degree, diploma	20.8%	18.7%	13.0% - 25.9%
Population (age 25+) with completed post-secondary education	52.9%	56.8%	50.3% - 64.7%

*Source: *2009 population projections. Remaining indicators based on 2006 Census of Canada, Statistics Canada*

Health Status

Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 60% of HNHB residents rate their health as 'excellent' or 'very good' (Source: Canadian Community Health Survey, 2007). However, significantly more HNHB LHIN residents say they are limited in activities because of a physical or mental condition or health problem.

Illness, Disease and Death

HNBH LHIN residents have significantly more arthritis/rheumatism, high blood pressure, and asthma compared to the province as a whole. Chronic conditions reduce the quality of life of those who suffer from the condition. Diabetes rates, while slightly lower than the provincial rates, are not significantly lower (Source: Canadian Community Health Survey, 2007).

Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, and treating disease, and reducing suicide. In 2005, there were 11,439 deaths among residents of the HNHB LHIN. Heart disease, lung cancer, and stroke were the top three leading causes of death.

HNHB residents lose more potential years of life. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the HNHB LHIN are higher than provincial rates (Source: Deaths, Provincial Health Planning Database).

Health Practices and Preventive Care

Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the HNHB LHIN smoke daily or occasionally, drink heavily, and are obese (Source: Canadian Community Health Survey, 2007).

Preventive health care services can help find disease early, which over the long term reduces illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as whole. Within the last three years, 71.7% of women in the HNH BLHIN had a Pap smear (for cervical cancer screening), 54.5% of women received a routine mammogram in the previous two years, and 36.9% had a flu shot in the past year (Source: Canadian Community Health Survey, 2005 and 2007).

Most people get their care through their family doctors. Doctors also play key role in coordinating care and managing chronic conditions. Most people (79.0%) in the HNHB LHIN talked, either in person or by phone, with a doctor in the last year. This is similar to the Ontario rate of 80.6%.

Summary

The HNHB LHIN covers 7,000 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With approximately 1.4 million people, it includes small rural communities and large urban centres, with population that is culturally and linguistically diverse.

Relative to the province (Ontario), HNHB has a higher percent of:

- lone parent families
- people limited in their daily activities
- daily or occasional smokers
- people who are obese
- people with arthritis/rheumatism, high blood pressure, and asthma

The HNHB LHIN also has:

- the most seniors of any LHIN
- a higher rate of premature death and hospitalization
- a lower percent of adults with post-secondary education

Engaging with our Communities

Local Health Integration Networks are required to engage their communities, which include residents, patients and health service providers. This requirement includes engaging with Aboriginal, First Nations and Francophone communities. The HNHB LHIN recognizes, respects and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

Local Health Integration Networks are mandated to work with Aboriginal communities for improved health and wellness. The HNHB LHIN has a responsibility to learn about and respect Aboriginal communities' approach to health and wellness and how this approach guides the identification of health needs and solutions. Respect for and inclusion of Aboriginal traditional practices with non-traditional health providers is essential for health solutions aligned with cultural identity, holistic health and community values.

A three-day Aboriginal health search conference was held in the HNHB LHIN at Six Nations of the Grand River Territory. Participants included Aboriginal persons from among the First Nations, Métis and urban Aboriginal health communities. The outcomes have resulted in ongoing planning and engagement activities for health improvement in the past year.

Partners in Health

The Aboriginal Health Network convened and adopted terms of reference. Its purpose is to create a forum that will harmonize the efforts of First Nations, Métis and urban Aboriginal health and social service providers toward creating a health system that:

- Meets the holistic health needs of Aboriginal people across the region from an Aboriginal perspective;
- Integrates traditional Aboriginal knowledge and healing systems for healthy people and healthy communities;
- Commits to input from Aboriginal communities regarding present and future programs and services;
- Improves the capacity of a broad range of stakeholders to contribute to improved health outcomes of Aboriginal people; and,
- Liaises with the HNHB LHIN Board to ensure decisions are positively impacting Aboriginal health status and access to services.

Health Improvement

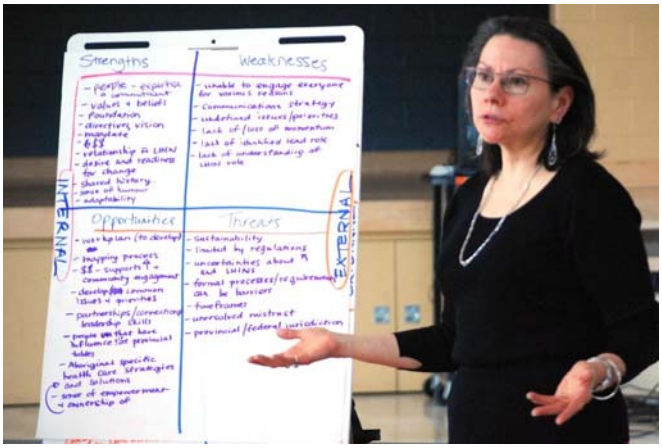
Two Aboriginal health improvement projects are underway in the HNHB, Waterloo Wellington and Mississauga Halton LHINs, funded by the federal Aboriginal Health Transition Fund (AHTF). Funded projects are intended to adapt health services to better meet the needs of Aboriginal people. Adaptation can be accomplished through the re-design, re-orientation and or modification of existing programs and services.

- The Discharge Planning initiative led by Six Nations is assessing how to improve Aboriginal persons' continuity of care and health experience as they move from hospital care to recovery at home. The goal is culturally appropriate care and supports for health recovery.

- The Mental Health initiative is focused on improved mental health and well being of Aboriginal children and their families through early identification and intervention. The goal is to improve links among traditional and non-traditional health services for Aboriginal children and their families who are at-risk for family breakdown and mental health issues or who are involved with child welfare services.

Looking Ahead

A workshop was held in March 2010 with First Nations, Métis and urban Aboriginal health and social service providers. The purpose was to reflect on collaboration and success, and future opportunities for improved health and well being.



Aboriginal Action Planning Session, March 19, 2010

Recommendations for next steps to sustain momentum include:

- Implement a web portal to improve access to LHIN information and facilitate knowledge sharing
- Continue to build relationships
- Map health and well being resources
- Share data and information to help identify issues
- Explore best practices Aboriginal - centred service programming

Francophone Health Engagement

The French Language Services Act, Ontario, 1986, recognizes the contribution of the French speaking population to the historical, cultural and linguistic heritage of Ontario. The Act guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. To this end, LHINs plan and promote French language health services and engage the French speaking community in the process; French speaking residents and stakeholders know their communities best. The goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Listening and Learning

The Centre de santé communautaire Hamilton Niagara is providing significant leadership for Francophone engagement in the LHIN.

Partners in Health

A workshop was held in June 2009 with Francophone community leadership from health and social service providers. The goal was to develop a road map to improve Francophone health and improve health care for Francophones. The map calls for the following:

Welcoming Environments

- Culturally welcoming and person focused environments provide appropriate supports and care or linkages to care in French.
- No matter where a French speaking person presents for care, the person is linked with services in French.

A Network of French Language Service Providers

- There are a limited number of French language service providers. A virtual network of health and related providers enhances relationships and knowledge for patient referrals, strengthens a professional community and attracts French language providers to the LHIN.

A Progress Report on Care

- Programs and services deemed priorities by Francophone communities are available in French
- Improved access to French Language Health Services (FLHS)
- Satisfaction with FLHS
- Communities are supportive of FLHS
- Integration of French speaking communities in planning and decision making

Stakeholder Engagement

As part of our stakeholder engagement strategy, HNHB LHIN Board and staff members meet with political representatives, including MPPs, throughout the year. Two meetings with mayors from the HNHB LHIN communities and regions took place throughout year. The focus of these meetings was to keep political representatives informed of HNHB LHIN initiatives and activities, including two major planning initiatives – the Clinical Services Plan and the 2010-2013 Integrated Health Service Plan – as well as to provide a forum for discussion about community health care needs, issues and concerns.

During the development of the Clinical Services Plan, HNHB LHIN Board and staff members held approximately 105 meetings, presentations, and information sessions with health service providers and various networks across the LHIN.

To build capacity, foster collaboration and support integration within the local health system, HNHB LHIN board and staff members strengthened relationships with health service providers.

In addition to orientation sessions, HNHB LHIN staff held individual meetings with all of its 100 community and mental health agencies to discuss the Community Sector Annual Planning Submission (CAPS) and Multi-Sector Accountability Agreement (M-SAA). The orientation sessions provided agencies with an overview of the new agreement and accompanying processes. At the individual sessions, agencies were given the opportunity to discuss their specific operations and expected outcomes and how they would align with the new agreement.

> "Throughout the planning process, the HNHB LHIN sat around the table, providing invaluable insight and support that ultimately helped to shape our final plan. We have been very pleased with the working relationship with the LHIN. The HNHB LHIN Board and staff's commitment to "walking the talk", listening to stakeholder ideas, and being open to consider fresh new approaches to local health challenges is having a positive impact in our local community."
>
> *-HNHB LHIN Health Service Provider, Long-Term Care*

As a result of the M-SAA, the quarterly reporting forms changed significantly. HNHB LHIN staff conducted training sessions in November 2009 for the HNHB LHIN's 100 community and mental health agencies. LHIN staff provided training on the CAPS Allocation Tool that assists agencies in preparing their quarterly report as well as their forecasts and analysis of in-year results.

In preparation for the Long-Term Care Annual Planning Submission (LAPS), HNHB LHIN staff conducted two orientation sessions on October 5, 2009 for the LHIN's 88 long-term care homes. LHIN staff provided a review of the LAPS components and a brief overview of the Long-Term Care Home Service Accountability Agreement (L-SAA). Following the orientation sessions, LHIN staff met with a number of long-term care homes on an individual basis for further discussion around the LAPS and L-SAA.

Open Houses 2009

Open House, Walker Family YMCA, St. Catharines, October 19, 2009

Throughout October 2009, the HNHB LHIN held 12 open houses across its communities, which were attended by more than 1,000 residents and health service providers. Residents spoke with LHIN Board members and staff to discover how the HNHB LHIN and its partners work to improve the local health care system, learn about our Integrated Health Service Plan (IHSP) directions, and share their thoughts and ideas for a healthier future.

People value the opportunity to have face to face conversations. Through the conversations and various feedback tools, we are learning about what our residents and health service providers value in their health care system.

A key tenet of health system improvement is the value placed on the experience, insights and wisdom of communities and their important contributions to health planning and decision making. The HNHB LHIN made a commitment to involving residents, stakeholders and providers in all of its work for health improvement, and the open house sessions are one expression of this commitment.

Open House, Hagersville United Church, October 15, 2009

Planning for the Future

HNHB LHIN RNAO Best Practice Spotlight Organization Candidacy

The Hamilton Niagara Haldimand Brant LHIN is one of 16 sites across the province that has been given the opportunity by the Registered Nurses Association of Ontario (RNAO) to become a Best Practice Spotlight Organization (BPSO). During the candidacy period April 1, 2009 to March 31, 2012, participating organizations will work together to implement best practice guidelines.

Participating organizations include:

- Brant Community Healthcare System
- Haldimand War Memorial Hospital
- Hamilton Health Sciences
- Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC)
- Hotel Dieu Shaver Health and Rehabilitation Centre
- Joseph Brant Memorial Hospital
- Niagara Health System
- Niagara Region Public Health
- Norfolk General Hospital
- St. Joseph's Healthcare Hamilton
- West Haldimand General Hospital
- West Lincoln Memorial Hospital

The HNHB LHIN is focusing on three best practice guidelines:

HNHB LHIN RNAO BPSO Open House, Symposium and Official Launch, March 24, 2010

- Prevention of Falls and Fall Injuries in the Older Adult
- Risk Assessment and Prevention of Pressure Ulcers
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence

On March 24 2009, the HNHB LHIN celebrated the official launch of its BPSO candidacy with representatives from all partner organizations. It was a day of learning, sharing, and celebration.

Health Professionals Advisory Committee (HPAC)

Since its inaugural meeting in March 2008, members of the Health Professionals Advisory Committee have played a pivotal role in bringing issues forward from each of their respective roles and professions. In February 2010, an ad hoc committee of HPAC formed with the objective to examine the issues related to

the implementation of interprofessional care and scopes of practice and bring recommendations to HPAC for discussion.

The ad hoc committee will serve as a forum for dialogue and action amongst the representative interdisciplinary professionals to advance interprofessional care in the HNHB LHIN and advise the LHIN to reach its goals and objectives.

Clinical Services Plan (CSP)

Now, and over the next 10 years, the challenges for health care are enormous. Our population is aging, illness burden is high, resources are finite, and the economy is in transition. At its November 24 2009 meeting, the HNHB LHIN Board approved the Clinical Services Plan (CSP). The CSP is an action call for a healthier population, improved ways of working together for better health outcomes and best practice organization and distribution of programs.

A steering committee was established in January 2009 to guide the development of the Clinical Services Plan. The steering committee was made up of a diverse group of health care and community leaders from across the LHIN who guided the process, assured sound planning, and consolidated and presented the final report to the HNHB LHIN Board of Directors for approval.

As part of the plan's development, 18 Planning Advisory Groups (PAGs) were established to gain expert insight into future models of service delivery for the LHIN. PAG membership consisted of both clinical and administrative leadership, with a mix of geography and perspectives that consider the entire continuum of care. HNHB LHIN staff also engaged primary care physicians to ensure this perspective was captured.

In total, more than 800 citizens, including health service providers, stakeholders and residents, participated in various planning sessions to help shape the development of the Clinical Services Plan. A series of community open houses hosted by the LHIN throughout October 2009 also sought comments on the plan's proposed themes.

Engaging the community was an essential part of the development of the CSP. Its three transformational themes reflect what citizens, stakeholders and providers having been telling the LHIN Board and staff over the last three years at various forums, meetings and presentations -- changes in the way services are delivered and utilized must occur.

> Now, and over the next ten years, the challenges for health care are enormous. Our population is aging, illness burden is high, resources are scarce, our ability to measure benefits of investments is poor, and the economy is flat. Tough decisions will need to be made to ensure quality of health care and appropriate access to the right health services for all of us living in our LHIN.

The Clinical Services Plan highlights the importance of e-Health as a key enabler for health system improvement and outlines three foundational themes:

- Interprofessional care
- Clinical program integration
- Community-based health service capacity

The Clinical Services Plan was a significant building block in the development of the Integrated Health Service Plan 2010-2013.

Integrated Health Service Plan (IHSP)

In 2006, the HNHB LHIN released its first Integrated Health Service Plan (IHSP). The plan guided early priorities for health improvement and funding decisions over three years. The LHIN's second IHSP provides a roadmap for health system change for the period April 1 2010 through March 31 2013.

The IHSP is informed by the Ministry of Health and Long-Term Care priorities for Ontario, and by local priorities. It will guide the HNHB LHIN's annual business plans, integration priorities and funding decisions for the local health system.

The LHIN and the ministry are partners in planning improvements for health care and both have important roles. The ministry sets and shares its strategic vision and priorities. The LHIN aligns with the ministry's directions, and sets additional priorities at the local level.

The HNHB LHIN's IHSP supports the ministry's priorities to promote equitable access to health care for all Ontarians, and to improve access to care, reduce wait times in emergency departments and reduce wait times in hospital for alternate care, and improve diabetes care (a chronic disease prevention and management priority). The ministry has also identified mental health and addictions and e-Health as key focus areas, both of which the HNHB LHIN supports through strategic priorities and activities.

At the same time, the IHSP reflects the unique challenges and opportunities of our local population and local health system.

The second phase of the IHSP, entitled, *Improving Our Health Care Experience: Integrated Health Service Plan 2010-2013*, was approved by the HNHB LHIN Board at its December 15, 2009 meeting.

The IHSP 2010-2013 focuses on three strategic priorities:

- Improve access to emergency room (ER) care by reducing the number of non urgent or less urgent presentations to the ER, and reducing the amount of time that people spend waiting in the emergency department;
- Reduce prevalence of chronic disease; and,
- Integrate and link services for mental illness and addictions prevention, management and recovery.

Moving our Priorities Forward

Chronic Disease Prevention and Management

> "The Hamilton Family Health Team appreciates the HNHB LHIN's capacity to see the "big picture" in its support of systemic improvements in Healthcare in our community. The participation of the HNHB LHIN in partnering with primary care to fill care gaps for diabetic patients and to work with other community partners to improve the sharing of patient information between hospitals and Family Physicians has contributed to both patient safety and more efficient delivery of care."
>
> *-HNHB LHIN Health Service Provider, Family Health Team*

In 2005, 74% of HNHB LHIN residents (approximately one million people) reported having at least one chronic condition, such as diabetes, arthritis, heart disease and asthma (Source: Profile of Chronic Conditions in the Hamilton Niagara Haldimand Brant LHIN). The number of people who report having a chronic condition is consistently rising due to our aging population. Because of the large demand for CDPM-related services, many of our health service providers provide services for the prevention and management of chronic conditions. Among residents with diabetes, complications are experienced by many. Each year more than 200 people in the HNHB LHIN have a foot or lower limb amputated due to complications with diabetes.

Successes in the past year:

In 2009, the LHIN hosted two Continuing Health Science Education events (*Raising the Bar in Chronic Disease Prevention and Management)* for health service providers to increase their knowledge of approaches for enhancing diabetes care in their communities.

- The CDPM Collaborative Advisory Committee identified guiding principles; a priority setting framework; an approach to implementing the CDPM model using the Triple Aim framework; and, initiated a collaboration with the Institute for Clinical and Evaluative Sciences (ICES) on sub-LHIN analysis to define a target population. The Triple Aim framework will be piloted in selected communities across the LHIN to improve the health of a targeted population while balancing the population's health, quality care and cost.

- The Diabetes Action Group Report was updated to include the completed Patient Education Materials Inventory. The inventory is a compendium of patient education materials that are based in best practices and meet accepted standards and literacy criteria, providing consistency in patient education materials throughout the LHIN.

- New diabetic foot care programs were started at the North Hamilton Community Health Centre (CHC) and LHIN Dialysis Centres, following the identification of a risk classification and management approach for diabetic foot care based on a review of best practice guidelines
    - Diabetic foot exams were included as a performance indicator in LHIN multi-sector service accountability agreements (MSAAs) for CHCs. Including foot exams will, over time, help to decrease the number of foot ulcers, wounds and amputations experienced by diabetics thereby improving the quality of life experienced.

Mental Health and Addictions

One in five persons in Canada will be affected by mental illness at some point in their lives and well over half of them will be diagnosed before the age of 18. In addition, as many as one in five people will have a substance use disorder in their lifetime.

These issues and their impacts have led the Ministry to develop a 10-year strategic plan on mental health and addictions in the province of Ontario. While the strategy is still under development, a number of steps have been taken in the HNHB LHIN to contribute to and align with the anticipated strategy.

Successes the past year:

- The HNHB LHIN, in conjunction with the LHIN-wide Mental Health and Addictions Network, contributed key inputs to the Ministry's 10-year strategy.

- 250 LHIN residents/clients and family members participated in focus groups and identified opportunities to address the need for community care and housing for persons with long-term mental health and addictions issues

    - Mental health and addictions stakeholders identified opportunities to decrease overall usage and length of stay in emergency departments. As a result, the LHIN will be participating in a province-led quality improvement project to implement these opportunities.

    - In 2009-10, the HNHB LHIN advised the Ministry of Health and Long-Term Care on the distribution of supportive housing units and case management supports for persons with problematic substance abuse.

Aging at Home

The Aging at Home (AAH) strategy is a three-year (2008 – 2011) provincial initiative designed to optimize seniors' health, well being and independent living in the community. Three sets of activities defined HNHB LHIN Aging at Home implementation this past year: evaluation of Year 1 programs for independent living, implementation of Year 2 strategies in fall 2009, with a strong focus on falls prevention; and, development of Year 3 strategies to be implemented in summer 2010.

Year 3 health improvement strategies were informed in part by the Integrated Decision Support (IDS) tool. The IDS is a newly developed data repository with associated analytics that identifies what hospital and Community Care Access Centre (CCAC) services LHIN residents are using and where, why, and how often. This helped the LHIN identify opportunities to match people's needs with the right services at the right time in the right place. Four sets of strategies were developed:

- Supportive housing in Dunnville that will provide an affordable and appropriate housing option for residents and will appropriately delay admission to a long term home;
- Enhanced specialized geriatric services to support frail seniors with complex needs early in the course of their illness burden, closer to home, and sooner;

- Rapid access assessment clinics in two hospital sites to enhance access to diagnostics, assessment, and care path within 24-48 hours of presentation to an Emergency Department (ED) - this will reduce wait times in the ED and unnecessary hospitalizations; and,
- An assess restore program to support recovery following a hospital stay.

The Year 3 envelope (approximately $5,029,000 annualized) and strategies were approved by the HNHB LHIN Board in February 2010 and are scheduled for implementation in summer 2010.

e-Health

The e-Health Project Management Office for the HNHB LHIN is now fully operational. This office plays a lead role in harnessing information technology and innovation to improve patient care, safety and access for the residents of our LHIN in support of the government's health strategy.

Over the past year, the provincial e-Health office has seen the implementation of a new management team and governance. Concurrent with these staffing changes, there has been a shift from a centralist model for e-Health to one where regional hubs are able to move and share local data. The HNBH LHIN is very well positioned to meet this new approach, confirmed by the following achievements over the past year:

- **ClinicalConnect**

The roll out of clinical portals to give physicians access to needed pieces of information continues. Using a secure internet-based dashboard, physicians and other approved users are able to access patient information including lab reports, diagnostic imaging, and case notes, from an increasing number of LHIN hospitals and the Community Care Access Centre.

- **Integrated Decision Support (IDS) Warehouse**

LHIN hospitals and the CCAC are providing monthly information extracts to a centralized data warehouse. Data contained within the IDS is being used for strategic and operational analysis of health care data to improve patient care and health care system efficiency. Through a user-friendly data repository and suite of business intelligence tools, a wide variety of licensed users have access to longitudinal data of a patient's journey through the health care system, including hospital visits and interaction with the CCAC. IDS provides a timely data repository to identify opportunities to improve the delivery of health care through patient-centric transformation initiatives.

- **e-Health Ontario Projects**

HNHB LHIN was very successful in receiving approval to proceed with a number of projects sponsored by the provincial e-Health office. The LHIN will obtain the positive benefit of moving forward our local strategic plan, synchronized with government priorities. The LHIN, in collaboration with other LHIN partners in Southwestern Ontario, was successful in our application to work on the following projects:

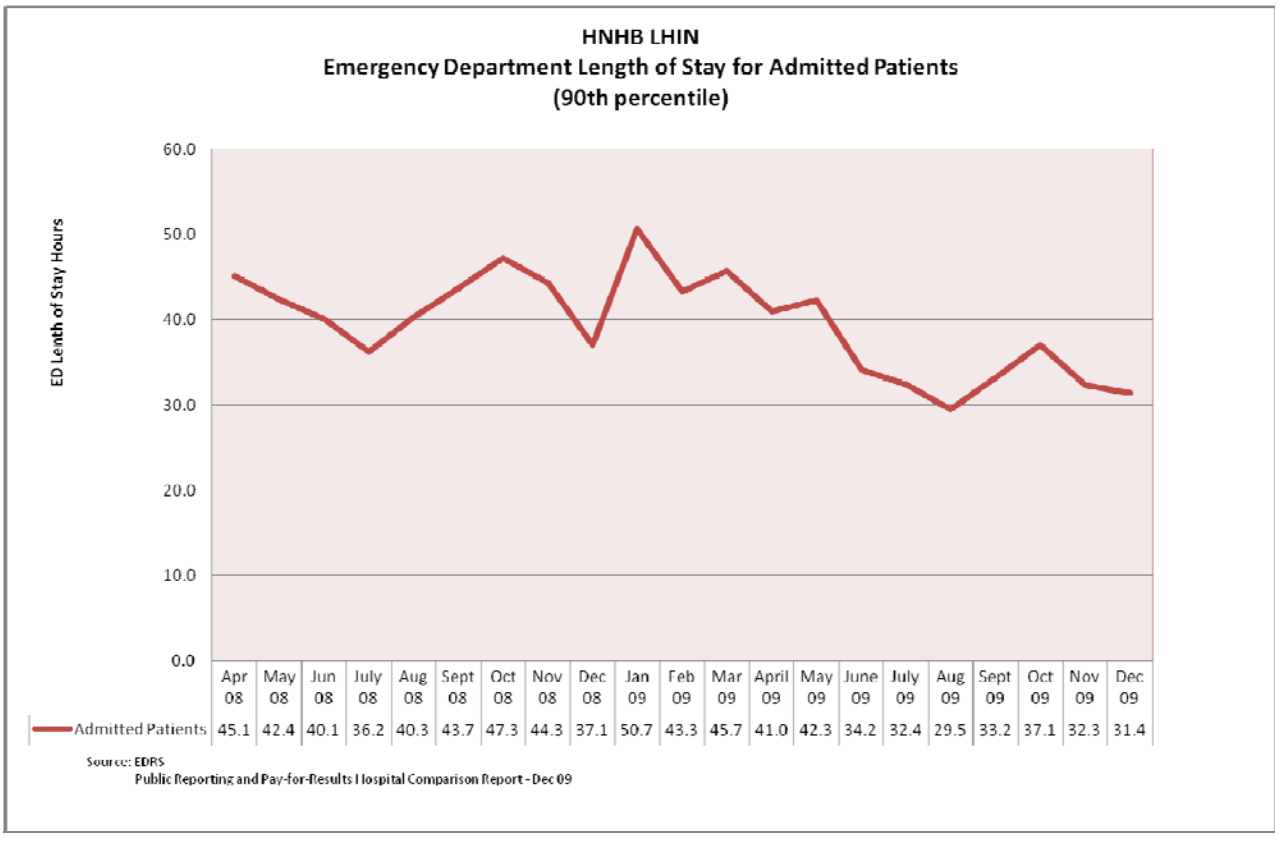
  - Integration Services – connecting multiple provider organizations within LHINs
  - e-Physician – providing value to community physicians through electronic access
  - Implementation and Adoption Strategy – leading the change management necessary for implementing shared infrastructure and processes
  - ALC Resource Matching & Referral – improving the process and efficiency of referring acute patients to other levels of care

Much of the success in obtaining funding for this work arises from the HNHB LHIN's interest in working with other LHIN partners. By building partnerships and coordinating our resources, the four LHINs in southwestern Ontario (Erie St. Clair, Waterloo Wellington, South West and HNHB) are working toward building an efficient and effective e-health system for the residents of our communities.

Emergency Room (ER) Wait Times

Reducing emergency room wait times continued to be a priority for the HNHB LHIN in 2009-10. The LHIN's success can be attributed to the commitment and participation of all its providers. Strategies to reduce wait times in the emergency room focused on reducing ER demand and improving efficiency in the ER.

Over the year, the LHIN has made progress in reducing the length of time residents wait in emergency rooms. Initiatives introduced in 2009-10 targeted at reducing wait times for specific ER populations started to show improvement over the latter part of the year. The most notable reduction in wait times across the LHIN was among residents waiting in the ER to be admitted to hospital, which as of December 2009, decreased by approximately 14 hours over April 2008 (Source: Electronic Data Resources Service (EDRS), *Public Reporting and Pay-for-Results Hospital Comparison Report December 2009*).



A wait time improvement of four hours was also seen for high acuity residents who did not need to be admitted to hospital. The LHIN has had the greatest challenge for residents identified as low acuity as wait times for this population have been relatively constant. The stable performance seen in the low acuity

population was accomplished despite increased ER volumes the LHIN experienced during the October 2009 H1N1 outbreak.

Key Activities to Reduce ER Demand and ER Wait Times

Pay for Results (P4R)

Five HNHB LHIN hospitals across seven sites participated in the Ministry of Health and Long-Term Care's Pay-for-Results (P4R) initiative. Through this strategy, hospitals focused on reducing the time residents spend waiting in the emergency room by implementing initiatives to streamline client flow. These initiatives included establishing *Rapid Assessment Zones* for low acuity patients, implementing patient flow coordinators, enhancing ER support services, and improving lab and diagnostic imaging turn around times.

Participating HNHB LHIN hospitals:

- Hamilton Health Sciences
    - Hamilton General Hospital
    - Henderson General Hospital
    - McMaster Children's Hospital
- Brant Community Healthcare System
- Niagara Health System
    - St. Catharines General Hospital
- Joseph Brant Memorial Hospital
- St. Joseph's Healthcare Hamilton

As of February 2010:

- All HNHB LHIN P4R sites showed an increase in the proportion of admitted patients treated within the recommended wait time. The increase ranged from 2-7%. Since April 2008, the number of hours residents spend in the emergency room waiting to be admitted to a hospital bed decreased by 12 hours.
- Five HNHB LHIN P4R sites showed an increase in the proportion of non-admitted high acuity patients treated within the recommended wait time. The increase ranged from 1-7%. The wait times for low acuity patients remained relatively constant.

Emergency Department Performance Improvement Program (ED PIP)

All HNHB LHIN P4R sites participated in the Ministry's Emergency Department Process Improvement Program (ED-PIP). This program applies LEAN methodology to hospital-wide patient flow processes by engaging multiple hospital departments focused on emergency room wait time improvement. ED PIP strategies focused on emergency room triage processes, streamlining patients by level of illness, improving processes for laboratory and diagnostic image testing, and improved discharge processes for in-patients to make room for the newly admitted ER patients.

Health Care Connect

This program, operated by the HNHB Community Care Access Centre (CCAC), connects residents without a family physician to primary care. Since the program's inception in February 2009, the HNHB CCAC has made 989 matches across the HNHB LHIN. As of March 31 2010, 123 physicians were participating in the program.

Increased Access to Urgent Care Centres (UCC)

Residents with less acute emergent health care needs can be treated at urgent care centres quicker than emergency rooms. As part of the implementation of Niagara Health System's Hospital Improvement Plan (HIP), two emergency rooms were converted to urgent care centres (UCCs). The conversions to UCCs took place in Port Colborne in July 2009 and Fort Erie in September 2009.

Residents accessing urgent care centres throughout the LHIN experienced wait times that were 50% shorter than emergency room wait times. Individuals with low acuity conditions spent on average 2.6 hours in an emergency room versus 1.4 hours in an urgent care centre.

Expansion of Nurse Practitioners in Long-Term Care Homes

This program allows residents to be treated in their long-term care homes, avoiding transfers to the emergency room or hospital which can be stressful for the resident and the resident's family.

- As of December 2009, 1,127 LHIN long-term care home residents were cared for by nurse practitioners. Based on those visits, it is estimated that 384 transfers from long-term care to emergency were avoided. Only 1.25-1.5% of long-term care home residents that were assessed by the nurse practitioner had a hospital transfer during this time. The Nurse Practitioner Long-Term Care Home team also provided 43 educational in-services to build clinical capacity within the long-term care home sector within the HNHB LHIN.

Community Care Access Centre (CCAC) Case Managers

As of February 2010, 2,956 emergency room admissions were avoided as a result of CCAC case managers being located in emergency rooms. Where appropriate, CCAC case managers can arrange for care to be provided in the community rather than in hospital.

Emergency Services Steering Committee

The HNHB LHIN's Emergency Services Steering Committee (ESSC) provides leadership to HNHB LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services within the HNHB LHIN community.

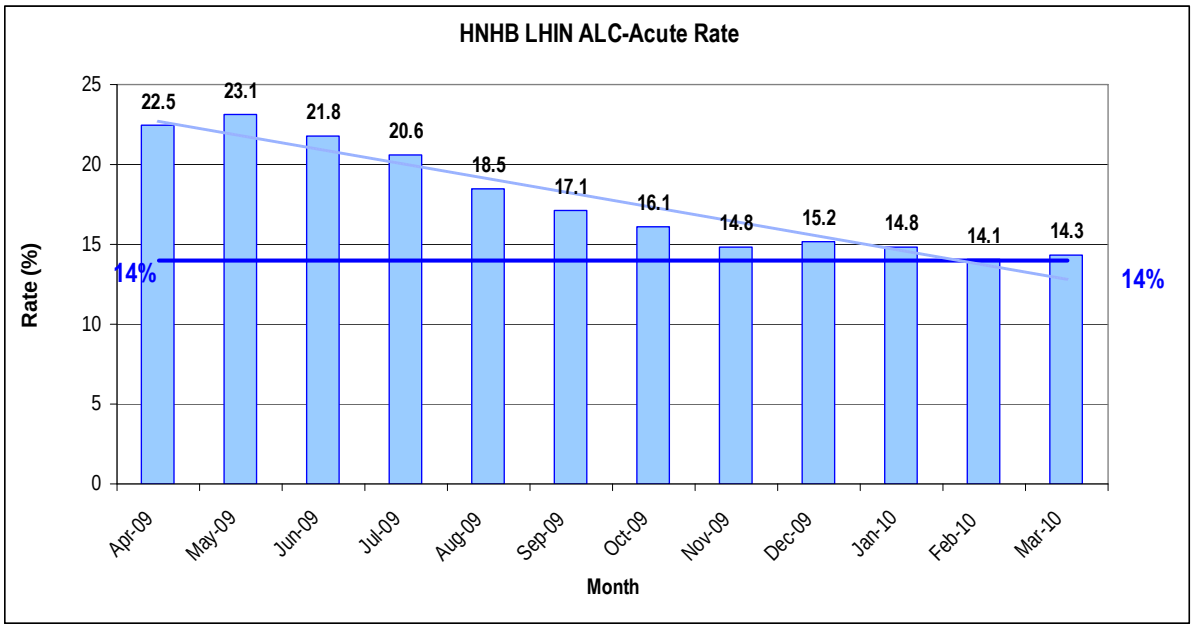
Over the course of the past year, the ESSC:

- Spent three months developing a model of care for emergency services with the HNHB LHIN as part of the development process of the Clinical Services Plan
- Monitored and advised on ED Pay-for-Results sites
- Organized and funded a LHIN-wide LEAN certificate course which was attended by clinical and administrative staff from HNHB LHIN hospitals and Emergency Medical Services (EMS)
- Made a financial contribution to support the ED Process Improvement Program participating sites
- Joined the steering committee of the SMART- AMI project – a LHIN-wide best practice project to treat an "ST Elevated" heart attack.

Facilitating the Right Level of Care

In 2009-10 the HNHB LHIN, in collaboration with its providers, CCAC and Alternate Level of Care (ALC) Steering Committee, implemented a strategic plan to enable residents who require post acute care to receive it in the right setting. This plan also addressed systemic hospital pressures related to patients occupying beds while waiting for an alternate level of care. All LHIN strategies focused on creating a safe environment that provided the necessary care and supports to enable clients to return home.

The LHIN's success over the past year is demonstrated by a substantial reduction in its acute ALC rate as it decreased from 22.5% in April 2009 to 14.3% in March 2010. This decreased ALC rate indicates that more people are moving into more appropriate care settings rather than staying in hospital. It also means that more people who need to be admitted to hospital have greater access to beds.



Source: HNHB Community Care Access Centre (CCAC) Report, March 2010

Key Activities to Improve ALC Issues

- Established 107 restorative in-patient care beds across the LHIN. By providing an environment where residents can receive additional care to build their strength and identify their long term care needs, 80% of patients admitted to these beds return home.

- HNHB LHIN hospitals and the CCAC collaborated to work with patients and their families to optimize their ability to return home from hospital. Providing the support needed for a timely return home from hospital avoids complications that can occur with long and unnecessary hospital stays. This program has contributed to the reduction of patients identified for long-term care home placement by 63% between May 2009 and December 2009.

- Supported 16 interim long-term care beds for residents who need the services provided by a long-term care home.

- Funded community programs that support residents' discharge from hospital. These programs included personal support in assisted living environments and outpatient slow stream rehabilitation.

Accountability and Performance

In 2009-10, the HNHB LHIN posted its first balanced scorecard on the LHIN website and updates it quarterly.

The scorecard provides a snapshot on the performance of the local health system using select performance measures across four domains:

- System integration
- Client access and outcomes
- Financial and sustainability
- Organizational health

Wait Times Strategy

The LHIN's 2009-10 MLAA performance indicators can be grouped into three categories that report on resident's access to the right care in the right place at the right time.

These are:

- Improving wait times for four elective surgery and two diagnostic services
- Improving hospital discharge to the right care for residents who have completed their acute stay
- Reducing wait times for emergency care.

In 2009-10, the LHIN built on the successful collaboration established with the HNHB LHIN Community Care Access Centre, the LHIN's Wait Time Advisory (and sub committee work groups), Emergency Services Steering and Alternate Level of Care Steering Committees and LHIN hospitals. Together these stakeholders contributed to the LHIN's achievements of the MLAA performance measures.

Performance - Selected Surgery and Diagnostic Services

This narrative provides a brief overview of the 2009-10 MLAA performance indicators for the HNHB LHIN (see table on page 33).

In 2009-10 the LHIN achieved wait time reductions for cataract surgery, total hip surgery and diagnostic MRI services.

Activities completed this past year that contributed to the reduced wait times include:

- Expansion of the Regional Joint Assessment Program to the Brantford General Hospital site
- LHIN staff, working with hospitals, completed four in-year reallocations. This allowed the movement of wait time volumes between LHIN hospitals to accommodate the demand using available hospital capacity
- Increased operating room time for surgeons with longer wait times
- Review of the orthopedic model of care by the Orthopaedic Expert Panel at hospitals with longer total joint surgery wait times
- Reduction of the LHIN's ALC rate

While there was not a reduction in wait times for selected cancer surgery, total knee replacement surgery and CT scans, wait times for these services were maintained or only increased slightly. Cancer surgery increased by four days but continues to be below the provincial target.

Challenges that limited wait time reduction included:

- Surgeon wait time management and reporting practices
- Higher wait times associated with specific cancer surgery services (increased demand for minimal invasive procedures)
- Surgery cancellations due to bed pressures as a result of unplanned increase hospital demand i.e. H1N1 outbreak, higher number of emergent cases
- Increased demand for CT and MRI services

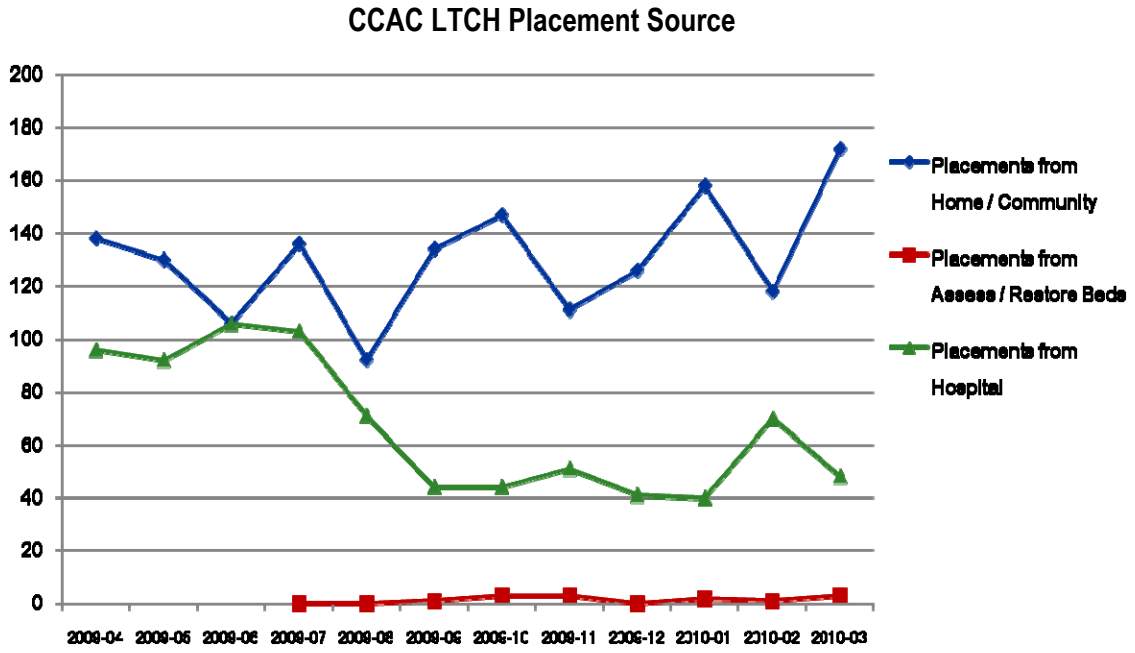
To improve wait times in 2010-11 the LHIN in collaboration with LHIN providers will undertake the following activities in 2010-11:

- Expansion of the Regional Joint Assessment Program to Niagara Health System
- Review surgeon wait list reporting practices
- Improve the timeliness of reallocating funding
- Increase operating room time for surgeons with longer wait times
- Implement hospital specific action plans to reduce wait times for key services

Wait Times for Long-Term Care Homes (LTCH)

The median wait time for LTCH placements increased in the last two quarters of 2009-10. This increase coincided with the LHIN discontinuing a Rotational 1A Crisis Pilot implemented in 2008-09 to assist the LHIN's high ALC rate in hospitals.

One of the unintentional outcomes of an extended 1A crisis in hospital is that individuals waiting for placement in the community experience longer wait times. The increase in median wait times in the latter half of 2009-10 can in part be attributed to the increase number of placements from the community (refer to diagram on page 33).



Source: HNHB LHIN CCAC March 31 2010

Hamilton Niagara Haldimand Brant LHIN MLAA Performance Indicators 2009/10

Performance Indicator	LHIN Starting Point 2009/10	LHIN Performance Target - 2009 /10	Most Recent Quarter 2009/10 LHIN Performance	FY 2009/10 LHIN Annual Results	LHIN Met Target/Within Corridor (YES/NO)
90th Percentile Wait Times for Cancer Surgery	54	50	61	58	NO
90th Percentile Wait Times for Cardiac By-Pass Procedures	NA	NA	NA	NA	NA
90th Percentile Wait Times for Cataract Surgery	107	103	108	104	YES
90th Percentile Wait Times for Hip Replacement	182	182	174	177	YES
90th Percentile Wait Times for Knee Replacement	182	200	201	209	NO
90th Percentile Wait Times for Diagnostic MRI Scan	104	87	106	100	YES
90th Percentile Wait Times for Diagnostic CT Scan	148	33	48	49	NO
Median Wait Time to Long-Term Care Home Placement -All Placements	147	109	234	178	NO
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	24.16%	14.00%	21.50%	21.56%	NO
Proportion of Admitted patients treated within the LOS target of ≤ 8 hours	33.00%	40.00%	36.63%	35.94%	NO
Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III	81.00%	87.00%	82.68%	82.60%	NO
Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours	82.00%	87.00%	83.13%	82.51%	NO

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Auditors' Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the statement of financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. 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 plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 30, 2010

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**546,544**	736,297
Accounts receivable - Ministry of Health and Long-Term Care ("MOHLTC")	**35,000**	223,200
Accounts receivable - Other	**6,634**	144
Due from MOHLTC to Health Service Providers ("HSPs") (Note 9)	**1,374,800**	4,559,149
Due from the LHIN Shared Services Office (Note 4)	**4,968**	-
	1,967,946	5,518,790
Liabilities		
Accounts payable and accrued liabilities	**555,276**	962,921
Due to the MOHLTC (Note 3b)	**54,863**	-
Due to HSPs from MOHLTC (Note 9)	**1,374,800**	4,559,149
Due to the LHIN Shared Services Office (Note 4)	**-**	16,233
Deferred capital contributions (Note 5)	**481,618**	701,891
	2,466,557	6,240,194
Commitments (Note 6)		
Net debt	**(498,611)**	(721,404)
Non-financial assets		
Prepaid expenses	**16,993**	19,513
Capital assets (Note 7)	**481,618**	701,891
Accumulated surplus	**-**	-

Approved by the Board

_____ Juanita G. Gledhill, Chair

_____ Jack Brewer, Vice-Chair

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

		2010	2009
	Budget (unaudited) (Note 8)	Actual	Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**2,444,933,900**	**2,493,218,669**	2,385,618,620
Operations of LHIN	**5,005,757**	**5,096,546**	4,887,384
E-Health (Note 10a)	**600,000**	**600,000**	425,000
Residents First (Note 10b)	**-**	**209,750**	-
ER/ALC Performance Lead (Note 10c)	**-**	**100,000**	33,300
French Language Services (Note 10d)	**-**	**78,000**	-
Emergency Dept LHIN LEAD (Note 10e)	**-**	**75,000**	75,000
Aboriginal Planning (Note 10f)	**37,500**	**37,500**	49,000
Diabetes Self Management (Note 10g)	**-**	**35,000**	-
Diabetes Strategy (Note 10h)	**-**	**25,000**	-
Patient-Centric Transformation Initiative	-	-	223,200
Health Force Ontario	-	-	50,000
Amortization of deferred capital contributions (Note 5)	-	**229,600**	515,270
	2,450,577,157	**2,499,705,065**	2,391,876,774
Expenses			
Transfer payments to HSPs (Note 9)	**2,444,933,900**	**2,493,218,669**	2,385,618,620
General and administrative (Note 11)	**5,005,757**	**5,319,297**	5,402,654
E-Health (Note 10a)	**600,000**	**600,000**	425,000
Residents First (Note 10b)	**-**	**161,736**	-
ER/ALC Performance Lead (Note 10c)	**-**	**100,000**	33,300
French Language Services (Note 10d)	**-**	**78,000**	-
Emergency Dept LHIN LEAD (Note 10e)	**-**	**75,000**	75,000
Aboriginal Planning (Note 10f)	**37,500**	**37,500**	49,000
Diabetes Self Management (Note 10g)	**-**	**35,000**	-
Diabetes Strategy (Note 10h)	**-**	**25,000**	-
Patient-Centric Transformation Initiative	-	-	223,200
Health Force Ontario	-	-	50,000
	2,450,577,157	**2,499,650,202**	2,391,876,774
Annual surplus before funding repayable to the MOHLTC	-	**54,863**	-
Funding repayable to the MOHLTC (Note 3a)	-	**(54,863)**	-
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2010

	2010		2009
	Budget (unaudited) (Note 8)	Actual	Actual
	$	$	$
Annual surplus		-	-
Change in other non-financial assets	-	2,520	(17,750)
Acquisition of capital assets	-	(9,327)	(757,016)
Amortization of capital assets	-	229,600	515,270
Increase in net debt	-	222,793	(259,496)
Opening net debt	-	(721,404)	(461,908)
Closing net debt	-	(498,611)	(721,404)

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	229,600	515,270
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	(229,600)	(515,270)
	-	-
Changes in non-cash operating items		
(Increase) decrease in accounts receivable - other	(6,490)	4,652
Decrease (increase) in accounts receivable - MOHLTC	188,200	(223,200)
Decrease in due from MOHLTC to HSPs	3,184,349	2,339,833
(Decrease) increase in accounts payable and accrued liabilities	(407,645)	192,720
Increase (decrease) in due to the MOHLTC	54,863	(4,531)
Decrease in due to HSPs from MOHLTC	(3,184,349)	(2,339,833)
(Decrease) increase in due to the LHIN Shared Services Office	(21,201)	4,389
Decrease (increase) in prepaid expenses	2,520	(17,750)
	(189,753)	(43,720)
Capital investments		
Acquisition of capital assets	(9,327)	(757,016)
Financing transactions		
Capital contributions received (Note 5)	9,327	757,016
Net decrease in cash	(189,753)	(43,720)
Cash, beginning of year	736,297	780,017
Cash, end of year	546,544	736,297

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2010

1. Description of business

The Hamilton Niagara Haldimand Brant 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 Hamilton Niagara Haldimand Brant 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 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 in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are 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 the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. 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 in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital asset and impairment in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHTLC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including 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. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

2. Significant accounting policies (continued)

Capital assets (continued)

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

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

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

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

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	**Expenses**	**2010 surplus**	2009 surplus
	$	**$**	**$**	$
Transfer payments to HSPs	**2,493,218,669**	**2,493,218,669**	**-**	-
LHIN operations	**5,326,146**	**5,319,297**	**6,849**	-
E-Health	**600,000**	**600,000**	**-**	-
Residents First	**209,750**	**161,736**	**48,014**	-
ER/ALC Performance Lead	**100,000**	**100,000**	**-**	-
French Language Services	**78,000**	**78,000**	**-**	-
Emergency Dept. LHIN LEAD	**75,000**	**75,000**	**-**	-
Aboriginal Planning	**37,500**	**37,500**	**-**	-
Diabetes Self Management	**35,000**	**35,000**	**-**	-
Diabetes Strategy	**25,000**	**25,000**	**-**	-
	2,499,705,065	**2,499,650,202**	**54,863**	-

3. Funding repayable to the MOHLTC (continued)

b) The amount due to the MOHLTC at March 31, 2010 is made up as follows:

	2010	2009
	$	$
Due to MOHLTC, beginning of year	**-**	4,531
Funding repayable related to current year activities to the MOHLTC (Note 3a)	**54,863**	-
Amount recovered by the MOHLTC during the year	**-**	(4,531)
Due to MOHLTC, end of year	**54,863**	-

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**701,891**	460,145
Capital contributions received during the year	**9,327**	757,016
Amortization for the year	**(229,600)**	(515,270)
Balance, end of year	**481,618**	701,891

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2011	161,776
2012	160,835
2013	156,947
2014	163,313
2015	172,786
Thereafter	418,502

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2010 Net book value	2009 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**455,333**	**334,107**	**121,226**	212,293
Computer equipment	**129,582**	**113,754**	**15,828**	36,037
Leasehold improvements	**572,443**	**227,879**	**344,564**	453,561
	1,157,358	**675,740**	**481,618**	701,891

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of financial activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,493,218,669 is derived as follows:

	$
Initial budget	**2,444,933,900**
Adjustment due to announcements made during the year	**48,284,769**
Final budget	**2,493,218,669**

The final LHIN general and administrative budget of $6,266,123 is derived as follows:

	$
Initial budget	
LHIN operations	**5,005,757**
E-Health	**600,000**
Aboriginal Planning	**37,500**
Additional funding received during the year for:	
Stabilization Increase	**100,116**
Residents First	**209,750**
ER/ALC Performance Lead	**100,000**
French Language Services	**78,000**
Emergency Dept. LHIN LEAD	**75,000**
Diabetes Self Management	**35,000**
Diabetes Strategy	**25,000**
	6,266,123

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,493,218,699 (2009 - $2,385,618,620) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2010 as follows:

	2010	2009
	$	$
Operation of hospitals	**1,718,425,416**	1,649,379,136
Capital Contributions - Health Infrastructure Renewal Fund	**5,417,098**	-
Grants to compensate for municipal taxation - public hospitals	**462,075**	462,075
Long term care homes	**396,752,189**	386,280,945
Community care access centres	**228,780,891**	216,335,473
Community support services	**39,376,097**	36,210,913
Acquired brain injury	**6,086,497**	5,726,436
Assisted living services in supportive housing	**24,345,509**	23,025,180
Community health centres	**16,255,575**	11,083,096
Community mental health addictions program	**57,317,322**	57,115,366
	2,493,218,669	2,385,618,620

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As at March 31, 2010, an amount of $1,374,800 was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's financial activities and is included above.

10. a) E-Health

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $600,000 (2009 - $425,000). These funds were used toward initiatives in support of the 2010 update of the E-Health strategic plan.

b) Residents First

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $209,750 (2009 - $nil). As directed by the MOHLTC, these funds were used to support performance improvement in Long-Term Care homes and help to reduce pressures on the Emergency Departments.

c) ER/ALC Performance Lead

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $100,000 (2009 – $33,300). These funds were used to support the activities of the ER/ALC Coordinator.

10. (continued)

d) French Language Services

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $78,000 (2009 - $nil). These funds were used to support the Francophone community engagement activities.

e) Emergency Department LHIN LEAD

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2009 – $75,000). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

f) Aboriginal Planning

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $37,500 (2009 - $49,000). These funds were used to support Aboriginal Planning activities.

	2010	2009
	$	$
Travel	**101**	2,544
Consulting services	**500**	11,658
Meeting expenses	**36,812**	16,287
Supplies, other	**87**	18,511
	37,500	49,000

g) Diabetes Self Management

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $35,000 (2009 - $nil). These funds were used toward initiatives that would provide people living with are at risk of Diabetes with the knowledge, tools and resources needed to effectively self-manage diabetes in partnership with their health care team.

h) Diabetes Strategy

During fiscal 2010, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $25,000 (2009 - $nil). These funds were used toward improving the health and health care options for people with diabetes or are at high risk for the disease.

11. General and administrative expenses

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

	2010	2009
	$	$
Salaries and benefits	**3,248,887**	2,841,880
Board Chair per diems	**55,650**	68,775
Directors' per diems	**73,150**	74,950
Board expenses	**57,095**	128,146
Travel	**48,246**	76,164
Consulting services	**481,998**	458,707
Community forums & communication	**122,186**	110,937
Supplies, equipment, maintenance, other	**318,105**	286,798
Accommodation	**309,380**	541,027
Amortization	**229,600**	515,270
Shared services	**375,000**	300,000
General and administrative expenses	**5,319,297**	5,402,654
E-Health	**600,000**	425,000
Residents First	**161,736**	-
ER/ALC Performance Lead	**100,000**	33,300
French Language Services	**78,000**	-
Emergency Dept. LHIN LEAD	**75,000**	75,000
Aboriginal Planning	**37,500**	49,000
Diabetes Strategy - Self Management	**35,000**	-
Diabetes Strategy	**25,000**	-
Patient-Centric Transformation Initiative	**-**	223,200
Health Force Ontario	**-**	50,000
	6,431,533	6,258,154
Reconciliation to MOHLTC approved budget:		
General and administrative and initiatives expenses	**6,431,533**	6,258,154
Less: amortization	**(229,600)**	(515,270)
Add: due to MOHLTC	**54,863**	-
Add: purchase of tangible capital assets	**9,327**	757,016
	6,266,123	6,499,900

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 30 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 2010 was $210,063 (2009 - $186,699) for current service costs and is included as an expense in the Statement of financial activities. The last actuarial valuation was completed for the plan on December 31, 2009. 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 of the comparative figures have been reclassified to conform with current year presentation.

Board Members

Juanita G. Gledhill
Chair

Jack Brewer
Vice-Chair

Douglas Archibald
Board Member

Ruby Jacobs
Board Member

Carolyn King
Board Member
(Term completed February 5, 2010)

Robert (Bob) Lawler
Board Member

William (Bill) McLean
Board Member

William (Bill) Millar
Board Member

Janice Mills
Board Member

Senior Staff Members

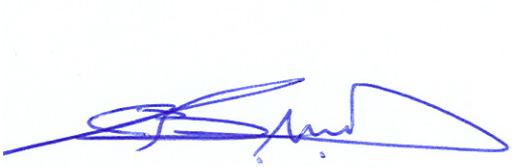
Pat Mandy
Chief Executive Officer

Alan Iskiw
Senior Director,
Performance, Contract and Allocation

Marion Emo
Senior Director,
Planning, Integration and Community Engagement

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2010.

Juanita G. Gledhill
Chair, Board of Directors



Jack Brewer
Vice-Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

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