Central West Local Health Integration Network

Annual Report
2009- 2010

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

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• LEADING THE HEALTH SYSTEM

The creation of the 14 LHINs in 2006 ensured that those who lead the development of the local health system are working in the communities they serve. By building cooperative relationships with health service providers and with the public users of the health system, LHINs are realizing greater efficiencies and more effective health care.

The Central West LHIN works with health service providers to plan, fund, and integrate health services for residents in Brampton, Caledon, Etobicoke, Malton, Orangeville, Rexdale, Woodbridge and throughout Dufferin County.

In 2009, the Central West LHIN approved its second Integrated Health Service Plan (IHSP2), which lays out the LHIN's goals for the health system from 2010 -2013. The original IHSP covered the period 2007-2010. This Annual Report looks back on fiscal year 2009/2010, and covers the final year of our first IHSP and the time period when we finalized our IHSP.

• FROM THE CHAIR AND CEO

The unique mandate of the LHINs, to engage with those who use the health system and with those who deliver health-care services, ensured this was a year of considerable interaction with community groups, the public, health service providers and physicians.

The Central West LHIN spent a lot of time listening in order to facilitate the development of our second Integrated Health Service Plan (IHSP2). While we presented the accomplishments of our first IHSP, we also learned how people in the Central West LHIN felt about their health care services and the role of the LHIN.

It was encouraging hearing how people understand the LHIN's role and appreciate our engagement activities. We listened to their comments regarding how the LHIN might serve residents even better and what they felt was necessary in building a better health care system.

Also apparent is the fact that the LHIN model is helping health service providers' work more closely together in identifying and then bridging gaps in the health care system. For instance, our two hospital corporations clarified roles for maternal and child care – an important clarification in the LHIN with Ontario's highest birth rates. Our hospitals and Community Care Access Centre also created a regional geriatric service that will provide a broad set of services that will better meet the needs of seniors.

The plans for the re-development of the Peel Memorial Hospital site also moved forward in a significant way. The development of this site into an urgent care centre and ambulatory centre, and its services for seniors, mental health and addictions, and women and children, will create a ground-breaking new model of care for the people of the Central West LHIN.

The development of the primary care sector – the appropriate first point of contact for health services in the community that may be delivered by a family physician or other health care provider – continues to be an important focus. The Central West LHIN launched LHIN-led groups in Bolton and Shelburne to consult with community members and health service providers and to develop an implementation plan for new community-based Health and Care Centres. This innovative strategy will go a long way to addressing primary care issues in these communities while becoming a model for other communities.

This last year has been one of progress, learning, planning and establishing the Central West LHIN as a pivotal organization working with health service providers and with the public. The LHIN is continuing to transform the local health system by making the system easier for individuals to access and by making more of the right services available, so that the health system not only looks after those who need immediate attention, but also promotes the health and wellness of all residents.

Joe McReynolds
Board Chair of the Central West LHIN

Mimi Lowi-Young
Chief Executive Officer of the Central West LHIN

• MEMBERS OF THE BOARD

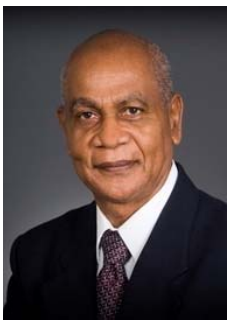
Joe McReynolds, Chair
June 9, 2008 – June 9, 2011

Terry Miller, Vice Chair
June 9, 2008 – June 9, 2011

Kuldip Kandola, Secretary
June 9, 2008 – June 9, 2011
(Currently on Leave)

Anita Gittens, Member
May 17, 2008 – May 17, 2011

Zygmond Novak, Member
June 17, 2007 – June 17, 2010



Winston Isaac, Member
January 13, 2010- January 13, 2012

The following key features describe the Central West Local Health Integration Network.

- The fastest-growing community in Canada
- A highly diverse population
- The highest birth rate in the province.

Understanding the health needs of the local population and how well the system is meeting those needs is critical to how the Central West LHIN is identifying local health system priorities.

The Central West LHIN covers approximately 2,590 square kilometres and includes all of Dufferin County, the northern portion of Peel Region, parts of northwestern Toronto and southwest York Region.

The geographic area includes a mix of urban, suburban and rural communities.

The Central West LHIN represents 6.1% of Ontario's population. The 2006 census estimated the population to be 739,957.[1]

The LHIN has experienced unprecedented growth. Between 2001 and 2006, the population grew by 18.1% and was highest among the 14 LHINs and higher than the Ontario growth rate of 6.6%.[1] The population is expected to grow by 25% between 2006 and 2016.[2]

The population of the Central West LHIN is younger compared to the province and the youngest among the 14 LHINs. The median age of the LHIN in 2006 was 34.9 years[1] The LHIN is expected to experience significant aging of the population in the period between 2006 and 2016.[2]

Central West LHIN women give birth to over 11,000 babies a year, the highest birth rate (6.2%) in all LHINs (since 2006 FY).[3]

The Central West LHIN has a highly ethno-culturally diverse population, with 46% identified as immigrants and over 50% as visible "minorities."[1]

[1] Statistics Canada 2006 Census
[2] Ministry of Finance Population Projections by LHIN from C2009-2036, based on Census Survey data up to 2008
[3] Discharge Abstract Database, CIHI

Central West LHIN residents report very good or excellent physical health overall. Life expectancy is longer in the Central West LHIN – 82.3 local years of age to 80.7 years of age for the province.[4]

Residents' rating of their own mental health as very good or excellent was 76.3% in 2008[5], slightly higher than the provincial rate.

The proportion of overweight and obese adults in the LHIN is growing. In 2008, those reporting being overweight was higher than the average in the province. In 2008, almost 1 in 5 youths in the LHIN was overweight or obese.[5]

Hypertension and diabetes are climbing in the LHIN. The percentage of residents with diabetes has increased from 3.9% in 2003 to 8.6% in 2008, higher than the provincial rate of 6.2%[5]

The percentage of residents reporting high blood pressure increased from 13.3% in 2003 to 16.3% in 2008, slightly lower than the provincial rate of 16.6%[5]

In 2008, the percentage of residents with arthritis or rheumatism was 10.9%, significantly lower than the province rate of 16.9%[5]

Reports of asthma from Central West LHIN residents increased from 7.7% in 2003 to 8.6% in 2008, slightly higher than the provincial rate of 8.3%[5]

Rates of prostate, ovarian and cervical cancer are relatively higher when compared to other LHINs. Most cancer screening rates remain low compared to those in other LHINs[6].

[4] Life Expectancy at Birth, Based on 2005 deaths
[5] Canadian Community Health Survey 2008
[6] iPort, Cancer Care Ontario

• LHIN PERFORMANCE INDICATORS

The Central West LHIN is accountable to the Minister of Health and Long-Term Care (MOHLTC). The following performance indicators regarding the operation of the Central West LHIN reflect the priorities laid out in our accountability agreement with the MOHLTC.

Central West LHIN MLAA Performance Indicators 2009/10

	Performance Indicators	LHIN Starting Point 2009/10	LHIN Target 2009 /10	Q4 2009/10	FY 2009/10	LHIN Met Target - Within Corridor (YES/NO)
1.	90th Percentile Wait Times for Cancer Surgery [1.1]	64	50	56	57	NO
2.	90th Percentile Wait Times for Cataract Surgery [1.1]	208	182	87	90	YES
3.	90th Percentile Wait Times for Hip Replacement [1.1]	222	182	158	156	YES
4.	90th Percentile Wait Times for Knee Replacement [1.1]	247	182	181	161	YES
5.	90th Percentile Wait Times for Diagnostic MRI Scan [1.1]	60	60	137	110	NO
6.	90th Percentile Wait Times for Diagnostic CT Scan [1.1]	28	28	40	31	YES
7.	Median Wait Time to Long-Term Care Home Placement -All Placements [2.1]	41	40	58	47	YES
8.	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution [2.2]	11.34%	9%	9.43%	9.46%	YES
9.	Proportion of Admitted patients treated within the LOS target of ≤ 8 hours [1.1]	34%	43%	31.02%	32.74%	NO
10.	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 [1.1]	76%	86%	74.64%	73.48%	NO
11.	Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours [1.1]	81%	87%	85.62%	83.31%	NO

Data Timeframe Definitions

1. Wait Time & ER LOS Indicators:

1.1 FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr. 2009 to Mar. 2010.

2. Non-Wait Time Indicators:

2.1 LTCH Placement Indicator - FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr. 2009 to Mar. 2010.

2.2 ALC Indicator - Q4 % ALC days is estimated based on Q1, Q2, & Q3 2009/10 Data. FY 2009/10 LHIN Annual Results are also estimated based on Q1-Q4 2009/10 Data.

3. Used Performance Value - FY 2009/10

3.1 For all 90th Percentile Wait Time Indicators, IF LHIN 20009/10 Starting Point is GREATER than Provincial Target; LHIN Year-End Performance will be assessed against Q4 2009/10 Actual Performance Value.

3.2 For all 90th Percentile Wait Time Indicators, IF LHIN 2009/10 Starting Point is LESS than Provincial Target; LHIN Year-End Performance will be assessed against FY 2009/10 Actual Annual Performance Value.

3.3 For Percentage of ALC Days, and Median Time to LTC Home Placement, the LHIN's performance will be assessed against the LHIN results available in Q4 for the fiscal year (i.e. data for 2009/10 Q1, Q2 and Q3).

3.4 For the 3 ER LOS indicators, LHIN Year-End Performance will be assessed against LHIN performance the full fiscal year. (FY 2009/10 Actual Annual Performance Value)

Target Assessment

YES = LHIN Met Target / Within Corridor

NO = LHIN Did Not Meet Target / Not Within the Corridor

Wait Time Indicators

By tracking and reporting wait time data, the LHIN can give hospitals the tools they need to improve wait times, while providing patients transparent and up-to-date information.

➢ 90th percentile wait times for cancer surgery

While the LHIN achieved the provincial target, the LHIN specific target was missed by 7 days. The factors contributing to improved performance include an efficient system of care and relevant practices established for diagnosis and treatment for specific cancers, such as lung and breast cancer.

➢ 90th percentile wait times for cataract surgery

Both LHIN and provincial targets were met, and performance was within the operational range established by the province (known as a performance corridor). Improved performance is the result of constant and vigilant monitoring of wait times by providers, who set in motion established strategies for extenuating circumstances if negative variances are identified.

➢ 90th percentile wait times for hip-replacement surgery*

Wait times were within the performance corridor, but below LHIN and provincial targets.

➢ 90th percentile wait times for knee replacement surgery*

Wait time performance was marginally below LHIN and provincial targets, but within the accepted operational range.

**Note for Hip and Knee*
Medical manpower changes in 2009/10 and the retirement of a high-volume hip and knee surgeon have contributed to increasing wait times, as the new replacement surgeon is building the practice slowly.

➢ 90th percentile wait times for diagnostic MRI scan

While specific targets were not achieved, the LHIN is forecasted to complete 14,030 volumes against an allocation of 13,689 volumes. The significant differential between demand and capacity has impacted wait time performance though the efficiency of the sole MRI provider in the LHIN. An increase in demand is due to a growing population, expected to grow by 10% over the next few years, as well as an increase in demand for MRI scans from within and beyond the LHIN.

Based on the above, the LHIN is supporting the allocation of base operational funding for an additional MRI scanner to meet capacity requirements.

- **90th percentile wait times for diagnostic CT scan**

The LHIN and provincial targets were marginally above the target goal, but within the performance corridor. Additional funding is required to achieve provincial wait times, as a large percentage of referrals is coming from outside the LHIN.

ER/ALC Performance Indicators

Reducing the length of time residents of the Central West LHIN spend waiting in the Emergency Department (ED) is a major priority. The performance indicators in this section measure progress toward lowering length of stay in emergency departments for high-acuity patients, or those who need urgent care, and for low-acuity patients, or those whose condition is less urgent. Patients are accessed when entering an emergency room according to the Canadian Triage and Acuity Scale (CTAS). This system assigns a level of severity of illness, or acuity, to patients who go to the emergency room for care. Having a rating of CTAS I, II or III represents seriously ill patients, or those with high acuity. A CTAS rating of IV or V represents less seriously ill patients, or low acuity.

- **Proportion of admitted patients treated within the length of stay target of ≤8h**

Although the LHIN did not achieve the 2009/10 targets, many challenges contributed to this outcome. The Central West LHIN had the highest growth in people using emergency departments than any other LHIN in the province. ED visits grew by 16,730 visits, or 9.6%, between 2008/09 to 2009/10[7]

- **Proportion of non-admitted high-acuity patients (CTAS I-III) treated within their respective targets of ≤8h for CTAS I and II and ≤6h for CTAS III**

The target for this performance indicator was not achieved in the Central West LHIN for 2009/10. Through initiatives in the Year 3 ED Pay for Results Action Plan, the LHIN anticipates an improvement toward the target in 2010/11. The initiatives will address the wait time for high-acuity patients by designing better processes to help patients move through the acute-care system.

- **Proportion of non-admitted low-acuity (CTAS IV and V) patients treated within the length of stay target of ≤4h**

The performance for this indicator was slightly lower than the target in 2009/10 for the Central West LHIN. Through initiatives in the ED Pay for Results strategy, the LHIN anticipates this performance will be met in 2010/11.

[7] Year-2 ER Pay for Results Reports from MOHLTC

The original Integrated Health Services Plan (IHSP) was created in October 2006 and covered the first three years of the LHINs' operations from April 2007 to March 2010. This section reports on the progress made in many of the priority areas set out in the original IHSP.

Aboriginal Health

In 2009, the Central West LHIN created a position to identify the local Aboriginal community and to develop a local community engagement strategy that will help identify and address local services, gaps and opportunities to improve access to appropriate health care services to the LHIN's Aboriginal community.

The Central West LHIN co-sponsored, with the LHINs in the Greater Toronto Area (GTA), the "Strengthening the Circle: Building an Aboriginal Knowledge Network." The purpose of this event was to discuss the opportunity of creating a new knowledge network on urban Aboriginal peoples to enable health planning in a respectful way that fosters the growth of mutually reciprocal relationships between the five GTA LHINs and the urban Aboriginal communities they serve.

Partnering with the Mississauga Halton LHIN, the Central West LHIN conducted an Aboriginal health needs assessment for the Aboriginal community living within both LHINs. The purpose of the study was three fold: a) provide a demographic profile, health needs priority and health status of Aboriginal people living within the Central West LHIN and Mississauga Halton LHIN service areas, according to the residents and service providers; b) to determine the community needs and strategic directions for addressing the health needs; and c) to develop an Aboriginal community engagement strategy.

Chronic Disease Management and Prevention

➢ Diabetes

William Osler Health System was named as the Regional Coordination Centre for Diabetes in the Central West LHIN.

Central West secured two additional Ministry-funded Diabetes Education Teams to add to the existing 9.5 teams.

The Diabetes Readiness Assessment and Plan, as well as a Physician Engagement Strategy and Plan to adopt e-Health strategies, were completed. These were conducted in response to the government's strategic direction for the Ontario Diabetes Strategy and the e-Health Diabetes Registry. The findings of these assessments and plans will strategically position our LHIN to respond to upcoming funding initiatives for these key government priorities.

➢ Chronic Kidney Disease (CKD)

The Central West LHIN worked with the Ontario Renal Network and local hospitals to identify regional chronic kidney disease (CKD) and to develop a regional CKD program in order to promote education and wellness to empower individuals to actively self-manage their chronic disease(s).

LHIN staff worked with the Ministry of Health and Long-Term Care (MOHLTC), as well as the Ontario Renal Network and representatives of the Greater Toronto Area (GTA) LHINs, to discuss gaps in the distribution of dialysis services across the GTA and to conclude deliberations on the location and size of a new dialysis satellite clinic within the Central West LHIN.

Diversity and Equity

As a Central West LHIN-initiated group, the Diversity and Equity Core Action Group worked closely with LHIN's diverse communities and health service providers to better understand specific issues and how to address them. The group also continued to facilitate the process of integrating cultural diversity and health equity into all LHIN priority areas.

Emergency Room Wait Times and Alternative Level of Care Days (ER/ALC)

Reducing emergency room (ER) wait times is critical, and the LHIN supported this provincial priority with an investment of over $10 million in 2009/10. Wait times are coming down despite the fact that visits to the ER are going up in the Central West LHIN.

The Central West LHIN has one of the lowest rates of Alternative Level of Care (ALC) days in the province. These are patients occupying hospital beds who are unable to be discharged because the level of care that would be more appropriate for them is not available. This increases emergency room wait times since it means there are fewer hospital beds available for new patients in need of acute care.

Lower ALC days is linked to the Central West LHIN's commitment to creating acute-care capacity in hospitals and the fact that the LHIN has the shortest wait times for placement in Long Term Care (LTC) homes.

Time spent in the ER for high-acuity patients (most seriously ill) from the last quarter of 08/09 to the last quarter of 09/10 improved by 72 minutes, despite the growth in high acuity patients of 6.7%[7]

Time spent in the ER for low-acuity patients (less seriously ill) has improved by 36 minutes from the last quarter of 08/09 to the last quarter of 09/10, despite the growth in low acuity patients by 22.8%[7]

Several initiatives were directed to reduce ER demand in the Central West LHIN. These included:

- Nurse-led outreach teams, which aim to reduce avoidable transfers to the emergency department by providing enhanced support for residents in long-term care homes

- The Enhanced End of Life initiative, which provides enhanced services to palliative/end of life clients so they are able to stay in their homes rather than being admitted to the hospital
- The Short Term Extraordinary Circumstances initiative, which enables client to stay in their homes when a change in circumstances may have precipitated a trip to the ER.

French Language Services

There are 16,135 Francophones in the Central West LHIN, which represents about 2.2% of the population.

The Central West LHIN undertook a survey of health service providers to obtain information on their capacity to provide services in French. There are currently three identified agencies with the capacity to effectively serve the Francophone population: The Central West Community Care Access Centre and two community mental health services.

A French Language Health Services Coordinator position was created so the Central West LHIN can better engage with the Francophone community.

The Central West LHIN had community engagement meetings focused on the Francophone community as part of its process to produce its second Integrated Health Service Plan (IHSP2).

The Central West LHIN is continuing work with Greater Toronto Area LHINs and the Toronto Regional French Language Health Services Planning and Support Committee to plan how to leverage resources, knowledge and best practices for meeting the needs of the Francophone community.

Information Management

The Central West Physician eHealth steering committee and associated strategies were established with input from health service providers in our LHIN. This work aligns with the provincial eHealth strategy. The primary focus is increased adoption of provincially funded electronic medical records (EMR) systems for primary-care physicians and specialists across the LHIN. The physician steering committee is also overseeing the pilot projects, which include an automated physician to specialist referral system and patient to physician electronic communication project.

The Central West LHIN was an early adopter of the Integrated Assessment Record (IAR), which was created to enable care providers to access common assessment data, with the goals of facilitating collaborative client/patient care and supporting the sharing of assessment information. Mental health care providers in Central West LHIN will benefit from a more complete view of the client through use of the IAR, a tool that allows authorized users to view a client/patient's previous assessment information.

The Central West LHIN provided leadership to the regional development and introduction of a web-based Community Services Portal to facilitate communication and collaboration across community sector agencies.

Projects focusing on shared service delivery for information technology services as well as governance and privacy legislation compliance best practices were established and are ongoing.

A provincial reference model recommending the best practices for resource matching and referral (RM&R) processes was developed. RM&R is key to enabling process improvements designed to address challenges around wait times, including those in emergency rooms. The Central West LHIN documented current processes and identified the steps necessary to implement the recommended changes (phase 1 of the project). Funding approval for the next phase is currently under review with the province.

Information management deliverables continue to emphasize efficiency gains in the delivery of eHealth solutions. Projects focusing on shared service delivery for information technology services as well as governance and PHIPA-privacy-legislation compliance best practices have also been initiated.

Women and Children Services

Headwaters Health Care Centre (HHCC) and William Osler Health System (WOHS), the two hospital corporations in the Central West LHIN, established an agreement where HHCC will serve as a Level 1 facility, which includes care for healthy mothers and their newborns of 35 weeks gestation or older, and/or neonates that are equal to or greater than 2 kilograms. WOHS will provide Level II advanced services, including medical and obstetrical conditions arising from pregnancies greater than 32 weeks gestation, and maternal intensive care.

The number of Neonatal Level II Intensive Care Beds was increased to 4 at WOHS.

A Central West LHIN Maternal/Child Lead was appointed to support the development of services for this population group.

A Regional Perinatal and Children's Health Centre was established at the Brampton Civic Hospital site of the WOHS.

The LHIN identified Core Action working groups to identify clinical priorities in 6 areas serving women and children:

- antenatal services
- breastfeeding
- obesity
- speech and languages services
- maternal mental health
- medically fragile children.

Mental Health and Addiction Services

The Central West LHIN funds 10 organizations to provide specific mental health and addiction services along with 2 Community Health Centres that provide primary care and patient support to this population.

Punjabi Community Health Services was designated in 2009/10 as a new Mental Health and Addictions organization and as a community services agency for caregiver support providing ethno-cultural programs for the LHIN's diverse communities.

The Central West LHIN completed comprehensive studies in Dufferin County and Malton, which continue to help guide planning. The studies identified current service levels and gaps and requirements for mental health and addictions services.

The Dufferin Connect Integrated Support Network has been established to increase capacity in Dufferin County to serve individuals with mental health and/or addiction needs, who are in crisis or require time-limited transitional supports, including residential support. A website has been launched (www.dufferinconnects.ca) that allows visitors to download a referral form.

Palliative Services

The growing demand for palliative care services in a hospice environment is being addressed in the Central West LHIN.

- Established the Palliative Care Network with the Central West CCAC, local hospitals and community providers developing hospital/community-based model on best practices
- Supported the development of Bethell House operated by Hospice Caledon.

Primary Care

A well developed, strong primary healthcare system is foundational to the health system. It will have a positive impact on improving access and quality of care, enhancing the patient's experience and reducing emergency department volumes and wait times. The Central West LHIN has undertaken several initiatives to improve access to primary care, including:

- Plans for a Malton Community Health Centre have been established.
- The Central West LHIN obtained approval for another Family Health Team; there are now five approved family health teams in the Central West LHIN.
- Rexdale Community Health Centre has 2 new satellites — Jamestown and Albion/Kipling.
- The Central West LHIN is continuing to hold community consultations in Bolton and Shelburne, and is developing plans for a Health and Care centre in each community, based on input from local residents, health providers and municipal leaders.

➢ Peel Memorial Redevelopment

The vision for the Peel Memorial Centre for Integrated Health and Wellness includes:

- Expanding access to urgent care
- Creating a centre of excellence in ambulatory care
- Advancing women's and children's health and wellness
- A centre for community mental health and addictions, an intervention clinic and a crisis-management centre
- Improving access to health care for seniors and their families

Services for Seniors

Building on year- one consultations, the Central West LHIN identified service priorities and received proposals from local health service providers. The Year Two Aging at Home Detailed Plan was approved by the LHIN Board of Directors and submitted to the Ministry of Health and Long-Term Care.

The Central West LHIN invested in initiatives that support seniors who can leave acute hospital beds when they really don't need acute care any more. Short-stay transition beds will help seniors until they are ready to manage their own health, with or without a little support, in their own home.

Other programs the Central West LHIN invested in to support seniors:

- Outreach team in the community supporting the Regional Geriatric Service
- Increased funding for adult day programs in Brampton and Bolton
- Increased funding for supported living in Caledon
- Enhancing the variety of services to seniors living in supportive housing in Rexdale
- Case management in Dufferin County for seniors with mental-health issues
- In-home support services to seniors with mental-health issues who are at high risk of unnecessary visits to the hospital because of their living conditions
- Adult day program for Somali seniors in Rexdale
- Bathing program at Dufferin Oaks in Shelburne
- Transportation escort services in Dufferin County

The Central West LHIN also worked with hospitals and the CCAC to establish a regional geriatric program and supported the successful application to upgrade 337 long-term care beds at Kipling Acres and 96 beds at Pine Grove Lodge.

Rehabilitation Services

Over the past year, the Central West LHIN collected a substantial amount of information about rehabilitation services, including input from a number of local providers and a review of data that was compiled and analyzed.

To this end, the Central West LHIN completed a rehabilitation study (hip and knee, stroke, injury/accident, acquired brain injury) providing a baseline of existing rehabilitation services, as well as performance and direction for future program development.

• INTEGRATION OF SERVICES - SUCCESSES

Integrating services for the sake of better patient outcomes and to ensure residents are getting the right service in the right place at the right time is a key part of the LHIN mandate. Below are some examples of integration activities, where the LHIN brought service providers together to enhance their ability to meet the health needs of those they serve.

- Regional Geriatric Services – William Osler Health Centre worked with Headwaters Health Care Centre and the Central West CCAC to provide a broad continuum of services for seniors aimed at reducing ER utilization and wait times and improving acute-care bed use.

- Seniors Mental Health Intensive Case Manager - Alzheimer Society of Dufferin County worked with Trellis Mental Health and Development Services in a shared-service model to provide services to seniors with mental-health needs in Dufferin County.

- Seniors' Adult Day Program for the Somali community in Rexdale was developed through a partnership that included CANES Community Care, Dixon Community Services, Dorothy Ley Hospice, and the Rexdale Community Health Centre.

- The Integrated Service Teams for High Risk Seniors initiative sponsored by Supportive Housing in Peel identified partners to provide a continuum of in-home support services to frail seniors living in the community.

- The Central West LHIN tasked the Transportation Action Group to develop a proposal for an integrated transportation system for seniors, utilizing the 6 vans provided by the MOHLTC in 2008.

- Established Dufferin Integration Partnership Solution bringing together mental-health and service providers to improve access to mental health and addiction services in Dufferin County.

- Mental health and addiction services providers in the Central West LHIN agreed to pilot the MOHLTC-initiated Integrated Assessment Record.

- The Central West LHIN participated in the planning of the Peel Children and Youth Initiative intended to promote joint planning and collaboration among community organizations to give youth from the ages of 0 to 24 years the opportunity to experience and fulfil their full potential and to better meet the needs of children and youth who are vulnerable.

- The Central West LHIN received a report on back office integration to promote shared resources and collaboration for uniform and consistent business processes among providers and so that the LHIN can improve risk management, service quality and business controls.

- Many mental health and addiction services and community-support service providers have committed to implementing the Community Care Information Management Initiative to standardize human resources information systems.

- Mental health and addiction services have implemented a common assessment tool and integrated assessment record.

- A Community Services Provider (CSP) portal was developed to facilitate communication and collaboration across the community sector agencies.

Fiscal year 2009/2010 was a year of community engagement that included governance- to- governance sessions, consultations around year one of our Aging at Home Strategy, engagement opportunities for the provincial 10-Year Mental Health and Addictions consultations, public meetings on primary care in the communities of Bolton and Shelburne, and the establishment of our second Integrated Health Service Plan (IHSP2).

Governance to Governance

In response to Health Service Provider (HSP) interest and, as part of an integrated approach to HSP stakeholder engagement, the Central West LHIN implemented a series of governance to governance dialogue sessions throughout 2009-2010. These sessions included all Board members from HSPs meeting together.

Four initial pilot sessions (dialogue cafes) were held in late 2008 and in February 2009, the first of 7 formal dialogue sessions were held using the 'World Café" model of facilitation by tng Consultants to maximize the participation of participants.

DATE & TOPIC OF CAFÉ DIALOGUE SESSIONS – 2009-2010

DATES OF CAFE DIALOGUE	TOPIC OF SESSION
February 23, 2009	Multi Sector Accountability Agreement (M-SAA) Education Session
April 7, 2009	Aligning and Leveraging our Governance Responsibilities
May 28, 2009	Fulfilling our Performance Monitoring Responsibilities
June 22, 2009	Shaping our Health System Plan
September 21, 2009	Integrating our Planning
November 2, 2009	Integrated Health Services Plan - 2

The overarching objective of these sessions was to support HSP governors as they continue to:

- Ensure that HSP organizations do their very best with the resources they have to serve their clients.
- Ensure that our HSP organizations do this in a fiscally and ethically responsible manner.
- Understand the risks and opportunities that face our HSP organizations and to do their best to mitigate risks and seize opportunities.
- Ensure that our HSP organizations work more closely together; not only to improve efficiencies, but to significantly enhance the quality and accessibility of the services delivered in the community.

By far the most popular and successful of the 7 sessions was the last session held January 11, 2010, entitled "HSP Expo – Sharing our Successes" where the following HSPs provided an overview of 1 of their organizations recent "successes" with respect to governance.

Organization and Successes

1. **Caledon Meals on Wheels**
   (SMILE – Seniors' Exercise Program)
2. **Canadian Mental Health Association Peel**
   (Board presentation to other HSP boards and funders)
3. **Supportive Housing in Peel**
   (Strategic Planning Activity)
4. **Central West Community Care Access Centre**
   (Launch of 310-CCAC& Health Care Connects)
5. **Hospice Caledon**
   (Evolving to a full service agency)
6. **Region of Peel Long Term Care Division**
   (Pandemic Influenza Plan)
7. **Headwaters Health Care Centre**
   (Psychiatric Patient Referral Agreement)
8. **Rexdale Community Health Centre**
   (Ethno-Cultural Seniors' Program)
9. **CANES Community Care**
   (Home at Last Program)
10. **Central West LHIN & tng**
    (Governing Together Portal)

Another milestone for the Central West LHIN was pioneering the governance portal **www.governingtogether.ca,** which is a private and secure website exclusively developed for HSP governors, enabling HSPs to share organizational, board and board-member information and best practices.

The portal was developed to enable the LHIN and HSPs an opportunity to facilitate system-wide sharing, planning and collaboration. The portal was seed-funded by the Central West LHIN, and is being run by The Canadian Centre for Leadership & Human Values (a not-for-profit organization). Since its inception, the site has proved quite popular, and the Central West LHIN Board Chair has made several presentations to other LHINs and health care associations.

Aging at Home Year 1

The Central West LHIN held a series of 3 community forums to hear from local seniors about how the program impacted them in year one, and what they would like to see from it moving forward. These forums were held in Shelburne, Etobicoke and Brampton in late January and early February 2009, and provided a lot of positive feedback and ideas for service improvements.

Participants appreciated that the LHIN was reaching out to the community with the Aging at Home forums. They suggested that similar sessions would be an effective way to communicate what services are available. They were also pleased with the programs proposed for year two, especially the specialized regional geriatrics service. Other feedback included the need for increased personal support and home-care services, as well as better integration and coordination between local service providers.

Mental Health and Addictions

LHIN staff participated in the Mental Health System Design work group, which is one of the work groups supporting planning for the government's 10-Year Mental Health and Addictions Strategy.

Central West LHIN staff and a group of local mental-health and addiction services providers met with researchers from the York Institute for Health Research, to develop questions associated with a funded research project on mental-health and addiction services to the local diverse ethno-cultural population.

Community engagement sessions in Dufferin County and Malton identified some key issues faced by individuals with mental-health and addictions service needs including: limited resources such as shortages of community-based case management, psychiatrists, psychiatric beds, 24hour crisis support, supportive housing and supportive groups for families and friends.

Second Integrated Health Services Plan (IHSP2)

The Central West LHIN planned a series of 8 public consultations, as well as 1 meeting with local physicians, two family practice meetings and 1 event targeted to health service provider organizations. The public sessions occurred as follows:

- October 1, Brampton
- October 7, Shelburne
- October 8, French language session
- October 27, Brampton
- November 3, Orangeville
- November 9, Caledon
- November 10, Malton
- November 12, Rexdale

Each session began with a presentation on the LHIN's mandate, demographics and activities over the past 3 years. This was followed by an outline of the draft second IHSP and what the proposed priorities are for the next 3 years. Following the presentation, group discussions looked at answering two questions:
1. What do you like about what you heard about the Central West LHIN's plans for the next 3 years?
2. Is there anything else you didn't hear about that you would expect to be part of the LHIN's work over the next 3 years.

The feedback received validated the proposed priorities identified in the draft plan, but also provided useful insight into the way residents feel these priorities need to be addressed over the next 3 years, and highlighted some concerns of local communities, which the LHIN takes very seriously and will continue to keep in mind during the ongoing development of a local health system that meets the needs of all residents.

• CENTRAL WEST LHIN OPERATIONS

The Central West LHIN now funds 53 Health Service Providers with a total transfer payment of $728,122,000 in 2009/10.

Central West LHIN health service providers consist of:

- 2 Community Health Centres (with 2 satellite locations)
- 1 Community Care Access Centre (CCAC)
- 2 Hospital Corporations
- 10 Mental Health and Addictions Services Providers
- 23 Long-Term Care Homes
- 15 Community Support Services.

The LHIN Operational Budget amounted to less than 0.6% of the total transfer payment budget. This includes the 23 full-time staff and all consultant costs.

The Central West LHIN worked to be a role model to health service providers on operational efficiencies and modeled collaboration and effectiveness wherever possible.

Committed to ensuring the highest standard of integrity when spending tax payer's dollars on all operational matters from the procurement processes to travel expenses, the Central West LHIN ensured it was consistently in compliance with provincial spending and procurement practices.

In order to develop our Board and staff, the Central West LHIN ensured participation in various education and training opportunities to further the development of professionalism and to learn from best practices.

All staff members have annual performance reviews that are tied to specific goals and objectives supporting the overall organizational and stakeholder goals and identifying professional development opportunities.

The Central West LHIN has opened its doors to health service providers and other organizations so that they can access our videoconferencing/teleconferencing resources and continue to build relations between LHIN staff and our providers.

Deloitte.

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Auditors' Report

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

We have audited the statement of financial position of the Central West 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 Central West 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
May 7, 2010

Central West Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**932,648**	1,061,658
Accounts receivable		
Ministry of Health and Long-Term Care ("MOHLTC")	**1,701,807**	585,200
Health Service Providers ("HSP")		
MOHLTC Other	**113,501**	-
Other	**16,800**	-
	2,764,756	1,646,858
Liabilities		
Accounts payable and accrued liabilities	**900,812**	983,904
Due to MOHLTC (Note 3b)	**178,786**	63,482
Due to HSP	**1,701,807**	585,200
Due to the LHIN Shared Services Office (Note 4)	**1,316**	16,100
Deferred capital contributions (Note 5)	**85,021**	184,683
	2,867,742	1,833,369
Commitments (Note 6)		
Net debt	**(102,986)**	(186,511)
Non-financial assets		
Prepaid expenses	**17,965**	1,828
Capital assets (Note 7)	**85,021**	184,683
	102,986	186,511
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Central West Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Revenue			
MOHLTC funding			
Health Service Provider ("HSP") transfer payments (Note 9a)	**695,117,595**	**727,403,702**	680,355,501
Health Infrastructure Renewal Fund (HIRF) (Note 9b)	**1,074,261**	**1,074,261**	**-**
Operations of LHIN	**4,251,792**	**4,336,828**	4,203,807
e-Health (Note 10a)	**600,000**	**600,000**	425,000
e-Health Infrastrucure Blueprint (Note 10b)	**-**	**20,000**	**-**
e-Health Physician-Patient Portal (note 10b)	**-**	**30,000**	**-**
e-Health Privacy (note 10b)	**-**	**25,000**	**-**
e-Health Communications (Note 10b)	**-**	**3,500**	**-**
French Language Services (note 10c)	**-**	**160,400**	**-**
ER/ALC Performance Lead (Note 10d)	**-**	**100,000**	33,300
Emergency Department Lead (Note 10e)	**-**	**65,000**	75,000
Aboriginal Health (Note 10f)	**7,500**	**7,250**	7,500
Aboriginal Health Transition Fund (Note 10g)	**-**	**51,000**	12,250
Diabetes Self Management Note 10h)	**-**	**35,000**	**-**
Health System Plan (Note 10i)	**-**	**-**	49,738
Health Force Ontario (Note 10j)	**-**	**-**	50,000
Amortization of deferred capital contributions (Note 5)	**210,000**	**157,559**	181,683
	701,261,148	**734,069,500**	685,393,779
Expenses			
Transfer payments to HSPs (Note 9a)	**695,117,595**	**727,403,702**	680,355,501
Transfer payments to HSPs (HIRF) (Note 9b)	**1,074,261**	**1,074,261**	**-**
General and administrative (Note 11)	**4,461,792**	**4,527,733**	4,364,890
E-Health (Note 10a)	**600,000**	**600,000**	424,925
French Language Services (note 10c)	**-**	**132,000**	**-**
ER/ALC Performance Lead (Note 10d)	**-**	**100,000**	23,122
Emergency Department Lead (Note 10e)	**-**	**64,444**	60,535
Aboriginal Health (Note 10f)	**7,500**	**1,056**	7,340
Aboriginal Health Transition Fund (Note 10g)	**-**	**51,000**	-
Health System Plan (Note 10i)	**-**	**-**	43,984
Health Force Ontario (Note 10j)	**-**	**-**	50,000
	701,261,148	**733,954,196**	685,330,297
Annual surplus before funding repayable to the MOHLTC	**-**	**115,304**	63,482
Funding repayable to the MOHLTC (Note 3a)	**-**	**(115,304)**	(63,482)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**		-
Closing accumulated surplus	**-**	**-**	-

Central West Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2010

	2010	2009
	$	$
Annual surplus	**-**	-
Acquisition of capital assets	**(57,895)**	(47,985)
Amortization of capital assets	**157,557**	181,683
Change in other non-financial assets	**(16,137)**	(384)
Decrease in net debt	**83,525**	133,314
Opening net debt	**(186,511)**	(319,825)
Closing net debt	**(102,986)**	(186,511)

Central West Local Health Integration Network

Statement of cash flows

year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	**-**	-
Less items not affecting cash		
Amortization of capital assets	**(157,557)**	(181,683)
Amortization of deferred capital contributions (Note 5)	**157,557**	181,683
Changes in non-cash operating items		
Decrease (increase) in accounts receivable - MOHLTC	**(1,230,108)**	6,635,793
(Decrease) increase in due to the MOHLTC	**115,304**	(322,190)
(Decrease) increase in due to HSP's	**1,116,607**	(6,226,510)
Decrease (increase) in accounts receivable - Other	**(16,800)**	464
(Increase) Decrease in prepaid expenses	**(16,137)**	(384)
Increase (decrease) in accounts payable	**(83,092)**	94,001
Increase (decrease) in due to the LHIN Shared Services Office	**(14,784)**	12,184
	(129,010)	193,358
Capital transactions		
Acquisition of capital assets	**(57,895)**	(47,985)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**57,895**	47,985
Net increase in cash	**(129,010)**	193,358
Cash, beginning of year	**1,061,658**	868,300
Cash, end of year	**932,648**	1,061,658

1. Description of business

The Central West Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Central West 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, 2010.

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 Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto. 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 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 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 MOHLTC 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 expenses that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue 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.

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

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

For assets acquired or brought into use during the year amortization is provided for a full year.

2. Significant accounting policies (continued)

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.

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.

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 HSP's	**727,403,702**	**727,403,702**	**-**	-
Health Infrastructure Renewal Fund (HIRF)	**1,074,261**	**1,074,261**	**-**	-
LHIN Operations	**4,336,828**	**4,370,174**	**(33,346)**	20,600
Capital Contribution	**157,559**	**157,559**	**-**	-
E-Health (Note 10a)	**600,000**	**600,000**	**-**	75
eHealth Infrastructure Blueprint (Note 10b)	**20,000**	**-**	**20,000**	-
eHealth Physician-Patient Portal (note 10b)	**30,000**	**-**	**30,000**	-
eHealth Privacy (note 10b)	**25,000**	**-**	**25,000**	-
eHealth Communications (Note 10b)	**3,500**	**-**	**3,500**	-
French Language Services (note 10c)	**160,400**	**132,000**	**28,400**	-
ER/ALC Performance Lead (Note 10d)	**100,000**	**100,000**	**-**	10,178
Emergency Department Lead (Note 10e)	**65,000**	**64,444**	**556**	14,465
Aboriginal Health (Note 10f)	**7,250**	**1,056**	**6,194**	160
Aboriginal Health Transition Fund (Note 10g)	**51,000**	**51,000**	**-**	12,250
Diabetes Self Management Note 10h)	**35,000**	**-**	**35,000**	-
Health System Plan (Note 10i)	**-**	**-**	**-**	5,754
Health Force Ontario (Note 10j)	**-**	**-**	**-**	-
	734,069,500	**734,954,196**	**115,304**	63,482

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

	2010	2009
	$	$
Due to MOHLTC, beginning of year	**63,482**	385,672
Funding repaid to MOHLTC prior year	**-**	(385,672)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**115,304**	63,482
Due to MOHLTC, end of year	**178,786**	63,482

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, 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 LHIN 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 the LHINs.

5. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**184,683**	318,381
Capital contributions received during the year	**57,895**	47,985
Amortization for the year	**(157,557)**	(181,683)
Balance, end of year	**85,021**	184,683

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 are as follows:

	$
2011	221,443
2012	227,615
2013	225,779
2014	220,835
2015	92,014

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2010. Minimum funding for HSPs related to the next two years, based on the fiscal 2010 accountability agreements, and are as follows:

	$
2011	716,909,610
2012	716,909,610

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2010 Net book value	2009 Net book value
	$	$	$	$
Office furniture and fixtures	**273,504**	**221,854**	**51,650**	62,714
Computer equipment	**34,427**	**30,110**	**4,317**	9,572
Leasehold improvements	**540,375**	**511,321**	**29,054**	112,397
	848,306	**763,285**	**85,021**	184,683

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the final budget at June 30, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $727,403,702 is made up of the following:

	$
Initial HSP funding budget	**695,117,595**
Adjustment due to announcements made during the year	**32,286,107**
Total HSP funding budget	**727,403,702**

The total operating budget, excluding HSP funding, of $5,433,978 is made up of the following:

	$
Initial budget	**4,859,292**
Adjustment due to announcements made during the year	
E-Health Blueprint	**20,000**
E-Health Physician-Patient Portal	**30,000**
E-Health Privacy	**25,000**
E-Health Communications	**3,500**
French Language Services	**160,400**
ER/ALC Performance Lead	**100,000**
Aboriginal Surplus Returned to MOHLTC	**(250)**
Aboriginal Health Transition Fund	**51,000**
ED LHIN Lead	**65,000**
Diabetes Self Management	**35,000**
Stabilization Funding	**85,036**
Total budget	**5,433,978**

9. a) Transfer payments to HSPs

The LHIN has authorization to allocate funding of $727,403,702 (2009 - $680,355,602) 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	**465,785,181**	433,771,883
Grants to compensate for Municipal Taxation - Public Hospitals	**99,450**	99,450
Long Term Care Homes	**136,059,183**	131,498,900
Community Care Access Centres	**77,593,209**	72,039,992
Community Support Services	**6,668,770**	5,143,348
Assisted Living Services in Supportive Housing	**4,854,656**	4,182,997
Community Health Centres	**5,695,761**	3,865,265
Community Mental Health Addictions Program	**30,647,492**	29,753,666
	727,403,702	680,355,501

b) Health Infrastructure Renewal Fund (HIRF)

The LHIN has authorized to allocate funding of $ 1,074,261 (2009 - $nil) to support public hospital infrastructure renewal projects that are minor capital in nature. This is the first year that the Ministry of Health and Long Term Care has incorporated the funding into the Ministry LHIN Accountability Agreement directly and therefore the prior year disclosure has been adjusted accordingly.

10. a) e-Health

The LHIN received funding of $600,000 (2009 - $425,000) related to supporting the E-Health projects. E-Health expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and Benefits	**322,496**	
Staff Travel	**422**	
Communication Expense	**1,652**	
Recruitment fees	**2,500**	10,350
General repairs and maintenance		3,300
Consulting	**197,297**	411,030
Computer equipment	**20,062**	
Computer software	**52,982**	-
Office Supplies	**1,328**	185
Staff Development	**549**	-
Meeting expenses	**712**	60
	600,000	424,925

10. (continued)

b) e-Health Projects

The LHIN received funding of $78,500 (2009 - $0) related for specific technology initiatives as listed below. The initiatives have not been started as intended, and the funding is reflected as a payable to the Ministry of Health.

	2010	2009
	$	$
e-Health Infrastructure Blueprint	**20,000**	-
e-Health Physician-Patient Portal	**30,000**	-
eHealth Privacy	**25,000**	-
e-Health Communications	**3,500**	-
	78,500	**-**

c) French Language Services

The LHIN received funding of $160,400 (2009 - $nil) related to the French Language Services initiative. Expenses incurred during the year consist of $132,000 (2009 - $nil) to develop a French Language Services plan.

d) ER/ALC Performance Lead

The LHIN received funding of $100,000 (2009 - $33,300) related to the ER/ALC Performance Lead initiative. ER/ALC expenses incurred during the year of $100,000 (2009 - $23,122) related to salaries and benefits.

e) Emergency Department Lead

The LHIN received funding of $75,000 (2009 - $75,000) related to the Emergency Department Lead project. A surplus of $10,000 was returned to MOHLTC for a net funding amount of $65,000. Emergency Department Lead expenses incurred during the year consist of $60,526 (2009 - $60,535) for consulting fees as well as $3,918 (2009 - $nil) related to development and travel expenses for a total of $64,444. (2009 - $60,535)

f) Aboriginal Health

The LHIN received funding of $7,500 (2009 - $7,500) related to the Aboriginal Health project. A surplus of $250 was returned to MOHLTC for a net funding amount of $7,250. Aboriginal Health project expenses incurred during the year consist of $1,056 (2009 - $7,340) for meeting expenses.

g) Aboriginal Health Transition Fund

The LHIN received funding of $51,000 (2009 - $12,250) related to the Aboriginal Health Transition Fund Ontario Adaptation Plan. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and Benefits	**26,387**	-
Consulting fees	**20,331**	-
Other Expenses	**4,282**	-
	51,000	**-**

10. (continued)

h) Diabetes Self Management

The LHIN received funding of $35,000 related to the Diabetes Self Management Initiative. There were no expenditures incurred. The LHIN also received $25,000 in funding for Diabetes Strategy but this was returned to the MOHLTC during the year as there were no related expenses.

i) Health System Plan

This initiative was completed in 2009.

j) Health Force Ontario

Funding and expenses related to this initiative are now accounted for directly through Health Force Ontario.

11. General and administrative expenses

The Statement of financial activities presents expenses by function. The following classifies these same expenses by object:

	2010	2009
	$	$
Salaries and benefits	**2,669,292**	2,293,987
Occupancy	**179,409**	215,914
Amortization	**157,557**	181,683
Shared services	**362,714**	501,408
LHIN Collaborative	**12,286**	-
Public relations	**-**	5,505
Consulting services	**357,950**	591,365
Supplies	**47,201**	50,859
Board Chair remuneration	**75,775**	81,200
Board member remuneration	**63,725**	66,650
Board expenses	**47,608**	43,971
Mail, courier and telecommunications	**49,942**	39,485
One time initiative funding to Health Service Providers	**223,474**	-
Other	**280,800**	292,863
	4,527,733	4,364,890

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 24 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 $221,909 (2009 - $181,717) 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 in 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 amounts

Certain of the comparative data have been reclassified to conform with the financial statement presentation followed in the current year.

Central West **LHIN**

Contact Information

Telephone
Main Phone: 905.455.1281
Toll Free: 1.866.370.5446
Main Fax: 905.455.0427

Address:
8 Nelson Street West
Suite 300
Brampton, Ontario
L6X 4J2

Website:
www.centralwestlhin.on.ca

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Local Health Integration Network