Toronto Central **LHIN**

Delivering High-Value Local Health Care Through Collaborative Action

2009/10 Annual Report

Ontario
Local Health Integration Network

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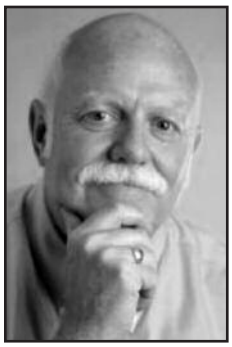


Dennis Magill

On behalf of the Board of the Toronto Central Local Health Integration Network, I am proud to share the LHIN's 2009/10 Annual Report. This past year, the LHIN together with local health care providers and stakeholders made measurable progress towards a health care system that is more accessible, accountable and equitable for the people we serve.

There is no denying that 2009/10 was an especially challenging year. The ongoing problems of rising health care costs related to chronic disease and health care disparities were amplified by the impact of the global recession. Yet these challenges appear to have galvanized Toronto Central LHIN partners. The interdependencies among health service providers and communities and the need for collaboration and integration have never been more apparent.

The Annual Report highlights the accomplishments and the issues that were tackled this past year. Of particular note, I would like to acknowledge the tremendous time, effort and thought our health provider and consumer partners, Board and staff put into the 2010-2013 Integrated Health Services Plan (IHSP-2) from April through to November 2009. The result is a plan for consumers and communities that involves the entire health care system. If we get the IHSP-2 right, every person in Toronto Central LHIN, regardless of race, income, age, education, sexual orientation and language, will have timely access to the health care options they require. And those with the most serious and complex conditions will receive the extra support they need.

Progress has been made on all the LHIN's priorities. Over the past year, we started to see continual and substantial improvements in ER wait times – a signature initiative for the province and the LHINs. Aging at Home initiatives such as Home First started to show a measurable impact on reducing the number of Alternate Level of Care patients in hospital who are waiting to be transferred to a more appropriate setting, a significant contributor to ER waits.

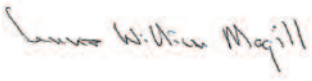
Last year there was an unprecedented level of collaboration in the Toronto Central LHIN. Collaboration occurred through large-scale initiatives such as Resource Matching and Referral which involved 53 health service providers using one system to match patients with the care they need. And collaboration occurred within sectors and around key issues such as health equity and supportive housing as a needed option to allow people with complex needs to live independently, in their communities.

Mental health and addictions providers and consumer/survivors are working together in new ways to coordinate services and to improve both the consumer experience and outcomes for people living with a mental health issue and/or addiction.

Something less tangible, but equally transformative is occurring. The culture of the local health care system is clearly changing. Organizations that never sat in the same room together before are now working on some of the most pressing health system issues. There is a heightened level of transparency as organizations and health professionals share data about their performance and provide the public with an unvarnished view of where the system is working well and where it is falling short.

While data and targets are critical to transforming the quality of the health care system, they do not provide the whole story. Ultimately, the health care system will be measured by the experiences of individuals and families who depend on it.

In closing I would like to thank the many local health system partners for their leadership and dedication to strengthening the local health care system. I would also like to acknowledge my colleagues on the Board and staff for their excellent work and commitment to public service, and the commitment and strong working relationship between board members and the senior management team at the Toronto Central LHIN.



Dennis Magill
Acting Chair

Letter from the CEO

Bonnie Ewart

As 2009/10 drew to a close I began transitioning from a Toronto Central LHIN Board Member to interim CEO.

As I became more exposed to the day-to-day work of the LHIN, what has been most striking is not the volume of activity carried out by the nimble LHIN staff and its partners; it is the incredible teamwork within the local health care system.

This teamwork – and commitment to doing what is best for the health care system and ultimately the people who depend on it – is in my mind the single most important factor driving success in the Toronto Central LHIN.

The 2009/10 Annual Report highlights the results that have been achieved through various collaborations. They show what is possible when organizations, health care professionals and community members pull together in one direction.

This past year the Toronto Central LHIN continued to implement a focused and outcomes-oriented plan. There were 8,800 seniors who directly benefited from Aging at Home last year, with many more receiving better care options as a result of other initiatives in the Toronto Central LHIN.

In 2010/11, we embark on the first year of the 2010-2013 Integrated Health Services Plan (IHSP-2). A number of the initiatives we have been planning together will be put on the ground including addictions supportive housing and value and affordability collaborations involving hospitals and community agencies.

Going forward, the challenges will still be there and we can expect the financial pressures facing all health care organizations to be even more intense.

Personally as I enter 2010/11, I am optimistic that the spirit of collaboration and shared commitment to patient/client-driven care will not only enable us to weather the trials ahead, but to transform health care for the better.

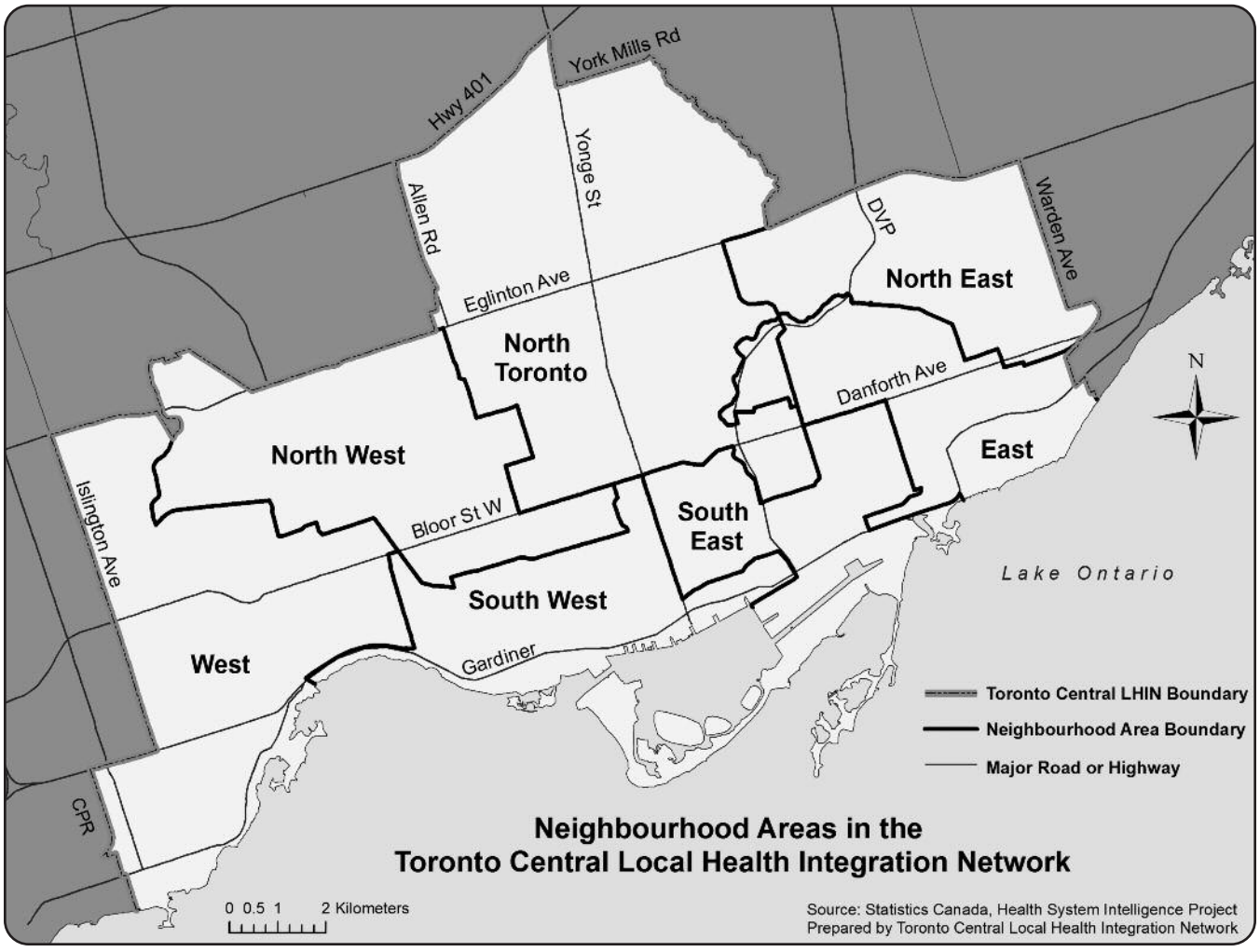
Bonnie Ewart
Interim CEO

Population Profile

Toronto Central LHIN is home to approximately 1.14 million people, or 8.67 per cent of the population of Ontario.

Between 2006 and 2010, the LHIN's population grew an average of 0.3 per cent each year, relatively less than the provincial growth rate of 0.8 per cent annually. According to the latest projections, more than 1.16 million people will be living in the Toronto Central LHIN by 2015, accounting for 8.3 per cent of the province's total residents.

According to the 2006 Census, immigrants make up 41 per cent of the Toronto Central population, and of this group, 20 per cent are recent immigrants who arrived between 2001 and 2006. The highest proportion of immigrants were from: Southern Europe (19 per cent); Eastern Asia such as the Philippines (13 per cent); South East Asia such as China, and Eastern Europe (11 per cent each); and Southern Asia such as India, Pakistan and Sri Lanka (10 per cent). Every country in the world is represented in our population and more than 160 languages are spoken here. The top 10 most frequently spoken languages other than English are Chinese, Portuguese, Spanish, Italian, Tagalog, Greek, German, Urdu, Polish and Russian. About 4.5 per cent of the Toronto Central LHIN residents have no knowledge of English or French.



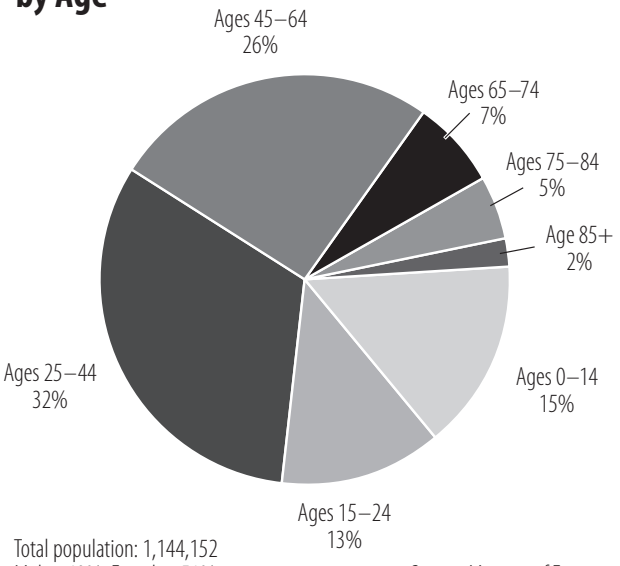
The City of Toronto has a French-speaking population of about 53,370 (based on June 2009 definition of Francophone by the Office of Francophone Affairs). Francophones are a group whose composition and needs have been changing in recent years. According to the 2006 Census, 7.4 per cent of Francophones (previous definition based on mother tongue) in the City of Toronto – which includes the Toronto Central LHIN – are recent immigrants and 20.6 per cent are part of a visible minority group. These numbers are significantly higher than provincial figures, which show 1.4 per cent of recent immigrants among Francophones, with 5.1 per cent of visible minorities. The Toronto Central LHIN's Francophone population is also characterized by a growing proportion of seniors and lower income among young families. However, this group has higher education levels compared to Francophone communities in the rest of the province.

According to the 2006 Census, there were approximately 16,200 residents of Aboriginal ancestry (1.5 per cent) in the Toronto Central LHIN. Aboriginals have much higher rates of chronic illnesses such as diabetes, arthritis, depression, asthma and heart disease than non-Aboriginal residents. They are also disproportionately represented among the LHIN's homeless population (between 14 to 16 per cent).

The Toronto Central LHIN has the largest LGBT community in Canada, with an estimated 10 per cent of the LHIN's population being gay, lesbian, bisexual, transgendered, transsexual, or two-spirited.

Over 30 per cent of Ontario's homeless population lives in the Toronto Central LHIN, and more than 70 per cent of the indoor and outdoor locations used by homeless people are in the central core of the city. This is a particularly vulnerable group, with 74 per cent of the homeless population suffering from a physical health condition and 33 per cent diagnosed with a mental illness.

2010 Toronto Central LHIN Population by Age



Total population: 1,144,152
Males: 49%; Females: 51%
Age 65+: 156,851 (14%)
Age 75+: 79,191 (7%)
Age 85+: 23,202 (2%)

Source: Ministry of Finance estimates (2006-2008) and projections (2009-2036) for LHINs

Compared to the rest of the province, a higher proportion of young adults aged 25 to 44 years of age live in the Toronto Central LHIN, representing 32 per cent of the LHIN's population. Young adults generally have the best health and the lowest use of health services.

While the Toronto Central LHIN has a youthful majority, seniors are an important group as they have higher rates of health needs and conditions, and account for the highest use of health care services. Seniors 65 years and older and seniors 85 years and older account for 14 per cent and about 2 per cent of the population in 2010, respectively. This age group is growing faster than all other age groups in the LHIN, with a projected increase of 22 per cent per cent between 2006 and 2010. This same group is projected to increase another 15 per cent between 2010 and 2015. The population of those 65 to 74 years of age accounts for seven per cent of the LHIN population and is projected to increase by 15 per cent between 2010 and 2015.

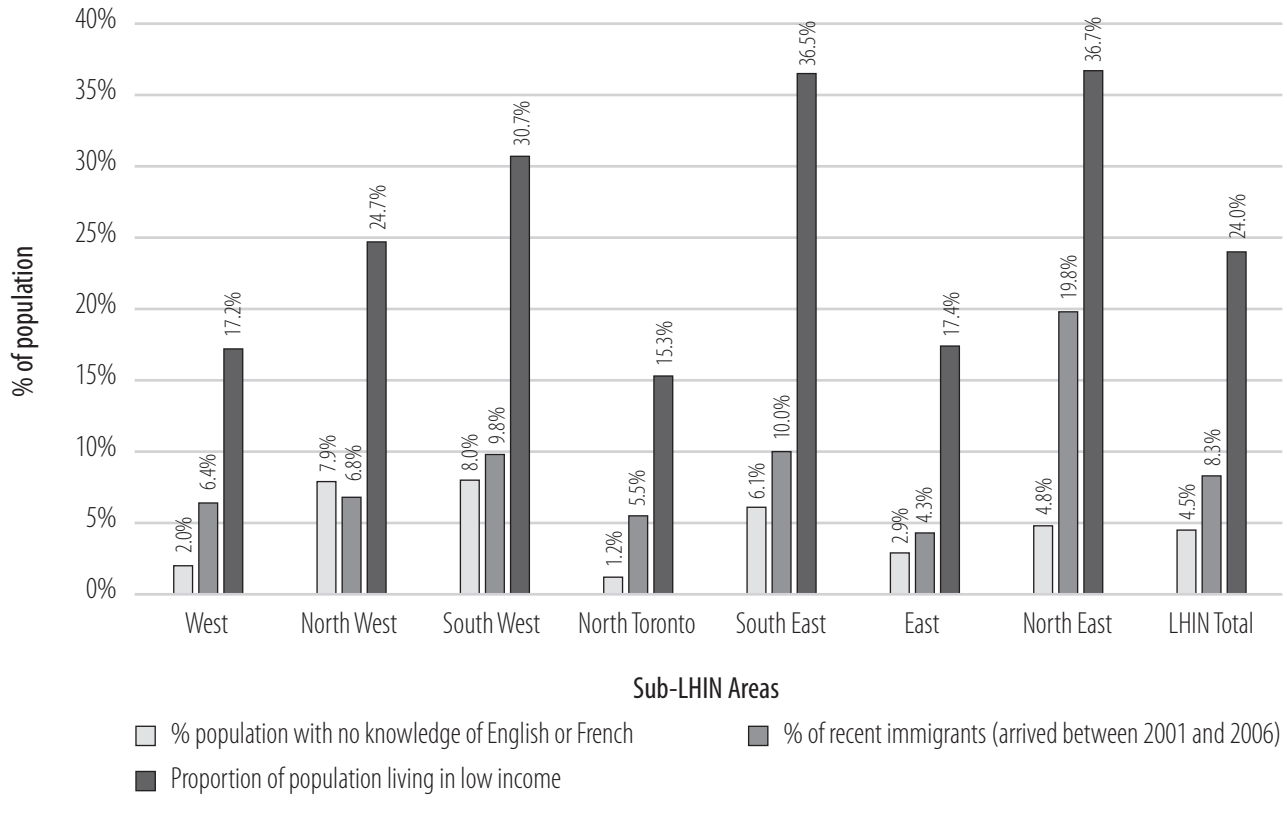
There are wide disparities in income and education levels among communities in the Toronto Central LHIN. Twenty-four per cent of the population is low income, according to the 2006 Census. The proportion ranges from 15.3 per cent to 36.7 per cent among the various areas in the LHIN. Residents with low incomes are more likely than those with higher incomes to report poor or fair health and to suffer from chronic diseases like diabetes and arthritis.

Recent immigrants, Aboriginal peoples, single-parent families, children, people with disabilities and visible minorities are all overrepresented in the low-income bracket. These groups all have distinct health care needs and can face barriers and issues that need to be addressed and supported by the health system.

Sources:

1. Statistics Canada, 2006 Census, provided by Health Analytics Branch, Ministry of Health and Long Term Care (MOHLTC) & TC LHIN
2. Population Estimates, 2006-2008, and Projections, 2009-2036, for Local Health Integration Networks (LHINs). Prepared by: Ministry of Finance, December 2009.
3. Toronto Central LHIN 2007 – 2010 Integrated Health Service Plan
4. Street Health Report, 2007
5. Street Health. *Homelessness – Diverse Experiences, Common Issues, Shared Solutions: The Need for Inclusion and Accountability. 2008*

Toronto Central LHIN Sub-LHIN Planning Area Characteristics: 2006 Census



Health Needs of Population

The Toronto Central LHIN community has a wide range of diverse health care needs with considerable disparities in access and health outcomes among different populations.

Compared to the rest of the province, the Toronto Central LHIN has a high concentration of infectious diseases, with 66 per cent of Ontario's syphilis cases, 44 per cent of AIDS cases, 30 per cent of gonorrhea cases, and 24 per cent of tuberculosis cases.

Chronic diseases and mental health and addictions remain among the most pressing local health issues. As the population ages, the prevalence of chronic disease is expected to grow. More than one in three of Toronto Central LHIN residents have at least one chronic condition such as diabetes, certain cancers, depression, arthritis, asthma, hypertension and chronic obstructive pulmonary disease.

Diabetes is of particular concern to the Toronto Central LHIN, which has a high prevalence of the disease. Almost 10 per cent of LHIN residents aged 20 and over suffer from diabetes. But these numbers are likely to be even higher, since many people with diabetes are unaware they have the disease. People with diabetes tend to have poorer overall health than the general population and often develop other chronic conditions.

Mental illness and addictions have also become serious health issues for the Toronto Central LHIN. Mental illness will affect 20 per cent of people in the Toronto Central LHIN in their lifetime. Prevalence is higher among those aged 65 and over, Aboriginals, and people who are homeless or living in poverty.

Meeting the needs in these key areas is an important challenge that has implications not only for the health and quality of life of those directly affected but also for the well being of the health care system as a whole.

Sources:

1. MOHLTC News Release – Ontario Launches Diabetes Strategy. Accessed at: http://www.news.ontario.ca/mhp/en/2008/07/ontario-launches-diabetes-strategy.html
2. inTool [Internet retrieval system]. Toronto: Institute for Clinical Evaluative Sciences; c2007. Accessed [September 2009] at: http://intool.ices.on.ca/.
3. MOHLTC Health System Intelligence Project, 2007. *Chronic Conditions in the Toronto Central LHIN Report*.
4. Mental Health and Addictions repeat emergency department ED visits, by patient and hospital LHIN, 2008/09. Provided by Health Analytics Branch, HSIMI Division, Ministry of Health and Long Term Care (MOHLTC).

Engaging the Toronto Central LHIN Community

Community engagement helps ensure that health system decisions in the Toronto Central LHIN are informed as much by the lived experiences and perspectives of those who provide and receive care as by data and evidence. Engagement is central to fostering the collaborative culture and shared accountability that are essential for health system transformation. To that end, the Toronto Central-LHIN understands and respects the unique role, knowledge and skills, and capabilities of its provider, consumer and family partners. The foundations for transformative change are these mutually respectful relationships.

Consistent with the Local Health System Integration Act (LHSIA), the Toronto Central LHIN defines community engagement in a broad sense encompassing the health care provider organizations, people who work in the health care system, communities who make up Toronto Central LHIN and the consumers and their families who receive care in the LHIN.

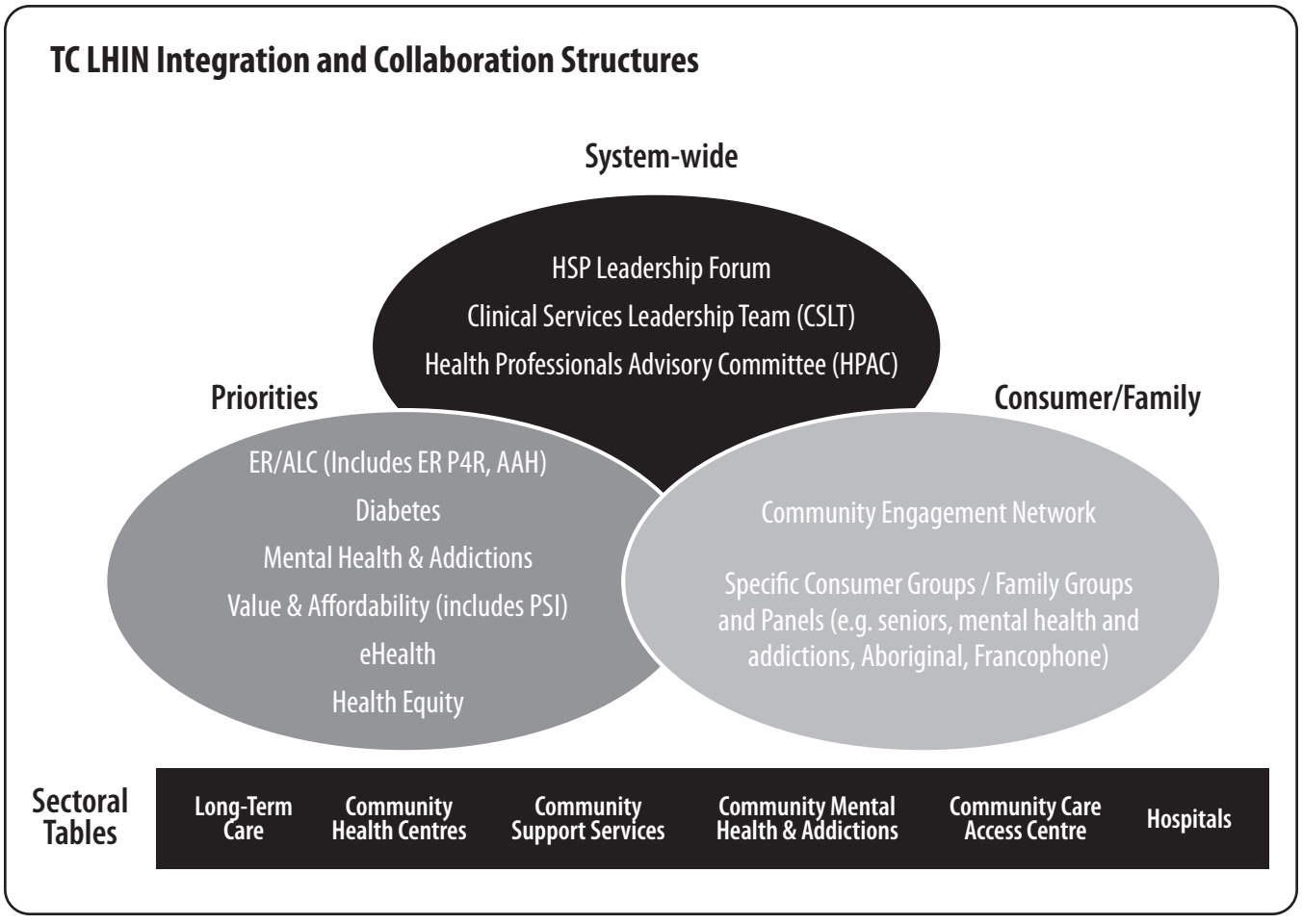
Toronto Central LHIN Engagement Structures

Toronto Central LHIN seeks ideas and advice from and collaborates with consumers, families, health care providers and professionals using a mix of purpose-built engagement structures and processes.

System-Wide Structures: Through the system-wide groups (Health Service Provider Leadership Forum, Clinical Services Leadership Team, and the Health Professionals Advisory Committee) the LHIN seeks advice related to "systems" issues and initiatives that require collaboration, integration and solutions among different organizations, sectors and disciplines. The Health Service Provider Leadership Forum is the LHIN's quarterly meeting between the LHIN, hospital CEOs and senior administrators of long-term care homes and community agencies. The LHIN and its providers review performance against the indicators in the LHIN's accountability agreement with the Ministry and cross-cutting strategies in areas including Alternate Levels of Care (ALC), improving care for seniors and high-needs populations and patient/client transitions between places of care.

The Toronto Central LHIN's Health Professional Advisory Committee and Clinical Services Leadership Team bring a critical health professional perspective to LHIN initiatives. Local decision-making is strengthened by the input of this diverse group of health professional leaders who bring a current and first-hand understanding of their patients' and clients' needs.

Priorities and Enablers: Each of the LHIN's initiatives (reducing ER wait times and ALC days; improve the prevention, management and treatment



of mental illness and addiction; improve the prevention, management and treatment of diabetes; improve the value and affordability of health care services) is steered by an advisory group comprised of a cross-section of health service providers, health professionals, researchers/academics and consumer/family representatives.

Sectoral Tables: Sector tables were formalized in late 2009/10 to provide a regular forum for senior executives of organizations within a sector to pursue integration and collaboration opportunities and tackle current operational, financial and performance issues facing the sector as a whole.

Consumers and Families: Consumer/family groups and panels provide the LHIN with a lens into the needs of targeted populations directly affected by the work in the LHIN's initiatives (e.g. consumers and families of persons with mental illness and/or addictions). To reach out more broadly into multiple, diverse communities, the LHIN initiated the Community Engagement Network comprised of community engagement and development professionals from health service provider organizations, many of whom have experience working with marginalized and disadvantaged people. The Toronto Central LHIN Community Engagement Network works through existing consumer and neighbourhood networks to seek broad consumer input into LHIN decision-making.

2010-2013 Integrated Health Services Plan (IHSP-2) Engagement

To create the LHIN's second three-year plan for the local health system – IHSP-2 – the Toronto Central LHIN tapped into the insights and experiences of health service providers, health professionals and a diversity of consumers and community members.

Over the course of the development of IHSP-2 in 2009, the LHIN engaged over 2000 people through special forums, breakfast events, surveys (paper and online), and 'piggy backing' on meetings already happening in the community with health service providers, consumers and their families. Some examples of IHSP-2 engagement activities include:

- Hosted a series of breakfast meetings with the Toronto Central LHIN's Board and CEO and the CEOs and Board Chairs of all 200 health service providers funded by the Toronto Central LHIN to seek feedback on the strategy, priorities, action plans and indicators.
- Held a breakfast engagement session with Toronto Central LHIN's Board and senior

management and local Members of Provincial Parliament.

- Worked directly with consumer survivor initiatives and mental health and addictions agencies to provide training to consumer/survivors and family members to facilitate focus groups with their peers. Input from the focus groups is informing the provincial Mental Health and Addictions Strategy and the Toronto Central LHIN's local Mental Health and Addictions action plan.
- Developed a paper-based and online survey for consumers, health service providers and health care workers. The questions asked people to reflect on their own experiences – as consumers, families, or health service providers – and to comment on priorities outlined in the plan.
- Held discussions with family physicians on the IHSP-2 priorities. These discussions were facilitated by a local family physician (who also chairs the Toronto Central LHIN's Health Professionals Advisory Committee) through a partnership with the Ontario Medical Association and the Ontario College of Family Physicians.

Promoting Equity

Since the Toronto Central LHIN is the most socially diverse urban area in Ontario, the LHIN is using innovative and inclusive tactics to reach under-served and marginalized communities. Examples include community animation where local community leaders are trained and provided with tools to hold culturally relevant sessions with existing community groups.

Healthy Connections 2010

Building on the success of the June 2008 health equity conference, Healthy Connections, the Toronto Central LHIN provided support for Healthy Connections 2010: Self-Managing Care: From Ideas to Solutions on February 17, 2010. Healthy Connections 2010 brought together front-line workers, administrators, policy-makers, consumers and families. Helping people be active partners with health service providers to manage their own care is an important topic within health equity. A growing body of evidence shows that disadvantaged and marginalized people have both the greatest health care needs and the worst health outcomes. Empowering people to be more proactive in their own care can help improve health outcomes.

Many participants commented that the conference enhanced their opportunity to network, exchange knowledge, and learn from others in the field. The conference offered skill-building workshops such as the Health Equity Impact Assessment (HEIA) Tool workshop, sponsored by the Toronto Central LHIN and facilitated by Dr. Bob Gardner of the Wellesley Institute and Anthony Mohamed of St. Michael's Hospital. The workshop received an excellent rating. This tool is being used by the Toronto Central LHIN and a number of local health service providers to assess the impact of decisions and investments on diverse populations. The HEIA was developed by the Ministry of Health and Long-Term Care's Health Equity Branch in partnership with the Toronto Central LHIN and the Wellesley Institute.

Francophone Engagement

The Toronto Central LHIN has improved and strengthened its Francophone engagement efforts during 2009-10, including participating in regular meetings with the regional French Language Health Services Committee, meeting with our designated French Language Services (FLS) health provider agencies, and holding focus groups and a think tank session in French surrounding mental health and addictions and for the development of Integrated Health Services Plan (IHSP-2). The insights gained from the IHSP-2 sessions were considered in the development of action plans and, specifically, for the health equity action plan.

Over the last year, the Toronto Central LHIN has worked with the four other Greater Toronto Area

(GTA) LHINs (Mississauga Halton, Central West, Central East, and Central) to develop engagement strategies aimed at increasing French language services throughout the GTA.

The Toronto Central LHIN takes an 'engage the engager' approach by working in partnership with funded FLS health service providers to reach Francophone community members through existing networks.

In order to inform the Francophone community about LHIN activities, the Toronto Central LHIN offers its newsletter, health system plans and publications, and media materials in French and distributes information through designated and identified FLS health service providers.

In 2009, Toronto Central LHIN addressed gaps in the availability of French-language materials by translating all IHSP-2 materials including an IHSP-2 consumer fact sheet and Toronto Central LHIN display materials. The Toronto Central LHIN's French web site was expanded with the goal of having all web pages and content for consumers available in French.

Primary Care Engagement

Over the past year, the Toronto Central LHIN utilized a multi-pronged engagement strategy with primary care and primary care physicians. Based on feedback and event evaluations, the LHIN's approaches are evolving and becoming more effective over time. Activities have included:

- Ensuring family physician and primary care team input through primary care membership on all Toronto Central LHIN advisory committees (e.g. Aging at Home Steering Committee, Mental Health and Addictions Steering Committee, Health Professionals Advisory Committee, Clinical Services Leadership Team, and Joint eHealth Council).
- Communications and reference groups/focus groups (in-person or telephone) organized by Ontario Medical Association District 11 and Ontario College of Family Physicians. These consultations have included using peer-led approaches whereby physicians led the agenda and presentation development and facilitated sessions.
- Regular touch point meetings with primary care groups – Toronto Family Health Team Network, and Community Health Centres.
- During the second H1N1 wave in fall 2009, the Toronto Central LHIN assigned Dr. Tara Kiran, a family physician from Regent Park Community Health Centre, to act as the LHIN's H1N1 primary care lead. With the guidance of a primary care advisory group and in partnership with the Ontario Medical Association, Toronto Public Health and others, Dr. Kiran led strategies to link primary care practitioners with other health care providers during H1N1.

Aboriginal Engagement

Over the past two years, the five LHINs that border the City of Toronto, have worked together to make services more accessible and coordinated for urban Aboriginal people across the GTA. This work was in response to consistent advice from Toronto Central LHIN Aboriginal agencies and key informant interviews in spring 2008.

This GTA LHIN partnership culminated in the *Strengthening the Circle: building knowledge on Aboriginal health in an urban environment* community forum on urban Aboriginal research/data collection, planning and service delivery. The idea for the conference came from a shared understanding among urban Aboriginal communities and the GTA LHINs that culturally competent, population-based data and research were required to guide Aboriginal health planning. This March event brought together over 85 participants from both Aboriginal and non-Aboriginal organizations, including academic institutions, health services and social services to discuss knowledge transfer and respectful research practices in an urban Aboriginal environment.

Highlights included a presentation by Dr. Janet Smylie, Aboriginal Research Scientist, Centre for Research on Inner City Health (CRICH) on working in partnership with Aboriginal stakeholders to develop and apply population-based urban Aboriginal health datasets; and an expert research panel featuring Mario Gravelle of the Métis Nation of Ontario, Dr. Heather Howard-Bobiwash of Michigan State University, and Bela McPherson of CRICH, discussed respectful Aboriginal research methodologies.

A public report on the event will be addressed through Toronto Public Health's Roundtable on Urban Aboriginal Health. Toronto Public Health is convening an advisory committee through the round table participants to provide recommendations on next steps in partnership with the Toronto Central LHIN.

Accomplishments in 2009-2010

The Toronto Central LHIN has adopted the Ministry of Health and Long-Term Care's vision of "a health care system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren."

2009/10 represents the last year of the Toronto Central LHIN's first Integrated Health Services Plan. As noted in the LHIN's 2008/09 Annual Report, during the summer of 2008, the LHIN Board and senior management team moved to focus and accelerate action on the following IHSP initiatives:

- improving the performance of the system, including reducing ER wait times and Alternate Level of Care days, and advancing eHealth and health equity;
- chronic disease management starting with diabetes; and
- mental health and addictions.

The following section outlines the past year's progress on these key priorities at the Toronto Central LHIN.

Reducing Emergency Room Wait Time and Alternate Level of Care days

Each day, hundreds of patients visiting Toronto Central LHIN Emergency Rooms (ERs) wait longer than recommended to be treated or admitted to hospital. While there are various and complex reasons for these delays, one key reason why emergency departments get backed up is that the hospital beds needed by ER patients are occupied by other patients whose acute care is completed and are waiting to be transferred to an alternate place of care that will better meet their needs. The changes required to reduce ER wait times and Alternate Level of Care (ALC) days will bring about system-level improvements. These changes will also particularly benefit people who tend to have the highest needs and poorest health – people with mental illness and/or addictions, and frail and at-risk seniors – which contributes to a more equitable local health care system.

The Toronto Central LHIN's ER wait times and ALC strategy's two main programs are 1) ER Pay for Results (P4R), which provided financial incentives to seven hospitals to meet ER wait times targets, and 2) Aging at Home, a three-year strategy designed to expand seniors' access to care options at home and in the community, and create locally-driven approaches to enhance seniors' independence and health status.

2009/10 Results

Efforts at the Toronto Central LHIN delivered substantial results in 2009/10 **with nine out of 10 patients waiting 20 per cent less time to be treated in the ER in March 2010** compared to March 2009.

While the number of ALC patients in the Toronto Central LHIN remained fairly steady throughout the past year, the number of ALC patients dropped incrementally throughout March 2009.

ER Pay for Results (P4R)

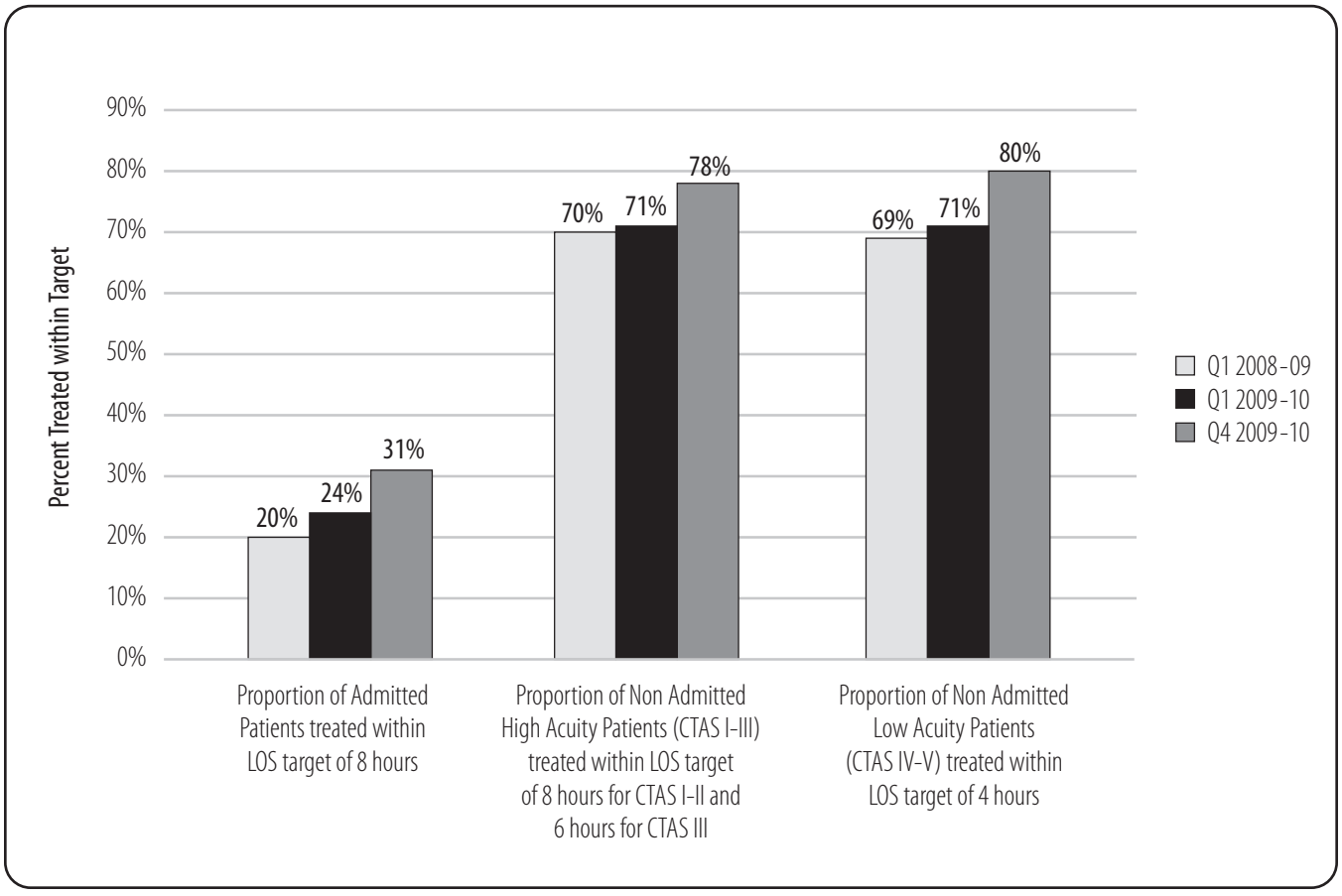
In 2009/10, the Ministry of Health and Long Term Care allocated $7.9 million to Toronto General Hospital, Toronto Western Hospital, St. Joseph's Health Centre, St. Michael's Hospital, Sunnybrook Health Sciences Centre, Toronto East General and Mount Sinai to reduce ER wait times.

In 2009/10, ER P4R built on the strengths of the previous year's program and focused the following improvement strategies:

- Focusing on patient flow and process improvements within the ER and hospital. Improvements include compressing the time to make decisions in the ER, improving access to diagnostic services, and creating specialized units and teams to prevent unnecessary admissions, expediting care for selected patients and enhance the patient experience.
- Increasing hospital capacity – including human resources – to respond to ER pressures is a key focus of continued and new investments for ER P4R hospitals.
- Investment in information technology to support ER wait and ALC improvement initiatives.

In 2009/10, the program targets for three different groups of patients were:

- proportion of patients admitted from the ER to inpatient hospital beds treated within eight hours;
- proportion of acutely ill or injured patients who are not admitted and are treated within eight hours in the case of patients with CTAS[1] level I



or II, or within six hours in the case of patients with CTAS level III; and

- proportion of patients with minor, uncomplicated injuries or illness treated within four hours.

In 2009/10, ER wait times progressively improved for patients in all three groups above. Over the P4R program's first two years, the Toronto Central LHIN's hospitals made great strides in reducing ER wait times, with gains accelerating in 2009/10.

The ER Pay for Results program encourages hospitals to look beyond their four walls, to learn from each other and pursue collaborative solutions across hospitals, community services and other sectors. The Toronto Central Community Care Access Centre (CCAC) is a standing member of the P4R working group, recognizing the importance of addressing ALC and supporting patients to transition from hospital to home, community and long-term care.

In January 2010, the ER P4R working group hosted a discharge planning forum which brought together Acute and Rehab/CCC hospitals and the Toronto Central CCAC to identify best practices, challenges and opportunities for local discharge planning in the Toronto Central LHIN. Resulting from this forum is a concerted effort amongst hospitals to develop standardized discharge planning principles across hospitals with an aim of helping people return home or advance to the next level of care sooner.

Improving care for vulnerable populations

St. Joseph's Health Centre has one of the busiest mental health and addictions programs in the LHIN and has been able to markedly reduce ER wait times and improve the accessibility and experience of patients throughout the hospital by reducing barriers and bottlenecks preventing timely access.

The Mental Health and Addictions Program at St. Joseph's Health Centre operates a number of services that treat patients with schizophrenia, clinical depression, bipolar affective disorder and concurrent mental health and addictions issues. The program is also one of the few in the city that has an addictions team that can see patients quickly in the ER.

The hospital developed four major strategies to improving patient flow:

- Decrease the amount of time patients are waiting in the crisis area of the ER for an inpatient bed.
- Decrease the patient's average length of stay on inpatient units.
- Standardize daily patient discharge times at 11 a.m. and 2 p.m.
- Decrease the time it takes to transfer a patient from the crisis unit to inpatient floor.

The program's management staff meet weekly with the other clinical programs in the hospital to report on previous week successes and barriers of access and flow to sustain everyone's attention and efforts on this important initiative. The program has enabled the hospital to cut in half the average time it takes to transfer a patient from the crisis unit to the inpatient floor and significantly reduce the amount of time patients wait in the crisis area of the ER for an inpatient mental health bed.

"There are fewer patients waiting in the ER, shorter inpatient stays, planned discharges, improved communication and linkages in the community and a decrease in re-admission rates," said Dan Land, Administrative Program Director, Mental Health and Addictions Program at St. Joseph's Health Centre.

St. Joseph's Health Centre's efforts have delivered substantial results with nine out of 10 patients waiting 25 per cent less time to be treated in the ER in March 2010 compared to April 2008.

Aging at Home

The Aging at Home strategy is designed to provide supports that seniors need to spend their later years living where they want, in the way they

1. The Canadian Triage & Acuity Scale (CTAS) is a tool that enables Emergency Departments (ED) to triage patients according the type and severity of their presenting signs and symptoms

Home First: Getting and Keeping Seniors at Home

Home First is transforming the experience for alternative level of care patients (ALC) in acute care hospitals across the Toronto Central LHIN. A partnership between Toronto Central Community CCAC, hospitals and community agencies, this Aging at Home program is resulting in ALC patients getting home faster and safely and, in many cases, remaining home instead of going to long-term care. Home First is designed to identify and support seniors who can wait at home rather than in the hospital to make this important decision about their future care.

"Moving to long-term care is a major life changing decision and one which is better made at home and not in hospital. Home First allows patients the time to get back on their feet in the comfort of their own homes before they make these life-changing decisions," says Stacey Daub, Toronto Central CCAC Senior Director, Client Services.

The program employs a specialized team led by a community care coordinator whose role is to support and assess the care needs of the patient and family within one to two days of discharge from hospital. The care coordinator supports the patient with seniors-focused intensive case management and has access to a specialized team of care professionals comprised of a pharmacist, occupational therapist and nurse practitioner.

"I'm managing quite well in my home with the assistance I'm getting," said 87-year-old client Doug, 10 days after he was discharged from hospital with the support of Home First. "I feel safe and confident with the support I'm getting and am very happy with the pace of my recovery."

Since Home First was launched in the fall of 2009 there has been a marked and steady decrease in the number of ER visits by seniors admitted to the CCAC. The percentage of ER visits by CCAC clients who visited an ER within 30 days of admission to the CCAC went down from 14 per cent in April 2009 to six per cent in February 2010, indicating that Home First and other Aging at Home Programs are providing seniors with the safe, quality care they need at home.

want. In 2009/10, Toronto Central LHIN invested $15.4 million to support 22 initiatives (17 from Year 1 of the program and five new initiatives) to help seniors live healthier and more independently in their homes and communities. The second year emphasized supporting marginalized and high-need seniors specifically those with dementia, mental illness and/or addictions by diverting seniors from avoidable ER visits, where appropriate, helping to transition seniors out of hospital and ALC beds to a level of care that better meets their needs.

Over the past year, Aging at Home initiatives directly benefitted approximately 8800 seniors. The program helped increase the range and quality of services available to seniors, helped seniors avoid hospitalization and ER visits, and improved the transition of seniors from the hospital to better places of care. It is creating a ripple effect by improving the wellbeing

of caregivers, families and communities and generating new health care options for older adults. The following are highlights from some of the programs that were funded by Aging at Home over the past year.

Getting patients to the right place of Care

Facilitating the safe discharge of seniors from hospital is a key part of Toronto Central LHIN's strategy to reduce ER wait times and ALC. An example is the Geriatric Emergency Management (GEM) nurses program, which delivers targeted geriatric assessment and facilitates care coordination for frail seniors in the ER who are at high-risk of readmission. GEM nurses are an important component of the range of services that help improve the health, self-sufficiency and wellbeing of seniors.

In 2009/10, Aging at Home investments enhanced the existing GEM nurses program. Over the past year, **1738 patients were assessed by GEM nurses in the ER and 1360 patients were safely discharged to a more appropriate care setting (home, community, long term care, institutional transfer, etc.)**

Better coordinated community services for seniors

Better coordinated, accessible services and supporting seniors to transition between health care services are key aims of the Aging at Home strategy. One example of this kind of initiative is Community Navigation and Access Project (CNAP). Thirty four participating agencies work collaboratively to simplify the navigation of an array of community services that can be confusing and feel disorganized to clients. These agencies have formed into neighbourhood-based hubs across the Toronto Central LHIN and use tools such as a standardized client intake process to help identify and assist frail seniors, and an online library of community services available through the CCAC's Community Care Resources website that allows intake workers to more quickly connect clients with the closest agency providing a specific service. Seniors and their families only need to visit www.cnap.ca to access the program, and soon, a 1-800 number will be available. **Over 3000 new client referrals were done using CNAP's standardized intake form in 2009/10.**

Expanded supportive housing

Supportive housing is an important option for people who are able to live at home, but are either homeless or underhoused or require specialized assistance and support available through supportive housing programs. **In 2009/10, 588 more people in the Toronto Central LHIN received supportive housing in the Toronto Central LHIN**. Without supportive housing, many of these individuals would have been pre-maturely admitted to long-term care, hospitalized or homeless.

Enhanced access to home and community care options

Aging at Home supports specialized teams of health professionals to provide individualized care to seniors at risk of hospitalization.

House Calls, for example, is a mobile, physician-led, multidisciplinary geriatric outreach and assessment team that provides care to seniors with complex needs in the comfort and dignity of their own homes.

> "By providing these services, we are helping these people avoid going to the hospital and stay at home longer, which is more cost-effective from a health system point of view. From the patient's point of view, it's about having a better quality of life."
>
> *Dr. Mark Nowaczynski, House Calls*

In 2009/10, House Calls served 157 vulnerable seniors, which included facilitating the discharge of 38 of these individuals from hospital (ER or acute ALC beds) and providing them with the services they needed to stay at home.

Maintaining health in the home

An 81-year-old man was feeling increasingly discouraged. He was bed ridden and isolated from social interaction. A grassroots group funded by the Outreach to Diverse and Vulnerable Seniors project reached out to him and gave him the help he needed. Now volunteers from the group regularly visit and assist him to get showered, do his laundry and shop for groceries.

The client recounts how from the first moment he met with the volunteers who spoke his language and knew his culture, he felt a weight had been lifted off his shoulders. "That was the moment when more than 50 per cent of my problems were solved," he said.

Wellness/prevention

Improving the overall health of seniors is an important part of Aging at Home. Providing seniors with the support they need at home enhances their quality of life and reduces the risk of declining health and hospitalization. Last year, WoodGreen Community Services funded 10 grass-roots groups through Outreach to Diverse and Vulnerable Seniors. Projects were located within priority neighbourhoods with growing levels of poverty and/or focused outreach to recent immigrant populations with little knowledge of English.

These grassroots groups draw upon their informal resources and networks to provide care and support that is both culturally and linguistically appropriate, and cost effective for the health system. Groups have used funding to create customized programs that fulfill specific community needs including home based care, health and wellness programs, outreach groups, symposiums on illness prevention and care options, workshops on culturally relevant care options, and caregiver education/training.

Since its introduction in 2008, the Outreach to Diverse and Vulnerable Seniors has served 3,102 seniors living in Toronto Central LHIN, including 1,350 in 2008/09 and 1,752 in 2009/10.

Mental Health and Addictions

Improving the prevention, management and treatment of mental illness and addictions continues to be an urgent priority for the Toronto Central LHIN.

It is estimated that one in five adults will experience mental illness and/or addictions in their lifetime. Of these, three per cent of adults will be seriously affected. Moreover, 20 per cent of Toronto Central LHIN seniors aged 65 and over lives with a mental illness. The Toronto Central LHIN has the highest rate of people who revisit the ER within 30 days of a psychiatric discharge. Unmet needs for mental illness and/or addictions clients in the community contribute to long ER wait times and high ALC days in hospitals.

In 2009/10 the Toronto Central LHIN's mental health and addictions strategy focused on three main areas: 1) enhanced services targeting key populations including supportive housing intensive case management and integrated care; 2) better service coordination through client referral, intake and assessment tools; and 3) enhancing mental health and addictions data to enable performance improvement and evidence-informed decision making.

2009/10 results highlights for people living with mental health and addictions

- **Expansion of supportive housing units, with 337 clients (or 57 per cent) of the 588 clients served by the new supportive housing units** living with mental illness and/or addictions, including dementia and related conditions.
- **Outreach services to help seniors** with mental illness and/or addictions stay in their community, such as the St. James Town Outreach Program (STOP), which has helped over 110 clients maintain their housing and get connected to services in the last year.
- **Development of a transitional unit** to help hospitalized seniors with mental health challenges return home.
- **A standard process for client intake and referrals**, starting with supportive housing through the Coordinated Access Supportive Housing (CASH) program. **All 28 mental health supportive housing providers – comprising nearly 100 per cent of the Toronto Central-LHIN funded units for mental health – have created one common wait list and application form for supportive housing clients**. At the core of this initiative is

"STOP is about meeting people where they live, which helps us to identify problems, including health issues, and putting them in touch with the health services and community support they need."

Karen Edwards, outreach worker with the Community Resource Connections of Toronto

a single, coordinated access point that connects clients to the supportive housing services they need. Instead of filling out multiple application forms for different agencies, users submit only one form and are on one common waiting list.

- **Specialized tools and education materials** to help ER staff identify and assess seniors with mental health issues, and to link these clients with the post-ER care options they need;
- **An integrated model of care** through the Toronto Community Addictions Team that helps clients with problematic substance use or a concurrent disorder (a person with a mental illness and a substance use or gambling disorder) get connected to the care options that are right for them.
- **Improve outcomes for people with concurrent disorders** by enhancing the knowledge and skills of mental health and addictions agency staff. Initiatives include implementing a concurrent disorders certification program for agency leaders and supporting the use of a common screening tool in organizations serving transitional age youth and adult populations.

Helping clients with substance use issues get connected to care; reducing repeat ER visits

Toronto Community Addictions Team (TCAT) is an innovative two-year, Toronto Central LHIN-funded pilot project led by St. Stephen's Community House in collaboration with St. Michael's.

The goal of the project is to reduce readmissions and/or repeat visits to the ER and to Withdrawal Management Services (WMS) for those with problematic substance use issues and those who may have a concurrent mental illness and are often homeless or under-housed. TCAT brings together hospitals, community mental health and addictions agencies, and the City of Toronto to create an integrated care model using intensive case management to assist clients in meeting their range of needs.

Since launching in January 2010, the team has served 46 clients and has achieved a 98 per cent reduction in ER use by clients referred to TCAT. To date, 20 per cent of current clients have been provided with appropriate housing and another 20 per cent of current clients have elected to receive addiction treatment services as a step towards housing.

After years of community-led tool selection and provincial piloting, the province's Community Care Information Management Group (CCIM) in partnership with some of the LHINs led the implementation of the **Ontario Common Assessment of Need (OCAN)**, a tool that offers consumers an effective way to voice their needs and preferences and a more inclusive approach to care. Last year in the Toronto Central LHIN, 27 community mental health programs began training and implementation. A CCIM survey last year (including Toronto Central LHIN agencies) showed strong support for OCAN. **Seventy-five (75) per cent of consumers agreed that the tool was useful in assessing his/her needs and 81 per cent of staff reported the tool provides an accurate assessment of client needs**. Standardized tools such as OCAN will reduce the need for clients to repeat information at every encounter with health care providers and will provide invaluable insights into the impact of services on clients over time.

In 2010, the **Toronto Central LHIN Mental Health and Addictions and Homelessness Think Tank Advisory Committee** held a multi-sectoral forum that identified targeted opportunities to address the needs of people who are homeless and have a mental illness or substance use issue. Specifically, the think tank focused on identifying strategies to better support these clients as they transition through the health system, including strengthening relationships between organizations and sectors, and using existing resources more effectively.

In addition, through the Data Decision Support Working Group comprised of key mental health and addictions stakeholders, the Toronto Central LHIN continues **to improve its ability to collect, measure and apply data about mental health and addictions services**. The goal is to move to outcomes-focused measures for mental health and addictions over time to demonstrate the impact of actions on the health and quality of life of consumers.

An ounce of prevention

Live Free – Prevent Diabetes is a new program running out of the New Heights Community Health Centre aimed at reducing the onset of Type 2 diabetes for seniors primarily within Toronto's Caribbean and Latin American communities.

The program is one of the only diabetes prevention programs carried out mostly in the community at community centres, churches, shopping centres, and other neighbourhood settings. It features four workshops:

- A workshop providing information on diabetes and help clients set realistic goals for prevention;
- A workshop on nutrition;
- A cooking class that concentrates on local community dishes; and
- A workshop on exercise that appeals to the target communities.

By March 2010, the program had screened 468 people with about 151 participating in workshops.

Diabetes

By 2010, the number of people living with diabetes is expected to grow from 900,000 to 1.2 million. The Toronto Central LHIN has a high rate of diabetes, with 9.8 per cent of residents aged 20 years and older living with the disease. Besides the sheer number of people affected, diabetes puts people at risk of significant disease and disability, including heart disease, stroke and end-stage kidney disease.

One of the priorities of the Toronto Central LHIN is to improve the prevention, management and treatment of diabetes in the local population and contribute to the success of the provincial Diabetes Strategy. Better diabetes prevention and management will contribute to health equity in the Toronto Central LHIN since diabetes disproportionately affects visible minorities, low-income groups and marginalized populations. For example, 10 to 20 per cent of the Toronto Central LHIN region's South Asians and 22 per cent of Aboriginal people aged 65 and older have diabetes.

The Toronto Central LHIN carried out the following activities in 2009/10:

- The Toronto Central LHIN Diabetes Strategy Steering Committee **developed a model of care** for diabetes management for the Toronto Central LHIN with input from the community and health service providers which has been incorporated into a proposed regional coordinating centre model that the Ministry will be implementing.
- **Provided recommendations** to the Ministry on locations of new diabetes education programs, multidisciplinary teams composed of nurses, dietitians and social workers that provide counseling and other supports to help people manage their diabetes. New diabetes education programs in the Toronto Central LHIN are being delivered by New Heights, South Riverdale and LAMP Community Health Centres.
- **Provided expert advice** on the implementation of the provincial Diabetes Strategy, including recommendations for diabetes registry pilot sites.
- **Implemented two outreach and screening programs**. The South Asian Diabetes Prevention Program (SADPP) at Flemingdon Community Health Centre expanded in 2009/10. Building on the success of SADPP, a second program – Live Free – for Caribbean and Latin Americans communities got underway last year, with a third program being planned for urban Aboriginals.
- The Toronto Central LHIN Diabetes Steering Committee developed a work plan for a **pilot project to identify diabetes care gaps and needs within the Aboriginal community**, a crucial step to reducing the risks and consequences of diabetes among the Aboriginal population.

Value and Affordability

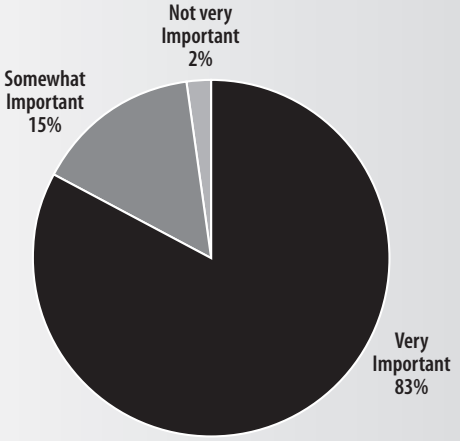
Current economic pressures have sharpened attention on how to get the best value out of limited health care funding. Increasing value in publicly funded health care requires making the best use of existing resources to deliver the best results possible.

The first Integrated Health Service Plan identified "Back Office Services" as one of its priorities. Recommendations from the Back Office Council led to the launch of the Toronto Central LHIN Partnerships for Service Improvement (PSI) in early 2009. Four initial PSI demonstration projects were announced in June 2009 spanning human resources and legal, information management/ information technology, infection prevention and control, and pharmacy.

In June 2009, as part of the Hospital Annual Planning Submission (HAPS) process, hospital CEOs worked with the LHIN to undertake six HAPS Value and Affordability task forces. This has resulted in a focused set of shared collaboration priorities which hospital CEOs are driving to achieve greater value and affordability in select

What consumers think about value and affordability

For the people who use health services in the Toronto Central LHIN, an affordable, value-based health system is very important. This chart shows the results of a recent survey where over 100 respondents were asked how important it was that the LHIN focus on finding ways to increase the value and affordability of health care services.



areas including laboratory services, clinical efficiency, and intensive case management for key populations with complex needs including mental health and addictions clients, adults with complex and chronic conditions and frail seniors.

Creating an Integrated Health Care System

The LHINs' legislation – Local Health System Integration Act – provides the LHINs with different tools to foster integration of health care services. Integration means that service providers work in

Voluntary Integrations	
COTA Health and Homeward	Homeward services transferred to COTA Health. Commitment to improve and expand MHA services available to clients, leveraging COTA's strengths and relationships in mental health and justice systems.
Sudbury Regional Hospital and St. Michael's	Collaborative trauma services, faster referrals of critically injured trauma patients.
Funded Integrations	
LTC Outreach Teams	Toronto Western Hospital and Toronto East General Hospital Mobile Outreach Teams: Over 18 months (October 2008 to March 2009) some 75% of potential ER visits avoided
Home First	Led by Toronto Central CCAC, Home First is getting and keeping seniors safely at home
Stepping Stone Project	LOFT, CAMH and acute hospitals 2009/10 project's first full year. Partnership allows seniors with psychogeriatric conditions to live in the community, transition to permanent housing
St. Hilda's Enhanced Care Program	Toronto Central CCAC and St. Hilda's. Expanded in 2009/10. Helping seniors convalesce between hospital and home
Integrations in Implementation	
Resource Matching and Referral	53 providers referring clients electronically; most extensive electronic referral system in Ontario
Bed Holding Policy	GTA Rehab Network. Adopted by all Toronto Central LHIN rehab and complex continuing care hospitals
Women's College Urgent Care Patient Transfer Protocol	Developed under the leadership of the Toronto ER Network. Timely transfers from Women's College Hospital Urgent Care Centre
CNAP (Community Navigation and Access Project)	Aging at Home initiative – 34 agencies using coordinated system, over 3000 referred in 2009/10
CASH (Coordinated Access to Toronto Mental Health and Addictions Supportive Housing)	One wait list for all 28 mental health and addictions supportive housing agencies
OCAN (Ontario Common Assessment of Need)	Local implementation of consumer-led assessment tool began in 2009
CAISI (Client Access to Integrated Services and Information)	Electronic health records for homeless. 42 agencies and 650 providers using CAISI for case management with over 11,000 homeless clients registered in 2009/10

collaboration with one another so they can provide better care. It is a key means of improving accessibility and quality for consumers and achieving better value for health care investments.

A unique feature of the LHINs is their ability to enable organizations, health professionals and consumers to work together 'on the ground' to solve problems and improve local health care services. The Toronto Central LHIN views integration as a powerful means to create a better coordinated, well functioning health care system for health care providers and, most importantly, for the consumers they serve.

In 2009/10, 13 health service formal integrations among two or more organizations were either completed or well underway in the Toronto Central LHIN. Two were voluntary integrations that were initiated by HSPs and brought to the LHIN's public Board meeting for review. There were four funded integrations whereby the LHIN provided funding to enable different forms of integration and seven were large multi-organization and multi-year integrations of services, systems and processes that the LHIN supported in various ways.

Critical Enablers of Transformation

The Toronto Central LHIN's priorities are supported by a number of factors. Two of these are particularly critical to transforming the health care system: health equity and e-health.

Health Equity – ensuring equal opportunities for health for all

Health equity is of particular concern in Toronto Central LHIN, where the tremendous range and diversity of incomes, languages, education and other cultural and socio-economic factors have led to inequities in access to services and in health outcomes.

Health inequities are costly for both the system and the individual. Access barriers among different groups have been linked to prolonged lengths of stay, avoidable hospitalizations and readmissions, as well as over and under-utilization of medical procedures. Overall, health inequities in our system contribute to poorer quality, less efficiency and less patient satisfaction.

In 2009, the Toronto Central LHIN required hospitals to begin reporting on equity and all 18 hospitals created health equity plans.

In addition, the Toronto Central LHIN partnered with the Ministry of Health and Long-Term Care's Health Equity Branch and the Wellesley Institute to develop a Health Equity Impact Assessment Tool that can be used by the LHIN and health service providers to assess the impact of decisions and investments on different populations. Use of the tool is designed to ensure that equity is considered in planning, program design and decision making. The tool was launched along with the Year 3 Aging at Home Call for Proposals in November 2009. Short-listed applicants were required to complete and submit a Health Equity Impact Assessment as part of the selection process. The use of the tool is also being promoted through the extended Hospital Service Accountability Agreements and all hospitals are required to use the tool in the next round of hospital health equity plans in 2010/11.

eHealth

eHealth is a significant enabler to the Toronto Central LHIN's priorities. eHealth tools and initiatives have already resulted in significant changes in health care, bringing tremendous advances in patient safety and management of surgical wait times in Ontario. In Toronto Central LHIN, where a multitude of healthcare providers across the system look after the needs of thousands of people each year, using technology to share patient and treatment information can help people get the appropriate treatment faster, reduce duplication of tests and minimize medical errors.

Over the past year, Toronto Central LHIN and its partners have made excellent progress towards the implementation of electronic tools to integrate clinical information across the continuum of care.

Resource Matching and Referral

Resource Matching and Referral (RM&R) is an electronic information and referral system that contributes to reducing ALC days, a key factor affecting ER wait times. RM&R matches patients/clients to the earliest available and most appropriate care/support setting, ensuring more people receive the right level of service at the right time.

In 2009/10 the Toronto Central LHIN completed RM&R implementations for acute care (medical and surgical in-patient units), rehab/complex continuing care, long term care, Community Care Access Centre (CCAC) in-home services, and convalescent care programs.

At the end of last year, 53 Health Service Provides in the LHIN were using RM&R to facilitate their referral processes, including six acute care organizations, eight rehab/complex continuing care organizations (including one from Central LHIN), 38 long-term care homes, as well as the Toronto Central CCAC. The RM&R system has significantly shortened referral times and patients are getting from hospital to the next level of care faster and freeing up hospital beds for acutely ill patients who require hospital care. The average time it takes from the submission of a referral to the receiving organization responding to the referral has dropped from 3 days in August 2009 to 1.9 days in March 2010 – a decrease of 37 per cent.

In 2009/10 the Toronto Central LHIN also initiated planning activities with the community support services, and the mental health and addictions sectors to better understand client and sector needs, privacy and information technology (IT) implications, as well as requirements for a RM&R implementation. In addition, the Toronto Central LHIN participated in a collaborative RM&R initiative with six others LHINs (Central, Central East, Central West, Mississauga Halton, North Simcoe Muskoka, and South East) to address client referral needs from a broad, multi-LHIN perspective. This project documented the current referral processes and future-state considerations between acute care, adult, in-patient medical and surgical programs, and four post-acute destinations (long term care, rehab, complex continuing care and CCAC in-home services).

ConnectingGTA

ConnectingGTA (cGTA) is a joint initiative of the five GTA LHINs (Toronto Central, Central, Central East, Central West, Mississauga-Halton) to connect all the disparate clinical information systems of healthcare organizations within the GTA, thereby allowing GTA healthcare providers to view all relevant healthcare information related to their patients at the point of care. The integration of these systems will improve clinical decision making and the quality of patient care.

"RM&R has the potential to transform the way we deliver health care. This system will indicate which types of clients are waiting and not getting timely access to the care they need so that we can address inequities and service gaps and make the health system respond more effectively for everyone," says Bonnie Ewart, CEO, Toronto Central LHIN.

The cGTA project made significant progress in 2009/10. Lab information is anticipated to be implemented into the system in summer 2010.

GTA West Diagnostic Imaging Repository (DI-r)

The GTA West DI-r will enhance diagnostic imaging service across the region serviced by the GTA West hospital sites by enabling access to images between sites by an expected 10,000 clinicians. The project has the potential to improve patient flow, reduce medical errors, improve quality of care in diagnosis and treatment, decrease patient transfer and wait times, and enhance clinical collaboration.

In 2009/10, the project completed foundational activities including gaining support from participating organizations, selecting a vendor, and securing funding from eHealth Ontario and Canada Health Infoway.

Client Access to Integrated Services and Information (CAISI)

CAISI, an initiative funded by the Toronto Central LHIN, is an electronic medical record that features case and bed management tools and medical record capabilities tailored to meet the needs of shelters, drop-in centers, outreach teams, health clinics and hospitals working with homeless and at-risk populations. **In 2009/10, the CAISI project saw a large growth in its user base and currently 42 agencies and 650 providers are using CAISI for case management and over 11,000 homeless clients have been registered in the system in the past year.**

Driving Health System Performance Improvement and Accountability

In 2009/10, the Toronto Central LHIN met or exceeded targets for cataract, hip and knee replacement surgeries and CT scans.

The following innovations contributed to success in these key Ministry-LHIN Accountability Agreement (MLAA) targets.

The LHIN's Hip and Knee Central Intake Model continues to contribute to the low wait times for these procedures. The model was created to manage the multiple bookings made at hospitals in order to streamline the patient referral process, and thereby shorten wait times for patients.

The LHIN's Diagnostic Imaging (DI) Network is another key initiative contributing to lower wait times. The Network brings together clinicians and administrators from across Toronto Central LHIN hospitals to share best practices and advise on the causes of and strategies to address clinical or systemic issues behind wait times for diagnostic procedures.

In 2009/10, the Toronto Central LHIN did not meet targets for a number of MLAA indicators. In all cases, the LHIN has undertaken a plan of action to improve performance in these areas. The Board reviews a performance scorecard on a quarterly basis and discusses performance challenges and the steps being taken to tackle these challenges. The LHIN's Clinical Services Leadership Team (CSLT), made up of recognized leaders from different health professions, provides clinical insights into the results. A joint meeting between the CSLT and the LHIN's Board Finance and Audit Committee is an important forum for reviewing indicators and progress against targets. The LHIN also works directly with hospitals and other health service providers, as needed, as a group or individually on specific plans to address issues.

At the Quarterly Health Service Provider Leadership Forum, the LHIN reviews performance against MLAA targets and engages CEOs, Executive Directors and senior management from health service provider organizations on collaborative strategies to raise performance on these health

system measures. The sector tables which began in 2009/10 allow CEOs/Executive Directors/ Administrators to work together and with the LHIN to develop solutions to specific operational, cultural or 'systems' issues affecting performance.

Toronto Central LHIN MLAA Performance Indicators 2009-2010

Performance Indicator	LHIN 2009/10 Starting Point	LHIN 2009/10 Performance Target	Most Recent Quarter 2009/10 LHIN Performance	Full Year 2009/10 Annual Results	LHIN Met Target/ Within Corridor
90th Percentile Wait Times for Cancer Surgery	66	53	67	66	NO
90th Percentile Wait Times for Cataract Surgery	104	100	99	100	YES
90th Percentile Wait Times for Hip Replacement	125	124	113	123	YES
90th Percentile Wait Times for Knee Replacement	137	128	122	129	YES
90th Percentile Wait Times for Diagnostic MRI Scan	93	91	136	122	NO
90th Percentile Wait Times for Diagnostic CT Scan	60	60	35	38	YES
Median Wait Time to Long-Term Care Home Placement – All Placements	89	77	108	98	NO
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	10.53%	8.80%	10.80%*	10.80%*	NO
ER LOS indicator: Proportion of Admitted patients treated within the LOS target of ≤ 8 hours	24.00%	33.00%	31.26%	27.90%	YES
ER LOS indicator: 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	73.00%	82.00%	77.01%	75.61%	NO
ER LOS indicator: Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours	71.00%	81.00%	77.01%	75.20%	NO

*ALC Indicator: Q4 %ALC days is estimated based on Q1, Q2, & Q3 2009/10 Data. Full year 2009/10 LHIN annual results are also estimated based on Q1-Q4 2009/10 Data.

Additional specific performance improvement measures:

Cancer surgery

The number of cancer surgeries and complexity of surgeries continues to increase and place a strain on available resources. The Toronto Central LHIN is working with Cancer Care Ontario to develop a report on resource efficiency for cancer surgery to provide an accurate and evidence-based assessment of the resource challenges – largely human and financial – affecting cancer surgeries.

MRI scans

TC LHIN continues to work with the Diagnostic Imaging Network to develop strategies to reduce MRI wait times. ICES is working with the Network and LHIN to study appropriateness of specific MRI tests – believed to be a significant contributing factor to wait times in the Toronto Central LHIN.

ER wait times

While the Toronto Central LHIN and health service providers made continual improvements in the three wait time targets, two of the three targets were not achieved over the entire year. The Toronto Central LHIN has a comprehensive ER and ALC wait time strategy detailed in the accomplishments section. The key success factor in the LHIN's approach to ER wait times is to bring hospitals, the Toronto Central CCAC and community agencies together to identify the 'systems' issues contributing to ER waits including improving the transitions from hospital to other levels of care and providing customized community supports for high ER users to reduce the risk of avoidable ER visits.

ALC and Long Term Care (LTC) Placement

The LHIN has a comprehensive strategy to address ALC and its contribution to ER wait times. Aging at Home initiatives are specifically designed to reduce the number of people in ALC beds through enhancing their access to care options that are not only more appropriate but often preferred by individuals and their families.

Home First is an example of a strategy that is addressing ALC and specifically alleviating LTC wait lists. A partnership between Toronto Central CCAC, hospitals and community agencies, the Home First program is resulting in ALC patients getting home safely faster and, in many cases, remaining home instead of going to long-term care. There was a sharp reduction in the number of seniors on LTC wait lists in the Toronto Central LHIN coinciding with the launch of Home First last fall. In fact, over 200 seniors were diverted from premature LTC admission over the past year because of the increase in community services offered through programs such as Home First.

Conclusion

This past year the Toronto Central LHIN, together with local community members and health care providers, advanced our mission to provide a high-performing and equitable health care system for our community. We continue to improve access to services and enhance efficiency and effectiveness by moving care delivery to the most appropriate settings.

We also continue to achieve greater integration within our health care system with a greater level of cooperation among our health care providers, long term care and community agencies, enabling a number of integration activities that are pivotal to improving the health of the people in our community.

The past year, the Toronto Central LHIN developed its second Integrated Health Services Plan (IHSP-2) through careful examination of latest evidence and data; consultation with health service providers, health professionals and experts; and extensive community input. Over the next three years, the Toronto Central LHIN will strive to build on the successes of the LHIN's first three years and focus on accelerating the process of transformation outlined in the IHSP-2.

Our Board of Directors

Name	Current Position	Appointed	End of Current Term	Length of Term
Coyles, Stephanie	Director	29 October, 2008	28 October, 2011	3 years
Dhanani, Mohamed	Former Chair	7 March, 2007	May 31, 2009 (stepped down)	2 years 2 months
Everett, Barbara	Director	17 May, 2006 16 June, 2007	16 June, 2007 15 June, 2010	13 months 3 years
Ewart, Bonnie	Former Acting Vice-Chair	17 May, 2006 16 June, 2007	16 June, 2007 8 March, 2010 (stepped down)	13 months 2 years, 9 months
Kennedy, Tom	Director	27 June, 2007 27 June, 2008	26 June, 2008 26 June, 2011	1 year 3 years
Komori, Lloyd	Director	21 August, 2008	20 August, 2011	3 years
Magill, Dennis	Acting Chair	7 March, 2007 7 March, 2010	6 March, 2010 6 March, 2013	3 years 3 years
Nott, Harley	Director	2 June, 2005 2 June, 2008	1 June, 2008 1 June, 2011	3 years 3 years
Virmani Kumar, Anju	Director	14 May, 2008	18 May, 2011	3 years

Stephanie Coyles
Director

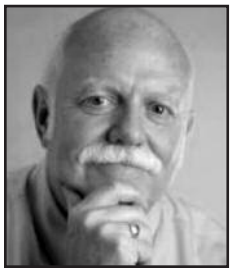
Mohamed Dhanani
Former Chair

Barbara Everett
Director

Bonnie Ewart
Former Acting Vice-Chair

Tom Kennedy
Director

Lloyd Komori
Director



Dennis Magill
Acting Chair

Harley Nott
Director

Anju Virmani Kumar
Director

Deloitte & Touche LLP
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Toronto ON M2N 6L7
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Auditors' Report

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

We have audited the statement of financial position of the Toronto Central 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 Toronto Central Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and in 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

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**2,117,680**	1,857,932
Due from Local Health Integration Networks ("LHINs") (Note 3)	**33,172**	272,897
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**2,333,699**	10,855,983
	4,484,551	12,986,812
Liabilities		
Accounts payable and accrued liabilities	**2,089,583**	2,132,555
Due to HSPs	**2,333,699**	10,855,983
Due to MOHLTC (Note 4b)	**46,070**	550
Deferred revenue	**66,700**	25,950
Deferred capital contributions (Note 5)	**783,608**	985,319
	5,319,660	14,000,357
Net debt	**835,109**	1,013,545
Non-financial assets		
Prepaid expenses	**51,501**	28,226
Capital assets (Note 6)	**783,608**	985,319
	835,109	1,013,545
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Toronto Central Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

	Budget (unaudited) (Note 7)	2010 Actual	2009 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding	**5,827,821**	**5,732,821**	5,590,235
MOHLTC Funding to LHIN Collabarative (LHINC) (Note 16)	**670,000**	**670,000**	-
Health Service Provider ("HSP") transfer payments (Note 8)	**4,118,133,600**	**4,200,566,501**	4,043,555,722
E-Health (Note 9)	**-**	**600,000**	425,000
Emergency Department ("ED") Leads (Note 10)	**-**	**75,000**	75,000
Diabetes Strategy (Note 11)	**-**	**95,000**	561,500
Aboriginal Health Transition Planning (Note 12)	**-**	**63,500**	26,625
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**-**	**100,000**	33,300
Amortization of deferred capital contributions (Note 5)	**-**	**781,191**	726,832
Amounts recovered/recoverable from the LHINs for LHINC (Note 16)	**650,000**	**159,714**	-
Amounts recovered/recoverable from the LHINs for LSSO	**4,457,601**	**4,161,756**	3,835,585
	4,129,739,022	**4,213,005,483**	4,054,829,799
Expenses			
Transfer payments to HSPs (Note 8)	**4,118,133,600**	**4,200,566,501**	4,043,555,722
General and administrative (Note 14)	**5,827,821**	**6,102,387**	5,960,266
LHIN Shared Services Office expense (Note 15)	**4,457,601**	**4,572,366**	4,191,836
LHIN Collaborative (Note 16)	**1,320,000**	**829,714**	-
E-Health (Note 9)	**-**	**600,000**	425,000
Emergency Department ("ED") Leads (Note 10)	**-**	**75,000**	75,000
Diabetes Strategy and Diabetes Registry (Note 11)	**-**	**95,000**	561,500
Aboriginal Health Transition Planning (Note 12)	**-**	**63,500**	26,625
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**-**	**100,000**	33,300
	4,129,739,022	**4,213,004,468**	4,054,829,249
Annual surplus before funding repayable to the MOHLTC	**-**	**1,015**	550
Funding repayable to the MOHLTC (Note 4a)	**-**	**(1,015)**	(550)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**	**-**	-
Closing accumulated surplus	**-**	**-**	-

Toronto Central Local Health Integration Network

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

	Budget unaudited (Note 7)	**2010**	2009
		$	$
Annual surplus	-	**-**	-
Acquisition of capital assets	-	**(579,480)**	(478,474)
Amortization of capital assets	-	**781,191**	726,832
Change in other non-financial assets	-	**(23,275)**	(26,173)
(Decrease) increase in net debt	-	**178,436**	222,185
Opening net debt	-	**(1,013,545)**	(1,235,730)
Closing net debt	-	**(835,109)**	(1,013,545)

Toronto Central 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	781,191	726,832
Amortization of deferred capital contributions (Note 5)	(781,191)	(726,832)
	-	-
Changes in non-cash operating items		
Decrease (increase) in due from LHINs	239,725	(204,248)
Decrease (increase) in due from MOHLTC regarding HSP transfer payments	8,522,284	(4,814,106)
Decrease in accounts payable and accrued liabilities	(42,972)	(720,691)
Decrease in due from MOHLTC	-	355,037
(Decrease) increase in due to HSPs	(8,522,284)	4,814,106
Increase in due to the MOHLTC	45,520	550
Increase in deferred revenue	40,750	25,950
Increase in prepaid expenses	(23,275)	(26,173)
	259,748	(569,575)
Capital transactions		
Acquisition of capital assets	(579,480)	(478,474)
Financing transactions		
Increase in deferred capital contributions (Note 5)	579,480	478,474
Net change in cash	259,748	(569,575)
Cash, beginning of year	1,857,932	2,427,507
Cash, end of year	2,117,680	1,857,932

Toronto Central Local Health Integration Network

Notes to the financial statements
March 31, 2010

1. Description of business

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

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

The 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 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 and losses in the value of assets.

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 financial statements do not include any MOHLTC managed programs.

2. Significant accounting policies (continued)

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 initially 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 historic cost. Historic 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 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

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

Segmented financial reporting

The financial statements of the LHIN include the accounts of its LSSO and LHINC divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

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. 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. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LHINC is responsible for providing advice to all LHINs in the areas of planning integration and community engagement, allocation methodologies, accountability performance and system alignment and co-ordination. Any portion of the LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LHINC. This is all done pursuant to the LHINC Agreement the LHINC has with all the LHINs. At the direction of the MOHLTC for the period from April 1, 2009 to July 2009 all operating costs of LHINC were paid for by the Mississauga Halton LHIN. LHINC became a division of TC LHIN effective July 2009. Mississauga Halton LHIN was reimbursed for costs incurred from the LHINC budget, and these costs are included in LHINC expenditures outlined in Note 16.

4. 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 the current activities is made up of the following components:

	Revenue	**Expenses**	**2010 Surplus**	2009
	$	**$**	**$**	
Transfer payments to HSPs	**4,200,566,501**	**4,200,566,501**	**-**	-
LHIN operations	**5,732,821**	**5,731,806**	**1,015**	550
E-Health	**600,000**	**600,000**	**-**	-
ED Leads	**75,000**	**75,000**	**-**	-
Diabetes Strategy	**95,000**	**95,000**	**-**	
Aboriginal Health Transition Planning	**63,500**	**63,500**	**-**	-
ER/ALC	**100,000**	**100,000**	**-**	-
	4,207,232,822	**4,207,231,807**	**1,015**	550

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

	2010	2009
	$	$
Due to MOHLTC, beginning of year	**(550)**	355,037
MOHLTC payment	**-**	(355,037)
Funding repayable to the MOHLTC	**(44,505)**	-
Funding repayable to the MOHLTC related to current year activities (Note 4a)	**(1,015)**	(550)
Due (to)/from MOHLTC, end of year	**(46,070)**	(550)

5. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**985,319**	1,233,677
Capital contributions received during the year	**579,480**	478,474
Amortization for the year	**(781,191)**	(726,832)
Balance, end of year	**783,608**	985,319

6. Capital assets

			2010	2009
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	**251,685**	**239,117**	**12,568**	62,905
Computer equipment	**2,015,534**	**1,250,366**	**765,168**	617,297
Leasehold improvements	**1,261,883**	**1,256,011**	**5,872**	305,117
	3,529,102	**2,745,494**	**783,608**	985,319

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in 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 approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $4,200,566,501 is made up of the following:

	$
Initial HSP Funding budget	4,118,133,600
Adjustment due to announcements made during the year	83,149,001
Re-allocation between LHINS	(716,100)
Total HSP Funding budget	4,200,566,501

The total operating budget excluding HSP Funding of $ 6,761,321 is made up of the following:

	$
Initial budget	5,827,821
Additional funding received during the year for:	
E-Health	600,000
ED Leads	75,000
Diabetes Strategy	95,000
Aboriginal Health Transition Planning	63,500
Emergency Room and Alternative Level of Care (ER/ALC) Note 13	100,000
Total budget	6,761,321

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,200,566,501 (2009 - $4,043,555,722) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2010 as follows:

	2010	2009
	$	$
Operation of hospitals	**3,284,060,297**	3,172,123,582
Grants to compensate for municipal taxation - public hospitals	**736,800**	736,800
Long-term care homes	**233,431,076**	224,682,836
Community care access centres	**184,791,680**	169,033,788
Community support services	**43,192,053**	42,425,230
Assisted living services in supportive housing	**42,116,912**	37,916,102
Community health centres	**72,497,865**	66,446,702
Community mental health addictions program	**89,763,672**	86,093,371
Addictions program	**22,553,652**	21,913,442
Specialty psychiatric hospitals	**227,377,944**	222,139,319
Grants to compensate for municipal taxation - psychiatric hospitals	**44,550**	44,550
	4,200,566,501	4,043,555,722

9. E-Health

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

	2010	2009
	$	$
Salaries and benefits	**588,575**	356,470
Translation Services	**1,055**	42,200
Other	**10,370**	26,330
	600,000	425,000

10. Emergency Department ("ED") Leads

The LHIN received funding of $75,000 (2009 - $75,000) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	**15,000**	17,500
Consulting	**60,000**	57,500
	75,000	75,000

11. Diabetes Strategy and Diabetes Registry

During the year, the LHIN was provided funding of $95,000 (2009 - $561,500) from the MOHLTC for Diabetes Strategy and Diabetes Registry Program. The Diabetes program expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	**94,590**	528,088
Consulting	**-**	19,250
Other	**410**	14,162
	95,000	561,500

12. Aboriginal Health Transition Planning

During the year, the LHIN was provided funding of $63,500 (2009 - $26,625) from the MOHLTC for Diabetes and Diabetes referrals Program. The Aboriginal Planning expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	**59,285**	2,771
Consulting	**2,265**	22,915
Other	**1,950**	939
	63,500	26,625

13. Emergency Room and Alternate Level of Care (ER/ALC)

During the year, the LHIN was provided funding of $100,000 (2009 - $33,300) from the MOHLTC for the ER/ALC program. The LHIN incurred $100,000 (2009 - $33,300) ER/ALC expenses related to salaries and benefits.

14. 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	**4,430,938**	3,868,461
Occupancy	**265,333**	232,460
Amortization	**370,580**	370,580
Shared services	**362,714**	300,000
LHINC	**12,286**	-
Public affairs and communications	**44,494**	8,804
Consulting services	**72,522**	711,581
Translation services	**33,890**	-
Professional services	**39,624**	-
Supplies	**102,557**	110,237
Governance	**104,554**	153,181
Mail, courier and telecommunications	**63,586**	46,041
Other	**199,309**	158,921
	6,102,387	5,960,266

The following lists the Board Chair and Directors per diem costs as well as their travel which are included in governance expense in the general and administrative expenses above.

	2010 Budget	2010 Actual	2009
	$	$	$
Board Chair per diem cost	**54,600**	34,225	82,250
Directors per diem cost	**103,500**	66,325	63,700
Board travel	**6,900**	4,004	7,231
	165,000	104,554	153,181

15. Common LHIN services expenses

The Statement of Financial Activities presents the common LHIN services expenses as a function, the following classifies the same expenses by object:

	2010	2009
	$	$
Salaries	1,093,259	980,259
Benefits	137,687	182,275
Supplies	31,489	15,037
Telecommunications	22,000	21,201
Recruitment and staff development	60,417	14,346
Computer expense	663,941	217,109
Consulting fees	262,800	180,587
Professional services	34,904	-
Meeting expenses	2,444	4,124
Accommodation and amortization	126,469	428,759
Other	34,106	59,925
Shared services	2,465,564	2,388,214
Total common LHIN services expenses	4,935,080	4,491,836
Less inter-entity transactions eliminated on consolidation	(362,714)	(300,000)
	4,572,366	4,191,836

16. Collaborative LHIN services expenses

The Statement of Financial Activities presents the collaborative LHIN services expenses by function; the following classifies the same expenses by object:

LHINC receives $670,000 funding from MOHLTC and the balance of the revenue from all the LHINs. Costs allocation is based on the percentage proportionate on the funding received.

	LHINs	MOHLTC	Total
	$	$	$
Salaries	-	325,387	325,387
Benefits	8,543	73,851	82,394
Supplies	6,337	-	6,337
Telecommunications	4,894	30,891	35,785
Recruitment and staff development	888	47,746	48,634
Computer expense	83,692	-	83,692
Consulting fees	15,135	191,680	206,815
Meeting expenses	7,584	-	7,584
Accommodation and amortization	40,299	-	40,299
Other	4,628	445	5,073
	172,000	670,000	842,000
Less inter-entity transactions eliminated on consolidation	(12,286)	-	(12,286)
	159,714	670,000	829,714

17. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 37 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 $379,969 (2009 - $301,068) 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 as of December 31, 2009. At that time, the plan was fully funded.

18. 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.*

19. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due next year and thereafter are as follows:

	$
2011	392,000
2012	600,122
2013	614,592
2014	632,645
2015 and thereafter	976,740

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2011 and 2012.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule 1
year ended March 31, 2010

	2010	2009	2010	2009	2010	2009	2010	2009
	Toronto Central Operations		Shared Services Office		Collaborative		Total	Total
	$	$	$	$	$	$	$	$
Financial assets								
Cash	**650,198**	665,053	**1,364,852**	1,192,879	**102,630**	-	**2,117,680**	1,857,932
Due from the LHIN Shared Services Office*	**187,628**	147,296	**-**	-	**-**	-	**187,628**	147,296
Due from Local Health Integration Network ("LHIN")*		-	**33,172**	272,897		-	**33,172**	272,897
Due from the LHIN Collaborative**	**67,805**	-	**-**	-	**-**	-	**67,805**	-
Due from Ministry of Health and						-	**-**	-
Long-Term Care ("MOHLTC")	**-**	-	**-**	-	**-**	-	**-**	-
Due from MOHLTC regarding HSP transfer payments	**2,333,699**	10,855,983	**-**	-	**-**	-	**2,333,699**	10,855,983
	3,239,330	11,668,332	**1,398,024**	1,465,776	**102,630**	**-**	**4,739,984**	13,134,108
Liabilities								
Accounts payable and accrued liabilities	**796,181**	813,875	**1,258,577**	1,318,680	**34,825**	-	**2,089,583**	2,132,555
Due to TC LHIN*	**-**	-	**187,628**	147,296	**67,805**	-	**255,433**	147,296
Due to HSPs	**2,333,699**	10,855,983	**-**	-	**-**	-	**2,333,699**	10,855,983
Deferred revenue	**66,700**	-	**-**	25,950	**-**	-	**66,700**	25,950
Deferred capital contributions	**12,568**	383,149	**771,040**	602,170	**-**	-	**783,608**	985,319
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**46,070**	550	**-**	-	**-**	-	**46,070**	550
	3,255,218	12,053,557	**2,217,245**	2,094,096	**102,630**	**-**	**5,575,093**	14,147,653
Net debt	**(15,888)**	(385,225)	**(819,221)**	(628,320)	**-**	-	**(835,109)**	(1,013,545)
Non-financial assets						-	**-**	
Prepaid expenses	**3,320**	2,076	**48,181**	26,150	**-**	-	**51,501**	28,226
Capital assets	**12,568**	383,149	**771,040**	602,170	**-**	-	**783,608**	985,319
Accumulated surplus	-	-	-	-	**-**	**-**	**-**	-

* Amounts due from the LHIN Shared Services Office, due from the LHINC and due to TC LHIN is eliminated upon combination.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule I (continued)
year ended March 31, 2010

	2010 Toronto Central Operations		2009	2010 Shared Services Office		2009	2010 Collaborative		2010	2009
	Budget	Actual	Actual	Budget	Actual	Actual	Budget	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$
Revenue										
Amounts recovered/recoverable from the LHINs*	-	-	-	4,620,000	4,524,470	4,135,585	700,000	172,000	4,696,470	4,135,585
MOHLTC funding	5,827,821	5,732,821	5,590,235	-	-	-	670,000	670,000	6,402,821	5,590,235
HSP transfer payments (Note 8)	4,118,133,600	4,200,566,501	4,043,555,722	-	-	-	-	-	4,200,566,501	4,043,555,722
E-Health funding (Note 9)	600,000	600,000	425,000	-	-	-	-	-	600,000	425,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	75,000	75,000
Diabetes Strategy (Note 11)	95,000	95,000	561,500	-	-	-	-	-	95,000	561,500
Aboriginal Health Transition Planning (Note 12)	63,500	63,500	26,625	-	-	-	-	-	63,500	26,625
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	100,000	100,000	33,300	-	-	-	-	-	100,000	33,300
Amortization of deferred capital contributions (Note 5)	-	370,581	370,581	-	410,610	356,251	-	-	781,191	726,832
	4,124,894,921	4,207,603,403	4,050,637,963	4,620,000	4,935,080	4,491,836	1,370,000	842,000	4,213,380,483	4,055,129,799
Expenses										
General and administrative (Note 14)	5,827,821	6,102,387	5,960,266	-	-	-	-	-	6,102,387	5,960,266
Common LHIN Services*	-	-	-	4,620,000	4,935,080	4,491,836	1,370,000	842,000	5,777,080	4,491,836
Transfer payments to HSPs (Note 8)	4,118,133,600	4,200,566,501	4,043,555,722	-	-	-	-	-	4,200,566,501	4,043,555,722
E-Health (Note 9)	600,000	600,000	425,000	-	-	-	-	-	600,000	425,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	75,000	75,000
Diabetes Strategy and Diabetes Registry (Note 11)	95,000	95,000	561,500	-	-	-	-	-	95,000	561,500
Aboriginal Health Transition Planning (Note 12)	63,500	63,500	26,625	-	-	-	-	-	63,500	26,625
(ER/ALC) (Note 13)	100,000	100,000	33,300	-	-	-	-	-	100,000	33,300
	4,124,894,921	4,207,602,388	4,050,637,413	4,620,000	4,935,080	4,491,836	1,370,000	842,000	4,213,379,468	4,055,129,249
Annual surplus before funding surplus repayable	-	1,015	550	-	-	-	-	-	1,015	550
Funding surplus repayable to the MOHLTC (Note 4(a))	-	(1,015)	(550)	-	-	-	-	-	(1,015)	(550)
Opening accumulated surplus	-	-	-	-	-	-	-	-	-	-
Closing accumulated surplus	-	-	-	-	-	-	-	-	-	-

* These amounts have been adjusted by $362,714 related to Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs. (Note 15)
* These amounts have been adjusted by $12,286 related to Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs. (Note 16)

Local Health Integration Network
Local Shared Services Office

Schedule of financial position and financial activities - Schedule II
year ended March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**1,364,852**	1,192,879
Due from LHINs	**33,172**	272,897
	1,398,024	1,465,776
Liabilities		
Accounts payable and accrued liabilities	**1,258,577**	1,318,680
Due to TC LHIN	**187,628**	147,296
Deferred revenue	**-**	25,950
Deferred capital contribution	**771,040**	602,170
	2,217,245	2,094,096
Net debt	**(819,221)**	(628,320)
Non-financial assets		
Prepaid Expenses	**48,181**	26,150
Capital assets	**771,040**	602,170
Accumulated surplus	**-**	-

		2010	2009
	Budget (unaudited)	Actual	Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	**4,620,000**	**4,524,470**	4,135,585
Amortization of deferred capital contributions	**-**	**410,610**	356,251
	4,620,000	**4,935,080**	4,491,836
Expenses			
Common LHIN Services	**4,620,000**	**4,935,080**	4,491,836
Annual surplus	**-**	**-**	-

Local Health Integration Network
LHIN Collaborative (LHINC)

Schedule of financial position and financial activities - Schedule III
year ended March 31, 2010

	2010	2009
	$	
Financial assets		
Cash	**102,630**	-
Liabilities		
Accounts payable and accrued liabilities	**34,825**	-
Due to TC LHIN	**67,805**	-
	102,630	-
Net debt		
Accumulated surplus	**-**	**-**

		2010	2009
	Budget (unaudited)	**Actual**	Actual
	$	**$**	$
Revenue			
Amounts recovered/recoverable from the LHINs	**700,000**	**172,000**	-
MOHLIC funding	**670,000**	**670,000**	-
	1,370,000	**842,000**	-
Expenses			
Collaborative LHIN expenses	**1,370,000**	**842,000**	-
Annual surplus	**-**	**-**	-