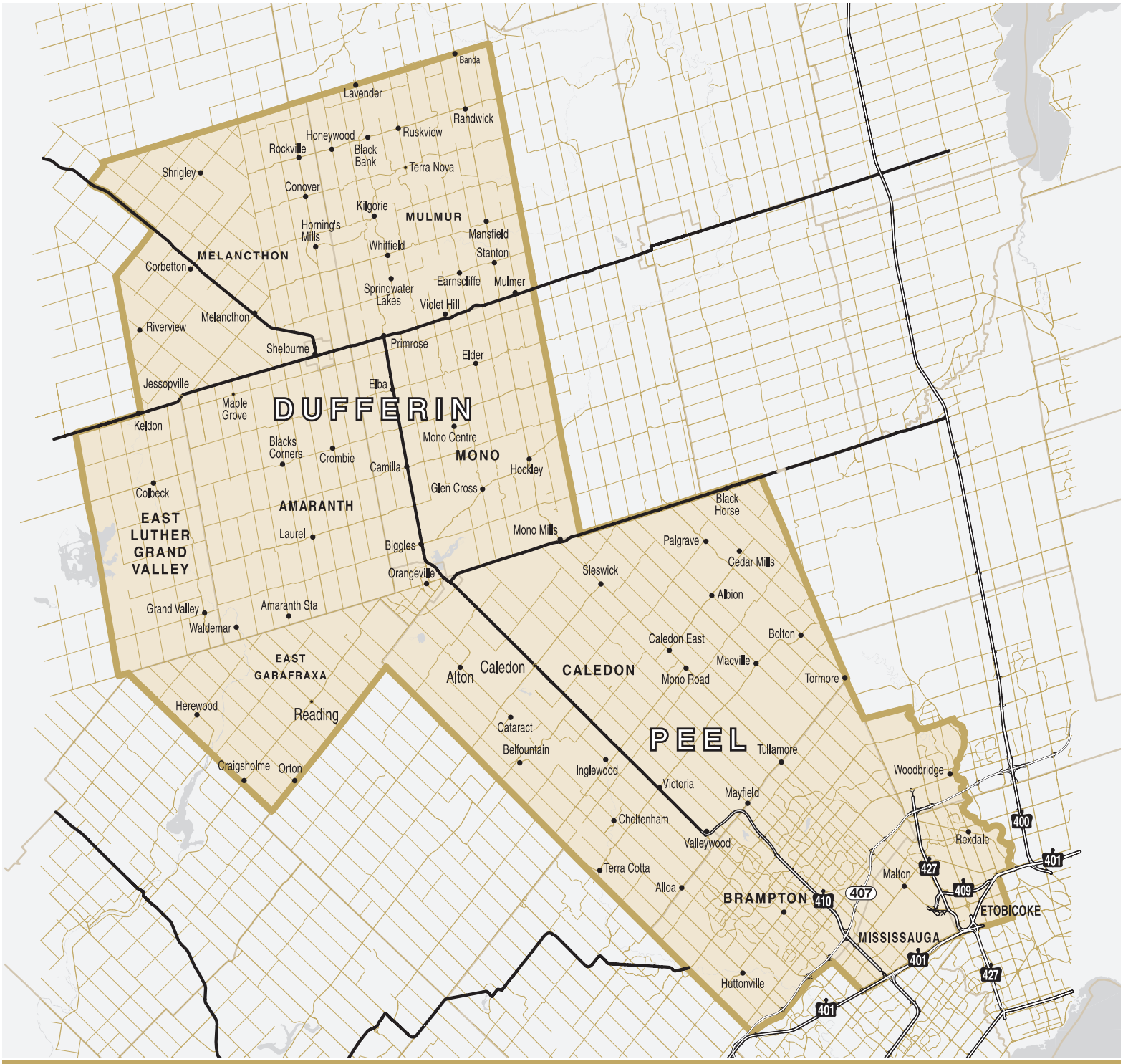
Central West
LOCAL HEALTH INTEGRATION NETWORK

MOMENTUM IS BUILDING

Creating Our Local System for Enhanced Health

Central West LHIN – 2006/2007 Annual Report

Ontario



Moving health system planning close to home

The Central West LHIN is one of 14 local health integration networks (LHINs) in Ontario founded on the principle that local health care is best planned and funded in a coordinated way locally, because local people best know their own health service needs and priorities. We were designated by the Ministry of Health & Long-Term Care, under the Local Health System Integration Act, 2006, to plan, coordinate, integrate and fund local health services, and do so for 49 health service providers including a community health centre, community care access centre, two hospitals, 10 mental health and addiction services, 13 community support services and 22 long-term care homes. The Central West LHIN presents a new and unique opportunity for communities to be a partner in defining issues, establishing priorities and developing action plans to improve local health services.

For more information about the Central West LHIN, visit www.centralwestlhin.on.ca

Making health work for you
Message from the Chair and CEO

Storytelling is a powerful tool. And we've heard many stories this past year. Very personal stories of triumph over tremendous odds, of courage in the face of death, of joy in the presence of new life, of acceptance with growing old, and of compassion for others unable to help themselves. These were your stories of experiencing health care in your community.

Nowhere does a community touch lives with greater emotion than in health care. We witnessed that firsthand as we traveled throughout the region meeting with community residents and health service providers in a bid to gain an up-close and personal perspective of our local health system. And we did.

From stories that praised the compassion of our health care professionals to those that identified barriers to accessing services, we listened, we learned, and we acted.

We took everything you told us and used it to help develop our first Integrated Health Service Plan (IHSP) for the region. This is a plan that outlines the health care services that you said should be a priority: maternal and child services, mental health and addiction services, palliative and end-of-life services, rehabilitation services and services to seniors.

In the coming months, you will be hearing more about the IHSP and how you can get involved in helping us to address these priority areas. Your feedback is always welcome, and your participation encouraged.

We share your enthusiasm and desire to strengthen our local health system, and soon we will be in an even better position to help you do that. On April 1, 2007, as one of 14 local health integration networks in the province, we will assume responsibility for planning, integrating and funding local health services.

Our thanks to the members of the Board, the Central West LHIN staff, and to the many individuals throughout our communities who contributed so passionately to our work over the past year.

We look forward to our continued collaboration with you in the year ahead as we work to address our priorities. Let's all embrace the passion we share for improved health, and put it to good work in our communities.

Joe McReynolds,
Board Chair, Central West LHIN

Mimi Lowi-Young,
CEO, Central West LHIN

Members of the Board

Joe McReynolds, Chair
09-June-2005 to 08-June-2008

While the LHIN has certain authorities under legislation, our intent is to work in a collaborative way and encourage similar collaboration amongst providers in Central West.

Terry Miller, Vice Chair
09-June-2005 to 08-June-2008

My goal is to make the health system easier to use for citizens. Our role in integrating services makes the LHIN the instrument of change in local health delivery.

Kuldip Kandola, Secretary
09-June-2005 to 08-June-2008

Leadership is about listening and being responsive to the public and provider community, and together, endeavouring to take our health care to the next level in every perceivable aspect.

Anita Gittens, Member
17-May-2006 to 16-May-2008

Most important is to honour our core values of person centeredness, transparency, integrity and stewardship and our guiding principles whilst working towards achieving our vision.

Sukhjinder Mintoo Mand, Member
05-January-2006 to 04-January-2008

Leadership within the context of a group, such as the LHIN, must focus on community needs and the improvement of health for the patients in every part of the province.

Zygmond Novak, Member
17-May-2006 to 16-June-2010

The level of energy and zeal shown by both the Board and LHIN staff guarantees that the new concept for health care will succeed.

Carol Seglins, Member
17-May-2006 to 04-April-2007

Working with the LHIN is the best opportunity for health care providers and the community to achieve the cooperation and coordination needed to deliver health care when and where it is needed.

Mavis Wilson, Member
05-January-2006 to 04-February-2010

Change requires courage. With cooperation and respect for our roles, together, we have the potential to change health care in our community for the better.

Change begins with strong leadership

It takes tremendous commitment to achieve the transformational change that will be needed to move our health system from its current state to one that truly reflects and responds to this region's health needs.

The Central West LHIN's Board of Directors embodies just that. Appointed by the Government of Ontario, each of our board members contributes an exemplary level of expertise in health care, public administration, management, accounting, finance, law, human resources, labour relations, communications or information management. All live or work in communities within the Central West LHIN bringing added depth to boardroom discussions and decision-making.

In our first full year as a board, we have invested considerable time in learning to work together as a team. We have worked hard to enhance our knowledge of best practice in health care governance and of the current structure of the local health system. The Ministry of Health and Long-Term Care has been very supportive in this regard, conducting governance training with LHIN boards across the province and sharing its knowledge of the health care sector.

We established an Audit Committee to assist the Board to oversee the integrity of the LHIN's financial position. A Governance Committee advises the Board on matters relating to board governance processes, evaluation of board effectiveness, as well as the community nomination process.

Relationships key to success

Building relationships is a key theme to describe the board activities we undertook over the past year. We used every opportunity to meet with and listen to local residents, community leaders and health care providers from across the LHIN.

Your voices lend tremendous credibility to the work the LHIN is undertaking. You told us what is working, what isn't, and what is missing. Our ability as a board to make informed decisions that will improve our local health system is fueled by your personal experiences as users and providers of the system.

We respect the governance of local boards and expect and encourage them to continue to lend their voices to shaping the health system. With that in mind, we started our work together as a collective by bringing together board members and senior executives from all 49 health service providers within the LHIN.

This initial introduction marked the first steps towards agreeing upon a common vision, values, and plan for our health system. Delivering local health care services that are easily understood and accessible will only be possible if we maintain an ongoing dialogue with those who develop the visions and strategic plans for their respective organizations.

Historically, health service providers have maintained a close relationship with the Ministry of Health & Long-Term Care, and with Ministry staff in regional offices. With LHINs assuming full responsibility for planning, coordinating, integrating and funding local health services on April 1, 2007, that relationship is changing. Recognizing the significant change this represents for health service providers, many of our meetings have focused on helping them to better understand the role of the LHIN, and to explore how we can best work together to bring about needed change in the local health system.

The development of our first Integrated Health Service Plan (IHSP) will guide the activities of the Central West LHIN Board, CEO and staff over the next three years. It sets out the priorities we will focus on. It is our roadmap for health system change.

A commitment to accountability and transparency

Our role as a Board is to monitor the progress being made on those priorities and to make sure we're meeting our responsibilities as a LHIN as required by The Local Health System Integration Act 2006.

These responsibilities are outlined in the Memorandum of Understanding (MOU) between the Central West LHIN and the Ministry of Health & Long-Term Care. The MOU sets clear requirements for the LHIN in key areas such as the Appointment of Board Members, Governance and Administration, and Communications. The Board reviewed and approved the MOU in March 2007.

All Board members of the Central West LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy.*

Strict conflict of interest rules ensure that LHIN Board members are meeting public expectations for transparency, accountability and professionalism.

As the Central West LHIN assumes its expanded role in the coming year, we will work closely with LHIN staff and health service providers to solidify accountability agreements with hospitals and make crucial decisions regarding service planning, integration and funding.

Committed to transparency and accountability, the Board welcomes members of the community to its monthly board meetings where you can learn firsthand about our work. Guidelines were established to enable delegations the opportunity to make presentations to the Board.

> ***"The ability to join together and formulate ideas as a group with a common goal will only help to further our integration activities within the LHIN"***
>
> Karen Murphy, Board Chair,
> ***CMHA – Peel Branch***

* as per written statement to Central West LHIN from Hon. Sydney L. Robins, QCC, Conflict of Interest Commissioner

Who we serve

Our Communities' Profile

The Central West LHIN is comprised of Dufferin County, northern Peel Region, southwest York Region, and north Etobicoke. It includes densely populated areas like Rexdale (Toronto), Malton (Mississauga), Brampton, Orangeville and Woodbridge. Less populated areas include Dufferin County and Caledon. These communities are home to over 772,973 people, representing 6.09% of Ontario's population.

The people who live in our region are relatively young with a median age of 34.78 years. While the proportion of the population over the age of 65 is smaller than the Ontario average, the population of seniors in the region is expected to grow by 54.73% (or over 37,711 people) from 2006 to 2016, eventually making it the highest amongst the 14 LHINs.

Both the unemployment and low income rates in our region are lower than provincial rates. While almost 44% of adults (age 20+) have completed post secondary education, nearly 30% haven't finished high school.

Enriched by its cultural diversity, the Central West LHIN is home to the highest proportion of visible minorities in Ontario who represent about 40 percent of its population.

More than half the entire population of the Central West LHIN lives in the City of Brampton which has 433,806 residents. According to Statistics Canada (2006 Census Data), Brampton's growth rate (33.3%) was more than four times the national average for a city over 100,000 people. Caledon (12.7%), Shelburne (22.2%) and Woodbridge (31.2%) have also witnessed rapid growth in the past six years.

Our Communities' Health Profile

Based on studies, population health profiles and health service utilization data, residents living in the Central West LHIN appear to be doing their part to stay healthy by practicing behaviours that support a healthy lifestyle.

The self-reported levels of daily smoking, heavy drinking, life stress, and consumption of fruits and vegetables are similar to the Ontario averages. Fifty-five percent of people living in the Central West LHIN rate their overall health as 'Excellent' or 'Very Good', which is close to the provincial average of 57.2%.

Our LHIN has the highest birth rate in Ontario, welcoming over 10,000 new lives into the region each year. This represents 7.8% of all births in Ontario. We also have 9.1% of all the low birth weight babies.

Relative to the province, the Central West LHIN has a lower prevalence of arthritis, rheumatism and heart disease, lower hospitalization rates and the lowest mammography and flu shot rates.

However, provincial comparisons also indicate that a higher proportion of the population is physically inactive. Based on body mass index, 35% of the adult population is considered overweight and 16.8% are obese.

This health profile was instrumental in the development of our three-year Integrated Health Service Plan (IHSP).

Setting a course for change

better coordinated and linked services

adequate level of the right kinds of services and supports

timelier, easier access to high quality, client-centred services

What brings focus to our work every day is a compelling vision – one that should resonate with every community resident and health service provider within the Central West LHIN.

We will work to create "a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren."

We know that local health care is best planned and funded in a coordinated way within our communities, because you are the ones who best know your own health service needs and priorities.

Our mandate is to improve access to, and the quality of, those health services through better integration and coordination of services within the Central West LHIN. This represents a major shift in the way health care has been planned in the past.

The most important aspect of what we do involves working with community residents and health service providers to make sure that our health care plans for people living in the Central West LHIN make the best use of available resources and reflect the needs of the communities.

Inviting community participation

Over the past year, you told us what you believe is working well in the health system, what could be improved, and what should be added to address perceived gaps. From health care professionals to community leaders, from young mothers to retired seniors, every perspective lends some valued insight into our current health system.

We held over 50 introductory discussions and 'meet and greet' sessions, hosted 19 public consultation events, conducted a poll of 602 households, surveyed 75 health service provider organizations and met with numerous community leaders.

What you told us is that we need to improve access to services, provide a better flow of information across service providers, make the transition for patients from one health care provider to another an effortless experience, recruit more health care professionals, increase levels of community-based and hospital services, encourage more collaboration between health service organizations, and provide more specialized regional services.

Developing our first integrated health service plan

Your personal experiences with our local health system helped inform the development of our initial Integrated Health Service Plan (IHSP).

Aligned with the Ministry of Health & Long-Term Care's strategic directions and priorities, this comprehensive document communicates key local health service issues, highlights our strategic directions, and identifies action plans to improve access to health services through the coordination and integration of health services.

This was a major milestone for us in our first year of operation, as it sets the course for health system change over the next three years and lays the foundation for future health planning and integration in the region.

Our strategies for change focus on enhanced integration (better coordinated and better linked services), increased capacity (an adequate level of the right kinds of services and supports), and improved access (timelier, easier access to high quality, client-centred services).

We are using these strategies to help inform our activities as we address each of the following priorities that are outlined in the IHSP.

Maternal/Child Services

Our meetings with key stakeholders told us that we can do a better job at coordinating maternal/child services across the region. While pre-natal education services drew accolades, difficulties that were highlighted included accessing post-natal education, doctors and long waiting lists for some services.

We were successful this year in bringing together health service providers, public health workers, and others who provide services to this population to lay the groundwork for identifying local issues and begin to discuss opportunities to improve access to local services. A second planning forum is scheduled in late 2007 to help determine our next steps in planning for more integrated local maternal/child services.

Mental Health & Addiction Services

Since introducing our IHSP in the fall of 2006, we have been working with local health service providers that specialize in mental health and addiction services and our local consumer survivor network. This team will form the core action group that will ensure we are appropriately engaging our stakeholders as we identify integration opportunities. We have begun the process of developing a local integrated mental health and addiction services plan built on a single 'coordinated system of access and case management' encompassing the principle of 'no wrong door'.

Palliative/End-of-Life Services

Central West LHIN staff is currently examining the interest and feasibility of developing a Palliative Care Network based on the geographical boundaries of the Central West LHIN.

This network would bring together local stakeholders to develop a local palliative care services integration plan that would include a comprehensive directory of existing services, common language, common definitions and common assessment and care plan tools.

Rehabilitation Services

This past year, our initial study, Understanding the Needs for Rehabilitation in the Central West LHIN, identified a need to build a continuum of rehabilitation programs and services and formalize the roles of all sectors that deliver rehabilitation services.

Our next step is to bring together a panel of local health service providers and external experts to develop more coordinated hospital and community-based physical rehabilitation services.

Services for Seniors

We successfully brought together community-based health services, Central West CCAC, long-term care home and hospital representatives to dialogue about the services that exist for seniors within the LHIN, and to begin to identify integration opportunities.

This work is laying the foundation for how we can best integrate existing services to better focus on the needs of seniors, adopting an 'Aging in Place' philosophy.

Diversity

Earlier this year we examined how we might better engage the rich diversity of the residents in the region and the tremendous opportunities we have to develop and deliver culturally competent health care services.

Many barriers separate individuals from access to quality care including challenges with completing forms, language and interpretation, and the cultural appropriateness of referrals and services.

We seek to strengthen our relationships with ethno-cultural and faith organizations, and subsequently transfer the knowledge we gain to health service providers and extend culturally sensitive services to all members of our community.

Chronic Disease Prevention & Management

In early 2007, the Central West LHIN held sessions with family health teams, physicians and health service leaders from across the LHIN to introduce best practices in chronic disease prevention and management. They focused on improving the prevention and management of chronic diseases at the community, organization, practice and patient levels. We know that having physicians champion quality improvement efforts in chronic disease prevention and management will be critical to success in improving the lives of those living with chronic diseases like heart disease, diabetes and arthritis, and significantly reducing future pressures on the local health system.

Primary Care Linkages

Physicians represent the first point of contact with the health system for most community residents. If we are to realize the successful integration of services across the LHIN, the involvement of physicians is crucial.

Although we do not fund them, we are supporting the development of Family Health Teams in our LHIN, acting as a conduit to help them connect with other health service providers throughout the region. We liaise regularly with the Central West Mississauga Halton Community Family Medicine/Public Health Network connecting us with physicians from five hospitals and with family doctors in the community whose purpose is to coordinate patient care in the hospital and in the community.

We connected with physician leaders in the community seeking their feedback in the development of our IHSP.

We continue to meet with developing Family Health Teams and will work closely with physicians to support their information needs with regards to managing patients with chronic diseases.

Critical Care Strategy

Dr. Michael Miletin, our Critical Care Lead on the Ontario Critical Care Expert Advisory Panel, continues to champion enhancement of critical care services within the Central West LHIN.

This year, we welcomed the addition of two critical care beds at William Osler Health Centre's Peel Memorial Hospital and will increase critical care bed capacity in the region with the opening of the new Brampton Civic Hospital in the fall of 2007.

Using an Ontario-wide intensive care unit database, William Osler Health Centre is now able to benchmark itself against other hospital ICUs. Headwaters Health Care Centre and William Osler Health Centre's Etobicoke General Hospital have also both been selected to participate in focus groups regarding future training initiatives for providers of critical care services.

e-Health Strategy

The Central West LHIN and the Mississauga Halton LHIN joined forces in August 2006 to collaborate on a joint e-Health Strategy. It is a first step in building support for an electronic health record, so that you can enter the system at any point and be confident that your health care providers will have timely access to your most up-to-date medical information.

Our goal is to make sure you have the information you need to make decisions about your health and health care, that providers are able to focus on timely and high quality care, and that the LHINs, together with their respective member organizations can deliver an accountable, equitable, effective and efficient health system.

Next steps include moving forward with implementing a governance structure, developing a funding strategy and developing an action plan for activities in the first year.

French Language Services

Brampton is designated under the French Language Services Act and it is important that local planning address the needs of the estimated 9,400 Francophones who reside in the Central West LHIN.

The Central West LHIN participated and provided leadership in a consultation session with the GTA francophone community about the availability and accessibility of French language health services. The Central West LHIN will continue to work in cooperation with the LHINs of the GTA to determine the action required to address the issues and priorities involved in providing health services to the francophone community.

Aboriginal Health

We have been working closely with provincial, GTA and local groups to identify members of the Aboriginal community to make sure their voices are heard in the development of health care services within the Central West LHIN. We have about 2,900 Aboriginals living in our communities, and we will build upon our initial efforts to support their needs locally.

Developing the LHIN team

When we embarked upon the foundational year for the Central West LHIN, we started with a small team that included the CEO, two senior directors, an executive assistant and an office manager.

Setting up our permanent office location at 8 Nelson Street West in Brampton, launching our community engagement process, and realizing development of our first Integrated Health Service Plan (IHSP), was accomplished by a small, but dedicated LHIN team.

As the year progressed, we successfully recruited a group of seasoned professionals and bright young talent who lend a welcome breadth of expertise to our health care planning initiatives.

Transferring knowledge

One of the most significant exchanges that has taken place over the past year is the transfer of knowledge from the Ministry of Health and Long-Term Care to the Central West LHIN.

Through 'transfer of knowledge' sessions, we learned more about the function of the various programs and services within the Ministry and discussed the funding and phasing-in of LHINs on April 1. These sessions have proven instrumental in preparing staff for our expanded responsibilities working with health service providers across the region.

Facilitating service agreements

Among the tasks the Central West LHIN will be charged with when it assumes its expanding role on April 1, is coordinating service agreements with each of our 49 health service providers over the next three years.

These service agreements include performance goals and objectives for the LHINs, performance standards, targets and measures, and a plan for allocating the money the LHINs receive.

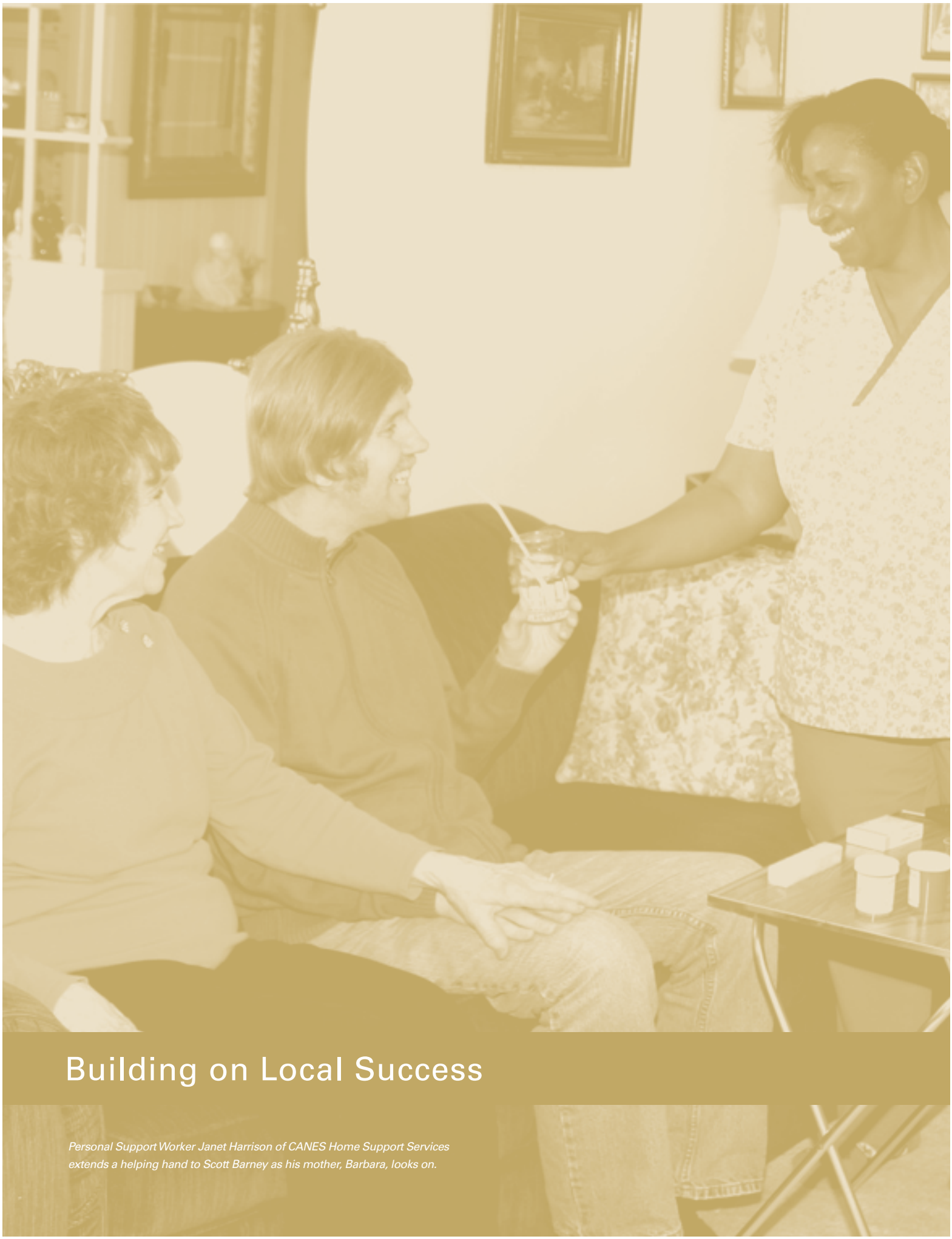
We will be encouraging health service providers throughout the region to look at health services from a broader systems perspective when they're doing their planning, so services to individuals is integrated within the system.

In preparation for that work, Central West LHIN senior staff has been meeting with each of the health service providers to help smooth the transition once the LHIN takes responsibility for developing these agreements in collaboration with providers.

Meeting our performance targets

One of the ways we have been successful in improving access to health services is by reducing the time you have to wait for them. As part of Ontario's Wait Time Strategy, we report regularly on the wait times for cancer surgery, total hip and knee joint replacements, cataract surgery and MRI and CT Scan services.

This past year, wait times within the Central West LHIN showed improvement across most areas and we continue to work together with local health service providers to improve our performance.



Building on Local Success

Personal Support Worker Janet Harrison of CANES Home Support Services extends a helping hand to Scott Barney as his mother, Barbara, looks on.

As the Central West LHIN prepares to plan, integrate and fund local health services, we can't help but be inspired by the integrated service approach that some health service providers have already embraced.

Here we highlight two such initiatives, both of which promise to improve resident access to local emergency services. These projects received a welcome financial boost from the Central West LHIN this past year when we announced a $614,170 investment in the Home at Last and Advanced Directives initiatives.

Building on local successes like these, we will continue to encourage health service providers to be innovative when planning services and proactive in identifying opportunities to work together. Collaboration will be the hallmark of our local health system.

Home at Last

When Barbara Barney's middle-aged son, Scott, was ready to be discharged from Etobicoke General Hospital, the 78-year old didn't know how she was going to get him home. She didn't drive. And would she be able to help him get comfortable at home without assistance?

Like Barbara, senior caregivers for spouses or other family members often fall between the cracks when support is needed to help a family member in the transition from hospital to home.

This is a challenge faced by patients and families in our health system every day. We see many patients, particularly frail seniors, who would prefer to return home following completion of their medical care, but often remain in hospital because adequate support isn't immediately available to support their transition home.

It's those experiences that were the inspiration behind the new Home at Last program, a joint initiative among William Osler Health Centre, CANES Home Support Services, Etobicoke Services for Seniors, Caledon Community Services and CANES Family Health Team.

Home at Last helps frail seniors who no longer require hospital care to get home sooner. Assistance is provided with transportation from hospital to home, meal preparation, medication reminders and other services until the family caregiver is able to take over.

"This project is a wonderful example of how hospitals and community-based services can work together to improve the patient and family experience in our health system," says Gord Gunning, Executive Director, CANES Home Support Services, the lead agency for the project.

"It models a system where the patient moves from one service to another in an effortless way."

For Mrs. Barney, the program couldn't have come at a better time. While Scott is not a frail senior, his mother is his primary caregiver, and discharge planners immediately recognized an opportunity to use the Home at Last program to provide the support Mrs. Barney and her son needed.

"This is a program that really makes a difference," says Mrs. Barney. "I don't know how I would have managed were it not for the friendly support of the caregivers who brought Scott home, helped get him comfortable and supported me with getting him to the table for lunch."

Mrs. Barney and her son have benefited from the program twice now, and welcome the assistance of health care professionals, like Janet Harrison, a personal support worker, who relieve some of the worry that comes with the transition from hospital to home. "As a health care provider, it's been rewarding to see what an impact a program like

this is having on individuals' lives," says Janet, who has supported many patients and families through the Home at Last project.

While directly benefiting patients and their family caregivers, the program is also having a direct impact on access to emergency services at the hospital.

"Not only are patients being discharged getting the support they need in the transition from hospital to home, but their more timely discharges means that patients entering the hospital through the Emergency Department are now receiving faster access to inpatient care," says Ruth Beck, Vice President, Patient Services and Site Executive, Etobicoke General Hospital.

"There's nothing more rewarding than seeing that 'home at last' expression on clients' faces when they're back in familiar surroundings," says Janet Harrison. "I'm glad we're here to help make that possible."

Advanced Directives

The Advanced Directives project is about making sure that residents in long-term care homes and complex continuing care facilities are given the option of expressing their end-of-life wishes, and that health care providers and family members are well apprised of what those wishes are.

"Working together with our health care partners, we have an exceptional opportunity to prevent unnecessary hospital admissions," notes Kim Cook, Vice President and Chief Nursing Executive, Headwaters Health Care Centre. "Developing a common Advanced Directives tool that is recognized across the continuum of care within the Central West LHIN will enhance communication and coordination of patient care amongst health care providers to ensure that end-of-life wishes of patients are being met."

The project involves the development of a standardized tool that will help guide the discussion about 'end-of-life' care with both the patient and family in long-term care and complex continuing care settings, and will also include a decision tool that will aid in deciding whether and when to transfer a patient to hospital.

"It is very challenging for residents and their families to deal with health care decisions that relate to life and death," says Josée Coutu, Director, Halton Peel Palliative Care Network, and one of the community-based partners involved with the project. "Advanced care planning as a process allows individuals and their families to think about their choices, identify unanswered questions and needs, and then express their choices about their future care."

William Osler Health Centre's Brampton Civic Hospital will open in October 2007 with 479 beds providing the community with advanced medical equipment and a comprehensive range of health services. It will expand to 608 beds by 2011/2012.

Deloitte.

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Auditors' Report

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

We have audited the statement of financial position of Central West Local Health Integration Network (the "LHIN") as at March 31, 2007 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 Central West Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
May 2, 2007

Member of
Deloitte Touche Tohmatsu

Statement of Financial Position
March 31, 2007

	2007	2006 (Notes 3, 14)
FINANCIAL ASSETS		
Cash	**$ 361,090**	$ 26,827
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	**302,335**	-
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**39,330**	26,827
Due to the LHIN Shared Services Office (Note 5)	**53,337**	-
Deferred capital contributions (Note 6)	**441,447**	547,592
	836,449	574,419
NET DEBT	**(475,359)**	(547,592)
NON-FINANCIAL ASSETS		
Prepaid expenses	**33,912**	-
Capital assets (Note 7)	**441,447**	547,592
	475,359	547,592
ACCUMULATED SURPLUS	**$ -**	$ -

Approved by the Board

Joe McReynolds, ***Board Chair***

Kuldip Kandola, ***Board Secretary***

Statement of Financial Activities
Year ended March 31, 2007

	2007		2006
	Budget	Actual	Actual
	(unaudited) (Note 8)		(Notes 3, 14)
REVENUE			
MOHLTC funding	**$ 2,959,867**	**$ 2,951,336**	$ 341,286
E-Health funding	**181,000**	**181,000**	-
Amortization of deferred capital contributions (Note 6)	**-**	**141,796**	136,898
	3,140,867	**3,274,132**	478,184
EXPENSES			
General and administrative (Note 9)	**$ 2,959,867**	**$ 3,124,131**	$ 451,357
E-Health (Note 10)	**181,000**	**110,671**	-
	3,140,867	**3,234,802**	451,357
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	**-**	**39,330**	26,827
FUNDING REPAYABLE TO THE MOHLTC (related to the E-Health Project - Note 10)	**-**	**(39,330)**	(26,827)
ANNUAL SURPLUS	**-**	**-**	-
OPENING ACCUMULATED SURPLUS	**-**	**-**	-
CLOSING ACCUMULATED SURPLUS	**$ -**	**$ -**	$ -

Statement of Changes in Net Debt
Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
ANNUAL SURPLUS	**$ -**	$ -
ACQUISITION OF TANGIBLE CAPITAL ASSETS	**(35,651)**	(684,490)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	**141,796**	136,898
CHANGE IN OTHER NON-FINANCIAL ASSETS	**(33,912)**	-
DECREASE (INCREASE) IN NET DEBT	**72,233**	(547,592)
OPENING NET DEBT	**(547,592)**	-
CLOSING NET DEBT	**$ (475,359)**	$ (547,592)

Statement of Cash Flows
Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Annual surplus	**$ -**	$ -
Add (deduct) items not affecting cash		
Amortization of deferred capital contributions (Note 6)	**(141,796)**	(136,898)
Amortization of capital assets	**141,796**	136,898
	-	-
USES		
Increase in prepaid expenditures	**33,912**	-
SOURCES		
Increase in accounts payable	**302,335**	-
Increase in due to MOHLTC	**12,503**	26,827
Increase in due to LHIN Shared Services Office	**53,337**	-
	368,175	26,827
NET CASH GENERATED FROM OPERATIONS	**334,263**	26,827
CAPITAL TRANSACTIONS		
Acquisition of tangible capital assets	**(35,651)**	(684,490)
FINANCING TRANSACTIONS		
Increase in deferred capital contributions (Note 6)	**35,651**	684,490
NET INCREASE IN CASH	**334,263**	26,827
CASH, BEGINNING OF YEAR	**26,827**	-
CASH, END OF YEAR	**$ 361,090**	$ 26,827

1. DESCRIPTION OF BUSINESS

Formation and status

The Central West Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act*, 2006 (the "Act") as the Central West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an annual Accountability Agreement for the 2006/07 fiscal year with the Ministry of Health and Long-Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN operations

The objects 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 Central West LHIN covers Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto.

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.

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

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.

Deferred contributions

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.

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized over the useful life of the asset reflective of the provision of its services. This amortization revenue is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible 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 tangible 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 tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

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

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

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

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Use of estimates

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

3. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $547,592 on the Statement of Financial Position. On the Statement of Financial Activities amortization of deferred capital contributions increased by $136,898 as did general and administrative expenses. On the Statement of Changes in Net Debt acquisition of tangible capital assets increased by $684,490 amortization of tangible capital assets increased by $136,898 and closing net debt increased by $547,592.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities in its records on behalf of the LHIN as at March 31, 2006.

5. 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, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs not paid by the LHIN at the year end are recorded as a payable to the LSSO. This is all done pursuant to the Shared Services Agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$ 547,592**	$ -
Capital contributions received during the year	**35,651**	684,490
Amortization for the year	**(141,796)**	(136,898)
	$ 441,447	$ 547,592

7. CAPITAL ASSETS

	2007			2006
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Office furniture and fixtures	**$ 211,397**	**$ 81,160**	**$ 130,237**	$ 155,524
Computer equipment	**4,500**	**1,500**	**3,000**	-
Web development	**14,159**	**-**	**14,159**	-
Leasehold improvements	**490,085**	**196,034**	**294,051**	392,068
	$ 720,141	**$ 278,694**	**$ 441,447**	$ 547,592

8. BUDGET FIGURES

The total operating budget of $2,959,867 has been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

9. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC.

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transition, certain amounts related to prior period expenses were not accrued. For the year ended March 31, 2007, these amounts were included in the Statement of Financial Activities of the LHIN.

9. GENERAL AND ADMINISTRATIVE EXPENSES (continued)

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2007	2006
Salaries and benefits	**$ 1,181,850**	$ 312,231
Occupancy	**158,596**	389
Amortization	**141,796**	136,898
Shared services	**290,201**	-
Public relations	**134,329**	-
Consulting services	**745,690**	-
Supplies	**45,957**	1,762
Board member remuneration	**157,563**	-
Board member expenses	**63,297**	-
Mail, courier and telecommunications	**38,090**	11
Other	**166,762**	66
	$ 3,124,131	$ 451,357

10. E-HEALTH EXPENSES

The Statement of Financial Activities presents the expenses by project, the following classifies these same expenses by object:

	2007	2006
Consulting	**$ 93,881**	$ -
Salaries	**15,575**	-
Board member expenses	**1,011**	-
Meeting expenses	**204**	-
	$ 110,671	$ -

The MOHLTC approved that $30,999 of E-Health funding is appropriate to fund certain general and administrative expenses. As a result, only $39,330 is repayable to the MOHLTC.

11. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 14 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 2007 was $79,064 (2006 - $20,297) for current service costs and is included as an expense in the Statement of Financial Activities.

12. 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*.

13. COMMITMENTS

The LHIN has commitments under various operating leases. Minimum lease payments due in each of the next four years are as follows:

2008	$ 212,932
2009	212,932
2010	212,422
2011	87,447
	$ 725,733

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 9, 2005 to March 31, 2006.

During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

"We look forward to taking this health care journey with local health service providers and community residents. Together, we will explore the possibilities and realize our shared vision for health care in our communities."

Mimi Lowi-Young
CEO, Central West LHIN

Our Vision

The Central West LHIN will work to create "a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren."

Our Leadership

Board of Directors
Joe McReynolds, Board Chair
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Terry Miller, Vice Chair
Kuldip Kandola, Secretary

Members
Anita Gittens
Sukhjinder Mintoo Mand
Zygmond Novak
Carol Seglins
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