

Toronto Central **LHIN**

Connecting Communities

2007-2008 Annual Report



Introduction

The launch of Local Health Integration Networks in 2006 marked a sea change in health care in Ontario. No longer would our health care system be centrally managed. Instead the province was divided into 14 territories and a Local Health Integration Network (LHIN) established in each. Each LHIN is responsible for planning, integrating and funding the health care delivered in all the hospitals, long-term care homes, community health centres, community care access centres, community support services and mental health and addictions agencies within its borders.

The benefits of the LHINs are many. They bring health care planning closer to home so that local needs can be reflected more easily. They enable greater opportunities for continuous and meaningful engagement with the communities they serve and the

health service providers that deliver the care. And they allow flexible solutions to neighbourhood health needs to be crafted.

Each LHIN has created an Integrated Health Service Plan, a blueprint for the health care needs of the community from 2007 through to 2010. This was done at Toronto Central LHIN with the input and advice of more than 6,000 community residents and health service providers. We are now carrying out that plan

On April 1, 2007, LHINs across the province received funding authority and responsibility for monitoring health service providers. This is our first annual report with our full authority reporting on the progress of our Integrated Health Service Plan.

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Letter from the Chair



The annual report is a time to pause and consider where we have come from and where we are headed. We have called this annual report “Connecting Communities.” The title reflects our mandate to create the conversations that bring consumers and families into the health care dialogue and generate connections between the diverse parts of our health care system.

We are a two year old organization now, still young, but with deepening responsibilities. This year has been an important one for the Toronto Central LHIN. Not only have we welcomed a new Chief Executive Officer but we have also progressed from an organization that was forming and defining itself to one that is performing and delivering tangible benefits to our community.

As a result of our efforts we have greater connections with the community we serve and a reserve of goodwill with the health service providers who work here. And we now have a solid track record of delivering results, with all of our planned first-year activities achieved and our first projects funded.

The coming years will see greater responsibilities and challenges. While we are adapting to meet the current needs of our communities, we are also planning to satisfy future demands from our aging population.

In the next 12 months we will be focusing our efforts on a few high-impact areas, facilitating equitable access to health services and supporting the provincial focus on emergency room wait times and family health care for all.

As Ontario’s ‘urban LHIN’ we have a unique set of challenges. Great disparities in health status, many languages and cultures, plus transient and homeless populations make finding better ways to deliver local health services a complex task. I am confident that we will succeed with the combined strengths of our community, our health service providers and our LHIN staff.

Yours truly,

A handwritten signature in black ink, appearing to read 'Mohamed'.

Mohamed Dhanani
Chair

Letter from the Chief Executive Officer



As a Toronto native it gives me great pleasure to sign the annual report of this Local Health Integration Network – the one that serves my family and friends.

I have held the position of Chief Executive Officer for only a few months but during that time I've been witness to a tremendous amount of work – effort that will transform our health care system and make it truly consumer-focused. I have also had the opportunity to work alongside the staff of the Toronto Central LHIN prior to taking up my role as CEO, particularly on e-Health initiatives. I've been witness to the skill and dedication of the LHIN staff, health service providers and those members of the community who have taken the time to work with us through our Councils and Advisory Panels. This is truly a collaborative venture.

It is this collaboration that is the driving theme of our work over the past year. We have engaged our stakeholders, built and strengthened relationships and reached out to connect with people whose voices were not heard before in the health care conversation. What we heard in community engagement sessions, the cornerstone of our work over the previous 12 months, is directly linked with the achievements of the past year.

The LHIN has a mandate to transform the local health care system – to re-orient it to better serve the community and to enable health service providers to do their best. I am pleased to report that working with health service providers in our LHIN, we have made significant advances. We have

- met all but two health care performance targets set out by the Ontario government to reduce wait times for patient access and improve outcomes
- completed all of the first-year activities that were described in our Integrated Health Service Plan,
- funded 16 projects that will improve access to services and make it easier for people to find the care they need, and
- launched major new ventures such as our Hip and Knee Replacement Program and our local Aging at Home Strategy.

These efforts will shape the face of health care in Toronto, helping our system to work better and faster and improving the quality of life for Torontonians and those outside our LHIN who come to us for specialized care.

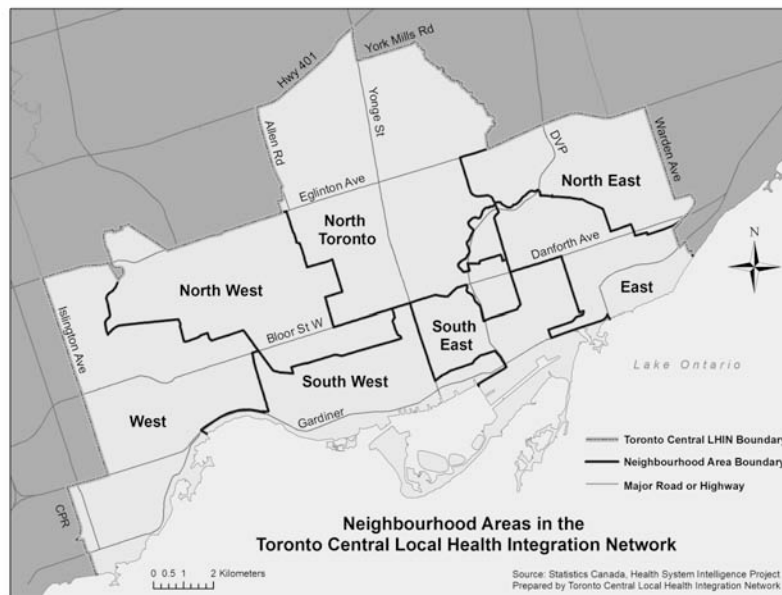
Ownership implies both responsibilities and benefits. I am happy to note that the communities that make up Toronto have come together to take ownership of our LHIN, helping it work better. They will reap the benefit of better and more responsive health care as a result of their effort.

Yours truly,

A stylized, handwritten signature in black ink, appearing to read 'Matthew Anderson'.

Matthew Anderson
Chief Executive Officer

Population & Health Profile



The world in miniature – a portrait of diversity

The Toronto Central LHIN is neither the largest LHIN by geographical size nor by population. Yet it is unique, standing out from the other 14 LHINs across the province as Ontario's only fully urban LHIN. Its borders are entirely within a major city. The Toronto Central LHIN is home to approximately 1,159,440 people; 9.1 per cent of the population of Ontario (2006 population estimates). The population growth in our LHIN is slower than the province. From 1996-2006, the Toronto Central LHIN population grew, on average, by 0.7 per cent each year while the population of Ontario increased by 1.4 per cent annually during this same time.

Every day the population of Toronto expands by more than 500,000 people – the equivalent of the population of Hamilton – as workers commute to their jobs, students go to school, patients come to specialist health care centres and tourists take in the sights.

The Toronto Central LHIN serves a diverse population and residents come from many parts of the world. More immigrants to Ontario choose

Toronto as their home than any other urban centre. In 2006, 41 per cent of Toronto Central LHIN residents were immigrants and 20 per cent of them arrived between 2001 and 2006. Most (59 per cent) of recent immigrants have come from East Asia and the Middle East. A smaller number have come from Eastern and Southern Europe and Africa (12, six and six per cent respectively).

This diversity is reflected in the variety of languages you are likely to hear spoken on the streets of the city (and in our health care centres). More than 160 languages and dialects are spoken here. The top 10 languages, other than English, are Chinese, Portuguese, Spanish, Italian, Tagalog, Greek, German, Urdu, Polish, and Russian. While English is still the dominant language, a minority (five per cent) do not speak English or French. For about 23,000 people (two per cent), French is their mother tongue.

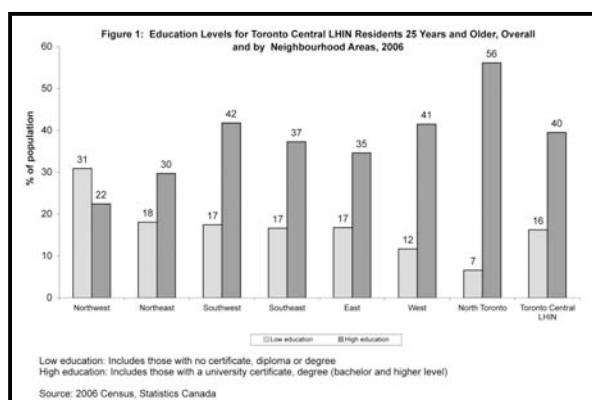
The visible face of this LHIN is similarly varied. Of the total population, 32 per cent are in racialized groups. The three largest groups in Toronto self-identify as Chinese, South Asian or Black.

Further adding to the diversity of the population are differences in religion, variance in physical ability and differences in sexual orientation. One out of 10

adults living within the boundaries of the LHIN are gay, lesbian, bisexual or trans-gendered.

But the colour of our skin, the countries we were born in and the languages we speak are only part of who we are. The socioeconomic status of the residents of Toronto shows the same level of variation. We have both limited and extensive formal education – a little less than one in five (16 per cent) adults 25 or older have no certificate, diploma or degree, high school or otherwise. Yet two in five (40 per cent) have a university education, a much higher proportion than in Ontario generally (where less than one in five holds a degree). Working age people (25 to 64) tend to be better educated than seniors. What complicates this picture is who is educated and where they live inside the boundaries of our LHIN.

Education levels vary greatly across the seven neighbourhood areas within our LHIN. Those living in North West Toronto, for example (see map, page 6) are more likely to have a low level of education than those in neighbouring North Toronto (31 per cent versus seven per cent).



Income also varies considerably in the LHIN. The proportion of people in private households in Toronto Central LHIN below the before-tax Low Income Cut-Off (LICO) is considerably higher (24 per cent) than in Ontario (14.7 per cent). This proportion varies by neighbourhood area, ranging from 15.3 per cent (in North Toronto) to 37 per cent (in the South East).

While the picture is complicated in its details, like the mosaic that the Toronto Central LHIN is, it becomes clear at a higher level. No two Torontonians are the same. Diversity demands unique ways to provide health care, a challenge the Toronto Central LHIN has taken up.

Toronto is a thriving hub of teaching and research and specialized health care – a walk down University Avenue, the MaRS research centre and the hospitals that line the route shows this.

It's not just Torontonians who use these hospital services. More than half (56 per cent) of all acute hospitalizations and a third (34 per cent) of emergency room visits in the Toronto Central LHIN involved people who live outside our LHIN. And more than two thirds of the specialized health care (heart procedures like bypass surgery and hip and knee replacements) provided was for residents of other LHINs.

Who we are shapes our health

The diversity that makes the Toronto Central LHIN unique is also what drives the variations in health status and in turn shapes our health care planning. While people living within the boundaries of our LHIN are less likely to suffer from some chronic diseases and are more likely to make healthier lifestyle choices than their counterparts in other LHINs, their health status and care needs differ widely across the LHIN.

People with low incomes are more likely to report poor or fair health and to suffer from chronic diseases like diabetes and arthritis than those with higher incomes. Recent immigrants, Aboriginal peoples, lone parent families, children, people with disabilities and visible minorities are all over-represented in the low income bracket.

These groups all have distinct profiles that demand tailored health care responses. About two per cent of the population of Toronto Central LHIN is composed of Aboriginal people. They are more likely to be younger, have low incomes, limited education, be unemployed and head (or come from) a lone parent family than the average LHIN resident. Aboriginal people are also over-represented among the homeless, those with HIV and addictions as well as victims of violence or injuries. As well, they have much higher rates of some chronic illnesses – diabetes, arthritis, depression, asthma and heart disease, than the non-Aboriginal population when age differences are taken into account.

As an entirely urban LHIN it is not surprising that many homeless people live within our boundaries. Homeless people have significant health challenges.

Three out of four (74 per cent) have at least one physical health condition and one in three (35 per cent) has been diagnosed with a mental disorder.

Similarly, our gay, lesbian, bisexual and transgendered community has a higher incidence of health problems than the general population. Their challenges range from mental health (anxiety, depression and suicide) to substance abuse, sexually transmitted diseases and some types of cancers.

By share of the population, seniors (65 and older) make up a considerable group within the Toronto Central LHIN. More than 150,000 seniors (accounting for 13 per cent of the population) live here and that population is growing, particularly older seniors (85+). The majority (80 per cent) of younger seniors (those 65 to 74) report good health and independence. Older seniors (85 and older) are nine times more likely than younger seniors to live in an institution or long-term care home. In addition to higher rates of institutionalization, seniors also make greater use of the health care system, especially in-patient rehabilitation and complex continuing care where seniors make up 69 per cent and 80 per cent of admissions respectively. They also account for a larger share of Emergency Department visits (19 per cent of all visits to Toronto Central LHIN hospitals were by seniors) and acute hospitalizations (32 per cent of such hospitalizations were to care for seniors).

However, the need to help seniors stay healthy and independent and to respond to emergency and rehabilitation care needs are only some of the challenges we face. Our health care system is much more complex than it was even twenty years ago. Helping seniors with language barriers who may have immigrated from other countries or who live alone (22 per cent of male seniors and 42 per cent of female seniors live by themselves - Census 2001) is a focus for the Toronto Central LHIN.

A picture of the health needs in the LHIN

Our community is challenged by a number of health care needs. Through discussions with members of the community and health service providers, three in particular emerged as needing immediate attention. They are: rehabilitation, chronic disease and mental health and addictions. Meeting needs in these areas will not only improve the quality of care in Toronto Central LHIN but also help relieve the pressures

facing service providers in two areas: the number of individuals designated as requiring Alternate Level of Care and in hospital Emergency Departments. (The Alternate Level of Care designation refers to those who no longer require the level of care provided by their current service provider but who remain in care because discharge is prevented due to their special needs, policy issues or system capacity to admit them elsewhere. These patients have a significant impact on wait times and the region's Emergency Departments). Making sure that the right care is delivered in the right setting (in a hospital or in the community) helps the system work better and deliver care more effectively.

Almost one in five (19 per cent) of families in our LHIN are led by lone parents; most (85 per cent) of these parents are women.

Rehabilitation – restoring as far as possible someone to a full and productive life, is a major aspect of health care within the Toronto Central LHIN. This type of care is becoming much more complex and successful; people with severe injuries are surviving and those with disabling or chronic conditions are living longer thanks to comprehensive approaches to rehabilitation. Toronto is a centre for rehabilitation services, creating a corresponding demand for services from those within our boundaries and without. Of those accessing these services, almost three in five (57 per cent) come from another LHIN. This in turn creates more need for a comprehensive range of health and other services, such as community supports, outpatient programs and housing support, plus putting more demand on such existing services. We are working with health service providers to ensure that the transition from hospital to community care and home is easier and smoother.

Chronic disease management is like rehabilitation – both demand ongoing and customized care, often for a person's entire life. We are expecting that chronic disease will grow in the Toronto Central LHIN as the population ages. Just more than one in three (31 per cent) of the residents of this LHIN have at least one chronic condition, including diabetes, cancer, depression, arthritis, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The two most common chronic diseases in the Toronto Central LHIN are arthritis and hypertension (affecting 13 and 12 per cent of adults respectively). It is easy to see the dramatic impact of chronic disease on the local health care system – one out of four admissions to a hospital and one in 10 Emergency Department visits are caused by a chronic disease, as are one in five visits to a family doctor. A

challenge for us is encouraging healthier lifestyles to reduce the incidence and impact of chronic diseases. Almost half of the adults in the Toronto Central LHIN are physically inactive and about 40 per cent are either overweight or obese.

Raising community awareness of mental health

The Dream Team is a group of men and women living with mental illness living in supportive housing. They have come together to speak out on behalf of the thousands of people in Toronto suffering from mental illness who need safe, secure, affordable and supportive housing.

By telling their stories, Dream Team members have shown the life-altering benefits of supportive housing for people living with mental health illness, far too many of whom have experienced homelessness.

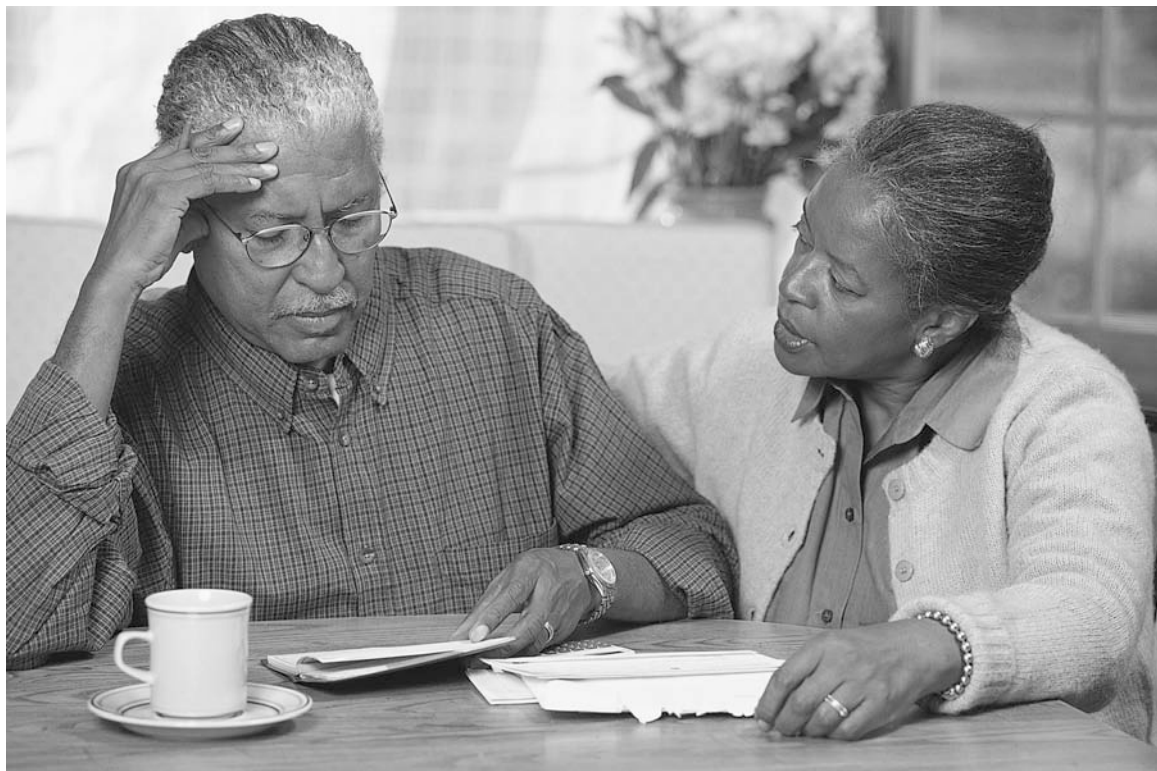
This year co-coordinated access to mental health and addictions housing and supports was enhanced through development of an electronic central access system funded by Toronto Central LHIN through LOFT.

But health is not just about physical well-being. That's why we are also working with health care partners to address another significant challenge in Toronto – mental illness and addictions. One in 10

adult residents of our LHIN has experienced symptoms of mental illness (major depression, mania disorder, panic disorder, social phobia and agoraphobia) in the past year. Many population groups in our LHIN, including seniors, Aboriginal people, immigrants and the homeless experience higher rates of mental illness. Drug and alcohol addiction often goes hand in hand with mental illness – a third (30 per cent) of people diagnosed with mental illness will have an addiction of some sort, well above the rate for the rest of the community (10-20 per cent).

Health equity

We began work this year to prepare a health equity framework that will assist health service providers to address health inequities among these diverse and marginalized populations. The Toronto Central LHIN health equity framework will serve as a guide to decision-making at the LHIN and will assist health service providers in formulating their own plans. In September 2007, the Toronto Central LHIN board directed hospitals within the Toronto Central LHIN to prepare Health Equity Plans for submission to the LHIN by October 1, 2008.



Community Engagement

Our Approach

A community is a group of people sharing a common interest or quality. Using this definition the Toronto Central LHIN is a world in miniature with many different communities within and without our boundaries. We are a collection of village-like neighbourhoods from Forest Hill to Regent Park. We are groups of seniors, specific ethnicities and cultures, people with low incomes, new immigrants, gay, lesbian, bisexual and transgendered people. We are often the very health service providers who work in our system. And many people may in fact belong to several distinct communities at once. This demands an agile approach to consultation and engagement.

Engagement is the process of involving communities in the development and delivery of health care services within the LHIN. We have to engage the community not simply because legislation demands it of us but because it is the only way we can tailor health care solutions to the actual needs of the consumer. In order to operate effectively we need to create, maintain and enrich meaningful relationships with the diverse communities we serve.

Many voices need to be heard and just as importantly they have to be involved in planning and decisions. The fundamental question is how to do this. The Toronto Central LHIN has undertaken a threefold approach:

- Let every voice be heard – involve people and communities that are often overlooked or harder to connect with
- Don't stop the conversation – make the engagement process continuous and an integral part of our way of working
- Create an environment where people are encouraged to get involved and shown that their voices count.

More than 6,000 people and 200 organizations helped us shape the 2007-2010 Integrated Health Services Plan, the roadmap to improvements in health care in our LHIN.

It is an engagement strategy that has delivered significant results. Our tactics change as the importance and complexity of an issue increases. Depending on the issue we may: inform and educate, gather input, consult and discuss or involve our communities. Here are some examples of how this process worked over the past year:

Inform and educate – we send electronically the Toronto Central LHIN Report, a quarterly newsletter, to more than 2,000 community stakeholders, keeping them abreast of current issues and upcoming events. We also use our website (www.torontocentrallhin.on.ca) to keep people aware of what is going on in our LHIN, including not only the dates for our open Board meetings and consultation sessions but also the action notes for all meetings. And we participate in many local community events such as the Toronto Diabetes Symposium and the Toronto Seniors' Health Forum, sharing our work with the public.

Gather input – we use focus groups to get the perspectives of community members as well as health service providers. This engagement targets the activities outlined in the Integrated Health Service Plan and issues that might affect our ability to achieve those objectives. This sort of work has allowed us to get a greater understanding of services available in our community (resulting in an inventory of mental health services for seniors, for example) and produced useful aids for health service providers, such as a screening tool to help identify frail marginalized seniors. We also use electronic surveys to get the perspectives of health service providers on a wide range of issues.

Consult and discuss – this next level of engagement involves fuller, more comprehensive involvement, typically using consultation, such as the City of Toronto's five Greater Toronto Area LHIN dialogue meetings. We used this method to help us with our local Aging at Home Strategy, reaching out to doctors, seniors and their caregivers, resulting, for example, in a decision to fund supportive housing services for seniors with mental health and addictions issues.

Involve – at the peak of the engagement pyramid is this intensive, often formal, consultation. Examples include our Councils, Advisory Panels and Working

Groups that have identified the priority projects for the year.

In order to enable this last level of engagement the Toronto Central LHIN created eight Advisory Councils and four Advisory Panels in the past year. It is our hope that these will function as pipelines to the on-the-ground wisdom, experience and knowledge of consumers, caregivers, families and health service providers.

Each Council supports one of our priorities and includes both health service providers and consumer and family representatives.

Our Eight Advisory Councils

- 1. Mental health and addictions**
- 2. Rehabilitation**
- 3. Seniors**
- 4. Health human resources**
- 5. Education and research**
- 6. e-Health**
- 7. Energy and environmental management**
- 8. Back office integration**

The Panels include community residents from each of the seven neighbourhood areas (see map, page 6) as well as various diverse groups including Aboriginal people, Francophones, newer immigrants and other ethnocultural communities.

Our Four Advisory Panels

- 1. Mental health and addictions, consumer survivor**
- 2. Mental health and addictions, family**
- 3. Seniors**
- 4. Rehabilitation**

Although it is not yet functional, our Health Professionals Advisory Committee will soon be providing advice and enabling us to sharpen the focus of our work and make health care services more patient-centered.

Because of our responsive approach to our community and legislative requirements, we are paying special attention to engagement with our Francophone and Aboriginal communities.

The Ontario government has advised that a “French language health planning entity” will soon be created to work with our LHIN. We plan to engage with that organization when it is operational. In the meantime we have brought Francophone voices to our Councils and Panels. We communicate in French through our

website and the materials posted there. The Toronto Central LHIN works with Francophone stakeholders such as Les centres d’accueil héritage, with whom we collaborated, for example, on an Aging at Home consultation. We are also a member of the Toronto Region French Language Health Service Planning Committee and we participate regularly in its meetings.

Similarly, there is work underway to build a provincial Aboriginal and First Nations “health planning entity.” It is not yet established so we engaged with local Aboriginal organizations and representatives directly including the City of Toronto’s Aboriginal Affairs Committee and individual members of our Councils and Panels. We are building relationships and working with Aboriginal health service providers to shape our strategy as well as sharing the results of our learning with other LHINs.

The Toronto Central LHIN met with more than 1,800 community members and health service providers in 150 engagement activities over the past year. We discussed topics ranging from help to keep seniors living at home to hip and knee replacement surgeries and annual hospital planning. We generated more willingness to collaborate with us (both from community representatives and organizations and health service providers) on topics including chronic disease management, Internet access and information about local services. We established partnerships, made people aware of the need to transform the local health care system and learned how we can improve what we do. Most promising is the fact that these partnerships are crossing LHIN boundaries, enabling a broader sharing of learning.

So what have we achieved through these conversations?

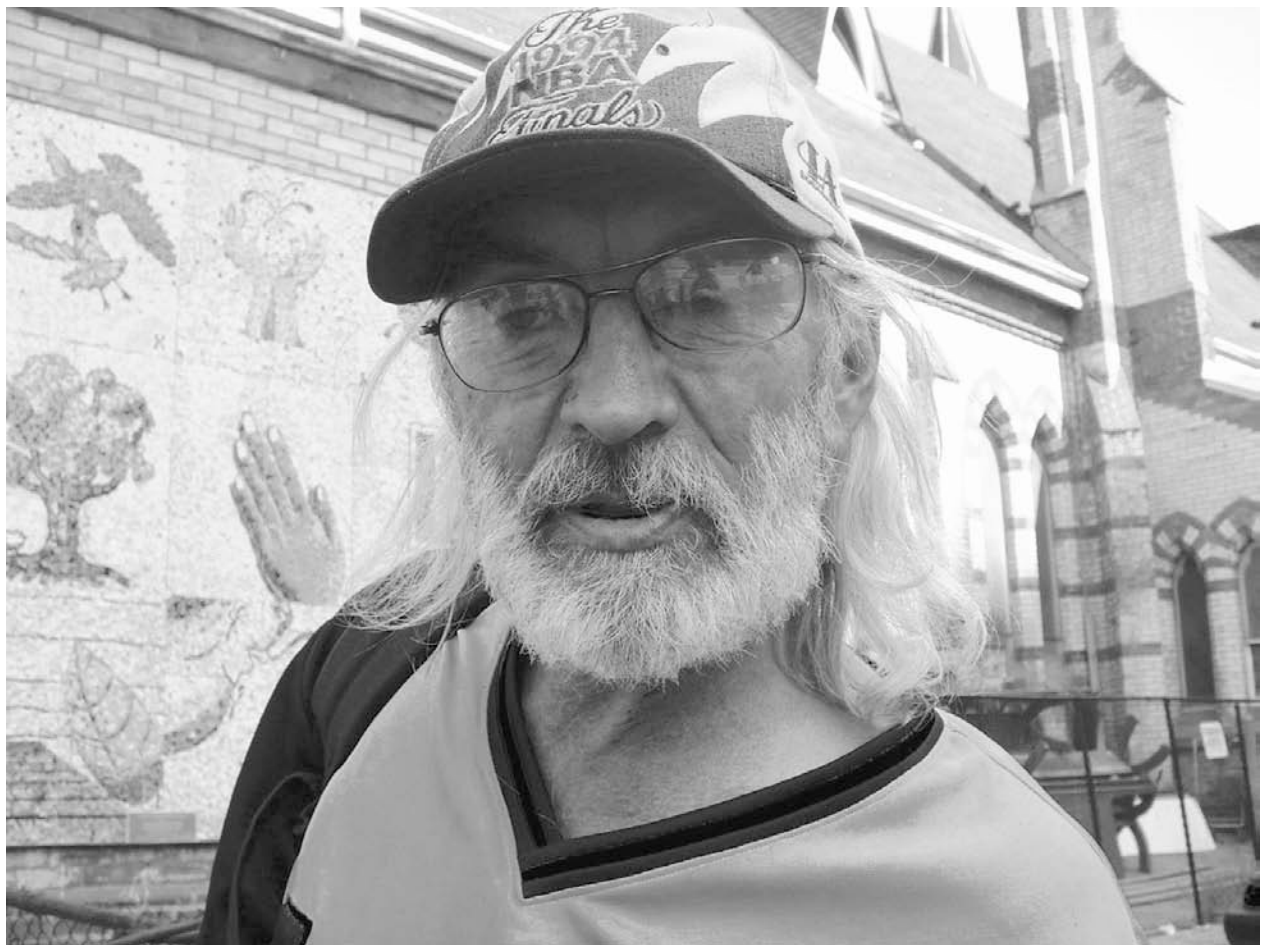
What we learned resulted this year in nearly \$5 million in funding for 16 urgent priority projects designed to improve integration, enhance access to services and ease system navigation. Detail on these investments follows in the achievements section of this Annual Report.

As mandated by the Ontario government, we expect to use a common assessment tool to gauge the success of our community engagement efforts when it is available.

In the meantime we asked a consultant to impartially evaluate the results of our work in order to answer important questions about our community engagement activities as a LHIN, such as: who have we engaged with and how well? What information, knowledge or understanding has been shared as a result of our community engagement activities? And what partnerships and collaborations have begun from our community engagement activities?

This review confirmed previous evaluations obtained through a sample of opinion leaders in the communities we engaged with, feedback surveys

from our activities, as well as anecdotal findings. We learned that there is still room for improvement. There is still skepticism about the LHIN's ability to fulfill its purpose. The fact that we are still not widely known by the public limits our ability to address needs. We need to work harder on communications, strengthen our relationships with our partners and communities and capitalize on opportunities to work closely with community partners.



Current Health System Performance

The Toronto Central LHIN is home to 18 hospitals, 18 community health centres, 72 community support services, 71 community mental health agencies and 6 family health teams. From a local health care system perspective, there is a great deal of activity happening within the LHIN. Part of our role is to collect and report information about the performance of the health care system within our boundaries. We are pleased that we have met all of the targets set out by the Ontario government for reducing wait times and enhancing patient access to health care services, except for magnetic resonance imaging (MRI) and computed tomography (CT) diagnostic imaging. It is important to note that those consumers who require immediate access to MRI or CT Services are receiving these scans in a timely manner. The Toronto Central LHIN is actively working with the hospitals to improve access to these services.

The Toronto Central LHIN with its partner organizations has made a significant difference to the care of consumers. Between April 2006 and March 31, 2008:

- Cancer surgery waits have gone **down 22% to 60 days**
- Angiography (a medical imaging technique in which an X-ray image is taken to visualize the inside of blood vessels and organs of the body) waits have gone **down 34% to 21 days**
- Angioplasty (the mechanical widening of a narrowed or totally obstructed blood vessel) waits have gone **down 29% to 15 days**
- Cardiac bypass surgery waits have gone **down 9% to 40 days**
- Cataract surgery waits have gone **down 63% to 118 days**
- Hip replacement waits have gone **down 44% to 130 days**
- Knee replacement waits have gone **down 58% to 136 days**
- CT scan waits have gone **down 31% to 59 days**

The LHIN continues to face significant pressures on timely access to long-term care homes and emergency departments wait times. The Toronto Central LHIN is committed to decreasing these system pressures and is actively working with its system partners, including hospitals and community agencies, to ensure people are receiving the right care in the right place at the right time.



Our Health System Transformation Accomplishments

The Toronto Central LHIN crafted a blueprint for health care within our boundaries. Covering a span of three years (2007-2010), the **Integrated Health Service Plan** was created with input and advice from members of our community as well as health service providers. It is available on our website. This plan identified priorities for the LHIN in nine key areas: mental health and addictions, rehabilitation, seniors' services, education and research, e-Health, energy and environment management, health human resources, back office integration and provincial ministry priorities.

What follows is a discussion of our progress in these areas and the related 16 key projects that were identified as urgent local priorities through our engagement efforts and funded this year. A wide range of challenges is being addressed including access to mental health and addictions services for seniors, patient referrals between hospitals, emergency department overcrowding and avoidable hospital and long-term care home admissions.

Improving Access and Navigation

In our meetings with our communities, one fact became very clear – lack of access to health care is a serious issue in our LHIN. Access to health care has many dimensions, including ensuring consumers know what services are available and how to get to them, matching health service providers with consumers and providing the supports that will help people get to these services. Our work in the past year has spanned all of these areas.

We began by creating an understanding of the services provided throughout the Toronto Central LHIN. Together with health service providers, consumers and their caregivers, we identified what programs and health care services are currently available, catalogued and 'mapped' them and made this information available to consumers, their health service providers and their caregivers and families through the Toronto Central Community Care Access

Centre's Internet database (www.toronto.communitycareresources.ca). This information is intended to make it easier for consumers, caregivers and health service providers to find up-to-date information on the health and community services currently available, and how to access them. We recently supported expanding the information included in this database to include additional health promotion resources available in our LHIN.

Because seniors make up such a large part of our community, we devoted significant effort to improve access to quality care for seniors and to increase community supports for them to enable them to live at home independently for as long as possible. We expect this will result in better quality of life for seniors and greater opportunities to get the care they need right in their communities. It will also create benefits in the health care system that will have ripple effects in other areas of care. For instance, if seniors are empowered to live at home longer, there will be reduced pressures on long-term care homes as well as hospitals, where seniors often end up and receive an inappropriate level of care based on their needs. Inappropriate admissions contribute to inefficient use of health care system funding and increased wait times for others awaiting those services.

We set out to create a better understanding of the challenges seniors face in accessing health care and supportive services so that we can plan ways to help them overcome these barriers. Of special concern were frail seniors who live alone, immigrants with limited knowledge of the English language, and those who have other issues that may affect their ability to access required health care. We also set out to improve our understanding of what services seniors require to assist them to age at home in the community. This evidence-based understanding of services needed provided the basis for funding the development of a model to help health service providers identify and meet the needs of frail and marginalized seniors.

Our LHIN also funded the development of a 'psychogeriatric framework' to help seniors who

have mental health and addictions issues get the care they need while still living in the community. This initiative commenced with identification of existing seniors' resources in our LHIN and making this information available on the Toronto Central CCAC's Community Care Resources Internet database.

Through its Aging at Home Strategy, the Toronto Central LHIN is providing supports to help seniors live independently in the community. Our health care partners have also initiated a project to reduce pressure on long-term care homes, through the Home at Last program to help older consumers move more easily from a hospital back to their homes. We expect that the sum of all these efforts will reduce demand for long-term care spaces and, as a result, lower wait times for those who truly need to move to this care setting. By improving patient transitions from the hospital back into the community, pressures within hospitals are relieved.

By providing better access to care in the community, Toronto Central LHIN is helping people to avoid unnecessary visits to the Emergency Department, reducing wait times. Greater support to allow individuals to live in their homes independently, combined with timely health care will improve system performance and care to consumers.

Engagement activities identified transportation as a key obstacle for seniors, preventing them from staying independent in the community and moving through the community-based health care system. So we have enhanced our funding of the Toronto Ride program, which provides transport and escorts to help seniors travel to health appointments in the Toronto area.

Turning to a younger group, we have worked to help our youth with rehabilitation needs make the move from youth-dedicated rehab services to adult services. This is a gap in our health care system that we are bridging in partnership with the Toronto Rehabilitation Institute and Bloorview Kids Rehab through the LifeSpan project. Behind the scenes we are working with the GTA Rehab Network to smooth the flow of consumers through our rehabilitation system with standardized in-patient referral forms and processes, grounded in an Electronic Resource and Referral Management System. We expect this will reduce the fragmented nature of the current rehabilitation system.

Similarly, we have focused effort on ensuring that people with mental health and addictions concerns

get the care they need in the most appropriate setting. This has necessitated both awareness-building (so consumers know how to connect with health service providers) and coordination efforts. The problems created by the lack of coordination and awareness are stark. Every year 54,000 people visit the Emergency Department of St. Michael's Hospital, just one hospital in the Toronto Central LHIN. Some who sought care in the ED, particularly those with mental health and addictions challenges, might have been better served elsewhere in the health care system. When people turn to hospitals it is often as a last resort, and often reflective of the fact that their attempts to access service in the community failed. The ripple effect of this common trend includes bottlenecks in hospital Emergency Departments, increased days spent in acute care beds, and an avoidable increased cost to the health care system. As an urgent priority we funded a project that mapped the flow of consumers using mental health and addictions services into and out of the Emergency Departments, with the goal of developing strategies to improve flow and the experience of consumers with those services.

Our work to improve access is just beginning but in two short years we have made major advances that improve understanding of what services are available and where (and how to access them). We are learning how to strengthen supports to enable people to access these services, enable smoother transitions from care settings (such as hospital to home) and how to enhance processes to improve patient flow through the system.

We expect this work will improve the quality of care, make the system more comprehensive and ultimately increase capacity. Our goal is an inclusive health system that is coordinated, integrated, accessible and responsive to the needs of consumers and their families.

Providing care in an appropriate setting

Gaining access to care is only one part of the equation. Consumers need to get such care when it is needed. And, in order for our health care system to work at its best, care needs to be delivered in the right place. At the moment, individuals turn to Emergency Departments for health care that could be delivered more efficiently and quickly in a family health care setting like a Community Health Centre.

This generates longer wait times and strains Emergency Departments, diverting attention from serious, emergency care to more routine issues. Some consumers end up being admitted to the hospital or to a long-term care home when in fact a less intense level of care could be provided in the community with the same health results.

That is why we invested this past year in initiatives that we expect will do three things:

1. Improve consumer satisfaction
2. Enhance the sustainability of our health care system
3. Build capacity to meet both current and future health needs of Toronto Central LHIN residents

Our priority is to help people to live in the community, with all the supports that may be necessary, for as long as possible. Moving prematurely from the community to, for example, a long-term care home puts pressures on the health care system (as spaces are limited in long-term care homes) and may not provide the quality of life for a person that living at home could.

In order to do this we have focused on keeping people healthy through wellness and health promotion activities. We also help people make the best care choices by providing them with the information they need to evaluate options and identify health care resources.

Co-ordinated Access for Community Services, which will create a common electronic process that will boost access and efficiency in admitting consumers to programs and services, was funded through WoodGreen Community Services in partnership the Ontario Community Support Association and other health service providers.

Other projects supported by the Toronto Central LHIN include supportive housing (part of our Aging at Home Strategy), the Home at Last initiative designed to make the transition from hospital to home easier and safer as well as the development of a psychogeriatric framework that will support seniors living in the community with mental health and addictions issues.

Building critical enablers

A ‘critical enabler’ is a supporting part of the health care system that helps other parts of the system do their jobs more effectively. Sometimes they are almost invisible, silently running in the background to empower the rest of the health care system and help transform it. Information technology (IT) is one such critical enabler. Other such enablers include the rich sources of information (including research reports) that can be applied for practical purposes and the men and women who work in our health care system (what we call our ‘health human resources base’). Our LHIN is harnessing all of these enablers to support the rest of the system as we re-orient towards a consumer-focused way of delivering care.

Our community engagement work told us that both consumers and health service providers want technology to be used to support health care initiatives, and they want it to be as efficient and effective as possible. So we have developed and approach that builds on existing e-Health initiatives and integrates the work of the provincial government, our LHIN, local facilities like hospitals, as well as other health service providers.

We are making significant investments in e-Health. Imagine freeing health care information within the constraints of privacy legislation so that it could follow a patient easily as he or she moves through the system instead of being trapped in paper files, x-ray film and faxes. Imagine helping consumers and providers navigate our system more effectively with ‘roadmaps’ to care. The Toronto Central LHIN has worked closely with our neighbour LHIN to the north – the Central LHIN -- on an e-Health Strategy that will make this world a reality. We are using e-Health to drive integration, creating a seamless electronic network that will improve the quality of, and access to, health care. Specific investments in the last year included such tools as a web-based inventory of seniors, rehabilitation and mental health and addictions services, a hip and knee surgical referral tracking system, a co-ordinated referral management system for Toronto Ride (which supplies escorted transportation to medical and other appointments for seniors), and a rehabilitation e-referral and a resource management tool.

Our technological goals in the coming year are to expand the e-referral management system used to link consumers to services in the community, create a

web portal to help those with diabetes to manage their condition as well as to work with the Ontario government to expand the use of the Ontario Drug Benefit Drug Profile Viewer in our hospitals (this enables hospitals to rapidly access a person's prescription drug history and make care decisions accordingly).

In Conclusion

This past year saw incremental advances in the integration of our local health care system toward a high performing entity. We have begun to improve access to services and make the system easier for the public to navigate, while improving efficiency and effectiveness by starting to move care delivery to the most appropriate settings. We will build on these successes in the coming year as we continue to partner with health service providers and community organizations on priority areas of health system improvements.

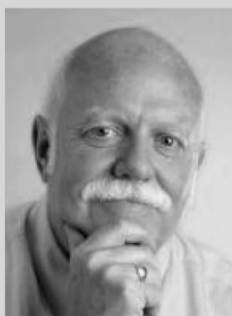


Our Board of Directors

Name	Position	Appointed	End of Current Term	Length of Term
Dhanani, Mohamed	Chair	7 March, 2007	6 March, 2010	3 years
Everett, Barbara	Director	17 May, 2006 16 June, 2007	16 June, 2007 15 June, 2010	13 months 3 years
Ewart, Bonnie	Director	17 May, 2006 16 June, 2007	16 June, 2007 15 June, 2010	13 months 3 years
Kennedy, Thomas	Director	27 June, 2007	26 June, 2008	1 year
Magill, Dennis	Vice Chair	7 March, 2007	6 March, 2010	3 years
Nott, Harley	Secretary	2 June, 2005	1 June, 2008	3 years
Vacancy	Director			
Vacancy	Director			
Vacancy	Director			



Mohamed Dhanani
Chair



Dennis Magill
Vice Chair



Harley Nott
Secretary



Barbara Everett
Director



Bonnie Ewart
Director



Thomas Kennedy
Director

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, 2008 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, 2008 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
May 9, 2008

Toronto Central Local Health Integration Network

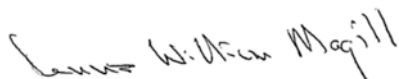
Statement of financial position
as at March 31, 2008

	2008	2007
	\$	\$
Financial assets		
Cash	2,427,507	1,989,784
Due from Local Health Integration Networks ("LHINs") (Note 3)	68,649	1,043,756
Accounts receivable	-	9,130
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	6,041,877	-
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 4b)	355,037	-
Due from Province of Ontario	-	25,000
	8,893,070	3,067,670
Liabilities		
Accounts payable and accrued liabilities	2,853,246	2,797,179
Due to HSPs	6,041,877	-
Due to MOHLTC (Note 4b)	-	1,962
Deferred revenue - MOHLTC WAN project	-	275,000
Deferred capital contributions (Note 5)	1,233,677	1,206,302
	10,128,800	4,280,443
Net debt	1,235,730	1,212,773
Non-financial assets		
Prepaid expenses	2,053	6,471
Capital assets (Note 6)	1,233,677	1,206,302
	1,235,730	1,212,773
Accumulated surplus	-	-

Approved by the Board



Mohamed Dhanani
Chair



Dennis Magill
Vice Chair

Toronto Central Local Health Integration Network

Statement of financial activities

year ended March 31, 2008

		2008	2007
	Budget (unaudited) (Note 7)	Actual	Actual
	\$	\$	\$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding	4,610,000	4,918,431	4,238,310
Health Service Provider ("HSP") transfer payments (Note 8)	3,884,459,300	3,897,601,538	-
E-Health (Note 9)	-	275,000	232,000
Joint Health and Disease (Note 10)	-	358,177	-
Aging at Home (Note 11)	-	243,000	-
Emergency Department (ED) Leads (Note 12)	-	37,500	-
Wait List Management (Note 13)	-	70,000	-
Energy conservation (Note 14)	-	-	25,000
Amortization of deferred capital contributions (Note 5)	-	670,268	276,701
Amounts recovered/recoverable from the LHINs	4,175,000	3,697,088	3,535,525
	3,893,244,300	3,907,871,002	8,307,536
Expenses			
Transfer payments to HSPs (Note 8)	3,884,459,300	3,897,601,538	-
General and administrative (Note 15)	4,610,000	5,313,033	4,477,781
LHIN Shared Services Office expense (Note 16)	4,175,000	3,972,330	3,570,793
E-Health (Note 9)	-	275,000	232,000
Joint Health and Disease (Note 10)	-	358,177	-
Aging at Home (Note 11)	-	243,000	-
Emergency Department (ED) Leads (Note 12)	-	36,746	-
Wait List Management (Note 13)	-	70,000	-
Energy conservation (Note 14)	-	-	25,000
	3,893,244,300	3,907,869,824	8,305,574
Annual surplus before funding repayable to the MOHLTC	-	1,178	1,962
Funding repayable to the MOHLTC (Note 4a)	-	(1,178)	(1,962)
Annual surplus	-	-	-
Opening accumulates surplus	-	-	-
Closing accumulated surplus	-	-	-

Toronto Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2008

	2008	2007
	\$	\$
Annual surplus	-	-
Acquisition of capital assets	(697,643)	(522,332)
Amortization of capital assets	670,268	276,701
Change in other non-financial assets	4,418	(6,471)
Increase in net debt	(22,957)	(252,102)
Opening net debt	(1,212,773)	(960,671)
Closing net debt	(1,235,730)	(1,212,773)

Toronto Central Local Health Integration Network

Statement of cash flows

year ended March 31, 2008

	2008	2007
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	670,268	276,701
Amortization of deferred capital contributions (Note 5)	(670,268)	(276,701)
	-	-
Changes in non-cash operating items		
Decrease (increase) in due from LHINs	975,107	(1,043,756)
Decrease (increase) in accounts receivable	9,130	(9,130)
Increase in due from MOHLTC regarding		
transfer payments	(6,041,877)	-
Increase in due from MOHLTC	(355,037)	-
Decrease (increase) in due from Province of Ontario	25,000	(25,000)
Increase in accounts payable and accrued liabilities	56,067	2,796,905
Increase in due to HSPs	6,041,877	-
Decrease in due to the MOHLTC	(1,962)	(18,936)
(Decrease) increase in deferred revenue	(275,000)	275,000
Decrease (increase) in prepaid expenses	4,418	(6,471)
	437,723	1,968,612
Capital transactions		
Acquisition of capital assets	(697,643)	(522,332)
Financing transactions		
Increase in deferred capital contributions (Note 5)	697,643	522,332
Net change in cash	437,723	1,968,612
Cash, beginning of year	1,989,784	21,172
Cash, end of year	2,427,507	1,989,784

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

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, 2008.

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.

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

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

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

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

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

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

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

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on 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.

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

2. Significant accounting policies (continued)

Consolidation and segmented financial reporting

The LSSO operations is reported separately from Toronto Central LHIN operations in the schedules accompanying the financial statements and are consolidated on the statements of financial position, financial activities, net debt and cash flows.

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. The full costs of providing these services are billed to all the LHINs on an equal basis. 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 the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

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	Surplus
	\$	\$	\$
Transfer payments to HSPs	3,897,601,538	3,897,601,538	-
LHIN operations	5,313,457	5,313,033	424
E-Health	275,000	275,000	-
Joint Health and Disease	358,177	358,177	-
Aging at Home	243,000	243,000	-
ED Leads	37,500	36,746	754
Wait List Management	70,000	70,000	-
	3,903,898,672	3,903,897,494	1,178

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

4. Funding repayable to the MOHLTC (continued)

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

	2008	2007
	\$	\$
Due to MOHLTC, beginning of year	(1,962)	-
Funding payable to LHIN by the MOHLTC	358,177	-
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(1,178)	1,962
Due to MOHLTC, end of year	355,037	1,962

5. Deferred capital contributions

	2008	2007
	\$	\$
Balance, beginning of year	1,206,302	960,671
Capital contributions received during the year	697,643	522,332
Amortization for the year	(670,268)	(276,701)
Balance, end of year	1,233,677	1,206,302

6. Capital assets

			2008	2007
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	251,685	138,442	113,243	148,848
Computer equipment	964,921	454,720	510,201	301,756
Leasehold improvements	1,254,542	644,309	610,233	755,698
	2,471,148	1,237,471	1,233,677	1,206,302

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2007. 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:

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

7. Budget figures (continued)

The total HSP funding budget of \$3,897,601,538 is made up of the following:

	\$
Initial budget	3,884,459,300
Adjustment due to announcements made during the year	17,622,338
Re-allocation between LHINS	(4,480,100)
Total budget	3,897,601,538

The total operating budget of \$5,593,667 is made up of the following:

	\$
Initial budget	4,610,000
Additional funding received during the year for:	
E-Health	275,000
Joint Health and Disease	358,177
Aging at Home	243,000
ED Leads	37,500
Wait List Management	70,000
Total budget	5,593,677

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$3,897,601,538 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2008 as follows:

	\$
Operation of hospitals	3,071,095,318
Grants to compensate for municipal taxation - public hospitals	736,800
Long term care homes	209,617,900
Community care access centres	161,321,400
Community support services	38,301,330
Assisted living services in supportive housing	36,486,300
Community health centres	62,469,613
Community mental health addictions program	84,791,023
Addictions program	21,244,554
Specialty psychiatric hospitals	211,492,750
Grants to municipal psychiatric hospitals - Psychiatric hospitals	44,550
Total	3,897,601,538

The LHIN did not authorize any funding to HSPs in fiscal 2007.

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

9. E-Health

The LHIN received funding of \$275,000 (2007 - \$232,200) related to the E-Health project. E-Health expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Salaries and benefits	197,981	65,821
Consulting	70,000	161,301
Other	7,019	4,878
	275,000	232,000

10. Joint Health and Disease

During the year, the LHIN was provided funding of \$358,177 (2007 - \$Nil) from the MOHLTC for Joint Health and Disease Management Program. The Joint Health and Disease expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Salaries and benefits	184,041	-
Consulting	100,764	-
Other	73,372	-
	358,177	-

11. Aging at Home Strategy

The LHIN received funding of \$243,000 (2007 - \$Nil) related to the Aging at Home strategy project. The Statement of Financial Activities presents the total expenses. Aging at Home strategy expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Salaries and benefits	81,625	-
Consulting	137,930	-
Other	23,445	-
	243,000	-

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

12. Emergency Department (ED) Leads

The LHIN received funding of \$37,000 (2007- \$Nil) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Salaries and benefits	3,300	-
Consulting	30,000	-
Other	3,446	-
	36,746	-

13. Wait Times Management

The LHIN received funding of \$70,000 (2007 - \$Nil) related to Ontario's Wait Time Strategy. Wait Times Management expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Salaries and benefits	70,000	-

14. Energy Conservation

During the prior year, the LHIN was provided funding of \$25,000 from the Ministry of Energy for its energy conservation project. These funds were used for consulting services in relation to this project.

15. General and administrative expenses

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

	2008	2007
	\$	\$
Salaries and benefits	3,360,521	1,751,057
Occupancy	222,349	182,237
Amortization	395,026	241,433
Shared services	300,000	290,201
Public relations	35,626	309,356
Consulting services	278,198	1,019,894
Supplies	183,440	235,667
Governance	198,709	70,616
Mail, courier and telecommunications	46,886	123,811
Other	292,278	253,509
	5,313,033	4,477,781

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

16. Common LHIN services expenses

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

	2008	2007
	\$	\$
Salaries	806,870	164,677
Benefits	135,304	46,543
Supplies	9,454	19,421
Communications	23,396	12,551
Recruitment and staff development	12,310	22,571
Computer expense	33,254	31,803
Consulting fees	76,621	283,142
Meeting expenses	2,377	25,014
Accommodation and amortization	307,979	131,977
Other	20,565	3,087
Shared services	2,544,200	2,830,007
	3,972,330	3,570,793

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 31 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 2008 was \$243,358 (2007 - \$69,659) for current service costs and is included as an expense in the Statement of Financial Activities.

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*.

Toronto Central Local Health Integration Network

Notes to the financial statements

March 31, 2008

19. Commitments

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

	\$
2009	263,063
2010 and thereafter	263,063
	<u>526,126</u>

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2009.

20. Segment disclosures

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



Toronto Central Local Health Integration Network

Unconsolidated statement of financial position and financial activities of
Toronto Central Local Health Integration Network and Local Shared Services Office - Schedule I
year ended March 31, 2008

	2008	2007	2008	2007	2008	2007
	Toronto Central Operations	Shared Services Office	Total	Total	Total	Total
	\$	\$	\$	\$	\$	\$
Financial assets						
Cash	977,812	787,523	1,449,695	1,202,261	2,427,507	1,989,784
Due from the LHIN Shared Services Office*	127,163	47,598	-	-	127,163	47,598
Due from Local Health Integration Networks ("LHINs")	-	-	68,649	1,043,756	68,649	1,043,756
Accounts receivable	-	9,130	-	-	-	9,130
Due from Ministry of Health and Long-Term Care ("MOHLTC")	355,037	-	-	-	355,037	-
Due from MOHLTC regarding HSP transfer payments	6,041,877	-	-	-	6,041,877	-
Due from Province of Ontario	-	25,000	-	-	-	25,000
	7,501,889	869,251	1,518,344	2,246,017	9,020,233	3,115,268
Liabilities						
Accounts payable and accrued liabilities	1,462,065	873,760	1,391,181	1,923,419	2,853,246	2,797,179
Due to TC LHIN*	-	-	127,163	47,598	127,163	47,598
Due to HSPs	6,041,877	-	-	-	6,041,877	-
Deferred revenue	-	-	-	275,000	-	275,000
Deferred capital contributions	753,729	943,531	479,948	262,771	1,233,677	1,206,302
Due to Ministry of Health and Long-Term Care ("MOHLTC")	-	1,962	-	-	-	1,962
	8,257,671	1,819,253	1,998,292	2,508,788	10,255,963	4,328,041
Net debt	(755,782)	(950,002)	(479,948)	(262,771)	(1,235,730)	(1,212,773)
Non-financial assets						
Prepaid expenses	2,053	6,471	-	-	2,053	6,471
Capital assets	753,729	943,531	479,948	262,771	1,233,677	1,206,302
Accumulated surplus	-	-	-	-	-	-

* The due from the LHIN Shared Services Office and due to TC LHIN is eliminated upon consolidation.

Toronto Central Local Health Integration Network

Unconsolidated statement of financial position and financial activities of

Toronto Central Local Health Integration Network and Local Shared Services Office - Schedule I (continued)
year ended March 31, 2008

	2008		2007		2008		2007		2008		2007	
	Toronto Central Operations		Shared Services Office									
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Total	Total	Total	Total
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Revenue												
Amounts recovered/recoverable from the LHINs*												
MOHLTC funding	-	-	-	-	4,175,000	3,997,088	3,825,726	3,997,088	3,997,088	3,997,088	3,825,726	3,825,726
HSP transfer payments	4,610,000	4,918,431	4,238,310	-	-	-	-	4,918,431	4,918,431	4,238,310	4,238,310	4,238,310
E-Health funding	3,884,459,300	3,897,601,538	232,000	-	-	-	-	3,897,601,538	3,897,601,538	-	-	-
Joint Health and Disease	-	275,000	-	-	-	-	-	275,000	275,000	232,000	232,000	232,000
Aging at Home funding	-	358,177	-	-	-	-	-	358,177	358,177	-	-	-
Emergency Department (ED) Leads funding	-	243,000	-	-	-	-	-	243,000	243,000	-	-	-
Wait List Management funding	-	37,500	-	-	-	-	-	37,500	37,500	-	-	-
Energy conservation funding	-	70,000	-	-	-	-	-	70,000	70,000	-	-	-
Amortization of deferred capital contributions	-	-	25,000	-	-	-	-	-	-	25,000	25,000	25,000
	-	395,026	241,433	-	-	275,242	35,268	-	-	276,701	276,701	276,701
	3,889,069,300	3,903,898,672	4,736,743	4,175,000	4,175,000	4,272,330	3,860,994	3,908,171,002	3,908,171,002	8,597,737	8,597,737	8,597,737
Expenses												
General and administrative												
Common LHIN Services*	4,610,000	5,313,033	4,477,781	-	-	-	-	5,313,033	5,313,033	4,477,781	4,477,781	4,477,781
Transfer payments to HSPs	-	-	-	-	4,175,000	4,272,330	3,860,994	4,272,330	4,272,330	3,860,994	3,860,994	3,860,994
E-Health	3,884,459,300	3,897,601,538	-	-	-	-	-	3,897,601,538	3,897,601,538	-	-	-
Joint Health and Disease	-	275,000	232,000	-	-	-	-	275,000	275,000	232,000	232,000	232,000
Aging at Home	-	358,177	-	-	-	-	-	358,177	358,177	-	-	-
Emergency Department (ED) Leads	-	243,000	-	-	-	-	-	243,000	243,000	-	-	-
Wait List Management	-	36,746	-	-	-	-	-	36,746	36,746	-	-	-
Energy conservation	-	70,000	-	-	-	-	-	70,000	70,000	-	-	-
	-	-	25,000	-	-	-	-	-	-	25,000	25,000	25,000
	3,889,069,300	3,903,897,494	4,734,781	4,175,000	4,175,000	4,272,330	3,860,994	3,908,169,824	3,908,169,824	8,595,775	8,595,775	8,595,775
Annual surplus before funding surplus repayable	-	1,178	1,962	-	-	-	-	1,178	1,178	1,962	1,962	1,962
Funding surplus repayable to the MOHLTC	-	(1,178)	(1,962)	-	-	-	-	(1,178)	(1,178)	(1,962)	(1,962)	(1,962)
Opening accumulated surplus	-	-	-	-	-	-	-	-	-	-	-	-
Closing accumulated surplus	-	-	-	-	-	-	-	-	-	-	-	-

* These amounts have been adjusted by \$300,000 related to Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs.

Local Health Integration Network

Local Shared Services Office

Statement of financial position and financial activities - Schedule II
year ended March 31, 2008

	2008	2007
	\$	\$
Financial assets		
Cash	1,449,695	1,202,261
Due from LHINs	68,649	1,043,756
	1,518,344	2,246,017
Liabilities		
Current		
Accounts payable and accrued liabilities	1,391,181	1,923,419
Due to TC LHIN	127,163	47,598
Deferred revenue	-	275,000
Deferred capital contribution	479,948	262,771
	1,998,292	2,508,788
Net debt	(479,948)	(262,771)
Non-financial assets		
Prepaid Expenses	-	-
Capital assets	479,948	262,771
Accumulated surplus	-	-
	2008	2007
	Actual	Actual
	\$	\$
Revenue		
Amounts recovered/ recoverable from the LHINs*	3,997,088	3,825,726
Amortization of deferred capital contributions	275,242	35,268
	4,272,330	3,860,994
Expenses		
Common LHIN Services	4,272,330	3,860,994
Annual surplus	-	-

* These amounts have been adjusted by \$300,000 related to Toronto Central LHIN transactions.
These numbers reflect LSSO operations on behalf of all 14 LHINS.