South West **LHIN**

South West Local Health Integration Network
Annual Report 2014-2015

Ontario
Local Health Integration Network

Contents

Preface

Local Health Integration Networks (LHINs) have built a strong foundation of transparency, performance and accountability, striving to ensure that health care dollars are spent efficiently and effectively, yielding the best results possible. This has been achieved through our mandated responsibilities related to planning, integration, community engagement and funding allocation.

LHINs operate within an accountability framework comprised of the Local Health System Integration Act (LHSIA), the Memorandum of Understanding (MOU), and the Ministry-LHIN Performance Agreement (MLPA). Within this accountability framework, LHINs must develop an Annual Report that outlines the progress and achievements made in the previous fiscal year. In addition to including specific requirements outlined in the key framework documents, the Annual Report contains audited financial statements for our organization.

This Annual Report will outline both progress and milestones achieved in the fiscal year of 2014-15. The Ministry of Health and Long-Term Care is required to table the Annual Report with the Legislative Assembly within 60 days of receipt. The Annual Report 2014-15 will then be shared publicly once the Minister tables it in the Legislature.

Message from Jeff Low, Board Chair and Michael Barrett, Chief Executive Officer

This fiscal year was another successful one for the South West LHIN as we continue our active role in leading and shaping the transformation of the health system through our planning, engagement, decisions and investments.

Our core objective for 2014-15 was to advance the goals outlined in our Integrated Health Service Plan (IHSP) 2013-2016. Our plan aims to create an integrated system of care that allows the LHIN and health service providers working alongside individuals and families to effectively improve health system performance, and advance innovative health system opportunities all within a patient-centred model.

We are making progress in achieving the strategic directions of the IHSP. There are fewer revisits to the Emergency Department within seven days of being discharged. Patients have spent more days at home – instead of in the hospital – because they received more appropriate care in other settings that better meet their needs. As well, more people were seen by their family health care provider within seven days of discharge.

The LHIN Board of Directors works closely with our health service providers in making investment decisions. We continue to fund our health service providers in a way that supports our residents to receive more care in the community and avoid unnecessary hospitalizations.

We know that patients recover better at home and care in the community is less costly than in hospital or long-term care. The Home First program in the South West LHIN shows a cost avoidance to the system of approximately $7 million in one year.

Home First has also led to improved integration between the hospital and the Community Care Access Centre. The South West LHIN continues to work with all its hospitals to ensure that patients return home with the appropriate community supports, instead of waiting in hospital unnecessarily.

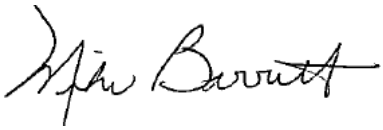
We continue to think at a system level so that resources are provided in an integrated way. We have taken an extensive look at some hospital services to improve how health care services are coordinated and delivered and to meet service capacity requirements well into the future. We are also realigning specialized Complex Continuing Care (CCC) beds and rehabilitation beds across the LHIN. Areas such as Grey and Bruce counties now have improved access to these beds.

Stronger support for those who rely most heavily on our health system is a priority for the South West LHIN. Health Links across the region will bring health care providers together to better coordinate services for people who need them the most. Providers are working to improve the services available in their communities such as crisis response teams – now available throughout counties in the South West. Crisis response teams offer a better response for someone facing a mental health crisis. Resources are being used more effectively, easing the pressure placed on emergency departments and police services.

As one of the largest LHINs in Southern Ontario, with a diverse population of almost one million people, the South West LHIN continues to engage with the public and our partners to ensure the best possible health care outcomes for South West LHIN residents.

This report outlines the important work completed in 2014-15, as well as new projects underway. We would like to extend our appreciation to all of our health system partners who work alongside us to build towards a healthier tomorrow.

Jeff Low, Board Chair, South West LHIN



Michael Barrett, CEO, South West LHIN

Board of Directors
Board members as of March 31, 2015

Jeff Low (London), Chair
February 7, 2014 – February 6, 2017

Ron Bolton (St. Marys) Vice Chair
May 12, 2013 – May 11, 2016

Andrew Chunilall (London)
April 11, 2013 – April 10, 2016

Ron Lipsett (Annan)
July 28, 2013 – July 27, 2016

Gerry Moss (Port Elgin)
May 17, 2011 – December 31, 2015

Wilf Riecker (Port Stanley)
November 6, 2013 – November 5, 2016

Lori Van Opstal (Tillsonburg)
November 6, 2013 – November 5, 2016

Aniko Varpalotai (Elgin County)
October 3, 2012 – October 2, 2015

Barbara West-Bartley (Wiarton)
April 18, 2011 – April 17, 2017

The South West LHIN

The South West LHIN is tasked with planning, integration and funding for 150 health service providers including: hospitals, long-term care homes, mental health and addictions agencies, community support services, community health centres, and the South West Community Care Access Centre.

Established in 2005, the South West LHIN covers a mixed rural and urban geography that ranges from Lake Erie to the Bruce Peninsula. By working together with all of our health service providers as a system of care – we ensure people receive the highest quality of care in the right place at the right time.

A high-performing health system improves people's health care experiences and ensures people receive timely, quality care with the best possible outcomes. It must also ensure the highest value for the money invested. To achieve these priorities and goals, all LHINs produce a three-year plan for the local health system that describes the vision, priorities, strategies and proposed outcomes. The plan, called the Integrated Health Service Plan (IHSP), identifies strategic directions and steps to make our overall vision of an improved health system a reality.

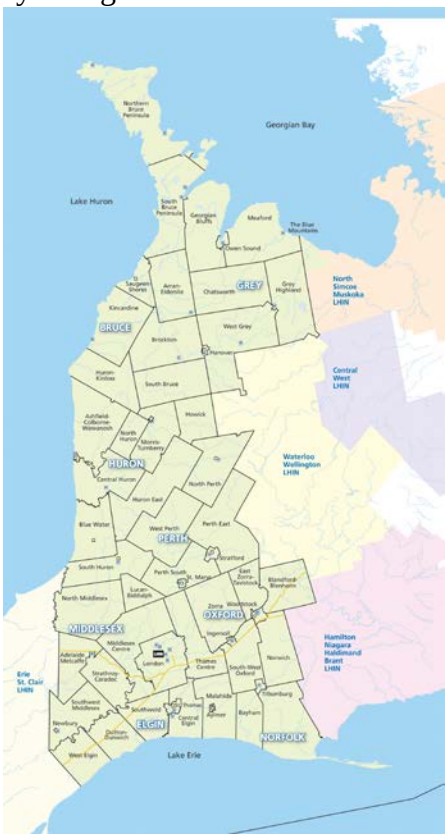
For the vast majority of people who require health care support, they receive it in their home community. Whether it is in-home care from a personal support worker, nurse or other health care professional, or an adult day program for individuals with dementia: community services are the key to the future sustainability of the health system. They allow for earlier discharge from hospitals, prevent re-admissions, and help delay or avoid admission to long-term care homes.

Hospitals in the LHIN provide care for those whose needs are beyond the services of a general practitioner, and our long-term care homes are there for those who can no longer live independently in their homes.

The following LHIN-funded organizations play a critical role in delivering services to South West LHIN residents:

- 79 Long-Term Care Homes
- 60 Community Support Services
- 36 Mental Health and Addictions agencies
- 20 Hospital Corporations across 33 sites
- 5 Community Health Centres
- 1 Community Care Access Centre

There are also a number of organizations and professionals that, while they are not funded by the LHIN, play a crucial role in the delivery of health care services including family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency medical services and labs. While these services do not have direct accountability to the LHIN, it is essential to work closely with them to achieve our health system goals.



Population Profile

The South West LHIN is home to approximately 961,435 people, which makes up 7.1 per cent of Ontario's population. London is the largest urban centre in the South West LHIN. It is home to 40 per cent of residents with a population of 385,535. Almost 30 per cent of the South West LHIN population live in a rural area and just more than 30 per cent live in small or medium communities.[1]

Projections for the South West LHIN suggest that population growth will be slower than Ontario as a whole. By 2016, the LHIN's population will have grown by about 1.6 per cent, compared to 3.0 per cent for the province overall (since 2013). By 2021, the population is projected to increase by 4.7 per cent (compared to a projected increase of 8.6 per cent for Ontario overall).[2]

In 2006, 14.6 per cent of the LHIN's population was aged 65 years or over. By 2016, seniors will account for 18.7 per cent of the LHIN's population. By 2021 it will be 21.3 per cent. The South West LHIN continues to have a higher proportion of adults aged 65 years or over than the province.[2]

In 2011, just more than 85 per cent of the LHIN's population reported English as their first language. While 14.8 per cent of the South West LHIN's population were immigrants in 2011, fewer than 2 per cent were recent immigrants (arriving in Canada between 2006 and 2011). According to 2011 census data, Francophones account for 1.3 per cent and Aboriginals 1.4 per cent of the South West LHIN population.[1]

Socioeconomic Characteristics

Overall, the LHIN's population is lower than the Ontario average on a number of measures including education and percentage of low-income residents. The unemployment rate for the South West LHIN is also lower than the Ontario average.[1]

	South West	Ontario
Unemployment Rate 2011 (age 15+)	7.6%	7.8%
Education:		
Without certificate/degree/diploma	12.6%	10.2%
Completed post-secondary education	61.3%	67.2%
Living in low-income	11.7%	14.5%

[1] Statistics Canada 2011 Census
[2] Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

General Health

Sixty-one per cent of residents say they have *very good* or *excellent* health, and 69 per cent reported *very good* or *excellent* mental health. Also, 51 per cent of those aged 75+ still report very good/excellent health. Approximately 14 per cent of LHIN residents say they usually experience moderate or severe pain/discomfort, and 26 per cent say they experience activity limitations because of long-term physical or mental health problems. A total of 93 per cent of LHIN residents report having a regular medical doctor (similar to the provincial average).[3]

Risk Factors

Approximately 18 per cent of residents are smokers and 58 per cent were regular drinkers in the last 12 months (similar to provincial rates). In addition, 54 per cent of LHIN residents are overweight or obese. Among LHIN residents aged 65-74, 68 per cent are overweight or obese. A total of 49 per cent of LHIN residents are physically inactive and 60 per cent report inadequate consumption of fruits and vegetables (consuming fewer than 5 servings daily).[3]

Life Expectancy and Leading Causes of Death

Residents have a slightly lower life expectancy (at birth and at age 65) compared to Ontario overall.[4] Ischemic heart disease, lung cancer, cerebrovascular disease (stroke), breast cancer, and cancer of lymph/blood are the leading causes of death.[5]

Chronic Disease

Approximately 39 per cent of South West LHIN residents (age 12+) have a chronic condition, and 16 per cent have multiple chronic conditions. The prevalence of multiple chronic conditions increases with age. Forty-two per cent of LHIN residents age 65-74 and 46 per cent of those aged 75+ have two or more chronic conditions.[6] Chronic conditions account for four out of 10 deaths, one out of five acute hospital discharges, and one out of four acute hospital days for LHIN residents.[7] The prevalence of most chronic conditions in the South West is similar to provincial rates as described in the chart below.[7]

[3] Canadian Community Health Survey, 2013, Statistics Canada
[4] Statistics Canada, Table 102-4307 Life expectancy, at birth and at age 65, by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional (years)
[5] Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO
[6] Canadian Community Health Survey, 2013, Statistics Canada
[7] Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Conditions	South West	Ontario
Prevalence (2013), rate per 100 people, age 12+		
Arthritis	20.0	15.9
Asthma	9.0	8.0
Cancer	1.0	2.4
COPD	3.1	2.7
Diabetes	7.0	6.6
High blood pressure	17.5	16.9
Heart disease	4.7	4.9
Have a chronic condition	39.0	36.8
Have multiple chronic conditions	15.6	14.4

Primary Care

There are more than 1,000 primary care physicians in the South West LHIN – 558 of them are part of the approximately 70 primary care groups (e.g. family health teams, family health organizations, etc.) in the South West LHIN.[8]

To improve access to primary care there are two key provincial programs: Primary Care Enrollment Model (PEM) and Health Care Connect (HCC) Program.

Primary Care Enrollment Models focus on the comprehensive care needs of the patient, not the number of services performed by a physician. In most models, patients have access to all primary care members in the enrolling group, after hour clinics and/or Telephone Health Advisory Service.

The Health Care Connect Program is a service that allows people to find a family physician. Between its launch in February 2009 and February 2015, 42,567 LHIN residents have registered with the program and 87.8 per cent of them have been referred to a family health service provider.

Health Human Resources Profile

The delivery of health services depends on regulated and non-regulated health human resources across the LHIN. Regulated health care professionals include disciplines such as physicians, nurses, occupational therapists, physiotherapists, speech language therapy, midwives, chiropodists, pharmacists, audiologists, dieticians, massage therapists, psychologists and respiratory therapists. Non-regulated resources such as personal support workers, acupuncturists, naturopaths and chiropractors also play a critical role.

Physicians

In 2013, the total number of physicians in South West had increased by 16.7 per cent reaching a total of 2,217 (from 1,900 in 2006).[9] The physician-to-population rate in the South West increased to 230.6 physicians per 100,000 people in 2013 (from 202.7 in 2006). The ratio of family physicians in the South West LHIN increased to 92.8 per 100,000 people in 2013 (from 78.7 per 100,000 population in 2006), and the ratio of specialists per 100,000 people increased to 119.3 in 2013 (from 103.3 in 2006).

[8] Health Analytics Branch, Ministry of Health and Long-Term Care, March 2015

[9] Ontario Physician Human Resources Data Centre (OPHRDC), Physicians in Ontario report, extracted April 2015

Nurses

In 2014, the total number of nurses in South West increased by 21.6 per cent reaching a total of 13,924 (from 11,260 in 2006) while the nurse-to-population rate increased to 1,448.3 nurses per 100,000 people (from 1,201.3 nurses per 100,000 people in 2006).[10] Compared to the province, in 2014 the South West had higher Registered Nurses, Registered Practical Nurses and Nurse Practitioners rates per 100,000 people. The number of Nurse Practitioners in the South West increased by 354 per cent to a total of 227 in 2014 (from 50 in 2006).

[10] College of Nurses of Ontario (CNO) data query tool, extracted April 2015

Community Engagement

The 2014-15 Communication and Community Engagement plan focused on engaging health care providers, partners and the public in working towards an integrated health system of care.

We used a variety of strategies to inform and educate, consult, involve, collaborate and empower stakeholders. Our aim was to make all engagements as valuable as possible for participants, boost participation, and practice core principles of community engagement.

The South West Communications and Community Engagement Plan, as well as the directions of the 2013-2016 Integrated Health Service Plan, and the Annual Business Plan guided our engagement approach.

Over the course of 2014-15, we were involved in a broad range of engagement activities including:

- Regularly scheduled advisory committee meetings
- Regular meetings with Area Provider Tables
- Sector and network meetings
- Project and program-specific meetings
- Health Services and Information Sessions
- South West Health Links Leadership Collaborative
- Health Links Learning Collaborative
- Governance education and dialogue sessions
- The Quality Symposium
- Physician Engagement in Partnership with the Ontario Medical Association
- Health System Leadership Council
- Health System Funding Reform Local Partnership

Ongoing Engagement

Health Links

The South West LHIN holds health services information and discussion sessions across the South West and the focus this year was Health Links. Sessions were held in Oxford, Elgin and London-Middlesex with future sessions planned for Grey Bruce and Huron Perth. Important discussions have occurred between governors and senior staff from many organizations on how they could work together to support people with high care needs in their geography.

From an operational point of view, the South West Health Links Leadership Collaborative guides overall planning and implementation, giving opportunities for Health Links leaders to learn from each other and build consistency in approach. Development of an overall implementation strategy, determining electronic enablers to support Health Link implementation and approving communication strategies were main accomplishments of the Leadership Collaborative this year.

Physicians and staff members who are participating in or leading the coordinated care planning process are being asked to work differently together. As a result of this change, the South West LHIN launched a Health Links Learning Collaborative where physicians and staff from all sectors in a particular geography are forming teams in order to work better together to coordinate care using known best practices. The first cohort includes teams from Huron Perth and London-Middlesex who came together in March 2015 for their first learning session on ‘how to’ implement a coordinated care plan with people who have chronic obstructive pulmonary disease. This cohort will have two more learning sessions in the next year. In future years, two more cohorts

will be added to support similar opportunities for North and South Grey Bruce, Oxford and Elgin.

Annual Quality Symposium

The 4th Annual Quality Symposium was held on May 14, 2014, in Stratford, Ontario. More than 350 guests representing all health care sectors in the South West LHIN attended to engage in discussions on quality, experiential learning and health care transformation.

The focus was on "Shaping the Future of Quality Health Care." The day featured leading experts who spoke about quality improvement and helped to position health service providers to lead and support system-level change.

The day closed with a celebration of quality achievements in the region. The South West LHIN Quality Awards are presented annually by Jeff Low, South West LHIN Board Chair, and are designed to recognize sustainable and ongoing quality improvement initiatives.

Overall, we received positive feedback from those who attended with most respondents indicating that they were satisfied with the day – with 86 per cent saying they felt positive or somewhat positive about the day.

Physician Engagement Sessions

As part of the South West LHIN mandate to engage with health care professionals, annual engagement sessions are organized to discuss, understand and educate physicians and other allied health professionals on health care topics related to their work.

In 2014, our engagement focused on improving patient access and flow in the South West LHIN, with a keynote discussion related to quality improvement (an important aspect of improving patient access and flow). In addition to hearing the perspectives of other physicians, participants had an opportunity to learn about some initiatives that are currently underway aimed at improving access and flow including: the Critical Care Access and Flow project, Discharge Planning, the Emergency Department Mental Health Access Project and eConsult.

Long-Term Care Home Network Forum

On June 17, 2014, the South West Long-Term Care Homes Network Council brought together 100 local long-term care providers in Stratford for the second annual Long-Term Care Forum. The forum featured speakers from the Ontario Long Term Care Association, the Ontario Association of Non-Profit Homes and Services for Seniors, the South West Community Care Access Centre, Behavioural Supports Ontario, and long-term care providers from the South West area.

Priorities for Investment Plan Development

Each year, the South West LHIN executes a Priorities for Investment Plan (PFI) to invest the discretionary funding allocations received from the Ministry of Health and Long-Term Care. In 2014, the LHIN used funding towards a number of key initiatives and projects with the goal of maximum impact and coordination of services and resources. From April to September of 2014, the South West LHIN held meetings with each community sector, meetings with those involved in proposed programs and projects, meetings with Health System Leadership Council (health care leaders from across the South West LHIN tasked to guide and lead health care changes at a system-wide level), a meeting with the CEO Leadership Forum (Hospital/CCAC/LHIN) and two open conference calls for all health service providers to consult and engage them in the plans around funding.

French Engagement

Targeted engagement activities were conducted with the Francophone community to increase the LHIN's understanding of their health needs and promote awareness of services in French.

The South West LHIN engages Francophone communities through the French Language Health Planning Entity. The LHIN has regular meetings with the Entity where progress on a Joint Action Plan is discussed as well as community engagement activities. A number of community engagement and planning initiatives were undertaken by the LHIN in collaboration with the French Language Health Planning Entity in 2014-15 including:

- The announcement and launch of the *French Mental Health and Addiction System Navigator Program* and the creation of an advisory committee where representatives from different organizations and Ministries were brought together to support the implementation of this program.
- *Bonjour Ontario* – a special edition on French-language health services in Central-South West Ontario was published and distributed to approximately 27,000 households
- Community partners meetings where different strategies to increase access to quality services for our Francophone population are discussed
- Participation and presentations to various network tables

In addition, the South West LHIN engages with its Francophone communities through the following work:

- The Home and Community Supports survey was provided in French
- French Language Services Toolkit distribution at the South West LHIN Quality Symposium 2014
- The French Language Coordinator continued support to health service providers in the development and implementation of French Language Services
- The data and site navigation enhancement to the French component of the healthline.ca

Aboriginal Community Engagement

Across the LHINs, meaningful Aboriginal community engagement is critical to understanding and responding to the health needs of diverse Aboriginal peoples. By working in partnership with the Aboriginal community and involving Aboriginal people in the planning process, we are able to enhance the quality of care and patient experience for those most vulnerable and in need of health care services.

The South West LHIN engages the Aboriginal community formally through the *South West LHIN Aboriginal Health Committee*, comprised of Aboriginal representatives from First Nations communities, Aboriginal organizations and health service providers located across the region. The Committee advises the LHIN directly on Aboriginal health issues, integration and partnership opportunities.

The Committee also provides oversight to key initiatives, including the Aging At Home services, and provides advice regarding Aboriginal priorities for new investments.

In 2015, the Aboriginal Health Committee approved the development of a time-limited clinical focused working group of the Committee named the Reference Panel on Aboriginal Health (RePAH), that has convened in order to provide direction around key projects focused on the Indigenous patient journey as well as Aboriginal diabetes current state and needs assessment reports.

Here are some of the key engagement activities for 2014-15:

- In May 2014, the Indigenous Cultural Competency (ICC) training was launched in the South West LHIN. The ICC training is a unique, facilitated on-line training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people. The goal of the ICC training is to develop and promote individual competencies and positive partnerships with Indigenous patients, families and communities. There have been almost 1800 health professionals trained across Ontario since May 2014 with the largest concentration in the South West LHIN.
- Bi-monthly, face-to-face South West Aboriginal Health Committee meetings
- The Reference Panel on Aboriginal Health (RePAH) has met three times in 2015, and will continue to support the Aboriginal Health Committee throughout 2015.
- Engagement with Aboriginal communities in the development of a current state and needs assessment report to support the planning for future direction of the Aboriginal diabetes strategy in South West LHIN.
- The development of an Aboriginal roadmap to advance Indigenous informed pathways to hospice palliative care and Health Links. In 2014-15, Aboriginal people were engaged in respectful ways to share their patient journey stories to ensure the patient/caregiver voice is at the centre of this work.
- Engagement with Aboriginal/First Nation Home and Community Care Programs in identifying recommendations and options to address a more integrated and supportive approach to care for Aboriginal peoples who require enhanced levels of care.
- Collaboration on the development of regional Aboriginal cancer plan for the South West LHIN.
- Coordination and participation in a pan-LHIN Aboriginal network to support the advancement of a system wide strategic approach for Aboriginal health planning and engagement.
- Development of Aboriginal specific recommendations for the Mental Health and Addictions Community Capacity Report Refresh - create action plan for next three years

Integrated Health Service Plan 2013-2016

Improving people's health care experiences and ensuring people receive timely, quality care with the best possible outcomes is what defines a high-performing health system. We also need to ensure that we get value for the money invested. To achieve these priorities and goals, we have developed an Integrated Health Service Plan (IHSP) for 2013-2016 that outlines strategies and objectives to support people to live healthy, independently and safely at home.

The IHSP is a call-to-action for health service providers and their boards outlining numerous areas where collaboration among primary care partners, community-based care, long-term care and hospitals will be essential to ensure an optimal health care system.

The IHSP sets three goals:

1. Improve population health and wellness
2. Improve person experience with the health system
3. Improve sustainability of our health system

To meet these goals, we have set out four strategic directions to guide progress:

- Improve access to family health care
- Improve coordination and transitions of care for those most dependent on health services
- Drive safety through evidence-based practice
- Increase the value of our health care system for the people we serve

To achieve these strategic directions we have developed 16 Program Areas with 87 initiatives in total that continue to be implemented in collaboration with our health service providers. The 16 Program Areas include:

- Access to Care
- Behavioural Supports Ontario
- Chronic Disease Prevention and Management
- Clinical Services Planning
- Connecting and Empowering People
- Critical Care
- Diagnostic Imaging
- Emergency Services
- Health Links
- Hospice Palliative Care
- Long-Term Care Home Redevelopment
- Mental Health and Addictions
- Quality and Value
- Safety
- Technology to Connect and Communicate
- Transportation Best Practices

In addition, there are three Key Drivers that will enable achievement of the strategic directions and initiatives:

- Technology to connect and communicate
- Quality and value
- Connecting and empowering people

The 'big dots' are indicators that measure our system performance and include:

- Increasing availability of family health care
- Reducing 15,000 emergency room visits and hospital readmissions, resulting in 10,000 more days at home
- Increasing availability and access to community supports for people, resulting in 7,100 more days at home

Integration Activities

With each integration activity the South West LHIN experienced, it became more evident that further policy and procedure refinement was needed to clarify the variety of avenues integrations could follow, while taking into consideration the need for public scrutiny as well as improvements to business efficiency and effectiveness.

The integration policy was refined and procedures are in place to better articulate the LHIN's integration approach and implementation process for the period of April 2014 to March 2016.

In July 2014, the South West LHIN Board of Directors approved the revised Integration Policy and Procedures, as well as four integration recommendations. Following LHIN Board approval, the Integration Policy and Procedures document and accompanying integration tools were posted to the LHIN website.

Approved Recommendations and Progress to Date

Ensure consistency in how integration activity is brought forward to the Board

To enable the appropriate response by the Board, LHIN staff will use a classification tool to determine what and how integration activities will be brought forward to the LHIN Board for review – consistent with the legislation and protocols defined through the *Local Health System Integration Act* (LHSIA).

Progress:

- An *Integration Classification Matrix* was developed to enable LHIN staff to determine what and how integration activities will be brought forward to the LHIN Board for review, consistent with the legislation and protocols defined through the LHSIA. (The Board received an integration presentation in May 2014).
- The matrix helps to separate formal integrations from business efficiency activities that have integration elements.
- Going forward, all formal integrations, as well as business efficiency activities, will be summarized in an annual integration update to the Board of Directors.

Reinforce and align health service provider integration expectations to achieve outcomes in support of the Integrated Health Service Plan

The LHIN will continue to evaluate integration activities to ensure they are in the best interest of the public. The LHIN will also require proposed integrations to demonstrate impact on some or all of the following system level goals: improve population health and wellness; improve person experience with the health system; and improve sustainability of our health system.

Progress:

- An *Integration Outcomes Tool* was developed to enable health service providers to develop the appropriate outcome and process measures, along with a numerical target for improvement (e.g. Reduce rate of ED visits/revisits by 10 per cent) where appropriate.
- Outcome and process measures will demonstrate the integration outcomes and how progress will be tracked.
- The tool was designed to align measures to the System Level Goals and the nine Health Quality Ontario (HQO) Attributes for a High-Performing System.
- Going forward, the expectation is that all integration activities will leverage the tool to develop and report on outcome and process measures.

Proactively engage the LHIN Board of Directors to clarify Board-to-Board engagement opportunities in support of integration activities

To ensure the role of governance is clear and specific opportunities to support governance leadership and engagement are identified. South West LHIN staff will play a supportive

role in this process ensuring that LHIN identified integration initiatives are brought forward to the Board of Directors for review and discussion early in the planning stages.

Progress:

- The October 2014 South West LHIN Leadership Retreat identified a number of actions related to the South West LHIN Board's leadership role regarding integration.
- A more specific work plan to support implementation of the identified integration related actions will be brought forward to the next meeting of the Governance Committee.
- A communication strategy is being developed to further communicate and educate health service providers regarding the South West LHIIN's integration expectations and the role of governance; opportunities to align integration related communication and engagement activities with the development of the next Integrated Health Service Plan are also being considered.
- As we proceed with the implementation of the fourth recommendation (see below), LHIN Board assistance with the organizational assessment process will be required.

Implement organizational assessments

The LHIN will implement organizational assessments with health service providers that have been identified to have competence, capacity and/or compliance challenges. These assessments will help identify potential service, administrative and governance integration activities to strengthen the quality and accountability of the services provided.

Progress:

- To implement organizational assessments, an *Organizational Assessment Tool* has been designed and is still in the development phase. This tool is based on a self-assessment tool that Central East LHIN developed. The South West LHIN version has been developed for use with HSPs, with Board and LHIN staff assistance, to assess the organizations health by scoring statements in four sections:
    - Organizational Health (Governance and Executive & Strategic Leadership)
    - Human Resources (Staff and volunteers)
    - High Quality Health Services
    - Finance and Performance
- These comprehensive assessments could lead to potential service, administrative and governance integration activities to strengthen the quality and accountability of the services provided.
- The LHIN is now facilitating the testing of the tool with two health service providers (Hutton House and CMHA Middlesex). The end goal is to use the tool with organizations that may be identified to have competence, capacity and/or compliance challenges; however, we are initially testing the tool with organizations not currently identified to have capacity, competency or compliance issues. We realize we may together identify some challenges that we will want to address during these assessments. The main goal of testing is to ensure the tool is useful and use the learnings from these test assessments to make revisions to the tool.
- After both test assessments are complete (expected end of June 2015), LHIN staff will take back the results of the specific test to that provider and debrief on the tool and process, as well as discuss the actual results and what some next steps for the provider may be.
- Based on results of testing we will:
    - Make adjustments and finalize tool
    - Finalize and roll out strategy and tool to all health service providers

Ongoing 2014-15 Integrations

Back Office Collaboration and Integration Project

This project will focus on enabling effective and efficient use of system resources to achieve the highest quality back office services while making the best use of public resources to create readiness for future health system transformation.

The key deliverables for the project will be:

Phase 1

- Procure resource(s) for a LHIN-wide review of the current state within the South West;
- Create a critical path that will drive phase 2; and
- Form a Steering Committee to provide project oversight.

Phase 2

- Develop a Back Office Collaboration and Integration Framework based on engagement with health service providers and a LHIN-wide review.
- Options for Back Office Collaboration and Integration Project initiatives will include risks/benefits and a high-level assessment of Return on Investment (ROI).
- A list of recommendations will be formulated, with expressed rationale and implementation plan outlines, for Back Office Collaboration and Integration Project initiatives with the South West LHIN.

To guide this work, we have recruited a team of key decision makers, leaders and content experts to round out the membership of a Back Office Collaboration and Integration Project Steering Committee. This group will begin to meet in April 2015.

Phoenix Survivors and Choices for Change Youth Programs

Phoenix Survivors Perth County (Phoenix) and Choices for Change (CFC) operated separate youth programs in Stratford, Ontario. Both programs provided outreach services aimed primarily at homeless and street-involved youth who have issues related to mental health (Phoenix) and addictions (CFC). The combined youth program offers a drop-in centre for peer support and leisure activities to youth and young adults aged 16-30 in Stratford.

As the two organizations operated similar youth programs and served the same population, it was agreed that the programs would maximize service delivery and business efficiencies if they combined staff and service locations. This is a unique arrangement because Phoenix is a mental health Peer/Self-Help Initiative while CFC is an addictions agency. Phoenix and CFC were able to leverage their existing back office partnership to increase program activity and retain qualified staff within their existing funding. By coming together, the two programs are working to increase the amount of services offered at their Stratford site. This enables youth to access programs five-days a week and outside of drop-in centre times. Phoenix and CFC offer tools for youth to develop coping skills as well as opportunities for socialization and counselling services.

Phoenix and CFC's new partnership is one example of a small integration activity that can have a big impact on the people they serve. Integrations can take a broad range of forms, from service coordination to partnerships, alliances and business efficiencies such as the new relationship between Phoenix and CFC.

Alexandra Hospital, Ingersoll and Tillsonburg District Memorial Hospital Joint Board Initiative

Alexandra Hospital, Ingersoll (AHI) and Tillsonburg District Memorial Hospital (TDMH) partnered to form a Joint Board to govern and oversee both hospitals while maintaining separate corporate identities. Over the past couple of years, the Boards had been collaborating more on an operational and

governance level with the establishment of an Integrated Leadership Team, a Joint Venture Agreement as well as integrated Board Standing Committees between the two hospitals. A Joint Board initiative was explored and approved by both Boards. A Joint Board Agreement was been developed and approved by both Boards on April 29, 2014. AHI and TDMH Corporate by-law amendments have been made and approved by both Boards to align with the Joint Board initiative. The AHI and TDMH Joint Board agreement outlines the terms of the initiative including but not limited to: voting, conflict resolution, termination and Board of Directors indemnification.

The purpose of the Joint Board is:

- to govern and oversee TDMH and AHI as a coordinated system of health services with two separate legal operating corporations for the provision of health services in accordance with the Public Hospitals Act;
- that notwithstanding the above, the Directors of TDMH and AHI agree to exercise their fiduciary duties and responsibilities to protect and promote the diversity of the communities and the Hospitals;
- to maintain the respective identities and missions of TDMH and AHI; and
- to maintain appropriate decision making for each institution in accordance with the Public Hospitals Act and within the larger coordinated system created pursuant to the Joint Board agreement.

Oxford Hospitals Ambulatory Services Integration

Alexandra Hospital, Ingersoll, (AHI) Tillsonburg District Memorial Hospital (TDMH), and Woodstock General Hospital (WGH) and the South West LHIN worked together to develop a Joint Services Plan. The plan identifies opportunities to collaborate across the three hospital corporations. The Joint Services Plan Final Report was received by the South West LHIN Board of Directors on April 15, 2014. The South West LHIN Board recognized the development of the Joint Services Plan as a significant first step in support of a stronger hospital system of care in Oxford County.

The Oxford Hospitals Joint Services Plan included a work stream consolidating cataract procedures at AHI and WGH, and consolidating endoscopy and cystoscopy procedures at TDMH and WGH. Evidence from emerging practice models demonstrates that consolidating certain surgical volumes can create economies of scale, improve operational efficiencies and increase standardized practice and patient outcomes. The three hospitals undertook considerable engagement in developing the Joint Services Plan and the surgical services work stream specifically.

The cataracts services integration consolidated cataract removal/lens insertion and elective eye procedures at AHI and WH, with the consolidation of all appropriate after-hour emergency eye procedures at WGH. Activities are ongoing to support and sustain the consolidation of surgical services between the three hospitals including the 24/7 on-call services for ophthalmology provided by WGH. The only patients that will continue to be referred to St Joseph's Health Care, London are urgent retinal cases. The endoscopy services integration consolidated endoscopy and cystoscopy procedures at TDMH and WGH.

Shared CEO Services - South Huron Hospital Association and Middlesex Hospital Association

South Huron Hospital Association (SHHA) approached Middlesex Hospital Association (MHA) in spring 2014 about an opportunity to contract CEO services from MHA. Board Chairs, other trustees, and the MHA CEO worked to develop an agreement to partner together to enhance services for patients, families and the communities they serve. The Boards of both SHHA and MHA supported this integration and felt there was a shared vision of clinical and operational excellence and innovation and a commitment to lead and seek ways to partner and integrate.

The organizations anticipate a shared CEO will offer the following potential benefits:

- Reduced administration costs for both organizations.
- Working together for enhanced access and more timely services for patients.
- Improved processes, which will result in more clinical expertise available and opportunities to attract more specialists, improve patient coordination and transitions of care, create and enhance centres of excellence and develop ambulatory centres/clinics for same day care.
- Increased sphere of influence for MHA and SHHA as partners. An enhanced presence and stronger ability to influence decision making in the local area.
- A larger rural coalition better poised to take advantages of opportunities as they arise.

The first year will be exploratory in nature both from the perspective of the CEO and Boards. There will be a site administrator at SHHA and the organizations are exploring cost efficient methods to implement this.

John Gordon Home

The London Regional AIDS Hospice/John Gordon Home (JGH) and the Regional HIV/AIDS Connection (RHAC) have decided to join together as one organization.

Benefits of the integration include:

- Both organizations have similar mandates and service the same population
- JGH as a small organization does not have the capacity to continue to meet increasing demands (services and reporting requirements)
- The organizations agree that the community would be better served by coming together and no longer compete in the recruitment of staff, volunteers, Board members or charitable dollars for their organizations
- People living with, at risk for or affected by HIV/AIDs and Hepatitis C will benefit from an enhanced continuum of care, no longer needing to navigate between two organizations to access the basket of services
- Administrative efficiencies will be achieved by reducing the number of financial contracts and report obligations

Update on South West LHIN Initiatives in 2014-15

Health Links

A Health Link is model of care to improve a person's health outcomes and quality of life through care coordination by all providers with the individual and their family. Partnering organizations are from the health, community, and social service sectors. The focus is to improve coordination of care with people who have complex conditions and have frequent interactions with the health system. The initiative was announced by the Ministry in December 2012.

In the South West LHIN we have six Health Links: North Grey Bruce, South Grey Bruce, Huron Perth, London Middlesex, Oxford and Elgin. Each Health Link must submit a business plan to the Ministry of Health and Long-Term Care (MOHLTC). Once approved, the Health Link receives one-time funding to implement the business plan with individualized care planning as the central outcome.

In 2014-15 the Huron Perth Health Link was in its second year of implementation. A care planning process was tested and revised so that all needed partners were able to participate and clients and their caregivers would feel that their goals were achievable. The process is now reliable and is being applied throughout Huron and Perth to ensure that all people with high care needs have the opportunity to work with their providers to develop a coordinated care plan.

London Middlesex Health Link had their business plan approved and is now poised to begin working with individuals and their families to coordinate care. North and South Grey Bruce Health Links worked together to develop their business plans, which were submitted to the MOHLTC in January 2015. Oxford and Elgin Health Links have submitted readiness assessments and are working with the South West LHIN to prepare for the business planning phase.

Partnering to Improve Emergency Department Wait-Times

Organizations in the South West LHIN have been working to improve patient wait times and overcrowding in Emergency Departments through two key improvement interventions: the provincial Emergency Department Pay-for-Results program and the South West Knowledge Transfer Project.

The South West Knowledge Transfer Project is a peer-to-peer improvement initiative, led by St. Thomas Elgin General Hospital. To date, the South West LHIN has provided $1,011,440 in funding to this project, which has enabled participation and collaboration among partner organizations and has focused on targeting a reduction in wait times by 20 per cent for admitted patients. Wait times for admitted patients have improved at many of the participating organizations since the start of the project. As at February 2015, compared to 2012-13, substantial reductions were realized at the following hospital organizations:

Hospital	Current Admitted Length of Stay Hours (90th percentile)	Reduction
Woodstock General Hospital	8.2	32%
Stratford General Hospital	11.9	27%
St. Thomas Elgin General Hospital	6.9	10%
London Health Sciences Centre (Victoria)	29	2%

Provincially, the South West LHIN continues to rank within the top five for all Emergency Department indicators as compared to the 14 LHINs. Of the 74 hospitals in the province that take part in the Pay for Results Program, three sites in the South West LHIN are top five overall performers: Grey Bruce Health Services (Owen Sound), Woodstock General Hospital and St. Thomas Elgin General Hospital. St. Thomas Elgin General Hospital had the lowest wait times of all participating sites in the province.

Improving Patient Access and Flow

Improving Mental Health Access and Flow: An initiative was launched targeting improvements in Emergency Department mental health access and flow. This intervention will impact how Form 1 mental health patients who are referred to and assessed at the Schedule 1 facilities in the South West LHIN. The initial goal is to have all Form 1 mental health patients referred to a Schedule 1 facility and assessed within 12 hours from the time the referral is made. The Working Group is currently focused on accessing data to inform the completion of a current state analysis and to support development of additional strategies to improve the system.

Given the challenges that remain with access to inpatient beds in the London hospitals, plans are underway for a more comprehensive strategy for improving patient flow across the LHIN. Providers are working together with the South West LHIN Leadership Forum and other key groups to understand and prioritize solutions based on the data. This approach will:

- Clarify accountabilities and responsibilities for improving patient flow within and across sectors, organizations and committees in the South West to develop a proactive approach to sustained improvement
- Develop a Regional System Responsiveness Plan (surge plan for peak periods), complimented by a public communications plan
- Establish on-going reporting to support understanding of progress related to patient flow in the South West

The LHIN and partners continue to monitor and report on progress and outcomes, and to share leading practices through participation in our Collaborative meetings every quarter.

Health System Funding Reform

Health System Funding Reform's (HSFR) two components – the Health Based Allocation Model (HBAM) and Quality Based Procedures (QBPs) present two different challenges to South West LHIN hospitals and the CCAC.

HBAM calculates a hospital's share of the overall available funding by comparing an expected (standardized) total cost for the hospital to the sum of the expected cost of all Ontario hospitals; a single hospital's percentage share of the total provincial expected cost then determines the share of the available funding. Hospitals in the high growth areas of the province are receiving an increasing share of the available funding as additional patient activity increases the total expected cost. The South West LHIN is growing, but not at the same pace as the Greater Toronto Area, and this results in flat or diminishing HBAM revenue for most of our hospitals.

South West LHIN hospitals have responded by reducing unit costs. For example, St. Thomas Elgin General Hospital has reduced the cost per emergency room weighted cases from $5,915 in 2012/13 to $4,853 in 2013/14. The shift of HBAM funding to high growth areas will still be a challenge for most of our hospitals in the coming years. The HSFR Local Partnership Committee comprised of the hospitals, CCAC, and the LHIN is working cooperatively to adapt to anticipated HBAM funding levels.

QBP funding is provided using a price per procedure (volume) formula. To date the South West LHIN has been receiving the status quo, or slightly better QBP funding. Funded volumes for QBP procedures such as hip and knee replacements have not shifted to high growth areas. Aligning to QBP funding requires adopting best practices as defined in the QBP clinical handbooks and controlling costs to match the QBP prices.

In collaboration with hospital partners, a QBP Assessment Survey was created and implemented in order to profile the current state related to QBP implementation in the South West LHIN, identify potential areas where collective action could increase efficiency and improve performance, and provide an update on emerging opportunities and next steps.

A key outcome of this work will help to support collaboration and efficiency by sharing strategies for reducing variation in any one or more QBPs. The information will also help us to support:

- Knowledge Transfer - by organizing webinars where our partners who are further advanced in certain QBPs profile and share the work they have done in order to support knowledge transfer
- Establishing collaboration for efficiencies in reporting and monitoring development related to QBPs

South West LHIN Strategies for the Home and Community Service Investments

In 2014-15, South West LHIN staff worked hard with health service providers across the LHIN to develop proposals for investing in home and community services. Approximately $14.5 million was targeted to priority projects and programs to expand access to home care and community care.

Significant investments included:

- Expanding the Assisted Living/Supportive Housing hub model to address unmet need for high needs clients including frail seniors and people with disabilities across the South West LHIN geography
- Adding more specialized spaces for Adult Day Program services, addressing unmet need for dementia and stroke-specific unmet need in the City of London and County of Elgin
- Enhanced funding for transporting clients to/from adult day programs
- Expansion of congregate/residential program for young adults with complex needs
- Creating a key point of coordination and access for community support services (CSS) with other system partners, including one number access and intake for CSS services in Huron and Perth counties
- Funding to provide health care at home through technology enabled participant self-management and communication with remote monitoring nurses that enhances the quality of life of Congestive Chronic Heart Failure (CCHF) and Chronic Obstructive Pulmonary Disease (COPD) participants in the South West LHIN
- Transitional and lifelong care clinic to support the needs of youth and adults with complex needs and physical disabilities of childhood onset who are transitioning into adulthood
- Training front line staff to better meet the needs of clients with responsive behaviours and at risk for falls
- Enhancements to community addiction supports including: assessment, screening, treatment and referrals of people with substance abuse issues and enhancements to addiction transitional case management supports for urgent need or community withdrawal management
- Mental Health and Addictions supportive housing

Mental Health and Addiction Services

London-Middlesex Mental Health Agency Amalgamation:

On March 6, 2015, local stakeholders and health system partners gathered to celebrate the one year anniversary of the amalgamation of WOTCH Community Mental Health Services, Search Community Mental Health Services and Canadian Mental Health Association (CMHA) London-Middlesex into CMHA Middlesex. Since launching last year, CMHA Middlesex has seen a 17 per cent increase in the number of individuals they support, and a 12 per cent increase in referrals. This demonstrates the amalgamation has improved access for individuals in our community seeking mental health supports.

Enhanced Services for Residents in Crisis:

On September 26, 2014, a five bed interim Crisis Stabilization Space opened up in London. The Crisis Stabilization Space provides short-term support for individuals experiencing a mental health and/or addiction crisis who do not require hospitalization. This includes experiencing personal distress and at risk of harm, including low to medium risk of suicide or harm to themselves, other persons or property. As of mid-January 2015, providers worked together to enable the space to be open 24/7. The space offers a safe, therapeutic environment for individuals to stay for up to a maximum of three days as an alternative to hospitalization.

Operational funding has been provided for a new Mental Health and Addictions Crisis Centre at the current Canadian Mental Health Association Middlesex, Huron St. Site. The Centre will be a co-located 24/7 walk-in

Centre with ten crisis stabilization beds. The Mental Health and Addictions Crisis Centre will enhance existing services being offered from the site and will create a direct link for individuals to connect with supports to help them transition back into the community after a crisis. It is conveniently located, recognized as a safe welcoming environment by individuals seeking services and is accessible by public transit. This new Centre is proposed to open in December 2015.

The co-located services will include Intake, Information and Referral, Mobile Crisis Team, Transitional Case Management, Clinical Services, Withdrawal Management, Housing Stability (Housing First Program), and access to the Waitlist Clinic. Currently, five crisis stabilization beds are offered 24/7 at an interim location and will move to the new Crisis Centre. The Centre will provide integrated, compassionate, expedient and effective Mental Health and Addiction supports to adults who are experiencing:

- Personal distress
- Symptoms of a mental health condition which may require triage, assessment and treatment
- Circumstances which require de-escalation to prevent relapses
- Mental health and addiction problems that if dealt with, may prevent hospitalization
- Emotional trauma, where assessment, crisis intervention and links to longer-term services can be made

Crisis services in Huron/Perth and Grey/Bruce were also enhanced to ensure there is access to crisis services 24/7 in all areas of the South West LHIN (Oxford, Elgin and Middlesex already were able to provide 24/7 access).

Mental Health Divestment:

The 2014-15 fiscal year, marked the completion of the divestment of mental health inpatient and related ambulatory services from St. Joseph's Health Care London's Regional Mental Health Care London (RMHCL) and St. Thomas (RMHCST) to further the principle of providing care closer to home for residents of Southwestern Ontario as per the 1997 Health Service Restructuring Commission (HSRC) directives. In addition to the divestment of inpatient and ambulatory services, the restructuring directives also called for an overall net reduction in the number of specialized mental health care beds at both mental health locations. This reduction was based on the principle of shifting care from institutionalized, residential models to one focused on recovery and return to successful community living.

Community Capacity Report Refresh:

In 2011, the South West LHIN completed a community capacity report that laid out a three-year implementation plan to provide enhancements to existing community services with a clear focus on integration and streamlining existing processes to enhance coordination and transition.

As part of the 2013-14 Priorities for Investment strategy, it was identified that a refresh of the Report was required to review implementation progress from the original report and set forth further recommendations for system redesign. Specifically, the objectives for the refresh project included:

- Determining system level outcomes achieved to-date based on 2011 recommendations;
- Updating key data points from 2011 report;
- Engaging stakeholders in dialogue about progress, success stories and current service pressures; and
- Developing system level indicators and criteria to monitor performance and track transformation.

The refreshed South West LHIN Community Capacity Refresh Final Report entitled, *Community Capacity Refresh: A Progress Report on the Implementation of the South West LHIN's 2011 Community Capacity Report for Mental Health and Addiction Services*, was received by the LHIN on June

20, 2014 and accepted by the South West LHIN Board of Directors at their July meeting.

The refreshed report focuses on: progress to date, making best use of the new investments, demonstrating system level outcomes, and some further areas to consider for service enhancement based on a review of existing capacity and levels of standardization including performance targets and service delivery models. The report outlines recommendations under nine domains that are focused on key areas for system improvement for the South West LHIN.

The priority areas of action identified are:

- Supportive housing
- Coordinated access
- Peer support
- Crisis response
- Primary Care
- Special priority populations including Francophone and Aboriginal
- Quality and Performance
- Service Enhancement

Coordinating Access to Mental Health Services:
Building off of the refreshed community capacity report recommendations, Addiction Services Thames Valley (ADSTV) has been designated as the lead agency in coordinating mental health services in the South area (Oxford, Elgin and London-Middlesex).

Beginning in 2014-15, funding has been provided for one full-time equivalent (FTE) to support the mental health and addictions providers in the South in continuing to work collaboratively to develop and implement a coordinated access model.

Grey Bruce and Huron Perth Networks will continue to review and refine their existing coordinated access models based on emerging best practices and the results of recent external evaluations of their respective partnership/alliance models.

Peer Support Project:
Consistent with the Community Capacity report recommendations, peer support was one of several key areas requiring system improvement. The peer support project is a direct result of this recommendation with a goal of strengthening peer support integration and infrastructure in the LHIN.

St. Joseph's was selected as the lead organization to manage the project. St. Joseph's was charged to work with South Western Alliance Network (SWAN) and the South West Addiction and Mental Health Coalition to ensure all key stakeholders (both providers and individuals with lived experience) were fully engaged and regularly consulted over the course of this project. A consultant team was identified to support the project and to make recommendations based on best practice models. The final Report with strategy, implementation implications and evaluation outcomes is expected in mid-April 2015. From there, an approach for going forward will be confirmed.

eHealth
In 2014-15 the South West LHIN continued to advance several key technology projects. While respecting the capacity and resources available, important steps were taken towards achieving excellence in health care by harnessing the power of information.

The 14 LHINs have developed a Cluster-based delivery model provincially for the implementation of eHealth initiatives. There are three Clusters which work together to coordinate and strategize eHealth opportunities:

- Cluster #1: South West Ontario (SWO)
- Cluster #2: Greater Toronto Area (GTA)
- Cluster #3: North East Ontario (NEO)

The SWO Cluster includes the Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brandt LHINs. LHINs use the Cluster model to provide project leadership and oversight to ensure successful implementation and

adoption of projects. The creation of the three provincial Clusters (SWO, GTA, NEO) provides a mechanism to coordinate, plan, implement and maintain eHealth enabling solutions in a streamlined fashion across the province.

The role of the Clusters is to:

- Support local eHealth as well as cluster or provincial (e.g. eHealth Ontario, OntarioMD, Ministry of Health) projects
- Facilitate delivery of local, cluster or provincial projects

- Represent initiatives within an individual LHIN and across a series of LHINs
- Support development and alignment provincially, locally and between Clusters

The South West LHIN, in collaboration with local, regional and provincial stakeholders, have identified 10 eHealth initiatives or areas of focus that have the most direct impact in helping us meet our organizational priorities and are listed below:

1. Access to Care eEnablers

- eNotification: Integrates information between hospitals and CCACs. When a person registers at a hospital Emergency Department, identifying information is sent to the CCAC to determine if the person is currently a CCAC client. This enables follow-up if changes need to be made to their care plan. In addition to eNotification in London and the surrounding area, the hospitals in the Grey Bruce and Huron Perth regions now have one-way communication (notification to the CCAC) in place with two-way notification (notification to the hospital) to be implemented in 2015-16.

- thehealthline.ca and its local version southwesthealthline.ca: Helps consumers, caregivers and service providers find accurate information about health care and community services across the province. In 2014-15 there were more than 4.3 million visits to the websites and database of 42,000 program and service listings. Enhancements on the SouthWesthealthline.ca made it simpler for service providers to submit and manage event information online and easier for consumers to search for up to date information about clinics, exercise programs and support groups in their communities.

- eScreener: A five-question tool administered by hospital staff when a person arrives at a hospital Emergency Department. If the outcome is "positive" they will require service from the CCAC when they are ready for discharge. eReferral automatically generates a notification for the CCAC and the case worker can follow-up so the planning for services begins at admission, not when a patient is ready for discharge, speeding the transfer to a community care setting. In 2014-15, the remaining hospitals in the South West LHIN went live with the eScreening tool.

2. eConsultation

- The eConsultation project allows primary care providers - primarily physicians and Nurse Practitioners - to communicate electronically with Specialists to ask questions about a specific patient. Such communication may avoid a potential referral to a specialist. This communication takes place over a secure web based platform provided by the Ontario

Telemedicine Network (OTN). A pilot project is currently underway in six sites across the province. A total of 58 primary care providers and 26 specialist across 16 specialties in the London area are currently participating in the South West LHIN regional pilot site. The pilot project will end in September 2015. A benefits evaluation is being conducted that will inform the Ministry decision to roll this out province wide.

3. Health Links – Care Coordination Tool

- The Care Coordination Tool (CCT) is an information recording tool that supports the Care Coordination Process (CCP) across various care providers, the patient and their extended circle of support. The tool was developed to support Health Link patients that benefit from regular care conferences between the care providers. It serves to collaborate and share timely information between them. The tool was initially rolled out as a paper tool. The Ministry is currently piloting an electronic version of the tool. The Huron Perth Health Link is among the pilot sites that will test this tool in 2015-16.

4. Regional Integration (Clinical Connect)

- Connecting South West Ontario (cSWO) is a Regional eHealth Program funded by eHealth Ontario. The program involves health service providers in the four Local Health Integration Networks of Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant.

  cSWO's goal is to implement a regional ehealth program that will make an individual's health information from across the continuum of care available in a timely and secure fashion at any point of care. This includes: an integrated Electronic Health Record (EHR) and a Regional Clinical Viewer, ClinicalConnect™. The regional ehealth program incorporates a number of related services, such as data support, adoption and change management, project management, privacy management and policy development.

  The cSWO Program is implemented and delivered through a centralized program management approach, with London Health Sciences Centre as the delivery partner to eHealth Ontario with accountability for the cSWO Program management. There are delivery partners accountable for key components of the program, including: regional and provincial solutions, change management and adoption, and sponsorship and registration.

- ClinicalConnect is a regional Clinical Viewer where authorized health care providers can view all of a patients' electronic health care information, regardless of where in the health care continuum it was collected, in real-time, from anywhere in southwestern Ontario.

  (ClinicalConnect is a secure online portal that provides authorized health care professionals with real-time access to their patients' electronic medical information (electronic health records) from local hospitals and Community Care Access Centres. As well, information from provincial data repositories is available, including Ontario laboratories information

system (OLIS) and Southwestern Ontario Diagnostic Imaging Network Provincial Data Repositories (SWODIN).

Care providers within a patient's circle of care can readily and securely access information about their patients, including reviewing their medications and test results. This provides a complete view of the patient's clinical journey through the health system.

ClinicalConnect has been deployed to over 17,629 users as of March 31, 2015 across the four LHINs. By Summer 2015, all acute care hospitals in South West Ontario will be connected and contributing data. All four South West Ontario Community Care Access Centres (CCACs) integrations are completed. At of the end of the reporting period, ClinicalConnect had been deployed to 53 organizations across the South West LHIN. Implementation and adoption of this important clinical tool will continue throughout 2015-2016.

5. Hospital Report Systems (SPIRE / HRM)

- Hospital Report Manager (HRM) is a provincial application that enables primary care providers and specialists using OntarioMD certified Electronic Medical Record (EMR) systems anywhere in Ontario to receive patient reports electronically from participating hospitals or Independent Health Facilities (IHF).

  The cSWO Program and the cSWO change management and adoption delivery partners are working collaboratively with OntarioMD on the solution deployment/integration of the HRM, including active engagement with the sending facilities (hospitals) and receiving organizations (clinicians). The first three clinicians in the South West LHIN went live with HRM in mid-March 2015, and at the end of this reporting period, 109 clinicians in the LHIN have been engaged regarding deployment. In 2015-2016 HRM will continue to be deployed systematically to primary care physicians across South West Ontario, enhancing their access to EMR download services in conjunction to the functionality offered through SPIRE.

6. Integrated Assessment Record

- The Integrated Assessment Record allows users to view a client's Information to better plan and deliver services to that client. The IAR also allows assessment information to move with a client from one health service provider to another. With the vast majority of providers successfully implemented, attention in 2015-16 will go to monitoring use and ensuring best practice to maximize the benefits of this tool.

7. Ontario Laboratories Information System

- A province-wide initiative led by eHealth Ontario to develop a secure repository of laboratory results sourced from public hospitals and community labs so care providers can get timely access to test results. In 2014-15 the remaining hospitals in the South West LHIN successfully completed their data integration into the Ontario Laboratories Information System (OLIS).

8. Resource Matching and Referral

- This initiative is a critical component in supporting a positive patient experience during transitions. Through this initiative there is a plan for provincial standardization of referral data from acute care to the four in scope pathways: Long-Term Care (LTC), Community Care Access Centre (CCAC), Complex Continuing Care (CCC) and Rehabilitation (Rehab). Progress to date on the Resource Matching and Referral (RM&R) initiative is the result of significant engagement and collaboration with health service provider stakeholders across the province.

  Since the Provincial Referral Standards were finalized and approved in early 2014, individual LHINs have been tasked with implementing the Referral Standards at all remaining HSPs within their LHIN. In July of 2014, the Hospital and CCAC CEOs identified RM&R Leads for their organizations to help move this work forward.

  In 2014-15, significant progress was made in our LHIN in each pathway. The Acute to LTC pathway is 100 per cent complete and are using the provincial standards. In the Complex Continuing Care and Rehab pathways 74 per cent of hospitals in the South West LHIN are now using the provincial standards. Some organizations will continue their work into the first and second quarters of 2015/16 according to each organizations implementation team's internal timeline required for successful implementation. Additional progress has been made in creating electronic forms to capture and record the referral information. These electronic forms will be implemented April-September of 2015-16.

9. Surgical Wait List Management

- The Surgical Waitlist Management System is an approach to "centralized" wait list management. This is a key strategy identified by the South West LHIN's Orthopaedic Steering Committee and Working Group to allow faster access to surgeries in the LHIN. With centralized wait-list management patients wait on a central list rather that a specific surgeon's list and should access services faster. In 2014-15 the Surgical Waitlist Management Steering Committee made recommendations to the LHIN/Hospital/CCAC CEO Forum which resulted in the St. Thomas Elgin General Hospital leading the first implementation and successful procurement of an electronic system.

10. Telehomecare

- Telehomecare is an Ontario Telemedicine Network (OTN) project that allows remote monitoring of amenable patients with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure at home. A remote monitoring nurse engages to support amenable patients for remote monitoring, coaching and self-management. The program is part of an integrated care process that involves the primary care provider and associated agencies providing care to the patient. The South West LHIN plans to roll this program out in 2015-16.

Seniors and Adults with Complex Needs

In 2014-15 the South West LHIN continued several key projects aimed at improving care for seniors and adults with complex needs with the long-term goal of optimizing their health, being responsive to their changing needs and supporting safe and independent living in a fiscally responsible way.

Improving integrated hospice palliative care has been a key focus area in the South West, with the aim of establishing a comprehensive and coordinated system of hospice palliative care services that meets peoples' needs. The South West Hospice Palliative Care Network was formed to guide and inform the provincial commitments of hospice palliative care including: strengthening accountability and introducing mechanisms of shared accountability; improving integration and continuity across care settings; strengthening service capacity and human capital in all care settings; broadening access and increase timeliness of access, strengthening caregiver supports; and building public awareness.

To date, the Leadership committee continues to engage with health service providers through local collaboratives to ensure patients and their families are receiving improved palliative care support in the South West. Much of 2014-15 was spent building a strong regional South West Hospice Palliative Care Network structure that has the accountability, authority and mandate to achieve the goals outlined in the Declaration and are responsible for System Design, Capacity Planning, Learning and Development, Performance, Measures/Monitoring, Clinical Standardization, and Clinical Coordination/Common Clinical Processes.

Another important area of improvement is related to Access to Care work that continues to be an essential driver in supporting seniors and adults with complex needs in their homes for as long as possible, with community supports.

Supporting seniors and adults with complex needs through the Access to Care philosophy means ensuring that they receive improved access to intensive case management, flexible care plans in the home with CCAC services and/or access to assisted living/supportive housing, adult day programs and other community services.

Consistent eligibility criteria and admission processes to complex continuing care/rehabilitation (CCC/Rehab) and assisted living/supportive housing/adult day programs (AL/SH/ADP) have been established as well as implemented across the South West LHIN. We continue to monitor and ensure the Home First philosophy is sustained, with processes and protocols implemented across the LHIN to alleviate alternate level of care (ALC) pressures on hospitals. Community partners are working with clients to ensure they have access to the services they need.

In spring 2014, the South West LHIN Board received directional recommendations for Phase II CCC/Rehab bed realignment. Implementation planning occurred in 2014-15 and continues to date with further realignment opportunities being considered. In fall 2014, the South West LHIN Board also approved changes related to the adult day program redesign. Quality improvement implementation started in 2014-15 to improve access to high quality services. Expanding services to improve access will continue in 2015-16 and 2016-17.

In addition, the Board received recommendations for the implementation of assisted living hubs enabling clients living within defined areas to receive access to scheduled and unscheduled assisted living services. Implementation planning for hubs in five communities began in fall 2014. Four of the hubs are actively supporting clients as of March 31, 2015.

Diabetes Program Update

In fiscal year 2014-15 there has been enhanced coordination and integration of care to people with diabetes. Five working groups have been established comprised of partners in the government, facilities, and in the communities throughout the LHIN. Most notable, headway was made in consolidating data collection and reporting throughout the LHIN giving the MOHLTC data that better reflects need amongst various populations. This data will directly contribute to the development of a set of system level indicators for diabetes work

Additionally, much work has been done to establish coordinated access for diabetes education. The aim is to work with diabetes education programs to develop standard work around intake and placement of patients. Significant work will be invested in this initiative in the upcoming year.

The Diabetes Foot Ulcer Project is an integrated, system-level service delivery model based on a person-centred, preventative and interdisciplinary team approach that leverages existing services and organizations and utilizes a harmonized risk stratification and referral algorithms. This joint initiative between CCAC and St. Joseph's Health Care will implement the recommendations from a report commissioned by the LHIN last year.

SOUTH WEST LHIN PERFORMANCE INDICATORS

2014 - 2015 ANNUAL REPORT

May 12, 2015 Release

PI No.	Performance Indicator	LHIN 2014/15 Starting Point	LHIN 2014/15 Performance Target	Most Recent Quarter 2014/15	FY 2014/15 LHIN Result
1: Access to healthcare services					
1	90th percentile ER length of stay for admitted patients	23.80	23.50	28.13	25.30
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.50	6.50	6.33	6.32
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	3.77	3.90	3.63	3.62
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	91.00%	90.00%	92.87%	91.28%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	99.60%	90.00%	100.00%	100.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	97.00%	90.00%	93.07%	89.13%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	89.00%	90.00%	80.48%	77.76%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	83.00%	90.00%	73.43%	79.19%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	45.00%	60.00%	27.75%	28.83%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	90.00%	90.00%	65.92%	73.32%
2: Integration and coordination of care					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	10.51%	9.46%	7.27%	8.93%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	26.00	24.00	20.00	21.00
3: Quality and improved health outcomes					
13	Readmission within 30 Days for Selected CMGs**	16.81%	15.10%	16.86%	17.20%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	15.60%	15.60%	18.55%	17.63%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	31.80%	28.60%	18.43%	19.62%

*Fiscal Year 2014-15 is based on most recent four quarters of data (Q4 2013/14 - Q3 2014/15) due to availability

**Fiscal Year 2014-15 is based on most recent four quarters of data (Q3 2013/14 - Q2 2014/15) due to availability

Performance of Local Health System

The Ministry-LHIN Performance Agreement (MLPA) outlines obligations and responsibilities of both the South West LHIN and the Ministry of Health and Long-Term Care over a defined period of time and specifies indicators targeted for improvement. The above table reports on the performance of the South West LHIN on key MLPA measures.

Considering both the most recent quarter of data and the annual performance result, the South West LHIN has met its target and showed improvements over baseline in the following MLPA indicators:

- Emergency Room length of stay (wait time) for non-admitted complex patients and non-admitted minor uncomplicated patients
- Completing cancer surgeries within the access target (i.e. 84 days for non-urgent cases)
- Completing cardiac by-pass surgeries within the access target (i.e. 90 days for non-urgent cases)
- Percentage of Alternate Level of Care (ALC) days
- Wait time (in days) for Community Care Access Centre (CCAC) in-home services (application from the community setting)
- Repeat unscheduled Emergency Room visits within 30 days for substance abuse conditions

The South West LHIN met the goal for completing cataract surgeries within the access target (i.e. 182 days for non-urgent cases) in the most recent quarter and was less than one per cent off achieving the goal for the annual result.

Performance on the South West LHIN's MLPA measures is tracked along with three Big Dot outcome measures, twelve outcome indicators, and four key drivers or enabling strategies that reflect IHSP 2013-2016 objectives. Each quarter, scorecards are updated and communicated to the Board, Health Service Provider Boards, and to the public via the South West LHIN website. In addition, the South West LHIN has a Report on Performance e-tool tracking over 36 metrics and showing comparative and drill-down information at the provincial, LHIN and health service provider levels.

An accompanying Interventions Report summarizes current strategies and programs targeting improvement in MLPA and Scorecard indicators. Some of the actions and initiatives that contributed to improved or sustained performance in 2014/15 include:

- The provincial Emergency Department Pay-for-Results (P4R) program and South West Knowledge Transfer project to improve patient flow and wait times in Emergency Departments through an improvement focus and peer-to-peer learning and collaboration.

- Performance Management & Accountability—performance is reported and monitored and plans for improvement are submitted and reviewed following quarterly reviews against Service Accountability Agreement (SAA) targets.

- Investments to expand access to home care and community care and sustain the Access to Care initiative (including Home First, Assisted Living/Supportive Housing/Adult Day Program Redesign, and Coordinated Access to Complex Continuing Care and Rehabilitation beds) has been a key strategy to support people—specifically seniors and adults with complex needs—to live safely in their homes for as long as possible. We continue to see more people able to return to their homes following a

hospital encounter and less people staying in hospital when their acute phase is complete (i.e. as an ALC patient).

- Investments in mobile response team crisis services and transitional case management and improved collaboration and integration among community mental health and addictions service providers are impacting emergency department re-visit rates for substance abuse.

For both the most recent quarter of data and the annual performance result, the South West LHIN has not met its target for the following MLPA indicators:

- Emergency Room length of stay (wait time) for admitted patients
- Completing hip or knee replacement surgeries within the access target (i.e. 182 days for non-urgent cases)
- Completing MRI or CT scans within the access target (i.e. 28 days for non-urgent cases)
- Hospital readmission rate within 30 days for selected Case Mix Groups (CMGs)
- Repeat unscheduled Emergency Room visits within 30 days for mental health conditions

Improvements were observed over baseline for both knee surgeries and hospital readmissions in two of four quarters, but performance was still short of meeting the targets.

Some of the challenges in improving the surgical and diagnostic imaging wait times lie not only in the increasing demand for these services but also in hospitals having to make tough choices to manage spending which, for many hospitals, means completing only the funded volumes of hip and knee surgeries and operating only within the allocated funded hours for MRI and CT. The readmission and re-visit measures inherently require cross sector collaboration to improve and rates of improvement for those LHINs that have been able to make progress are generally less than 5 per cent.

Actions the South West LHIN has undertaken or plans to undertake to improve the above results include:

- A strategic focus on improving patient flow. Hospital and CCAC leaders are working with the LHIN to prioritize improvement opportunities and identify high impact solutions.

- A strengthened performance management process that includes enhanced reporting and monitoring and process improvement work to guide and drive improvement in the wait times for joint replacements and diagnostic imaging scans.

- Spreading best hospital discharge practices including improving communication between primary health care providers and hospitals and supporting and facilitating the development of Health Links to improve readmissions to hospital within 30 days of discharge.

- Quality improvement learning collaboratives that support best practices in managing chronic disease and the use of information systems to enhance patient flow and care.

- Five crisis stabilization beds have recently been open in London to provide short-term support for individuals with a mental health and/or addictions crisis. This centre is able to meet the support needs of some patients with mental health or addictions issues who may otherwise seek care in the ED. Community mental health partners are also collaborating to develop a Coordinated Access model of care to improve accessibility and are working

to identify potential service gaps and improvement opportunities for patients who frequently visit the ED.

Year three of our three-year IHSP will bring heightened efforts and energy to drive and support performance improvement in these MLPA measures as well as in our key strategic objectives and outcomes.

Improving the number of patients requiring an alternate level of care

As observed in 2013-14, at the start of the 2014-15 fiscal year, the South West LHIN had the lowest MLPA ALC baseline or "starting point" from which to measure progress and it was one of only two LHINs to adopt the challenging provincial target of 9.46 per cent ALC days. In 2014-15, the South West LHIN beat this target and had the second lowest per cent ALC days of all LHINs.

Reducing the number of patients remaining in South West LHIN hospital beds when they no longer require that level of care and services is essential to keep hospital beds available and accessible to those patients who do require that level of care. Reducing the number of patients waiting in hospital for long-term care, specifically, is important as wait times can be several weeks or months. Continuing to improve availability and accessibility to other care settings—including safe care at home and in affordable assisted living facilities—will further improve the South West LHIN's ALC rate.

Operational Performance

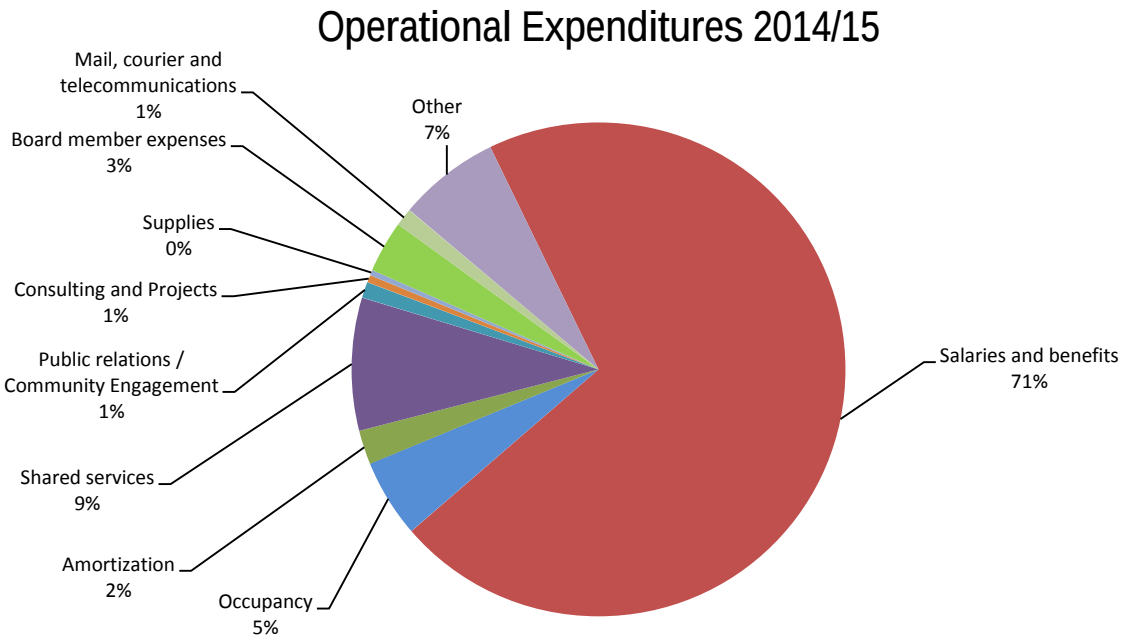
In 2014/15, the South West LHIN operating budget was made up of two components:

$5.0 million for operations

$2.1 million for special projects

Operations

The South West LHIN ended the year with an operating surplus of $1,298. Surpluses are returned to Ministry of Health and Long-Term Care (MOHLTC). The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure was salaries and benefits with 34 full-time employees (FTEs) which included two contract staff and one university student. The LHIN also had one seconded position.



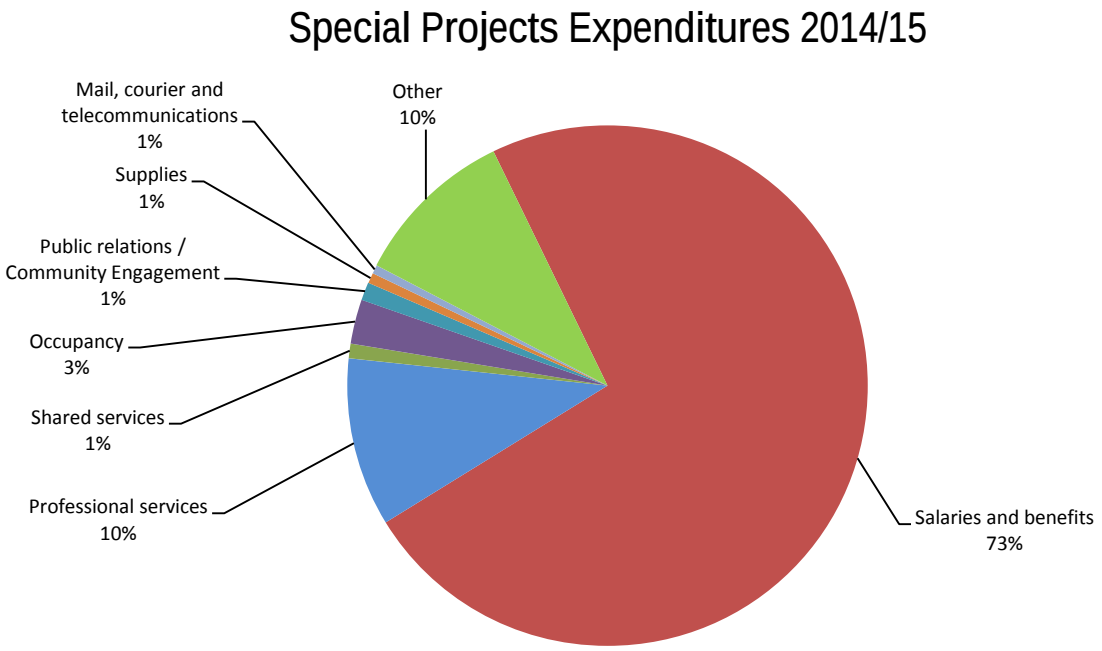
Salaries and benefits	**3,533,796**
Occupancy	**254,419**
Amortization	**111,406**
Shared services	**382,520**
LHIN Collaborative	**50,929**
Public relations	**52,295**
Consulting and Project expenses	**23,875**
Supplies	**17,840**
Board chair per diem	**43,225**
Board member per diem	**62,246**
Board member expenses	**62,933**
Mail, courier and telecommunications	**58,845**
Other	**330,805**
	4,985,134

Special Projects

The South West LHIN ended the year with surpluses of $54,338 relating to the funding for other special projects. Surpluses are returned to Ministry of Health and Long-Term Care. The chart below shows the 8 major categories of expenditures for the projects. Again, the largest expenditure was salaries and benefits with 15 full-time employees (FTEs) which included two contract staff.

The base and one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2014/15 fiscal year were:

Salaries and benefits	**1,557,657**
Professional services	**222,059**
Shared services	**19,142**
Occupancy	**58,481**
Public relations and community engagement	**23,788**
Supplies	**13,636**
Mail, courier and telecommunications	**11,314**
Other	**215,054**
	2,121,131



Enabling Technology Integration (ETI PMO)

Effective January 31, 2014, the LHIN entered into an agreement with three LHINs, Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "Cluster"), in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. The total Cluster funding received for the year ended March 31, 2015 was $2,040,000. Funding of $1,530,000 was allocated to other LHINs within the cluster who incurred eligible expenses of $1,474,095. The South West LHIN had expenses of $485,540 relating to ETI PMO funding.

Financial statements of

South West Local Health Integration Network

March 31, 2015

South West Local Health Integration Network

March 31, 2015

Table of contents

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Independent Auditor's Report

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

We have audited the accompanying financial statements of South West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2015, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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 comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2015 and the results of its operations, changes in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

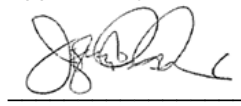
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 19, 2015

South West Local Health Integration Network

Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	**412,804**	848,079
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**13,800,587**	11,537,917
Harmonized sales tax receivable	**81,988**	59,791
Due from Waterloo Wellington LHIN (Note 3c)	**55,905**	-
	14,351,284	12,445,787
Liabilities		
Accounts payable and accrued liabilities	**453,340**	422,393
Due to Health Service Providers ("HSPs") (Note 9)	**13,800,587**	11,537,917
Due to MOHLTC (Note 3b)	**55,636**	537,813
Due to the LHIN Shared Services Office (Note 4)	**58,879**	3,316
Deferred capital contributions (Note 5)	**68,725**	140,632
	14,437,167	12,642,071
Net debt	**(85,883)**	(196,284)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**17,158**	55,652
Tangible capital assets (Note 7)	**68,725**	140,632
	85,883	196,284
Accumulated surplus	**-**	-

Approved by the Board



_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of operations
year ended March 31, 2015

	Budget (Note 8)	2015 Actual	2014 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**2,187,364,300**	**2,250,035,712**	2,215,597,061
Operations of LHIN	**4,895,720**	**4,875,026**	4,909,473
Project Initiatives			
Aboriginal Planning	**35,000**	**35,000**	35,000
French Language Services	**106,000**	**104,595**	106,000
Critical Care	**75,000**	**75,000**	75,000
Emergency Department ("ED") Lead	**75,000**	**75,000**	68,220
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead	**100,000**	**98,576**	100,000
Primary Care Lead	**75,000**	**75,000**	75,000
Enabling Technologies ETI PMO	**2,040,000**	**2,007,086**	2,320,000
Diabetes Regional Coordinating Ctr	**1,192,370**	**1,179,307**	946,212
E-Health SPIRE & cSWO	**-**	**-**	187,739
Amortization of deferred capital contributions (Note 5)	**111,406**	**111,406**	139,890
	2,196,069,796	**2,258,671,708**	2,224,559,595
Enabling Technologies ETI PMO allocated to other LHIN's	**(1,530,000)**	**(1,530,000)**	(1,740,000)
Funding repayable to the MOHLTC (Note 3a)	**-**	**269**	(237,813)
	2,194,539,796	**2,257,141,977**	2,222,581,782
Expenses			
Transfer payments to HSPs (Note 9)	**2,187,364,300**	**2,250,035,712**	2,215,597,061
General and administrative (Note 11)	**5,007,126**	**4,985,134**	5,048,519
Project Initiatives (Note 10)			
Aboriginal Planning	**35,000**	**34,638**	30,203
French Language Services	**106,000**	**104,555**	93,908
Critical Care	**75,000**	**73,374**	72,613
ED Lead	**75,000**	**73,728**	67,655
ER/ALC Performance Lead	**100,000**	**98,372**	84,386
Primary Care Lead	**75,000**	**74,457**	72,052
Enabling Technologies	**510,000**	**485,540**	511,019
Diabetes Regional Coordinating Ctr	**1,192,370**	**1,176,467**	816,627
E-Health SPIRE & cSWO	**-**	**-**	187,739
	2,194,539,796	**2,257,141,977**	2,222,581,782
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2015

	2015 Actual	2014 Actual
	$	$
Annual surplus	**-**	-
Change in prepaid expenses, net	**38,494**	(24,488)
Acquisition of tangible capital assets	**(39,499)**	(18,135)
Amortization of tangible capital assets	**111,406**	139,890
Decrease in net debt	**110,401**	97,267
Net debt, beginning of year	**(196,284)**	(293,551)
Net debt, end of year	**(85,883)**	(196,284)

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2015

	2015	2014
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	111,406	139,890
Amortization of deferred capital contributions (Note 5)	(111,406)	(139,890)
Changes in non-cash operating items		
Increase in due from MOHLTC HSP transfer payments	(2,262,670)	(3,032,095)
Decrease in due from LHIN Shared Services Office	-	17,190
(Increase) decrease in accounts receivable	(55,905)	3,879
(Increase) decrease in Harmonized Sales Tax receivable	(22,197)	19,278
Increase (decrease) in accounts payable and accrued liabilities	30,947	(373,391)
Increase in due to HSPs	2,262,670	3,032,095
(Decrease) increase in due to MOHLTC	(482,177)	361,702
Decrease in due to eHealth Ontario	-	(52,319)
Increase in due to LHIN Shared Services Office	55,563	3,316
Decrease (increase) in prepaid expenses	38,494	(24,488)
	(435,275)	(44,833)
Capital transaction		
Acquisition of tangible capital assets	(39,499)	(18,135)
Financing transaction		
Deferred capital contributions received (Note 5)	39,499	18,135
Net decrease in cash	(435,275)	(44,833)
Cash, beginning of year	848,079	892,912
Cash, end of year	412,804	848,079

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The South West Local Health Integration Network was incorporated by Letters Patent on July 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 South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

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

The 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 approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), 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.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. 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 tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

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

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

Deferred capital contributions

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 as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under “revenue” in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic 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 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 equipment, 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 provided for a full year.

Segment disclosures

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 operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards 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. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLPA, 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.

In accordance with the TPA, 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 eHealth Ontario.

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

			2015	2014
	Funding	**Eligible expenses**	**Funding excess**	Funding excess
	$	**$**	**$**	$
Transfer payments to HSPs	**2,250,035,712**	**2,250,035,712**	**-**	-
LHIN operations	**4,875,026**	**4,873,728**	**1,298**	844
Aboriginal Planning	**35,000**	**34,638**	**362**	4,797
French Language Services	**104,595**	**104,555**	**40**	12,092
Enabling Technologies	**2,007,086**	**1,959,635**	**47,451**	368,981
Critical Care Lead	**75,000**	**73,374**	**1,626**	2,387
ED Lead	**75,000**	**73,728**	**1,272**	565
Primary Care Lead	**75,000**	**74,457**	**543**	2,948
ER/ALC Lead	**98,576**	**98,372**	**204**	15,614
Diabetes Regional Coor. Centres	**1,179,307**	**1,176,467**	**2,840**	129,585
	2,258,560,302	**2,258,504,666**	**55,636**	537,813

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

	2015	2014
	$	$
Due to MOHLTC, beginning of year	**537,813**	176,111
Funding repaid to MOHLTC	**(537,813)**	(176,111)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**8,185**	237,813
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities	**47,451**	300,000
Due from MOHLTC, end of year	**55,636**	537,813

c) Enabling Technologies for Integration (ETI PMO)

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the “Cluster”) in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The South West LHIN is designated the Lead LHIN with this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2015 was $2,040,000 (2014 - $2,320,000).

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

Funding of $1,530,000 (2014 - $1,740,000) was allocated to other LHIN's within the cluster who incurred eligible expenses of $1,474,095 (2014 - $1,440,000). The LHIN has setup a payable to the MOHLTC for $55,905.

The MOHLTC collected from the LHIN, $30,000.00 (2014 - $Nil) as an in year recovery. The LHIN has setup a receivable from the MOHLTC for $8,454 to cover these expenses.

The following provides condensed financial information for the ETI PMO funding and expenses for the cluster:

			2015	2014
	Funding allocated	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Erie St. Clair LHIN	**510,000**	**510,000**	**-**	-
Hamilton Niagara Haldimand Brant LHIN	**510,000**	**510,000**	**-**	-
Waterloo Wellington LHIN	**510,000**	**454,095**	**55,905**	-
South West LHIN	**477,086**	**485,540**	**(8,454)**	68,981
	2,007,086	**1,959,635**	**47,451**	68,981

4. Related party transactions

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

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2015	2014
	$	$
Balance, beginning of year	**140,632**	262,387
Capital contributions received during the year (Note 8)	**39,499**	18,135
Amortization for the year	**(111,406)**	(139,890)
Balance, end of year	**68,725**	140,632

6. Commitments

The LHIN has commitments under various operating leases extending to 2019 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

	$
2016	126,263
2017	4,789
2018	4,014
2019	191
2020	191

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs, based on the current accountability agreements, are as follows:

	$
2016	2,193,291,572

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

7. Tangible capital assets

			2015	2014
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer equipment	**242,202**	**189,715**	**52,487**	42,000
Leasehold improvements	**1,588,790**	**1,588,501**	**289**	82,016
Office equipment, furniture and fixtures	**228,008**	**212,059**	**15,949**	16,616
	2,059,000	**1,990,275**	**68,725**	140,632

8. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,250,035,712 is derived as follows:

	$
Initial budget	**2,187,364,300**
Adjustment due to announcements made during the year	**62,671,412**
Final HSP funding budget	**2,250,035,712**

8. Budget figures (continued)

The final LHIN budget, excluding HSP funding, of $8,524,591 is derived as follows:

	$
Initial budget	**6,229,090**
Additional funding received during the year	**2,335,000**
Amount treated as capital contributions during the year	**39,499**
Final LHIN operating budget	**8,524,591**

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,250,035,712 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2014 as follows:

	2015	2014
	$	$
Operation of hospitals	**1,550,296,136**	1,551,196,371
Grants to compensate for municipal taxation - public hospitals	**439,800**	451,500
Long term care homes	**329,020,764**	313,729,659
Community care access centres	**214,373,167**	205,929,789
Community support services	**46,365,977**	42,588,870
Assisted living services in supportive housing	**19,864,254**	17,999,245
Community health centres	**20,772,244**	18,679,068
Community mental health addictions program	**68,903,370**	65,022,559
	2,250,035,712	2,215,597,061

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2015, an amount of $13,800,587 (2014 - $11,537,917) was receivable from MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

10. Project Initiatives

The LHIN received funds for various initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2015	2014
	$	$
Salaries and benefits	**1,557,657**	1,102,269
Professional services	**222,059**	294,000
Shared services	**19,142**	112,490
Occupancy	**58,481**	53,179
Public relations and community engagement	**23,788**	11,377
Supplies	**13,636**	10,126
Mail, courier and telecommunications	**11,314**	1,349
Other	**215,054**	57,400
	2,121,131	1,642,190

10. Project Initiatives (continued)

Diabetes Regional Coordination Centres

The MOHLTC provided the LHIN with $1,192,370 (2014 - $1,200,620) related to Diabetes Regional Coordination Centres initiatives. The LHIN incurred operating expenses of $1,176,467 (2014 - $816,627) and capital expenses of $13,063 (2014 - $8,544) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,840. Expenses incurred include the following:

	2015	2014
	$	$
Salaries	**926,404**	742,683
Operating expenses	**250,063**	70,239
One-time expenses	**-**	8,250
Total	**1,176,467**	821,172

11. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies general and administrative expenses by object:

	2015	2014
	$	$
Salaries and benefits	**3,533,796**	3,450,665
Occupancy	**254,419**	224,980
Amortization	**111,406**	139,890
Shared services	**382,520**	341,521
LHIN Collaborative	**50,929**	54,357
Public relations	**52,295**	87,185
Consulting and Project expenses	**23,875**	219,451
Supplies	**17,840**	20,983
Board chair per diem	**43,225**	44,145
Board member per diem	**62,246**	64,623
Board member expenses	**62,933**	55,832
Mail, courier and telecommunications	**58,845**	61,992
Other	**330,805**	282,895
	4,985,134	5,048,519

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan (“HOOPP”), which is a multi-employer plan, on behalf of approximately 42 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 2015 was $378,658 (2014 - $330,642) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2014. As at that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

14. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

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