South West LHIN

COMPASSION

COURAGE

EVIDENCE-INFORMED

South West Local Health Integration Network Annual Report 2009/10

INNOVATION

INTEGRITY

TRUST AND RESPECT

Ontario
Local Health Integration Network

South West Local Health Integration Network
Annual Report 2009/10

Table of contents

Message from the Board Chair and Chief Executive Officer

This past year, the LHIN released the *Health System Design Blueprint – Vision 2022*. It is in this document that we take a long-term system level view of health care in the South West LHIN. In the course of developing the Blueprint, we went out to our health service providers who are on the frontlines every day and to the communities in our LHIN, to hear about the issues and concerns that our residents experience with the system. Engagement of our key stakeholders, including the residents of the LHIN, is critical if we are going to transform the health care system in a way that will ensure quality care.

After 18 public sessions that took us from West Lorne to Lion's Head and points in between, we believe that the Blueprint reflects the needs of our communities, and lays out a comprehensive, long-term strategy to achieve an effective and affordable health care system that will be there for generations to come.

We remain steadfast in our commitment to deliver to the residents of the LHIN a health care system that will provide quality care efficiently and cost effectively. We also understand that difficult decisions may have to be made and that thoughtful consideration and our LHIN values of *compassion, courage, evidence-informed, innovation, integrity, trust and respect* will help guide us to the best outcomes for all residents of the South West LHIN.

In 2006, the LHIN released its first Integrated Health Service Plan (IHSP) that outlined the health care goals and priorities that had been identified through extensive engagement with all our health service providers and the residents of the LHIN. The work done in the past three years has been guided by those priorities and we have begun to see some tangible, positive results that are having real impact on the day to day lives of individuals.

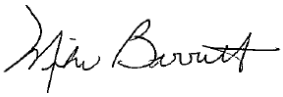
Many of the Aging at Home initiatives that first received funding in 2008 are now fully operational and continue to ensure seniors can live independently in their homes. Great strides have been made in wait times for certain surgeries and diagnostics. With a specific focus on emergency rooms and alternate level of care patients in hospitals, ER wait times have improved. Our health service providers have worked very hard to bring about changes that have improved health care delivery. However, we also recognize that much work remains to be done.

Last fall, we refreshed our IHSP for 2010-2013 which continues the implementation efforts of our first IHSP. It prioritizes the steps needed to achieve our Blueprint goal of an integrated health system of care by 2022. The goals and strategic directions of our IHSP are explained in greater detail in the body of this report.

The LHIN strives to ensure health care dollars are spent efficiently and effectively, yielding the best results possible. Accountability agreements between the LHIN and health service providers and between the LHIN and the Ministry of Health and Long-Term Care ensure the responsible use of precious health care resources, and the sustainability of the health care system.

This annual report reflects on the past 12 months, and provides a glimpse into what is to come. We are fortunate to have health service providers who have embraced the need for change and are prepared to work together to achieve a more accessible and sustainable system. We gratefully acknowledge their efforts as well as the hard work of a talented and dedicated LHIN board and staff.

Ferne Woolcott, Board Chair (A)



Michael Barrett, Chief Executive Officer

Board of Directors

Local Health Integration Networks (LHINs) are governed by an appointed Board of Directors and bound by accountability agreements with the Ministry. Each Board member is appointed by an Order-in-Council.

Board members are selected using a skills-based process, with all candidates assessed for the fit between skills and abilities of the prospective appointee and the needs of the LHIN. The appointment process is transparent and consistent, with clear and understandable guidelines applied to all Board member appointments. Board members are expected to possess relevant expertise, experience, leadership skills, and have an understanding of local health issues, needs and priorities.

In the South West, Board members not only bring a richness of backgrounds and experiences, but also represent the vast geography of our LHIN, allowing them to make decisions that will benefit all residents.

There were some changes to the Board this year, with the resignation of the Board Chair, and the end of term for a Board member. At the time of writing this report, recruitment is underway to fill the existing vacancies. Below is a list of Board members from 2009-10.

Ferne Woolcott (Acting) Board Chair
Term: May 17, 2006 to June 16, 2010

Janet McEwen
Term: June 1, 2005 to June 10, 2011

Murray Bryant
Term: May 17, 2006 to May 16, 2011

Linda Stevenson
Term: May 16, 2007 to May 15, 2012

Kerry Blagrave, Secretary
Term: June 1, 2005 to June 1, 2011

John Van Bastelaar
Term: January 5, 2006 to January 4, 2011

Barrie Evans
Term: May 17, 2006 to June 16, 2010

Members who left the Board during 2009-10:

Norm Gamble, Chair
Resigned October 9, 2009

Anne Lake
Term ended February 4, 2010

The South West LHIN gratefully acknowledges the contributions made by Norm and Anne during their years of service on the Board. Both were among the first appointees to the Board, and their guidance and dedication were most valuable in setting the LHIN on its current course.

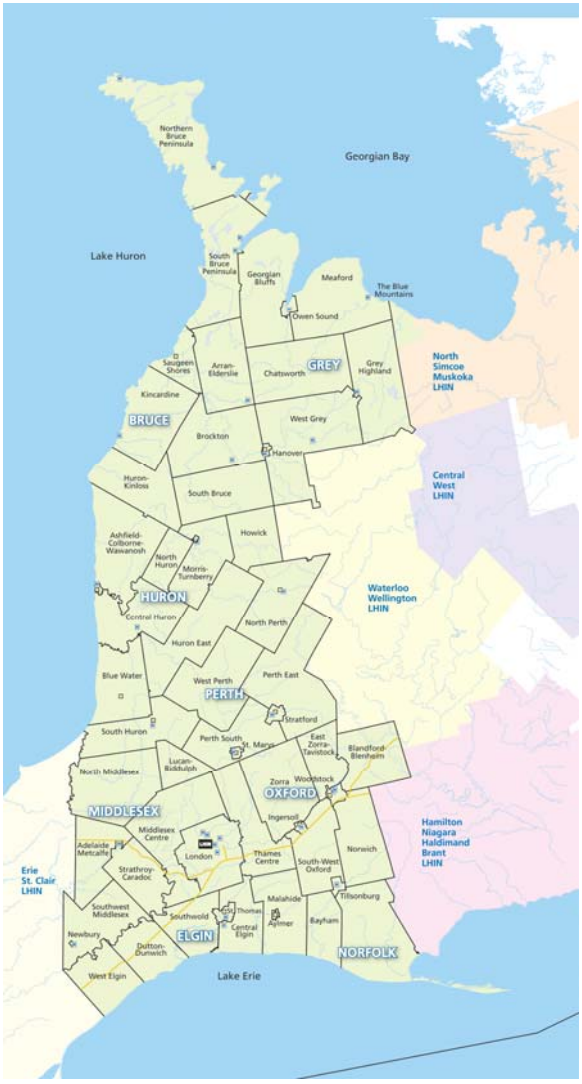
Our geography, our communities, our residents

The South West LHIN works closely with over 150 health service providers to ensure that all residents have access to quality care when they need it. Our geography stretches from Lake Erie in the south to the Bruce peninsula in the north and includes a rich diversity of communities – from farming communities, small villages and towns, to large urban centres, First Nations and Francophone communities. We are accountable to all residents and are committed to enhancing the health care experience today, tomorrow and for generations to come. The LHIN, now in its sixth year, is guided by a Board whose members are knowledgeable and committed community members.

The LHINs were established with a belief that health care decisions should be made locally. To do this, people must be given the opportunity to have their say and that is why we continuously reach out and invite input from our health service providers, our community service agencies, and the residents of our LHIN. Our goal of an integrated health system of care will only be achieved with the support and active collaboration of all stakeholders. We know that difficult decisions will have to be made and we will work in partnership with our health service providers to make sure the changes we are making are the right ones for the people we serve.

The South West LHIN, like other areas in the province, faces many health care challenges – a growing senior population, a shortage of many health care professionals, emergency department wait times, ever increasing costs, and limited financial resources. We have entered into service accountability agreements with all 20 hospitals corporations (33 sites) and 90 community sector agencies and have laid out performance targets that are monitored quarterly. In the coming year, service accountability agreements will also be developed with the 75 long-term care homes in the South West LHIN. These agreements are vital in ensuring that the residents of the South West LHIN are getting value for the health care dollars given to providers.

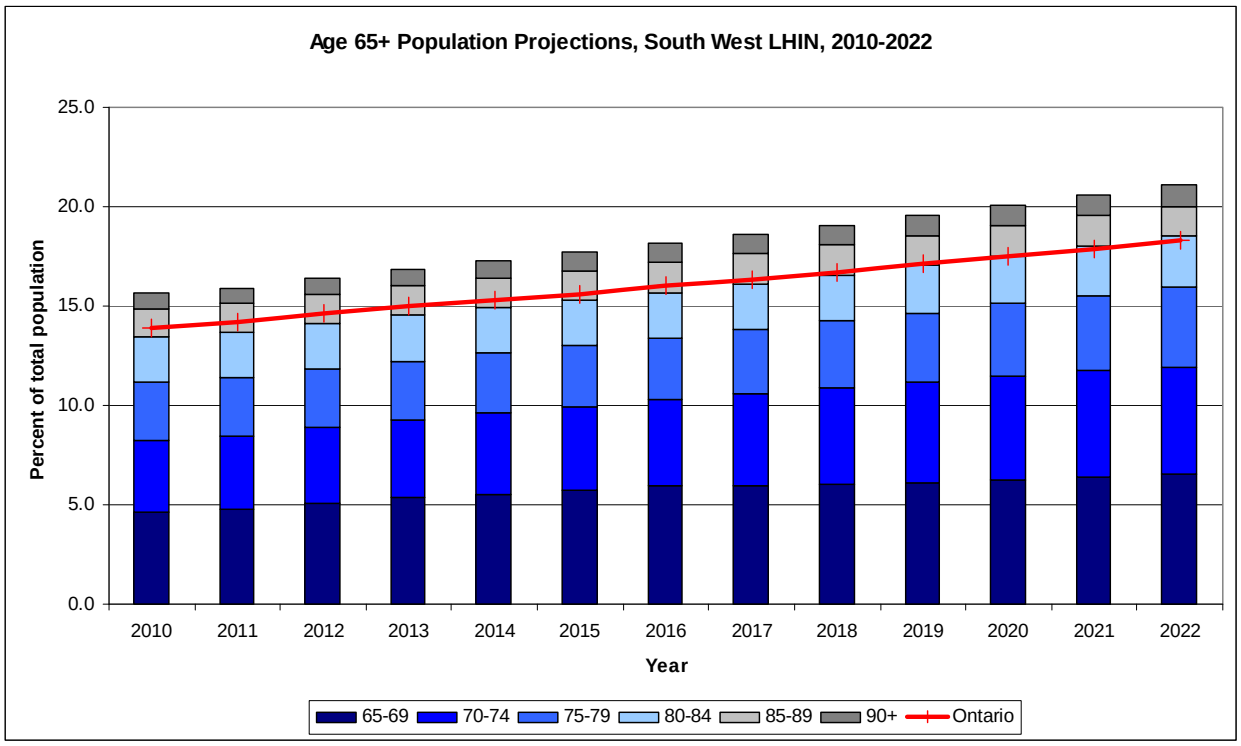
In 2006, we identified four integration priorities: strengthening and improving primary health care; preventing and managing chronic illness; building linkages across the health care continuum; and, accessing the right services in the right place at the right time by the right provider. In addition, two enabling priorities were identified: health human resources, and eHealth. This report will review the progress made in achieving these priorities, and will outline future direction.



Population profile

As we plan for a health system that meets the needs of all the people of the South West LHIN, we must recognize the diversity of needs of our Aboriginal and Francophone communities, the rural populations, and the large urban centres. Statistics about the people of the South West LHIN include the following:

- Of the approximately 900,000 people in the region, most (85%) list English as their mother tongue. However, French is the mother tongue for close to 11,000 people (1.2%). An additional 7,300 (0.8%) do not speak either official language.
- 1.4% of people in the South West identify themselves as Aboriginal. This compares with 2% for the province as a whole and represents a significant population with unique health challenges. There are five reserves in the South West with a population of close to 4,500 people. It is estimated that an additional 7,200 Aboriginals live off reserve.*
- The population in the South West LHIN is projected to grow to just over 1 million people by 2017.
- The percentage of the population aged 65+ in the South West LHIN is currently 15.6%. This compares with 13.9% for the province as a whole. As shown in the following table, the senior population is expected to grow rapidly in the coming years, to 21.1% (18.3% in Ontario) by the year 2022. **

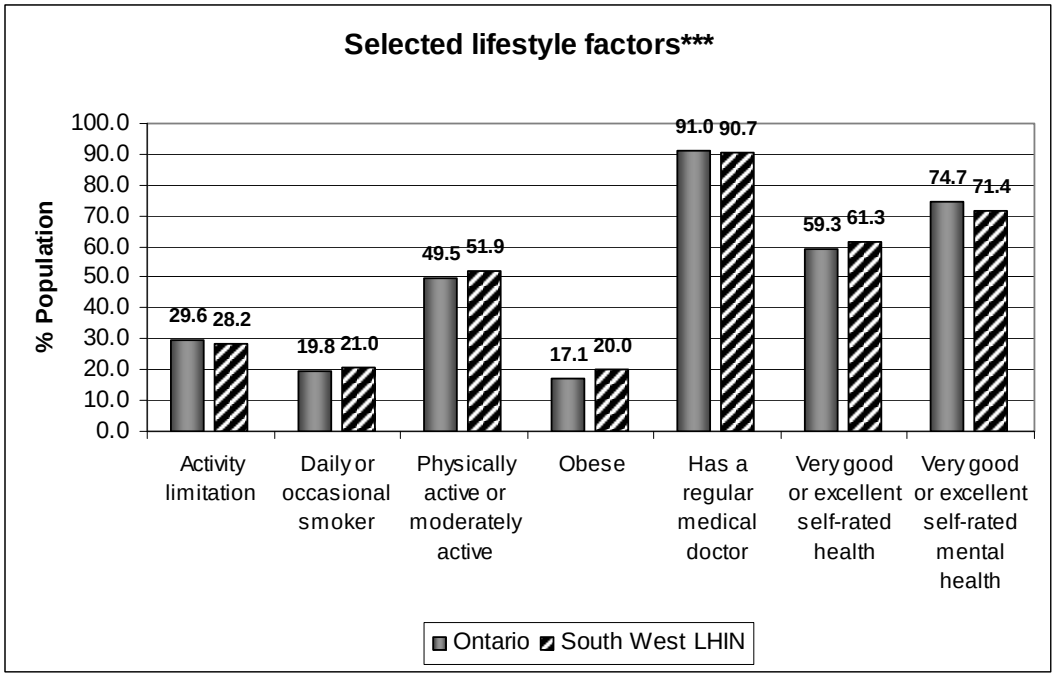


Population health profile***

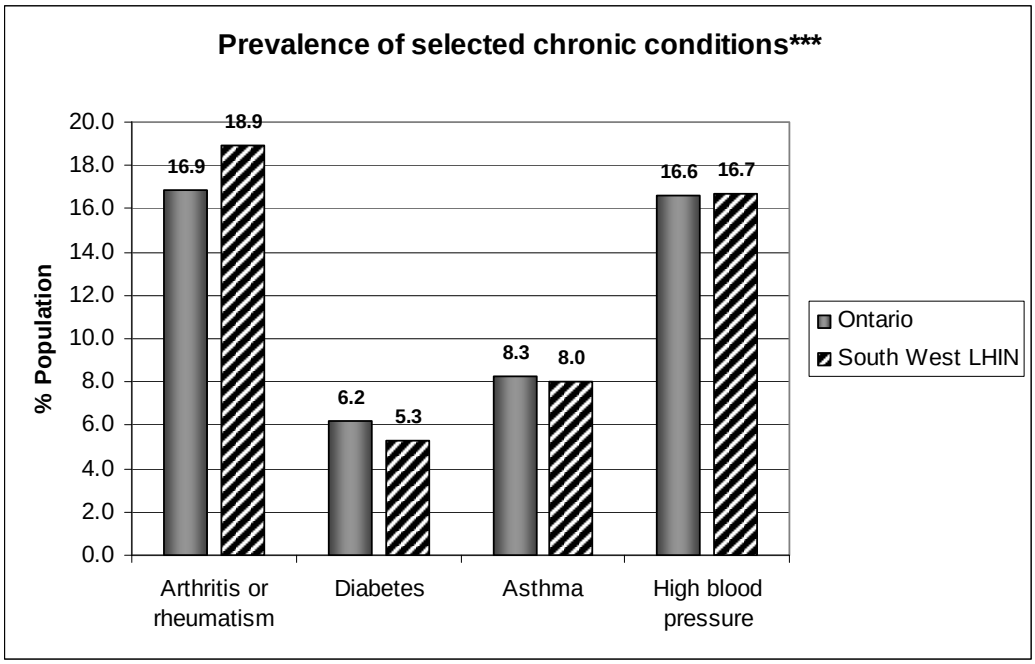
When developing a health care system for the future, it's important to understand today's needs, and the lifestyle factors of today's population which are likely to influence the health care needs of tomorrow. Following are some of the factors, and their prevalence within the South West LHIN, that must be considered as we move forward with the transformation of the health care system.

- Just over 61% of people in the South West rated their health as very good or excellent in 2008.
- The incidence of diabetes in the South West LHIN was 5.3% in 2008. This compares with 6.2% for the province.
- 19.4% of people over age 12 report alcohol consumption of five or more drinks at one time, at least once a month, compared to 15.5% for the province as a whole.
- 22.1% of the residents of the South West LHIN report high stress levels in their lives, compared with 22.3% of Ontarians.
- Canadian Community Health Survey data for 2008 suggests that 20% of adults aged 18+ in the South West are obese.
- 90.7% of South West LHIN residents reported that they had a regular family physician in 2008. This compares with 91% for Ontario.

The table below graphs some of the lifestyle factors and compares these to provincial statistics.



The following table shows the prevalence rates of various chronic conditions among the residents of the South West LHIN compared to the Ontario population.



Data Sources: *Indian and Northern Affairs Canada First Nation Profiles and Registered Indian Population by Sex and Residence, 2006. **Ministry of Finance Population Projections, Population Projections by Gender, Age and LHIN of Residence, 2006-2016, Health System Intelligence Project. ***Statistics Canada, Canadian Community Health Survey, 2008.

Ministry/LHIN Accountability Agreement

Engaging our communities and stakeholders

The South West LHIN believes that good health care decisions can only be made when all stakeholders have had the opportunity to contribute. From our earliest days, we established a strong tradition of engagement with our health service providers, the general public and health care organizations. We recognize that such extensive engagement is critical if we are to transform the health care system in a meaningful way.

This past year the LHIN conducted a successful series of 18 community sessions across the South West in July and September to help shape the future of health care. The goals of the sessions were to:

- Share information about current trends and issues
- Listen to ideas and concerns about the health care system
- Celebrate recent enhancements to the health care system
- Get feedback on proposed priority areas for improvements

More than 1,500 people attended the sessions. Additional opportunities to provide input included an online questionnaire and a telephone survey.

Overall the key themes that emerged were:

- a general agreement by participants with the LHIN's proposed priorities
- consistent issues were raised around emergency services, health human resources, mental health and addictions, access to health information and access to services including transportation and navigation through the system
- the recognition and acknowledgement by the LHIN that it has many partners that contribute to the overall health of residents in the South West and that it needs to ensure it engages with those partners (e.g. physicians, ambulance services, other ministries and municipalities).

In this manner the LHIN can share the information it has received from its engagements with the appropriate agencies to help ensure a stronger public voice in all processes

Three targeted Integrated Health Service Plan (IHSP)/Blueprint engagement sessions were also held with the aboriginal community, the francophone community and representatives who work with newly immigrated individuals.

We reached out to our health service providers for their input through a series of symposiums. These are the people who understand what's working, what's not, and, most importantly, what must change to achieve a fully integrated system of care.

Continuous engagement with LHIN steering and advisory committees occurred throughout the development of the IHSP and Blueprint. These committees included the Health System Design Steering Committee, Best Level of Care & Quality Steering Committee, Chronic Disease Prevention & Management Steering Committee, E-Health Steering Committee and Health Professionals Advisory Committee.

We also sought input from the three area provider tables (APT) and four geographic tables within our LHIN. At these tables, the majority of health care sectors, including some not funded by LHINs, e.g. Public Health, are represented. The South West Addictions & Mental Health Coalition was also consulted for feedback. These tables all have regularly scheduled meetings throughout the year. Their perspective and input are most valuable in helping shape the health care system of the future.

To help finalize the *Blueprint – Vision 2022* document, targeted refinement sessions were held with physicians, as well as with groups representing services for complex continuing care, long-term care, chronic disease prevention & management, cancer care, critical care, emergency, medicine, surgical, mental health & addictions, women and paediatrics.

The feedback from these engagement sessions was incorporated into the IHSP 2010-13 and our *Blueprint – Vision 2022*. Both documents will guide us toward a fully integrated system of care where individuals will receive the right care when they need it, from the right provider, in the most appropriate setting. It will be a long journey, but one that is essential if we are to continue to have one of the best health care systems in the world.

Ongoing engagement

The engagement sessions mentioned above were designed specifically to inform our IHSP and Blueprint. However, the South West LHIN believes that true engagement is ongoing, regular, and meaningful. Every meeting, every community event, every conversation is an opportunity to engage our stakeholders.

In the past year, we partnered with the OMA to host four physician engagement sessions. The South West LHIN will continue to actively engage our providers, partners and the public.

Below are some of the ongoing activities that allow us to hear about successes in the field, concerns, emerging issues and innovative ideas.

- board-to-board sessions with health service provider boards,
- monthly hospital and CCAC leadership forums,
- invitational meetings and presentations,
- surveys and focus groups.

Aboriginal engagement

This year we established the South West LHIN Aboriginal Committee to review issues and concerns of Aboriginal communities and work in partnership to seek solutions. The Aboriginal Committee identifies and, where possible, implements practical approaches to improving the health of Aboriginal people living within the South West LHIN. The committee meets monthly to:

- dialogue, advise, and partner with member organizations and with other appropriate bodies to identify needs and bring respective expertise and resources to joint initiatives to address those needs; including where practical the expertise and resources from other levels of government and other agencies
- provide advice to LHIN staff with regard to community issues and solutions
- coordinate with other advisory and working groups to ensure LHIN senior management is aware of regional Aboriginal community views, issues and initiatives
- promote and participate in gatherings to exchange information, discuss issues and ideas with Aboriginal citizens, their communities and service organizations
- facilitate appropriate Aboriginal representatives to various committees as requested

In addition to the Aboriginal Committee meetings, the LHIN also hosted its second annual Aboriginal Health Gathering in April 2009 that brought together over 70 health care providers and aboriginal community leaders from across the LHIN.

Francophone engagement

The LHIN meets regularly with representative members of the Francophone community and organizations in the South West. These meetings are an opportunity to identify gaps in the availability of French language health services and to establish a shared understanding of the challenges for Francophone individuals accessing health care.

In January 2010, the Ministry of Health and Long-Term care announced the establishment of French language planning entities in regions across the province through a new regulation under the *Local Health System Integration Act*. These entities will

be selected by the Minister of Health and Long-Term Care and will work with the 14 LHINs to ensure that the needs of Francophone communities are reflected in local health planning.
The advice and input the planning entities will provide to LHINs includes:

- methods of engaging the Francophone community in the area
- health needs and priorities of the local Francophone community
- identifying Francophone health services and health care providers currently available to the community, and
- improving access to, and the integration of, French language health services in the area.

The South West LHIN looks forward to working with the French language entity when it is established later in 2010.

Report on MLAA performance indicators

Under the *Local Health System Integration Act, 2006* the Ministry-LHIN Accountability Agreement supports the collaborative relationship between the MOHLTC and the LHIN to carry out the made in Ontario solution to improve the health of Ontarians through better access to high quality health services, to co-ordinate health care in local health systems and to manage the health system at the local level effectively and efficiently.

South West LHIN MLAA Performance Indicators 2009/10

Performance Indicator	Provincial Target	LHIN 09/10 Starting Point	LHIN 09/10 Performance Target	LHIN 09/10 Annual Results	Performance Corridor	LHIN Met Target or Within Corridor
90th Percentile Wait Times for Cancer Surgery	84 Days	88	70	96	63-77	NO
90th Percentile Wait Times for Cataract Surgery	182 Days	90	90	85	81-99	YES
90th Percentile Wait Times for Hip Replacement	182 Days	160	160	151	144-175	YES
90th Percentile Wait Times for Knee Replacement	182 Days	204	182	172	164-200	YES
90th Percentile Wait Times for Diagnostic MRI Scan	28 Days	132	110	64	82-137	YES
90th Percentile Wait Times for Diagnostic CT Scan	28 Days	34	28	41	21-35	NO
Median Wait Time to Long-Term Care Home Placement -All Placements	50 Days	90	88	84	66-110	YES
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	9.46%	12.55%	9%	10.57%	8.1-9.9%	NO
Percentage of admitted ER patients treated within the target 8 hours	90%	57%	59%	56.98%	58.00-59.00%	NO
Percentage of non-admitted ER patients with high acuity treated within target of 8 hours and with moderate acuity treated within target of 6 hours	90%	91%	92%	90.31%	92%	NO
Percentage of non-admitted ER patients with low acuity treated within the target of 4 hours	90%	91%	92%	89.86%	92%	NO

Please see explanatory notes on page 14

Our results show that we have attained our goals in many of the performance indicators, meeting not only our own LHIN's targets, but, in several areas, exceeding the provincial target. However, there are still some performance targets that we did not meet and we continue to work in partnership with our health service providers to improve those results.

We are particularly proud of the significant improvement in MRI wait times, where our results show a year over year reduction of more than 50% in the number of days, on average, a resident of the South West LHIN must wait for this diagnostic procedure. The MRI wait time has trended downward since 2007, when wait times were over 175 days. This impressive downward trend is a direct result of collaboration and sharing of resources by the MRI Task Team (Grey Bruce Health Services, London Health Sciences Centre (LHSC) and St. Joseph's Health Care London - the health service providers in the South West who offer MRI diagnostic scans). In addition, the implementation of process improvement methodology at St. Joseph's Health Care, which is now also being implemented at LHSC, has made the procedure process more efficient.

By ensuring the scanners are used more effectively and efficiently across the LHIN wait times for individuals requiring this important test has dramatically dropped.

The ALC indicator shows that the number of ALC days has improved since last year, but it remains higher than the provincial target. Several programs and initiatives in the South West have contributed to the year over year improvement. In addition, with the opening of 200 long-term care beds in March 2010, and another 400 beds scheduled to open over the next 12 months, it is anticipated that the downward trend will continue. But long-term care homes are only part of the solution to ALC pressures and several other programs have been funded either with Aging at Home funds, or with the LHIN Urgent Priorities Fund to help seniors return to or remain in their own homes with the supports they need. Many of these initiatives are listed in the Emergency Department /Alternate Level of Care section of this annual report.

Cancer surgery wait times have increased since last year. The London Regional Cancer Program has developed an improvement plan for cancer surgery wait times, a portion of which was funded through the Urgent Priorities Fund. The funded initiative will improve both the data being used to make decisions, as well as improve the decision making process. The increase in cancer surgery wait times is also due in part to some data quality issues that have resulted from the complex process undertaken to integrate the surgical wait time systems for the two major London Hospitals. As the London hospitals represent 75% of the LHIN's cancer surgery cases, even minor data quality issues at these sites can significantly impact the overall LHIN number. All system partners are working together to achieve better wait times for cancer surgery.

The South West LHIN is committed to ongoing system improvement and, as part of that commitment, will continue to identify and incorporate measures that align to local and provincial goals and priorities. With our health service providers, we will ensure that we have a robust performance measurement system to evaluate improvement in health care delivery.

LHIN Year-end performance notes

Wait Time & ER Indicators:

Fiscal Year (FY) 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr 2009 to Mar. 2010.

Non-Wait Time Indicators:

Long-term care home (LTCH) Placement Indicator: FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr 2009 to Mar. 2010.
ALC Indicator:- Q4 %ALC days is estimated based on Q1, Q2, & Q3 2009/10 Data. FY 2009/10 LHIN Annual Results are also estimated based on Q1-Q4 2009/10 Data.

Used Performance Value - FY 2009/10

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

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

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

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

Definitions:

Performance Corridor: All agreed upon performance targets have an associated range of acceptable performance. If performance falls outside of this range, the LHIN is required to develop a variance report for the Ministry of Health to demonstrate how it plans to improve its performance and achieve a value that is within the performance corridor.

90th Percentile Wait Time for cancer, hip/knee - wait time from when a patient and surgeon decide to proceed with surgery, until the time the procedure is completed. 90th = time in which 90% of all patients have received their procedure. Reported in days. Performance Corridor is +/- 10%.

90th Percentile Wait Time for MRI or CT Scans – wait time from when a diagnostic scan is ordered, until the time the actual exam is completed. 90th = time in which 90% of all patients have received their procedure. Reported in days. Performance Corridor is +/- 25%.

Percentage of Alternate Level of Care (ALC) Days – percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. Reported as a %. Performance Corridor is +/- 10%.

ER wait times and alternate level of care (ALC) challenges

Long wait times in emergency rooms (ER) and acute care beds occupied by alternate level of care (ALC) patients continue to present challenges across Ontario, including in some areas of the South West. Reducing wait times and the easing of ALC pressures remains a key priority for the Ministry of Health and Long-Term Care and for the LHIN. Several programs and initiatives are aimed specifically at this priority and are described below.

It is worth noting that the ER wait times and ALC pressures in the South West vary greatly by area as do the underlying causes.

Our senior population, currently at 15% of our total population and expected to rise to above 20% in 2022 is a significant contributing factor to our total ALC days. In London, the ratio of long-term care beds of 80 per 1000 of population over age 75 is considerably less than the long-standing benchmark of 100 beds per 1000 of population over age 75.

In addition to ALC patients, ER wait times are also impacted by the following:

- in 2008/09, 15.2% of emergency visits by seniors living in the community were non-urgent
- in 2008/09, 28.6% of ER visits were considered less or non-urgent for seniors with behavioural issues. 14.6% of the visits resulted in an inpatient admission
- ER visits among residents of the South West LHIN with chronic diseases such as cancer, diabetes, depression, heart disease, hypertension, stroke, asthma, COPD and arthritis are 1 in 10
- 465 of 1,095 ER visits (43%) by Aboriginal seniors population are for non or less urgent conditions
- a lack of service capacity within the community

The South West LHIN continues to focus more heavily on enhancing community capacity to reduce ER visits, and to reduce length of stay by using a combination of short and longer term strategies that achieve direct and indirect impacts related to ALC and ER avoidance/diversion.

The programs funded in year one and two of the Aging at Home (AAH) strategy have had an impact on ER avoidance however it is difficult to attribute a single strategy to ALC or ER outcomes. Investments from AAH contributing to ER avoidance include fall prevention programs, Safe at Home, adult day programs, First Link, and various wellness initiatives. The following are some actual results of funded programs:

- Geriatric Emergency Management (GEM): 30% of those screened were discharged home with contact to other services
- Safe at Home: 788 clients; 86% ER avoidance rate
- Nurse Led LTC Home Outreach: Efforts focused on establishing working partnerships and interventions required

Some of the funded programs also contributed directly to alleviating ALC pressures:

- Transitional Care Unit (TCU): 7,222 acute care patient days saved (09/10)
- Interim Long-Term Care Home Beds/Assisted Living in the Community: 14 admissions utilized 9 interim LTC spaces since March 2009 – successful reduction of 12 inpatient beds at Tillsonburg District Memorial Hospital, increased bed turns, increased number of clients supported in the community
- Community Stroke Rehab Team: Rehab ALC has reduced by 32% at St. Joseph's Hospital. All sites are seeing the ability to discharge stroke patients directly from ER to Community Stroke Rehab Team preventing hospital admission
- Another contributing factor to reduction in ALC days was the Wait at Home Program: 59 clients; 2104 hospital days saved

A number of these success stories are features in video vignettes on the South West LHIN website (www.southwestlhin.on.ca) and on the South West LHIN YouTube channel.

In addition to the AAH investments listed above, the largest ALC investment is 608 long-term care beds in London. The first of these opened in March 2010,

and the remaining 400 beds are expected to open over the next 12 months. It is anticipated that these additional beds will impact the alternate level of care days in London.

We will continue to direct our efforts toward enhancing community capacity to result in ER avoidance. We have made some inroads and are trending in the right direction. In the upcoming year, we will focus on seniors at high risk, those with challenging behaviours and chronic conditions, and aboriginal seniors as well as quality and process improvements to reduce waste and improve flow.

Integrated Health Service Plan priorities update

Our first Integrated Health Service Plan (IHSP) published three years ago was developed after extensive consultation with our health service providers and close to 4,000 residents of the South West LHIN. The IHSP was the foundational document that guided our activities to ensure that programs and initiatives supported by the LHIN were aligned with the heath care priorities identified. We are proud of the advances made in the South West in moving toward the achievement of an integrated system of care and want to share some of the activities and accomplishments that have contributed to our progress.

Based on our understanding of local issues and opportunities within the South West, four integration and two enabling priorities were identified.

Strengthening and improving primary health care

Having a strong primary health care infrastructure is a contributing factor to an improved health status for the entire population. Strengthening and improving access to primary health care services through better integration and coordination is therefore a fundamental component of an integrated health system in the South West.

In the past year, several activities have had direct positive impact on the availability of primary health care for the residents of the South West LHIN. As the fiscal year drew to an end, the new Community Health Centre in Woodstock was about to open its doors and the development of a Rural Health Centre in Markdale continues to progress. Both will bring together a multi-disciplinary team to provide a holistic health care environment to individuals, significantly improving access to primary care in these communities.

Preventing and managing chronic illness

While Ontarians enjoy relatively good health and have access to one of the best health care systems in the world, we also have a high incidence of chronic disease which creates an enormous financial burden both in terms of actual health care costs and in lost productivity to the economy. With our aging population, the prevalence of chronic illnesses such as diabetes or chronic kidney disease will continue to grow, and a reliance solely on an acute care system is not sustainable. Chronic disease management is a community responsibility supported by family physicians and the network of community-based health and social services to support patients to maximize their health and independence.

Teaching individuals to self-manage their illness and making appropriate resources available to them is foundational to the South West LHIN's chronic disease prevention and management (CDPM) strategy. Ontario's CDPM Framework illustrates that a health system oriented to good chronic care exists in a community where the environment, public policy and action influences and supports care delivery. It is within this framework that the South West LHIN has focused its efforts.

Through the Urgent Priorities Fund, the LHIN provided support to develop a toolkit for providers to assist them in encouraging and supporting their patients in managing their chronic disease. The result was *Self-Management in Theory and Practice*, a toolkit for providers, supported by a website and workshops to introduce concepts of self management and the role of the professional in patient self management. These were launched successfully in the summer of 2009 and by fiscal year end, 2,000 toolkits were produced and over 1,500 copies distributed across the province through the London InterCommunity Health Centre. The toolkit is considered a key resource provincially.

The self management strategy will continue to develop into a comprehensive approach that will include a variety of provider and consumer tools.

Funded by the Ministry of Finance, the *Partnerships for Health* initiative is designed to engage a number of health providers to help ensure coordinated care for

patients. It is an interdisciplinary, team-based approach to diabetes care that is improving glycemic control and ensuring that individuals with diabetes are receiving evidence-based chronic disease management and preventative care to reduce complications. Two years into the initiative, participating teams have initiated new processes to improve patient self-management, care coordination, redesign of the delivery system along with improved use of information and information technology with remarkable results.

The South West LHIN, identified as an early adopter of the *Ontario Diabetes Strategy* (ODS), was asked to provide recommendations for a service model, including program/service expansion and required resources that would build upon existing infrastructure. Our report included recommendations for model of service delivery based on regional and sub-LHIN coordination of all diabetes services. It also included recommendations for service expansion.

In November, the Ministry of Health and Long-Term Care announced its plans for service expansion that included the introduction of Regional Coordination Centres and for expansion of teams across Ontario. The South West received three new diabetes teams.

The *Ontario Renal Network* (ORN) is comprised of a provincial office housed at Cancer Care Ontario and 14 regional renal programs and represents a renewed approach to better organize and manage the delivery of renal services. Early priorities of the ORN include hiring of regional administrative directors and clinical leads for each of the regional renal programs, establishment and uptake of standards and guidelines in the delivery of quality renal care, development of information systems and performance measures, and ongoing needs assessment and capacity planning.

Accomplishments of the South West Renal Program, in partnership with the ORN include:

- needs assessment projecting out to 2013/2020
- capacity planning for satellite expansions
- patient-based minimum data set for performance reporting and management
- provision of motivational interviewing and self-management training to staff
- engagement with the long-term care sector to assess readiness and interest in provision of peritoneal dialysis
- home dialysis educational and awareness campaign for London patients
- planning for an outreach strategy to primary care to focus on prevention and earlier identification of pre-dialysis patients

Building linkages across the continuum – seniors and adults with complex needs

Seniors and adults with complex needs represent a growing population in the South West. To ensure that individuals can move through the system easily, health service providers across the continuum must work collaboratively to achieve optimal health outcomes.

With the introduction of the provincial Aging at Home Strategy in 2007, the LHIN was able to fund several initiatives that directly addressed the requirements of seniors and adults with complex needs. Some of the initiatives include:

- The Tillsonburg Assisted Living in the Community (ALCom) program, where individuals can receive supports in their own homes without having to move to a designated supportive housing unit. Social worker resources are also an integral part of the program, so that individuals and their families are able to work with the same person through the transition from hospital to the community. The transition care program has seen many successes in its first 11 months including:

    - 30 people were supported to return home to their community rather than be admitted to a long-term care home
    - Closure of 12 CCC beds at the hospital has been maintained with no additional strain to the system, enabling the hospital to focus its resources more appropriately
    - 26 individuals have been referred to the CCAC by the emergency department. The flow of these patients through the system is

made so much easier with the increased participation of the CCAC who can direct patients to the level and type of care needed
    - The opening of four interim long-term care beds, allowing 13 people to leave the hospital faster, and be supported in a more appropriate level of care setting. These beds are considered interim while those admitted await placement in a long-term care home of their choice.

- Transitional Care Unit at Parkwood Hospital allows seniors who still require hospital care, but who do not need to occupy an acute care bed. By transferring ALC patients to this unit, beds are freed for those requiring acute care. In 09/10, 7,222 acute patient-days were saved through the use of this unit.

- The Community Stroke Rehabilitation Team has had tremendous success in providing in-home rehabilitation services to recovering stroke patients. Hospitals in the LHIN are able to discharge stroke patients directly from the ER to the Community Stroke Rehab team, preventing hospital admission.

As we move forward with our refreshed IHSP 2010-13, we are developing our year three Aging at Home strategy which will continue to focus on avoidable emergency department visits and hospital admissions through:

- the creation of a system of care for seniors with behavioural challenges
- piloting a system of care for high risk seniors
- strengthening quality and process improvement programs
- enhancing services for Aboriginal seniors
- implementing self-management support programs for seniors with chronic conditions

Accessing the right services, in the right place, at the right time, by the right provider

In the latter part of 09/10, the South West LHIN launched its *Health System Design Blueprint – Vision 2022*. One of the guiding objectives of the Blueprint is to provide a response to our first IHSP priority to ensure access to the right services, in the right place, at the right time, by the right provider. Recognizing that health system transformation is not a "quick fix", the Blueprint sets a direction that will guide the work of the LHIN and health service providers from all sectors over a multi-year timeframe.

The LHIN has also supported the *Flo Collaborative*, the Change Foundation's Centre for Healthcare Quality Improvement (CHQI) province-wide initiative to address processes of care delivery so that patient transitions from acute hospitals to other settings are faster and smoother for patients and their families and the staff who care for them.

Ultimately, the Flo Collaborative has resulted in an unprecedented milestone in quality improvement for the two initiatives in the South West LHIN. Building on the momentum from the two initial sites, a spread strategy was launched in the spring of 2009 to extend key changes and ideas to other organizations in the LHIN that were not part of the initial pilot. The second phase saw several more partnerships formed to share ideas and best practices, and, most importantly, to implement changes that would have a positive impact on an individual's experience in a hospital setting. The collaborative is about efficient, cost-effective, patient-centred navigation through the health care system from the time an individual is admitted to a hospital, to discharge and beyond. The Flo Collaborative has enabled providers to get services to patients much faster, which means treatment is provided at a point in time that is most beneficial to the patient, in the right environment.

Our first IHSP also identified two enabling priorities: eHealth and Health Human Resources.

eHealth

eHealth initiatives taking place in the South West LHIN continued to advance throughout 2009 and into 2010 as the seeds of information and clinical technology systems planted in previous years began bearing fruit.

One such initiative was the Southwest Physician Office Interface to Regional Electronic Medical Records

System (SPIRE) which went live in 2009 with electronic hospital medical records shared with physicians electronically instead of by fax.

Another was Phase One of the Alternate Level of Care (ALC) Resource Matching & Referral (RM&R) Project – a four-LHIN collaboration between South West, Erie St. Clair, Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs which came to a successful conclusion just before fiscal year-end.

Through it all, the South West LHIN continued to work collaboratively with health service providers and eHealth Ontario, looking for synergies in both existing and new systems.

Health Human Resources

The ability to provide access to high quality, cost-effective patient-centred health services is dependent on having the right mix of health care providers with the right skills in the right place at the right time. Achieving and maintaining the appropriate mix of health care workers is critical to achieving the LHIN's mandate to develop a fully integrated health system of care in the South West.

To this end, the South West LHIN has been working closely with HealthForceOntario (HFO) through their Community Partnership program, an initiative designed to integrate and coordinate physician recruitment in the province. Community Partnership coordinators work within LHIN areas, and support communities and employers to increase their "recruitment readiness" by providing information and education on effective recruitment tools, strategies and resources.

To date the South West has experienced significant success recruiting family physicians and/or ER physicians. This success is largely attributed to the tireless work of our dedicated physician recruiters and the community/hospital committees that support physician recruitment and retention locally through various approaches, including the engagement of local youth into healthcare careers; identification of work/life balance opportunities for new families; and initiatives that support spousal employment needs within communities.

The Agency and regional recruitment focus has been on building direct linkages with medical schools in the province, working in collaboration with the International Medical Graduates (IMGs) and repatriating physicians from the United States. We look forward to building on the great work and success that has already been achieved with its HFO partners.

In addition to partnering with HFO, advancing our Health Human Resources priority requires that we understand today's environment. Recognizing that Emergency Departments are a critical gateway to the health care system, maintaining access to this gateway in the South West is a challenge that must be considered in the framework of the entire continuum of care.

In December 2008, the South West LHIN initiated a study of the human resources environment surrounding our emergency departments. Over 100 individuals were directly engaged in the work of this study . The level of expert participation allowed us an unprecedented detailed view of all the emergency departments in the South West LHIN.

The Emergency Department Human Resources Project Final Report was received by the South West LHIN Board of Directors at its meeting on May 27th 2009. It includes a detailed analysis of the emergency department human resources throughout the LHIN.

The report identifies a menu of strategies that can be utilized by hospitals to help address emergency room human resources challenges. In addition, it is recommended that system level strategies to align with ER resources to sustain access into the future be evaluated. The report is available in its entirety on the LHIN website.

Operational performance

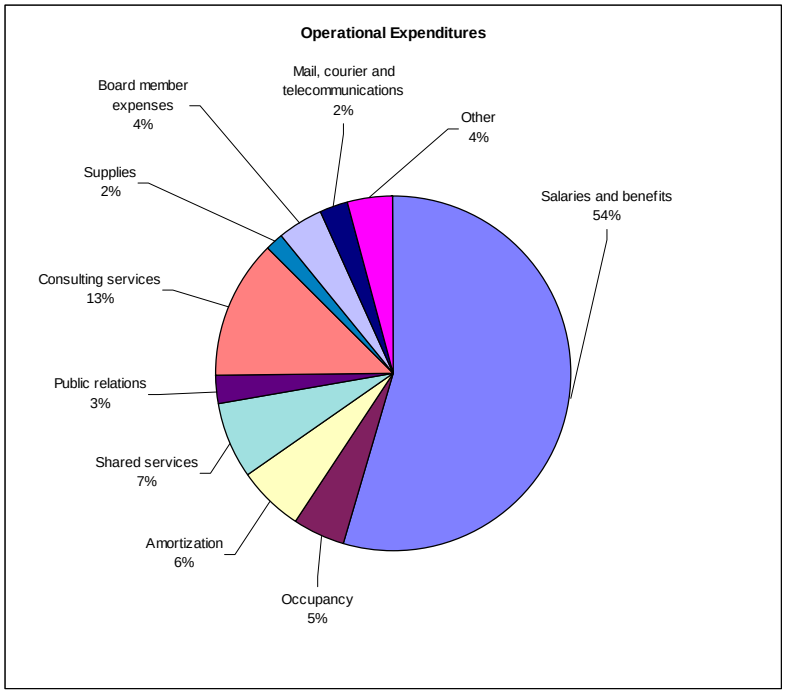
In 2009-10, the South West LHIN operating budget was made up of two components:

$5.0 million for operations
$0.8 million for special projects

The operating budget includes $35,000 annualized funding for Aboriginal community engagement.

Operations

The South West LHIN ended the year with an operating surplus of $14,645. There were other small surpluses relating to eHealth and diabetes registry funding. The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure is salaries and benefits with 30 full time staff and 7 staff hired on contract basis for specific projects.



Special Projects

The one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2009-2010 fiscal year were:

	Funding	Expenditure
E-Health	$549,092	$486,923
Diabetes	98,178	81,042
Emergency Department Lead	75,000	60,356
Emergency Room/Alternate Level of Care	100,000	105,701
Total	$822,270	$734,022

Financial statements

South West Local Health Integration Network

March 31, 2010

South West Local Health Integration Network

March 31, 2010

Table of contents

Deloitte & Touche LLP
One London Place
255 Queens Avenue
Suite 700
London ON N6A 5R8
Canada

Tel: 519-679-1880
Fax: 519-640-4625
www.deloitte.ca

Auditors' Report

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

We have audited the statement of financial position of the South West Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the South West Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 14, 2010

South West Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**705,687**	1,254,897
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**16,382,394**	2,113,558
Due from MOHLTC	**107,000**	-
Due from the LHIN Shared Services Office (Note 4)	**3,343**	-
Accounts receivable	**6,368**	2,826
	17,204,792	3,371,281
Liabilities		
Accounts payable and accrued liabilities	**576,742**	1,173,998
Due to Health Service Providers ("HSPs") (Note 9)	**16,382,394**	2,113,558
Due to MOHLTC (Note 3b)	**173,656**	65,842
Due to the LHIN Shared Services Office (Note 4)	**-**	17,883
Deferred revenue (Note 10g)	**72,000**	-
Deferred capital contributions (Note 5)	**504,144**	675,415
	17,708,936	4,046,696
Commitments (Note 6)		
Net debt	**(504,144)**	(675,415)
Non-financial assets		
Capital assets (Note 7)	**504,144**	675,415
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

South West Local Health Integration Network

Statement of financial activities

year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,950,587,846**	**1,996,757,391**	1,910,900,828
Operations of LHIN	**4,977,700**	**4,963,133**	4,989,934
Aboriginal Planning (Note 10a)	**35,000**	**35,525**	-
Diabetes (Note 10b)	**-**	**98,178**	127,500
E-Health (Note 10c)	**600,000**	**549,092**	650,000
Emergency Department ("ED") Lead (Note 10d)	**-**	**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10e)	**-**	**100,000**	33,300
70% Nursing Initiative (Note 10f)	**-**	**-**	50,000
Amortization of deferred capital contributions (Note 5)	**-**	**325,756**	306,463
	1,956,200,546	**2,002,904,075**	1,917,133,025
Expenses			
Transfer payments to HSPs (Note 9)	**1,950,587,846**	**1,996,757,391**	1,910,900,828
General and administrative (Note 11)	**4,977,700**	**5,269,071**	5,261,167
Aboriginal Planning (Note 10a)	**35,000**	**35,777**	-
Diabetes (Note 10b)	**-**	**81,042**	119,893
E-Health (Note 10c)	**600,000**	**486,923**	650,000
ED Lead (Note 10d)	**-**	**60,356**	62,629
ER/ALC Performance Lead (Note 10e)	**-**	**105,701**	22,666
70% Nursing Initiative (Note 10f)	**-**	**-**	50,000
	1,956,200,546	**2,002,796,261**	1,917,067,183
Annual surplus before funding repayable to MOHLTC	**-**	**107,814**	65,842
Funding repayable to the MOHLTC (Note 3a)	**-**	**(107,814)**	(65,842)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**	**-**	-
Closing accumulated surplus	**-**	**-**	-

South West Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Annual surplus	-	-	-
Acquisition of capital assets (Note 12)	-	**(154,485)**	(22,732)
Amortization of capital assets	-	**325,756**	306,463
Decrease in net debt	-	**171,271**	283,731
Opening net debt	-	**(675,415)**	(959,146)
Closing net debt	-	**(504,144)**	(675,415)

South West Local Health Integration Network

Statement of cash flows

year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**325,756**	306,463
Amortization of deferred capital contributions (Note 5)	**(325,756)**	(306,463)
Changes in non-cash operating items		
Increase in due from MOHLTC HSP transfer payments	**(14,268,836)**	(796,038)
Increase in due from MOHLTC	**(107,000)**	-
Increase in due from LHIN Shared Services Office	**(3,343)**	-
(Increase) decrease in accounts receivable	**(3,542)**	5,689
(Decrease) increase in accounts payable and accrued liabilities	**(597,256)**	365,714
Increase in due to HSPs	**14,268,836**	796,038
Increase (decrease) in due to MOHLTC	**107,814**	(143,439)
(Decrease) increase in due to LHIN Shared Services Office	**(17,883)**	14,749
Increase in deferred revenue	**72,000**	-
	(549,210)	242,713
Capital transaction		
Acquisition of capital assets	**(154,485)**	(22,732)
Financing transaction		
Deferred capital contributions received (Note 5)	**154,485**	22,732
Net (decrease) increase in cash	**(549,210)**	242,713
Cash, beginning of year	**1,254,897**	1,012,184
Cash, end of year	**705,687**	1,254,897

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 LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Provider ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2010.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers 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.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairments in the value of assets.

Ministry of Health and Long-Term Care Funding

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

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

The LHIN statements do not include any Ministry managed programs.

2. Significant accounting policies (continued)

Government transfer payments

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

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. 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 expenditures that are recorded as 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 financial activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

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

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

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

Use of estimates

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

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

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

	Revenue	**Expenses**	**2010 surplus**	2009 surplus
	$	**$**	**$**	$
Transfer payments to HSPs	**1,996,757,391**	**1,996,757,391**	**-**	-
LHIN operations	**5,288,889**	**5,269,071**	**19,818**	35,230
Aboriginal Planning	**35,525**	**35,777**	**(252)**	-
Diabetes	**98,178**	**81,042**	**17,136**	7,607
E-Health	**549,092**	**486,923**	**62,169**	-
ED Lead	**75,000**	**60,356**	**14,644**	12,371
ER/ALC Lead	**100,000**	**105,701**	**(5,701)**	10,634
	2,002,904,075	**2,002,796,261**	**107,814**	65,842

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

	2010	2009
	$	$
Due to MOHLTC, beginning of year	**65,842**	209,281
Funding repaid to MOHLTC	**-**	(209,281)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**107,814**	65,842
Due to MOHLTC, end of year	**173,656**	65,842

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 is 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

	2010	2009
	$	$
Balance, beginning of year	**675,415**	959,146
Capital contributions received during the year (Note 12)	**154,485**	22,732
Amortization for the year	**(325,756)**	(306,463)
Balance, end of year	**504,144**	675,415

6. Commitments

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

	$
2011	253,249
2012	249,223
2013	209,216
2014	198,349
2015	82,645

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:

	$
2011	1,708,112,525

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

7. Capital assets

			2010	2009
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer equipment	**88,030**	**63,585**	**24,445**	14,181
Leasehold improvements	**1,463,410**	**1,116,132**	**347,279**	523,104
Office equipment, furniture and fixtures	**199,205**	**66,785**	**132,420**	130,797
Web development	**21,998**	**21,998**	**-**	7,333
	1,772,643	**1,268,500**	**504,144**	675,415

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the statement of financial activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $1,996,757,391 is derived as follows:

	$
Initial budget	1,950,587,846
Adjustment due to announcements made during the year	46,169,545
Final HSP funding budget	1,996,757,391

The final operating budget, excluding HSP funding, of $5,830,913 is derived as follows:

	$
Initial budget	5,612,700
Additional funding received during the year	372,698
Amount treated as capital contributions during the year	(154,485)
Final LHIN operating budget	5,830,913

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,996,757,391 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2010 as follows:

	2010	2009
	$	$
Operation of hospitals	**1,478,403,457**	1,424,880,921
Grants to compensate for municipal taxation - public hospitals	**451,650**	451,350
Long term care homes	**246,734,108**	235,432,172
Community care access centres	**162,409,737**	148,561,357
Community support services	**29,644,098**	27,838,627
Assisted living services in supportive housing	**15,959,228**	13,067,348
Community health centres	**8,712,310**	7,417,723
Community mental health addictions program	**54,442,803**	53,251,330
	1,996,757,391	1,910,900,828

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2010, an amount of $16,382,394 (2009 - $2,113,558) was receivable from MOHLTC, and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of financial activities and are included in the table above.

10. a) Aboriginal Planning

The MOHLTC provided the LHIN with $35,525 related to aboriginal planning. The LHIN incurred operating expenses totaling $35,777.

b) Diabetes

The MOHLTC provided the LHIN with $98,178 (2009 - $127,500) related to diabetes management strategy funding. The LHIN incurred operating expenses totaling $81,042 (2009 - $119,893). The LHIN has setup a repayable to the MOHLTC for the remaining balance.

c) E-Health

The E-Health office of the MOHLTC provided $600,000 (2009 - $650,000) to the LHIN. The LHIN had a contract and retained services of the London Health Sciences Centre ("LHSC") during 2009 and spent all available funds. During 2010 the LHIN hired staff to create a project management office while incurring operating expenses of $486,923 (2009 - $650,000) and capital expenses of $50,908 (2009 - $Nil). The LHIN has setup a repayable to the MOHLTC for the remaining balance.

d) ED Lead

The MOHLTC provided the LHIN with $75,000 (2009 - $75,000) to hire a LHIN representative for emergency department planning. Dr. Lisa Shepherd was selected and remunerated a total of $60,356 (2009 - $62,629) through a monthly per diem and expense allowance as described by the MOHLTC. The LHIN has setup a repayable to the MOHLTC for the remaining balance.

e) ER/ALC Lead

The MOHLTC provided the LHIN with $100,000 (2009 - $33,300) related to emergency room management strategy funding. The LHIN incurred operating expenses totaling $105,701 (2009 - $22,666) and has set-up a repayable to the MOHLTC for the remaining balance. The LHIN has used operational funding to offset additional expenses.

f) 70% Nursing Initiative

The MOHLTC provided the LHIN with $50,000 related to nurse staffing strategy in the 2009 fiscal year. This funding was discontinued in 2010 and there were no expenses incurred (2009 - $50,000)

g) Deferred revenue

The MOHLTC provided the LHIN with $72,000 related to French Language Services in the 2010 fiscal year and has allowed the LHIN to retain these funds until the end of August 2010. No related expenses were incurred in fiscal 2010 and all funds were deferred.

11. General and administrative expenses

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

	2010	2009
	$	$
Salaries and benefits	**2,865,731**	2,824,036
Occupancy (Note 12)	**240,561**	190,509
Amortization	**325,756**	306,463
Shared services	**362,714**	300,000
LHIN Collaborative	**12,286**	-
Public relations	**139,432**	54,169
Consulting services	**664,610**	943,272
Supplies	**82,516**	96,615
Board chair per diem	**25,900**	46,839
Board member per diem	**65,010**	70,572
Board member expenses	**133,228**	169,923
Mail, courier and telecommunications	**130,495**	65,134
Other	**220,832**	193,635
	5,269,071	5,261,167

12. Recovered expenditures

The LHIN has an agreement with the Southwest Community Care Access Centre ("CCAC") to introduce a Chronic Disease Prevention and Management ("CDPM") Project. The CCAC will pay the cost of accommodations and initial office set-up on behalf of the CDPM to the LHIN.

During the 2010 fiscal year, amounts received for accommodations decreased occupancy expense by $58,200 to $240,561 from $298,761 and is included in the statement of financial activities.

13. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 26 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2010 was $256,430 (2009 - $208,061) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan on December 31, 2009. As that time, the plan was fully funded.

14. 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*.

15. Comparative figures

Certain of the prior year's comparative amounts have been reclassified to conform with the presentation adopted in the current year.

ISSN 1911-2858 June/10 ©2010

Ontario
Local Health Integration Network