South West LHIN

South West Local Health Integration Network
Annual Report 2011-12

Ontario
Local Health Integration Network

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

The past year has been full of growth, new challenges and many changes for the South West LHIN.

We continued to implement the South West LHIN's long-term vision the Health System Design Blueprint – Vision 2022 and our Integrated Health Service Plan. The Government of Ontario unveiled its Action Plan for health care system that will profoundly affect how the health care system is organized in the future and the role of LHINs within that system.

Several LHIN-funded projects achieved some notable milestones. The Life or Limb no refusal process for critical care referrals to hospitals in the South West LHIN has been successfully implemented and will be used as a model for province-wide implementation. We are seeing a significant reduction in cancer surgery wait times in the LHIN. The SPIRE project, which enables physician use of electronic medical records has over 400 physician users and has been a tremendous success eliminating waste. These three examples are only a snapshot of a much longer list of accomplishments, all of which we will continue to build upon.

With a commitment to openness and engagement, the Board continued a longstanding tradition of holding its meetings in many communities across the South West LHIN's geography fostering a stronger connection with local members of the public and interested stakeholders.

To build on that tradition of openness, in the last year we began to build stronger relationships with local communities. Beginning in London in May 2011 and continuing at our meetings in Mitchell, Ingersoll and Southampton, the LHIN Board added engagement sessions with local provider boards to our visits to local communities for regular Board meetings.

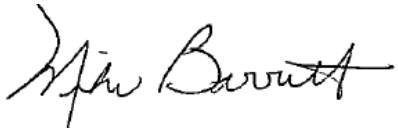
We also conduct engagement sessions for the general public in the evening and invite local providers to present on key issues relevant to the community. These have proven to be tremendously successful and we will be continuing them indefinitely.

We would like to take this opportunity to thank the many members of the LHIN's committees, working groups and task forces for their efforts on behalf of the health care system. Without that commitment of time and energy, so many projects that improve the system would never leave the pages of planning documents to become the frontline activity that allows the health care system to change with the changing needs of our local communities.

The boards and leadership of the health service providers in the South West LHIN also deserve many thanks for their service and their efforts to deliver results in one of the best health care systems in the world.

We would like to thank the health care workers across the South West LHIN's geography for their tireless efforts and dedication to their clients, residents and patients.

As we move into the 2012-13 fiscal year, we will continue to build on our successes and provide leadership for the health care system in our area.



Board members as of March 31, 2012

(Please note there is one vacancy as of March 31, 2012)

Jeff Low (London), Chair
February 7, 2011 - February 7, 2014

Linda Stevenson (St. Thomas)
Vice Chair
May 16, 2007 – May 15, 2012

Ron Bolton (St. Marys)
May 12, 2010 – May 11, 2013

Sheryl Feagan (Goderich)
June 17, 2010 – June 17, 2013

Ron Lipsett (Annan)
July 28, 2010 – July 28, 2013

Gerry Moss (Port Elgin)
May 17, 2011 - May 16, 2014

Barbara West-Bartley(Wiarton)
April 18, 2011 – April 17, 2014

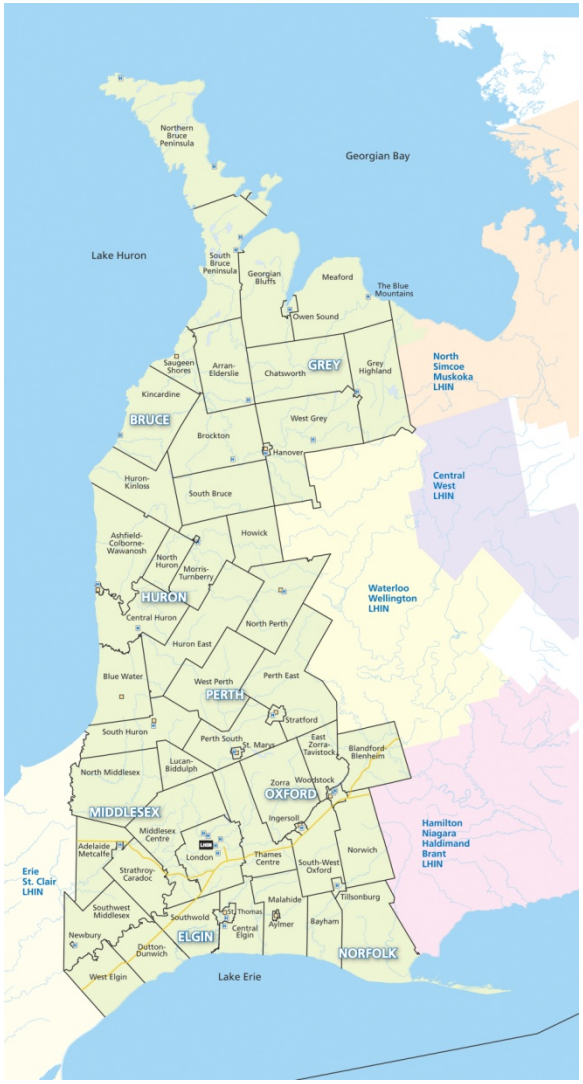
Robert Wood(London)
June 2, 2011 – June 1, 2014

Members whose terms expired during 2011-12

Kerry Blagrave, June 1, 2011 Murray Bryant, May 16, 2011 Janet McEwen, June 10, 2011

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

The South West LHIN…who we are, where we live



The South West Local Health Integration Network is a crown agency responsible for planning, integrating and funding health services. We work closely with 150 health service providers from the tip of the Northern Bruce Peninsula to the shores of Lake Erie, and everywhere in between. In the South West LHIN, our geography is as diverse as the people we serve. Our residents live in large urban centres, small towns and along rural routes. Our LHIN also has five First Nation reserves as well as a number of francophone communities. From Atwood to Zurich, close to one million residents call the South West LHIN home.

LHINs were established in 2006 with the belief that health care decisions should be made locally based on the needs of the community. Local also describes the decision-makers. The South West LHIN board is comprised of people who live here too. From Wiarton to Goderich, St. Marys and London, the vast geography of our LHIN is well represented around the board table by people who care about local health care.

So what are we responsible for? The South West LHIN oversees funding to:

- 20 hospital corporations (33 sites)
- 1 Community Care Access Centre (South West CCAC)
- 76 long-term care homes
- 60 community support services
- 5 community health centres
- 38 mental health and addiction agencies

In 2010, the LHIN identified two strategic directions in its Integrated Health Service Plan 2010-2013.

The first is to enhance capacity and integration of primary, specialized and community-based care with a focus on:

- Seniors and adults with complex needs
- People living with mental health and addiction challenges
- People living with or at risk of chronic disease

The second goal is to enhance access and sustainability of hospital-based treatment and care related to:

- Emergency services
- Medicine, surgical and critical care services

These two directions guide all LHIN activities and programs to move us toward a fully integrated system of care as outlined in our Blueprint – Vision 2022.

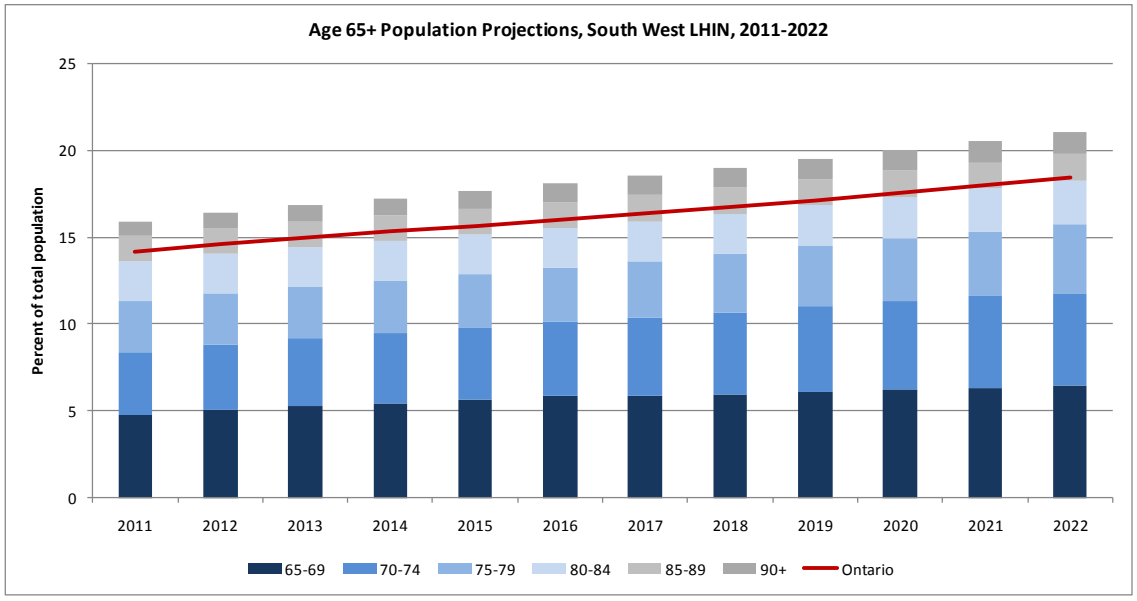
Population profile ***

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 that are determined by many factors. In the South West LHIN, one of the key factors that drives the health care needs of our population is age. The percentage of the population aged 65+ in the South West LHIN is approximately 16.4% (based on Ministry of Finance population projections from the 2010 base estimate). This compares with 14.6% 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 21.0% (18.4% in Ontario) by the year 2022**.

As we age, our health care needs change and grow. The time to plan for the anticipated increase in senior population is now. We must ensure community supports are in place, use hospital beds with only those who require hospital care, and utilize long term care homes for those whose needs have grown beyond the capacity of community supports. As we plan for a sustainable quality health care system, we must also take into account many other factors that influence the types of services that the health care system must deliver, such as:

- 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 2018.



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, 2009.

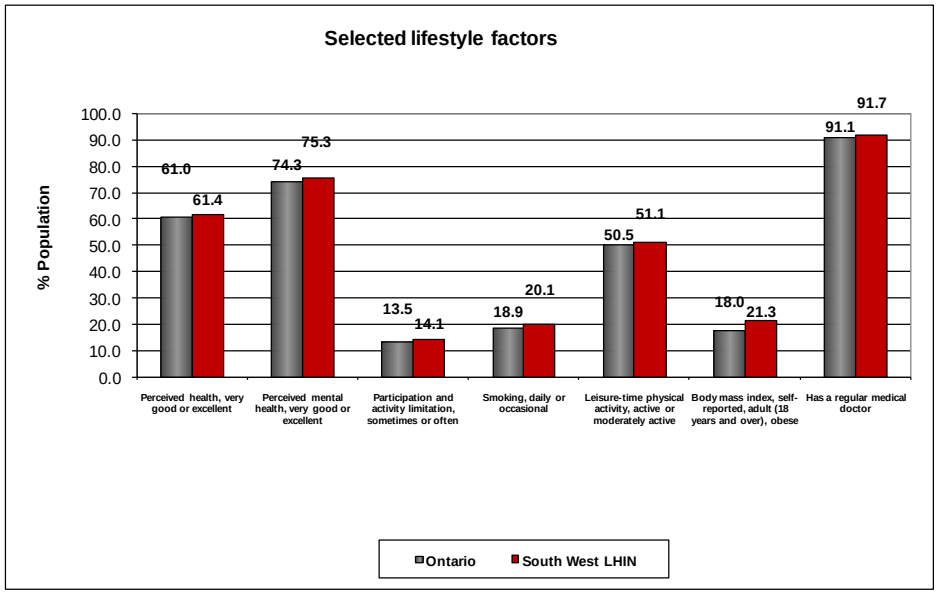
Population health profile

The health care system must serve the entire population, from the tiniest of newborns to the frail and elderly. Chronic conditions can lead to premature deaths, and stress the system of care. Lifestyle factors in part will determine if one individual will enjoy good health, while another will not. That is why we monitor the population profile of the South West LHIN, as well as in the rest of Ontario. The differences in the makeup of the population, the lifestyle factors that may be present in one part of the province and not another, and the access to care - all of this must be taken into account as we plan for a sustainable quality health care system. What may be an ideal program in south western Ontario may not be suitable in remote northern regions. This is why local decision making is critical to serving all the residents of the South West LHIN. Our health service providers who work on the front lines understand the needs of the population, and our staff and Board work closely with them to ensure that health care dollars are allocated judiciously and in the best interest of the people in our LHIN.

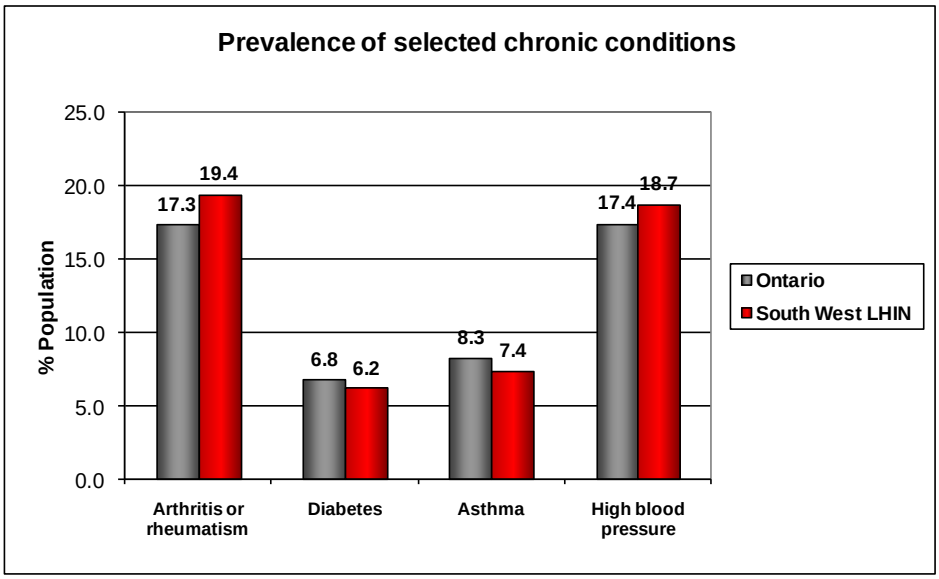
Some of the statistics that inform our decision making include the following estimates from the 2009/10 Canadian Community Health Survey:

- Just over 60% of people in the South West LHIN rated their health as very good or excellent.
- The incidence of diabetes in the South West LHIN was 6.8%. This compares with 6.2 for the province.
- 17.2% of people over age 12 report alcohol consumption of five or more drinks at one time, at least once a month, compared to 15.9% for the province as a whole.
- 21.3% of the residents of the South West LHIN report high stress levels in their lives, compared with 24% of Ontarians.
- Canadian Community Health Survey data for 2009/10 suggest that 21.3% of adults aged 18+ in the South West are obese.
- 91.7% of South West LHIN residents reported that they had a regular family physician. This compares with 91.1% for Ontario.

The way we live our life and the choices we make are some of the key factors that impact the state of our health. The following table graphs some of the lifestyle factors we track and compares these to provincial statistics.



The table below shows the prevalence of rates of various chronic conditions among the residents of the South West LHIN.



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, 2009.

Progress report on Integrated Health Service Plan 2010-13 priorities

The Integrated Health Service Plan (IHSP) 2010-13 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 IHSP identifies two strategic directions:

I - Enhance capacity and integration of primary, specialized, and community-based care, with a focus on the following populations:

i. Seniors and adults with complex needs

A number of initiatives have advanced our ability to focus on total health management including prevention, screening, identification, assessment, treatment and follow-up, and the provision of necessary supports. These initiatives are broad in scope, LHIN wide, and are coordinated and integrated through the efforts of health service providers. The **High Risk Seniors** project provided some learnings to embark on the larger **Access to Care** initiative that aligns three coordinated LHIN wide strategies to implement the Home First philosophy, realign Assisted Living/ Supportive Housing/ Adult Day Programs and Complex Continuing Care and Rehabilitation services while implementing coordinated access to these services through the CCAC. Another initiative of similar scope is the creation of a **Coordinated System of Care** for seniors with responsive behaviours through the creation of multiple expert response teams across the LHIN and broader service coordination activites. The implementation of the **interRAI CHA** has created a LHIN-wide collaborative that ensures evidence based assessments and improves system navigation to advance our ability to assist people to receive the right care at the right time.

Quality improvement initiatives such as **Residents First** and **Senior Friendly Care** have begun to highlight areas to improve the client/resident/patient experience in addition to sharing best practices.

Numerous localized service enhancements through **Aging at Home** have increased local capacity to support seniors and adults with complex needs. The successes and outcomes of these services are highlighted on the Southwest LHIN website.

ii. People living with mental health and addiction challenges

Implementation is underway for the **Tier 2 divestment** of beds, services, clients and associated resources from SJHC– Regional Mental Health Care (SJHC - RMHC) to four area Tier 2 receiving hospitals: Grand River Hospital (GRH), Windsor Regional Hospital (WRH), St. Joseph's Healthcare (SJHC) Hamilton and St. Thomas Elgin General Hospital (STEGH). Schedule 1 beds and Assertive Community Treatment (ACT) Teams and Transition Teams have been successfully transferred to GRH and WRH. Transfers to SJHC Hamilton and STEGH are planned for 2013/14. 156 longer-term mental health beds and 89 forensic mental health beds will be relocated to new facilities at SJHC, London and STEGH, respectively, in 2014. In parallel to the reduction of beds, there will need to be investment in the community to support the change to care and service for individuals transitioning into the community.

The **South West LHIN Community Capacity and Implementation Project**, completed November 2011, explored measures to maximize existing system structures, services and associated funding, including strategies to better coordinate existing programs where appropriate. In addition, priority areas for

enhancement of community capacity to best support the transition from institutional to community based care were identified. The implementation of the recommendations will be tackled in phases, with a focus on ensuring the continued provision of high quality care to consumers remains our highest priority throughout the process.

Through the **Data Quality Improvement Project**, a series of workshops were held with MHA agencies, consumer survivor agencies, and trainers who will be responsible for training front-line staff to ensure consistency and standardization of reporting client activity across health service providers within the South West LHIN, resulting in improved data quality for decision-making and system development, coordination and integration.

The **Ontario Common Assessment of Need (OCAN) Tool** was designed to gather comprehensive and consistent individual client information to enable consumers to be active participants in the assessment process and reduce the number of times they need to tell the same information. The aggregate information gathered informs organizational, regional and provincial-level planning and decision making and aids multi-agency communication and coordinated systems planning through common data standards.

The **Telemedicine Nursing Resources for Mental Health and Addictions** initiative supports the implementation of telemedicine-based services for patient care across the South West LHIN, with a focus on the mental health and addictions sectors. The Grey Bruce geographic area will focus on Primary Care with MHA while Huron-Perth and counties in the South will focus on Crisis and Community Withdrawal Management.

Aboriginal mental health service providers were engaged in July 2011 about mental health and addictions strategy development. The Committee has formed a joint South West and Erie St. Clair, Aboriginal Mental Health and Addictions Expert Panel to develop an Aboriginal specific strategy.

The Boards of the Canadian Mental Health Association (CMHA) London-Middlesex, Search Strathroy and Western Ontario Therapeutic Community Hostel (WOTCH) passed motions in January 2012 directing their Executive Directors to pursue **voluntary integration opportunities** in the form of a merger.

iii. People living with or at risk of chronic disease

A number of initiatives have continued or been initiated that have advanced our capacity to care for and support people living with or at risk of chronic diseases and to integrate primary, specialized and community-based care. Many of these initiatives integrate quality improvement methodology focused to improve chronic disease care. These initiatives include the **South West Self-Management Program**, the **Diabetes Education Improvement Project in Thames Valley** and **Partnering for Quality in Chronic Disease Care**.

Partnering for Quality in Chronic Disease Care helped maintain the gains made with patients with diabetes through Partnerships for Health by providing quality and e-health coaches to primary care settings and offering learning collaboratives. The initiative also ensured that clinical management systems used in primary care would support collection of data on which to base quality improvement plans and the diabetes education centres integrate their information systems with those of the hospitals hosting the centres.

A **Chronic Disease Prevention and Management Network** was formed to ensure oversight of, and integration between, disease-specific and primary care initiatives within the LHIN and implementation of provincial and LHIN-specific chronic disease initiatives that are evidence-based, promote partnerships and are grounded in quality improvement.

iv. Francophone Communities

Through **French language training** of health care professionals, the development of a draft **French Language Services Policy** in the South West LHIN and continued collaboration with the **French LanguageHealth Planning Entity**, the South West LHIN has made significant efforts to enhance capacity of primary, specialized and community-based care focusing on Francophone communities.

Services and supports for French-speaking seniors have been enhanced through the **Wraparound program**, a program that aims to create individualized supports for culturally diverse seniors through professionals and community members from those communities based on the unique needs of the senior.

v. Aboriginal Communities

Efforts to enhance the availability of and access to services for Aboriginal communities have been made through a focus on education and networking for improved and innovative partnering (e.g., **Joint Erie St. Clair and South West LHIN Aboriginal Health Symposium**), and continued engagement of the **Aboriginal Committee.**

Various services and supports for Aboriginal seniors (e.g., traditional healing, congregate dining, home maintenance, seniors health advocate, seniors support worker, RPN, nurse practitioners, senior program coordinator, cultural safety trainer and patient navigator) were provided across the LHIN to ensure effective **culturally appropriate service delivery** and to augment services and supports for seniors in the aboriginal community.

The South West Regional Renal Program has continued to work with the Southwestern Ontario Aboriginal Health Access Centre to ensure provision of culturally sensitive services at the proposed **Kidney Care Centre at Westmount Mall in London**.Both the South West LHIN Aboriginal and Francophone Leads became involved in the **South West Self-Management Strategy** to ensure that training opportunities are provided for peer leaders from Aboriginal and Francophone communities and that opportunities to expand resources and services offered to these communities are explored.

II - Enhance access and sustainability of hospital-based treatment and care focusing on:

i. Emergency Services

An **Emergency Department Physician Lead** was recruited in June 2011 and, along with the ED Project Lead, visited 100% of all EDs or alliances in the South West LHIN to gain a better understanding of site- and organizational-specific issues within the ED.

The ED Physician Lead and Project Lead are working with the Hips and Knees Lead to develop a **common order set and transport process** for patients requiring hip fracture surgery.

Improvements have been seen in ED capacity and performance through the implementation of **ED Process Improvement Programs (PIP)** that leverage LEAN methodologies and PIP teams.

Improvements have been achieved in flow and reduced wait times in the ED through the implementation of the **Provincial Pay 4 Results Program**.

The implementation of **Home First** is expected to positively impact admitted and non-admitted length of stay metrics as patients will not be designated ALC as frequently and added supports will be in place for these patients, getting them home sooner and opening up additional beds for patients admitted through the ED.

ii. Medicine, Surgical and Critical Care Services

A number of initiatives have resulted in improved access to and sustainability of hospital based services. System wide solutions to **access to hip fracture and cancer surgery** have resulted in meeting access targets. A system-wide approach to **access and flow was implemented using a dedicated phone number at each hospital** to guide both emergent/urgent requests for transfer and emergent/urgent phone consultations with hospital-based specialists to support patient care at the referring site. This has resulted in improved access to emergency care and facilitated repatriation of patients to their home hospitals to improve patient flow through the system.

Other critical initiatives that link with access and flow include:

- **Non-emergency transportation** where common clinical standards have been developed to ensure patient safety during transport between hospitals and other care facilities;

- **"Life or Limb No Refusal" policy** that ensures that the most critical patients are transferred to London in an expeditious manner and that access to these patients cannot be denied; and

- **Extramural On Call** supports critical emergency care in hospitals outside of the London area

eHealth Initiatives in the South West LHIN

The South West LHIN decided in 2011/2012 to partner with LHINs in Erie St. Clair, Waterloo Wellington and Hamilton Niagara Haldimand Brant, forming a "cluster" to better collaborate on the delivery of large complex eHealth projects and ensure they come online in a coordinated, integrated fashion.

Under the guidance of the newly created South West Ontario (SWO) eHealth Oversight Committee (a body made up of Chief Executive Officers from all four participating LHINs and representatives from both eHealth Ontario and the Ministry of Health and Long Term Care) projects like the South West Physicians' Office Interface to Regional EMR (SPIRE) Hospital Report Manager (HRM), eReferral and Resource Matching (RM&R) and Connecting South West Ontario (cSWO) are now being leveraged to deliver more services to more residents than ever before.

The SPIRE/HRM project now has over 400 physician subscribers and LHIN staff is working closely with eHealth Ontario and OntarioMD on infrastructure upgrades that will give new users access to the interface, starting with physicians' offices in the Erie St. Clair LHIN.

cSWO is in the process of creating an architecture and detailed implementation plan for integrated Electronic Health Record (iEHR) Services that are aligned with Ontario's eHealth Blueprint and standards, and that will result in timely access to personal health information from across the continuum of care at any point of care in South West Ontario.

2011/2012 also saw progress made on the future state design of the Alternative Level of Care (ALC) RM&R project – an initiative to move patients out of acute facilities and into more appropriate environments for their on-going care, using a protocol that will ensure consistency and standardization across the province.

The SWO "cluster" of LHINs mirrors similar clusters that have formed elsewhere in the province; LHINs in the Greater Toronto Area (GTA) and Northern and Eastern Ontario (NEO) are also leveraging existing eHealth solutions and collaborating on new ones.

By working together, the Provincial agenda around the iEHR will be able to proceed on multiple fronts and enjoy accelerated implementation. This will result in better patient outcomes and improved quality of care – not just for the residents of the South West LHIN, but for everyone in Ontario.

Engaging our communities and stakeholders

Over the past year, the South West LHIN has been striving to achieve five system level goals: A Healthier South West LHIN Community; Equitable Access to Services; Quality of Care and Service; Integration of Health Care Delivery; and, Sustainability of the South West Local Health System. The Blueprint – Vision 2022 and Integrated Health Service Plan 2010-2013 are grounded in these as well as the LHIN's vision, mission and values. The South West LHIN is working collaboratively with health system partners to implement the actions to create an integrated health care system, where quality care is delivered as close to home as possible.

The delivery of quality care within a dynamic, ever-evolving environment will happen if we work together to create system change. Health system partners are building a health care system where programs and services work together, where individuals and their families are able to access and receive the care they need, when they need it. We are putting patients and clients at the centre of the system, closing gaps between services and removing duplication.

The South West LHIN is responsible for engaging health care providers, consumers, volunteers and the public in the work that lies ahead. Through this engagement, the LHINs and health service providers are able to gather and share information with their communities and stakeholders.

The South West LHIN continues to develop and build on its engagement activities and plans based upon the International Association for Public Participation (IAP2) model and the provincial LHIN Community Engagement Guidelines and Toolkit which was released in February 2011.

This past year, the South West LHIN conducted a number of engagement activities that included targeted, topic-specific engagement sessions as well as ongoing, regular engagement opportunities aligned to our health system goals, including our new format of engaging health service provider Boards and the general public five times a year following our regular Board meetings.

Targeted Engagement

Mental Health and Addictions Engagement Sessions for Governance on Community Capacity Planning and Implementation Project: Three sessions were held across the South West LHIN in February 2011 with governance from mental health and addictions agencies to review and discuss the Mental Health and Addictions Community Capacity Implementation Project report recommendations and the role of the LHIN and health service provider governance in supporting the implementation of selected recommendations. The discussion was captured feedback was incorporated into the community capacity implementation plan.

Performance Management Teams (PMT): A regular series of meetings were held between the LHIN, hospitals, and CCAC and between the LHIN and community sector agencies to address service accountability performance (e.g. share best practice, identify system migration issues). The ultimate goal of this work is to have a LHIN-wide approach and framework for performance management as articulated through the SAA process. As well, the PMT concept will help foster joint responsibility and accountability for achievement of performance objectives amongst provider partners.

Report on Performance (RoP) Webinars: Two webinars were hosted for all health service providers to introduce the Report on Performance, a tool developed to help the LHIN and health service providers chart monthly and quarterly system and organizational performance against Provincial, LHIN and Health Service Provider targets. The RoP is just one way that the South West LHIN is working with HSPs to create an integrated system of healthcare through measurement.

Since February 2012, the *South West LHIN Primary Care Physician Lead* has been involved in engaging primary care

providers across the South West LHIN in order to strengthen and further integrate primary care into local health planning.

Advancing Quality in Long-Term Care Homes: In November 2011, the South West LHIN hosted an "Advancing Quality in Long-Term Care Homes" one day event with approximately 160 representatives from Long-Term Care Homes across the LHIN. Participants received an update related to quality improvement initiatives through South West LHIN, Health Quality Ontario, MOHLTC, and the South West CCAC. Small group activities also allowed the participants to become familiar with quality improvement tools as well as discuss strategies for Behavioural Support Ontario Long Term Care Home investments. The day resulted in the creation of a LHIN-wide LTC Home Network and Council.

Ongoing Engagement

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.

Health care providers and the public are informed of our engagement opportunities and invited to provide input and feedback to us through a variety of vehicles, including social media. Since 2010, the South West LHIN has had a presence on YouTube, Twitter, Facebook and Linked In, all of which have provided ongoing opportunities for engagement.

In combination with our regular board meetings, where we rotate meeting locations throughout communities in the South West LHIN, 2011/12 began our regular cycle of ongoing LHIN board to health service provider board engagement and community information session engagement sessions. This new strategy for engaging communities followed five of our LHIN board meetings. We used the World Café technique to spark dialogue with health service provider boards and our Community Information Sessions focused on inviting health service providers to share information about their services and key initiatives that are available to residents of those communities. A highlight of the Community Information Sessions has been the involvement of patients/clients or caregivers to speak on their experiences with specific services and the health care system in their community.

Again this year, we partnered with the Ontario Medical Association to host *three physician engagement workshops*, one in each of our three geographic planning areas of the South West LHIN. The objectives of the sessions were to:
Update physicians on the activities of the South West LHIN;
Obtain input and advice from physicians on our Access to Care key priority areas, including e-Health as an enabler;
Obtain input and feedback from physicians around the challenges and enablers to successful implementation of Access to Care in the South West LHIN.
Family physicians, specialists and a couple of nurse practitioners from across the LHIN attended the workshops and we received positive feedback. We have moved beyond conversations around what a LHIN is and the physicians who attended are interested in the LHIN initiatives and how they can do their part to improve the system and the care for their patients. The majority of physicians told us that they were satisfied overall with the sessions and that it was an effective learning experience, and they appreciated and found value in the small group discussions and the large group discussion with the interactive panel.
In addition to our annual LHIN/OMA physician workshops, we engaged with physicians and other health care professionals with several repeat and new activities.

Composed of ten primary care physicians and two nurse practitioners, the *South West Primary Care Network* is the primary conduit for regional programs and/or organizations to engage primary caregivers. The Network meets approximately eight times per year to discuss various issues and initiatives that impact primary care practitioners and patients. South West LHIN staff regularly attends Network meetings to provide updates and seek input on emerging strategies and priorities.

The Critical Care Network continues meets quarterly (one face to face and three video conferences) to provide an opportunity for critical care leaders across the South West LHIN to share best practices, discuss data and how to use it for decision making, and profile and share information about the critical care work happening across our LHIN.

Critical Care Physician Engagement involves quarterly meetings via teleconference and one face to face between the LHIN's Critical Care Physician Lead with physician groups from across the South West LHIN to understand the current pressures experienced in both our urban and rural critical care units. As a result of this engagement, local physician champions have been identified for regional and provincial initiatives and our Critical Care Physician Lead is building partnerships with critical care physicians across the LHIN and province. The Critical Care Lead meets regularly with Critical Care Leads from all other LHINs across the province where they discuss possible new provincial initiatives and initiatives that are being spread across the province such as Life or Limb – No Refusal. The Critical Care Lead also regularly communicates with stakeholders on progress of ExACCRT and any changes to the process in an effort to streamline the process. An email address has been established so stakeholders can provide feedback, and possible suggestions for further improving the process. Stakeholders can also use this email to flag any issues so the Critical care lead is able to follow up with them on an individual basis.

In 2011, the South West LHIN hired an *Emergency Department (ED) Lead* and under their direction, conducted site visits to all Emergency Alliances and an informal ED Network was established in the South West LHIN. The ED Lead and Project Lead regularly meet with EDs to discuss initiatives and strategies for improvement.

The *South West Chronic Disease Prevention & Management (CDPM) Network* brings together representatives from a number of chronic disease-related programs and networks across the South West LHIN to engage in dialogue related to current CDPM strategies, directions and issues. The Network meets five times a year to:

Share highlights related to programs' and networks' strategic directions, activities and initiatives;
Make connections to other CDPM program and network leads;
Explore opportunities for collaboration.

1st Annual Quality Symposium: In April 2011, the South West LHIN hosted its 1st Annual Quality Symposium: Building a Healthier System through Quality & Innovation. This one-day event brought together almost 500 health service providers and partners from across the South West LHIN and surrounding areas and all health sectors were represented. We targeted leadership, governance and anyone else responsible for leading and supporting quality in their organizations. A special session for governance was held following the main day session. We received extremely positive feedback overall through our multiple communications channels (evaluation forms, phone, email, in person, Twitter, Facebook).

Below are some of the additional ongoing activities that allow us to hear about successes, concerns, emerging issues and innovative ideas across the South West LHIN geography:

Monthly hospital and CCAC leadership forums
LHIN advisory groups and steering committees
Invitational meetings and presentations, including meetings with members of provincial parliament
Vendor Fridays
Surveys and focus groups
Social media

We also continue to seek input from the six area provider tables (APT) within our LHIN. The majority of health care sectors are represented at these tables, including some that are not funded by LHINs (e.g., Public Health). The South West Addictions & Mental Health Coalition is another group that we regularly consult for feedback. Both the APTs and Coalition meet regularly throughout the year. Their perspective and input is most valuable in helping shape the health care system of the future.

Aboriginal Engagement

Engagement with Aboriginal Stakeholders

- The South West LHIN Aboriginal Committee has a renewed Terms of Reference and all members are now formally assigned to the Committee by their respective Band Councils and/or Boards of Directors. The committee meets once a quarter.

- The LHIN held three engagement meetings across the South West and Erie St. Clair (ESC) LHINs to support the federal Health Services Integration Fund (HSIF) project planning. The South West LHIN is partnered on 2 HSIF projects with the ESC LHIN. One involving nine First Nation communities across both LHINs on mental health assessment integration and research, the second is a cross LHIN data management project lead by the independent First Nations and involving 4 First Nation communities. The LHIN will have membership on the steering committee for the data management project.

- There are ongoing challenges to comprehensive/successful engagement of urban Aboriginal and Métis communities within the ESC and South West LHINs and will be a focus over the next year.

Cultural Awareness towards Cultural Competency and Safe Care

- The ESC and South West LHINs jointly held an Aboriginal Health Symposium on November 16 , 2011 in Grand Bend. Over 150 participants attended with a 95% satisfaction rate. The symposium was focused on building partnerships and examining models and approaches to integrate western and indigenous traditional models of care to improve health status and health outcomes to Aboriginal people across the South West and ESC LHINs.

- The LHIN CEO Aboriginal Health Charter prioritizes cultural competency for LHIN boards, staff and health service providers. A 2.5 hour Cultural Competency Training session for HSP leaders occurred with 24 participants. Additional sessions are upcoming this fiscal.

Mental Health & Addictions

- The South West LHIN participated on the First Nations Children's Mental Health Working Group as lead by the Southern First Nations Secretariat to complete a service review and gap analysis.

- The South West and ESC LHINs are creating a joint Aboriginal specific Mental Health and Addictions Strategy as part of the LHIN level MH Strategy Planning process which will focus on improving access to care, access to specialists, detox services, aftercare, discharge planning, cultural supports and traditional healers.

Aging at Home and Seniors

- The South West LHINs continue to fund a broad set of services to Aboriginal seniors who are at risk through its Supporting Aborignal Seniors at Home Initiative.

- The Oneida First Nation opened a LTC Home in spring 2012 and is steadily growing to full capacity.

Francophone Engagement

The past year marked the first year of operation for the South West/ Erie St. Clair French Language Health Planning Entity (Entity), created by the Ministry of Health and Long-term Care to work with the francophone communities and identify French language health services needs. In its first year, the Entity has focused most of its efforts on operations learning about the LHIN's work with the Francophone population. The Entity team is now complete with one executive director and two planners. Its main office is located in Windsor with a satellite in London.

A Liaison Committee was also formed with representatives from the Entity, the South West LHIN, and stakeholders from the francophone community with a goal of improving health outcomes for the francophone population within their region.

The Liaison Committee developed the 2011-12 Joint Action Plan which focuses on three goals:

1. Define how each partner will work together and the roles and responsibilities of each partner and the development of an accountability framework;
2. Seek opportunities to improve access to, and accessibility of, services in French for priority populations, including people with mental health and addictions issues, people living with a chronic disease, and seniors and adults with complex needs;
3. Develop a mutual community engagement framework that defines the role of each partner.

In the South West LHIN, some specific actions that took place in the past year include:

- Hiring of a French Language Services Coordinator to work in partnership with the Provincial French Language Services office, provide planning, integration and community engagement expertise and support regarding the development, implementation and integration of French Language Services.
- Hosting a consultation with francophone stakeholders assessing system capacity, adequacy of current services and gaps in services around mental health and addictions for francophone populations.
- Coordinating French language training of health care professionals in the South West LHIN through notification to all identified HSPs and establishment of a promotion booth in 2 London Hospitals. This resulted in the training of 34 health care professionals.
- The French Language Coordinator met with 7 of the 9 identifies HSPs to ensure they understand and comply with French Language Services (FLS) requirements and to gain a greater understanding of the current state of FLS in their organization/agency.
- Six identified HSPs were asked to submit a report on the current state of FLS in their organization.
- A South West LHIN internal committee was created to develop and implement a South West LHIN FLS policy. This policy was drafted and is awaiting approval.

Integration Activities

The *Local Health System Integration Act, 2006* (the 'Act') was passed to:

> *"provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs)."*

The Act places an obligation on LHINs *and* on Health Service Providers to identify opportunities to integrate services through a broad range of activities including co-ordination, partnering with others, and transferring, merging or amalgamating services. While most LHIN initiatves have integration elements, the following are the service integrations that were initiated or fully implemented in the South West LHIN in 2011-12.

Mental Health Tier 2 Divestment: St. Joseph's Health Care (SJHC), London

Mental Health Tier 2 Divestment involves two components:

1. The phased Divestment of Beds and Services as follows:

- Phase 1: COMPLETE - Transfer of 50 beds, 1 Assertive Community Treatment (ACT) Team and 1 Transition Team to Grand River Hospital. When Cambridge Memorial Hospital will provide Schedule 1 Services is still to be determined.
- Phase 2: COMPLETE - Transfer of 59 bed and 3 ACT Teams to Windsor Regional Hospital.
- Phase 3: Transfer of 14 beds and Simcoe Clinic Resources to St. Joseph's Healthcare Hamilton in 2013/2014.
- Phase 4: Transfer of 15 beds and the Crisis and Relapse Prevention Services to St. Thomas Elgin General Hospital (STEGH). Timeframe for completion is to be determined.
- Phase 5: 156 longer-term mental health beds and 89 forensic mental health beds relocated to new facilities within SJHC-RMHC in 2013/14. The 156 London-based longer-term mental health beds are to serve Elgin, Oxford, Middlesex, Lambton, Huron Perth and Grey Bruce for longer term for psychosis, mood and anxiety, dual diagnosis, adolescent, geriatrics, along with various ambulatory services. The 89 forensic mental health beds will be located in St. Thomas and are a provincial resource.

2. An overall reduction of 70 longer- term mental health in-patient beds resulting in a new per capita bed ratio reflective of the changing direction of mental health care from institutionalized care to care and service in the community. In parallel to the reduction of beds, there will need to be investment in the community to increase community capacity to provide care and support to individuals in the community.

During fiscal year 2012/13 and beyond, the following activities in relation to Mental Health Tier 2 Divestment will continue:

- $2.9M in base funding will continue to flow to support the phased reduction of the 70 long term mental health in-patient beds and associated development of community services and program capacity
- South West LHIN to receive Transfer Agreements for divestments to St. Joseph's Healthcare, Hamilton and STEGH (timelines will vary)
- Patients, staff and services transferred to receiving hospitals per Transfer Agreement
- Transfer of funding to receiving hospitals consistent with the Program Transfer Methodology
- Ongoing communications regarding transfer process continues with stakeholders

- STEGH entered into the Capital process in 2011/12 and phase three will continue into 2012/13

Integration of Core Mental Health Service Providers – Thames Valley

The Mental Health and Addictions Community Capacity Project, presented to the South West LHIN Board of Directors at its October 26, 2011 meeting, identified and recommended service integration as a key area for implementation. In 2012/13, integration activities will be undertaken with core mental health services providers in the Thames Valley area. Work will begin to identify and investigate potential integration opportunities including identification of operational (e.g., back office) and governance commonalities; risks and financial impacts; and potential integration models. An implementation plan will be developed and may include partner agreements and memorandums of understanding; governance and leadership models; human resource, risk mitigation and communication plans; and evaluation criteria and measures. The goal is to implement the integration opportunities by fiscal year end 2012/13.

Joint Services Plan for Oxford County Hospitals

With the opening of the new Woodstock General Hospital in November 2011, capacity was added to Oxford County and area. In order to ensure that this the additional capacity is utilized efficiently and effectively, the South West LHIN has requested that the three hospitals in Oxford County (Woodstock General Hospital, Tillsonburg and District Memorial Hospital, and Alexandra Hospital in Ingersoll) work collaboratively to develop a framework for a Joint Services Plan in 2012/13. The Plan will include recommendations on items such as:

- Clinical services delivery to Oxford residents, including a description of the service delivery models across the three sites and an articulation of what clinical services will be provided at each hospital and to what extent (e.g. volumes, service units, etc.)
- Market share realignment (repatriation) from London Health Sciences Centre, St. Joseph's Healthcare, London and other neighbouring hospitals as appropriate
- Back office services integration
- Integration in other areas as relevant
- A governance and leadership model for the Oxford hospitals to successfully implement the joint services plan
- Timelines for completion
- Assignment of responsibilities for each component of the plan

The Plan will be based on:

- Evidence of strong community engagement
- Thorough analysis of:
  - Data including market share, projected demographics, current utilization patterns, etc.
  - Impact on neighbouring hospitals (e.g. London, St. Thomas, Stratford, Kitchener-Waterloo, etc.), the South West CCAC and other partners
- Consideration of the South West LHIN Blueprint and Integrated Health Service Plan

Back Office Integration

In addition to the integration of back office services related to the above two integration initiatives, the South West LHIN will continue to work with health service providers to identify opportunities for back office integration (e.g., human resources, information technology, etc.).

Huron Perth Healthcare Alliance (HPHA) – Vision 2013

In 2010, the HPHA began the process of implementing their vision for health services that ensures the future sustainability of hospital-based care for the residents of their catchment area. The Vision 2013 involves three main components**:**

1. Create Critical Mass through Bed Redistribution: in order to improve access to medical and surgical

beds, Vision 2013 includes a plan to redistribute bed types across the four sites.

2. Realignment of Services: to facilitate recruitment and retention as well as ensure high quality, safe care, Vision 2013 includes a plan to create more consistent groupings of patients among its four sites.
3. Adjust ER Hours to Strengthen ER System of Care: to increase recruitment, stabilize retention, and reduce the risk of unplanned ER closures due to physician and nursing coverage issues, the HPHA Vision 2013 plan includes two 24/7 ERs and two 16/7 ERs across its four sites.

The HPHA will complete the following phase throughout 2012/13:

- Phase 1 of Vision 2013 is the consolidation of adult outpatient physiotherapy from 4 sites to 2 sites (Seaforth and Clinton sites);
- Phase 2 is an increase in the number of beds at the Clinton and St. Marys sites; implementation date to be determined. This realignment of beds will lead to an increase in acute medicine beds and the potential to increase surgical inpatient capacity (with appropriate funding) at the Stratford site.
- Phase 3 is the relocation of the HPHA Rehab beds to the Seaforth site and a redistribution of beds from medicine, Complex Continuing Care and Rehabilitation.
- Creation of an ER system of care across the 4 HPHA sites will be evaluated in light of the provincial ER Task Force recommendations.

Integration of Hospice Services – London Middlesex

In 2011/12, Hospice of London (HoL) and the St. Joseph's Health Care Society (the Society) integrated in order to develop a new entity owned by the Society to deliver the services currently provided by HoL and the new residential hospice bedded service. The hospice will serve the diverse communities in London-Middlesex, respecting the different practical, religious, spiritual and cultural traditions associated with end-of-life care. Planning for the residential hospice began in late 2011/12 and will continue into 2012/13 and 2013/14. The new residential hospice is expected to open for residents in January 2014.

South West LHIN Integration Implementation Support Program

As part of the 2011/12 South West LHIN Priorities for Investment approach, the development of an Integration Implementation Support Program was identified as an area of focus based on an understanding of the following:

- Opportunities and readiness to advance provincial and local priorities as set out in the South West LHIN 2010-13 Integrated Health Service Plan (IHSP);
- Scope and current status of key initiatives funded by the LHIN;
- Lessons from previous investments by the South West LHIN and other LHINs; and
- Estimated financial capacity for new investment.

One-time funds were allocated and spent to eight projects through this initiative in 2011/12. Close out reports are expected for each project in early 2012/13 and consideration will be made as to if the program will be continued.

Ministry/LHIN Accountability Agreement Performance Indicators
2011-12

PI No.	Performance Indicator	LHIN 2011/12 Starting Point	LHIN 2011/12 Performance Target	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	10.67%	8.80%	11.69%	32.8%	12.40%
2	90th Percentile ER Length of Stay for Admitted Patients	26.42	23.75	26.72	12.5%	26.23
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	6.45	6.30	6.67	5.8%	6.45
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	3.88	4.00	4.02	0.4%	3.87
Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	93	80	65	-18.8%	82
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	49	49	34	-30.6%	44
7	90th Percentile Wait Times for Cataract Surgery	93	85	113	32.9%	104
8	90th Percentile Wait Times for Hip Replacement	186	178	207	16.3%	207
9	90th Percentile Wait Times for Knee Replacement	198	182	267	46.7%	253
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	67	44	97	120.5%	71
11	90th Percentile Wait Times for Diagnostic CT Scan	29	25	27	8.0%	26
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	15.84%	14.00%	16.71%	19.4%	15.83%
Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	15.50%	14.70%	15.18%	3.3%	15.30%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	26.30%	25.00%	28.89%	15.6%	27.30%
Access to Community Care						
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	28.00	26.60	26.00	-2.3%	27.00
	* A negative percentage means the LHIN is below its target					
	** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability					
	*** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability					

The following provides greater details on activities within the LHIN relating to the performance indicators on the previous page.

The South West LHIN worked alongside health service provider partners in making some of the necessary changes within the local health care system in 2011/12 to improve patient/client experiences and enhance services and programs in order to advance our performance objectives. The key measures the South West LHIN uses to monitor performance improvements are articulated within the South West LHIN Report on Performance Scorecard covering the Ministry-LHIN Performance Agreement (see South West LHIN Performance Indicators table) and the 2010-13 Integrated Health Service Plan priorities.

The time patients wait for cancer surgery has improved by 31% over the past year. Over the past 3 years, the South West LHIN had consistently reported the longest wait times for cancer surgery in Ontario. Within the last year, the South West LHIN, South West Regional Cancer Program and hospital partners delivering cancer surgery have worked together to launch a multi-pronged approach to improving surgery wait times for cancer patients and we are now seeing the positive impacts of our collective efforts. Although we have see better results, our work is not done as we continue to work towards sustained lower wait times to ensure patients have timely access to high quality cancer surgical services.

The Access to Care initiative remains a key component to our strategy to support people, specifically seniors and adults with complex needs, to live safely in their homes for as long as possible. Specifically, we are seeing more people able to be cared for safely in their homes following a hospital encounter and less people staying in hospital when their acute phase is complete (i.e. Alternate Level of Care (ALC) patients). Although our ALC measure has not shifted, it is important to note that the ALC measure is a historical look at this issue and does not well reflect in a timely way changes to patient flow and access. The most recent implementation efforts are showing positive signs and we expect further traction as expand the initiative across the LHIN.

Although we have seen good performance in many areas, we still have work to do in achieving other performance objectives. For example, our wait times for hip and knee total joint replacement surgery have worsened in the past year. A performance improvement intervention involving our hospital surgical sites was launched and is focused on using our data and information to identify ways to deliver high quality surgery in a timely manner. Another opportunity is timely access to Magnetic Resonance Imaging (MRI) scans. Despite a trend of MRI wait time reduction, we have seen a steady wait time increase in the past year that can be attributed to a higher demand for scans. This is a similar experience being experience across Ontario. New MRI service capacity has been opened locally to assist with the increased demand and may also assist in altering traditional referral patterns for service.

Our performance measures are showing good results in many areas but are also signaling further work that needs to be done in order to achieve our goal of an integrated health system of care. We will continue to measure our efforts to ensure providers are working closely together, improvements to point of care transitions are being made, value for money is being achieved, and people are pleased with the care being provided.

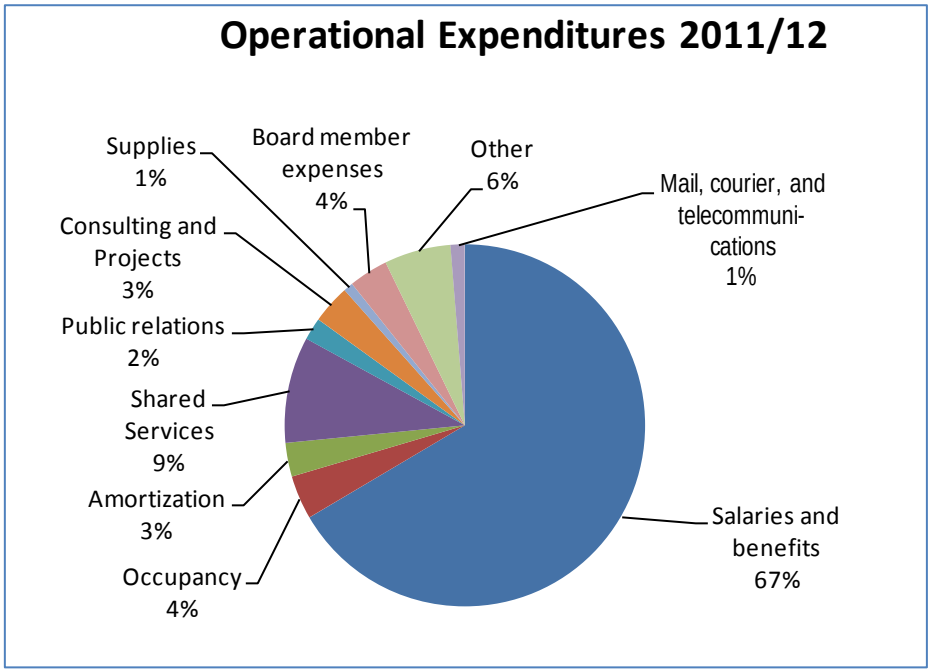
Operational performance

In 2011/12, the South West LHIN operating budget was made up of two components:

$5.3 million for operations
$1.3 million for special projects

Operations

The South West LHIN ended the year with an operating surplus of $10,827. There were small surpluses relating to the funding for other special projects - special project funding is listed below. The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure is salaries and benefits with 32.5 FTEs and 2 staff hired on contract basis for specific operational projects. The South West LHIN hired 12 FTEs with special project funding.



Special Projects

The base and one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2011/12 fiscal year were:

	Funding	Expenditure*
Aboriginal Planning (Base)	35,000	21,466
French Language Services (Base)	**106,000**	**87,247**
Critical Care Lead	75,000	73,831
E-Health (PMO & SPIRE)	892,297	829,506
Emergency Department Lead	62,132	62,132
Emergency Room/Alternative Level Care Lead	88,008	88,008
Primary Care Lead	18,750	16,091
Behavioural Support	57,000	54,735
Total	**1,334,187**	**1,233,016**

**Surpluses returned to Ministry of Health and Long-Term Care and eHealth Ontario*

Financial Statements

South West Local Health Integration Network

March 31, 2012

South West Local Health Integration Network

March 31, 2012

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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, 2012, and the statements of financial activities, changes 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, 2012 and the results of its financial activities, changes in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 23, 2012

South West Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**325,816**	525,094
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**2,025,893**	37,412,887
Due from the LHIN Shared Services Office (Note 4)	**-**	3,736
HST Receivable	**45,355**	65,468
Accounts receivable	**16,490**	1,421
	2,413,554	38,008,606
Liabilities		
Accounts payable and accrued liabilities	**308,018**	581,241
Due to Health Service Providers ("HSPs") (Note 9)	**2,025,893**	37,412,887
Due to MOHLTC (Note 3b)	**48,082**	28,518
Due to eHealth Ontario (Note 3c)	**62,791**	-
Due to the LHIN Shared Services Office (Note 4)	**7,440**	7,631
Deferred capital contributions (Note 5)	**267,754**	409,415
	2,719,978	38,439,692
Commitments (Note 6)		
Net debt	**(306,424)**	(431,086)
Non-financial assets		
Prepaid expenses	**38,670**	21,671
Capital assets (Note 7)	**267,754**	409,415
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

South West Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (unaudited) (Note 8)	2012 Actual	2011 Actual
		$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**2,059,417,457**	**2,169,260,125**	2,096,400,627
Operations of LHIN	**5,153,419**	**5,146,833**	5,099,732
Aboriginal Planning (Note 10a)	**35,000**	**35,000**	4,702
French Language Services (Note 10b)	**106,000**	**106,000**	10,000
Critical Care (Note 10c)	**75,000**	**75,000**	75,000
Emergency Department ("ED") Lead (Note 10d)	**75,000**	**62,132**	51,817
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10e)	**100,000**	**88,008**	100,000
Primary Care Lead (Note 10f)	**-**	**18,750**	-
Behavioural Support (BSO) (Note 10g)	**-**	**57,000**	-
E-Health (Note 10h)	**600,000**	**892,297**	940,795
Amortization of deferred capital contributions (Note 5)	**141,782**	**158,851**	149,628
	2,065,703,658	**2,175,899,996**	2,102,832,301
Funding repayable to eHealth Ontario (Note 3a)	**-**	**(62,791)**	-
Funding repayable to the MOHLTC (Note 3a)	**-**	**(49,207)**	(33,220)
	2,065,703,658	**2,175,787,998**	2,102,799,081
Expenses			
Transfer payments to HSPs (Note 9)	**2,059,417,457**	**2,169,260,125**	2,096,400,627
General and administrative (Note 11)	**5,295,201**	**5,294,857**	5,237,266
Aboriginal Planning (Note 10a)	**35,000**	**21,466**	4,702
French Language Services (Note 10b)	**106,000**	**87,247**	9,318
Critical Care (Note 10c)	**75,000**	**73,831**	74,643
ED Lead (Note 10d)	**75,000**	**62,132**	38,810
ER/ALC Performance Lead (Note 10e)	**100,000**	**88,008**	97,676
Primary Care Lead (Note 10f)	**-**	**16,091**	-
Behavioural Support (BSO) (Note 10g)	**-**	**54,735**	-
E-Health (Note 10h)	**600,000**	**829,506**	936,039
	2,065,703,658	**2,175,787,998**	2,102,799,081
Annual surplus and closing accumulated surplus	**-**	**-**	-

South West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	Budget (unaudited) (Note 8)	2012 Actual	2011 Actual
		$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	**(16,999)**	(21,671)
Acquisition of capital assets	-	**(17,190)**	(54,899)
Amortization of capital assets	-	**158,851**	149,628
Decrease in net debt	-	**124,662**	73,058
Opening net debt	-	**(431,086)**	(504,144)
Closing net debt	-	**(306,424)**	(431,086)

South West Local Health Integration Network

Statement of cash flows

year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	**-**	-
Less items not affecting cash		
Amortization of capital assets	**158,851**	149,628
Amortization of deferred capital contributions (Note 5)	**(158,851)**	(149,628)
Changes in non-cash operating items		
Decrease in due from MOHLTC HSP transfer payments	**35,386,994**	(21,030,493)
Decrease in due from MOHLTC	**-**	107,000
Decrease in due from LHIN Shared Services Office	**3,736**	(393)
(Increase) decrease in accounts receivable	**(15,069)**	4,947
Increase (decrease) in HST receivable	**20,113**	(65,468)
(Decrease) increase in accounts payable and accrued liabilities	**(273,223)**	4,499
Increase in due to HSPs	**(35,386,994)**	21,030,493
Increase (decrease) in due to MOHLTC	**19,564**	(145,138)
Increase in due to eHealth Ontario	**62,791**	-
(Decrease) increase in due to LHIN Shared Services Office	**(191)**	7,631
Decrease in deferred revenue	**-**	(72,000)
Increase in prepaid expenses	**(16,999)**	(21,671)
	(199,278)	(180,593)
Capital transaction		
Acquisition of capital assets	**(17,190)**	(54,899)
Financing transaction		
Deferred capital contributions received (Note 5)	**17,190**	54,899
Net decrease in cash	**(199,278)**	(180,593)
Cash, beginning of year	**525,094**	705,687
Cash, end of year	**325,816**	525,094

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 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.

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

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 and eHealth Ontario

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 the eHealth Ontario.

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

	Funding	**Eligible expenses**	**2012 Funding excess**	2011 Funding excess
	$	**$**	**$**	$
Transfer payments to HSPs	**2,169,260,125**	**2,169,260,125**	**-**	-
LHIN operations	**5,146,833**	**5,136,006**	**10,827**	12,095
Aboriginal Planning	**35,000**	**21,466**	**13,534**	-
French Language Services	**106,000**	**87,247**	**18,753**	682
Behavioural Support	**57,000**	**54,735**	**2,265**	-
E-Health	**892,297**	**829,506**	**62,791**	4,756
Critical Care Lead	**75,000**	**73,831**	**1,169**	356
ED Lead	**62,132**	**62,132**	**-**	13,007
Primary Care Lead	**18,750**	**16,091**	**2,659**	-
ER/ALC Lead	**88,008**	**88,008**	**-**	2,324
	2,175,741,145	**2,175,629,147**	**111,998**	33,220

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

	2012	2011
	$	$
Due to MOHLTC, beginning of year	**28,518**	173,656
Funding repaid to MOHLTC	**(28,518)**	(173,656)
Funding receivable from the MOHLTC related to current year activities (Note 10a)	**(1,125)**	(4,702)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**49,207**	33,220
Due to MOHLTC, end of year	**48,082**	28,518

c) The amount due to the eHealth Ontario at March 31 is made up as follows:

	2012
	$
Due to eHealth Ontario, beginning of year	**-**
Paid to eHealth Ontario during year	**-**
Funding repayable to the eHealth Ontario related to current year activities (Note 3a)	**62,791**
Due to eHealth, end of year	**62,791**

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

	2012	2011
	$	$
Balance, beginning of year	**409,415**	504,144
Capital contributions received during the year (Note 8)	**17,190**	54,899
Amortization for the year	**(158,851)**	(149,628)
Balance, end of year	**267,754**	409,415

6. Commitments

The LHIN has commitments under various operating leases extending to 2015 related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next three years are as follows:

	$
2013	261,894
2014	202,500
2015	84,375

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:

	$
2013	2,121,499,628

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

7. Capital assets

	Cost	Accumulated amortization	2012 Net book value	2011 Net book value
	$	**$**	**$**	$
Computer equipment	**139,868**	**95,733**	**44,135**	60,686
Leasehold improvements	**1,464,863**	**1,318,512**	**146,351**	244,713
Office equipment, furniture and fixtures	**218,003**	**140,735**	**77,268**	104,016
Web development	**21,998**	**21,998**	**-**	-
	1,844,732	**1,576,978**	**267,754**	409,415

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, 2011. 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 $2,169,260,125 is derived as follows:

	$
Initial budget	2,059,417,457
Adjustment due to announcements made during the year	109,842,668
Final HSP funding budget	2,169,260,125

The final LHIN budget, excluding HSP funding, of $6,707,041 is derived as follows:

	$
Initial budget	6,286,201
Additional funding received during the year	403,650
Amount treated as capital contributions during the year	17,190
Final LHIN operating budget	6,707,041

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,169,260,125 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2012 as follows:

	2012	2011
	$	$
Operation of hospitals	**1,569,651,483**	1,528,366,263
Grants to compensate for municipal taxation - public hospitals	**451,500**	451,500
Long term care homes	**293,210,720**	276,650,300
Community care access centres	**179,155,370**	170,394,969
Community support services	**37,367,473**	34,953,026
Assisted living services in supportive housing	**17,324,750**	16,619,916
Community health centres	**15,433,606**	12,404,709
Community mental health addictions program	**56,665,223**	56,559,944
	2,169,260,125	2,096,400,627

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2012, an amount of $2,025,893 (2011 - $37,412,887) 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. Programs

a) Aboriginal planning

The MOHLTC provided the LHIN with $35,000 (2011 - $34,992) related to aboriginal planning. The LHIN incurred operating expenses totaling $21,466 (2011 - $4,702). The LHIN has setup a payable to the MOHLTC for the remaining balance of $13,534.

b) French language services

The MOHLTC provided the LHIN with $106,000 (2011 - $10,000) related to French Language Services funding. The LHIN incurred operating expenses totaling $87,247 (2011 - $9,318). The LHIN has setup a payable to the MOHLTC for the remaining balance of $18,753.

c) Critical care lead

The MOHLTC provided the LHIN with $75,000 (2011 - $75,000) related to Critical Care initiatives. The LHIN incurred operating expenses totaling $73,831 (2011 - $74,643). The LHIN has setup a payable to the MOHLTC for the remaining balance of $1,169.

d) ED lead

The MOHLTC provided the LHIN with $75,000 (2011 - $75,000) related to Emergency Department initiatives. The MOHLTC collected from the LHIN, $13,072 as an in year recovery. The LHIN incurred operating expenses totaling $62,132 (2011 - $38,810). The LHIN has setup a receivable from the MOHLTC for $204 to cover these operating expenses.

e) ER/ALC lead

The MOHLTC provided the LHIN with $100,000 (2011 - $100,000) related to emergency room management strategy funding. The MOHLTC collected from the LHIN, $12,912 as an in year recovery. The LHIN incurred operating expenses totaling $88,008 (2011 - $97,676). The LHIN has setup a receivable from the MOHLTC for $920 to cover these operating expenses

10. Programs (continued)

f) Primary care lead

The MOHLTC provided the LHIN with $43,750 (2011 - $0) related to Primary Care initiatives. The MOHLTC collected from the LHIN, $25,000 as an in year recovery. The LHIN incurred operating expenses totaling $16,091 (2011 - $0). The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,659.

g) Behavioural support (BSO)

The MOHLTC provided the LHIN with $57,000 (2011 - $0) related to behavioural support planning. The LHIN incurred operating expenses totaling $54,735 (2011 - $0). The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,265.

h) eHealth Ontario

The LHIN entered into a transfer payment agreement with eHealth Ontario provided $902,900 (2011 - $942,000) to the LHIN $600,000 related to PMO and $302,900 related to Southwest Physicians Interface with Regional EMRs (SPIRE). The LHIN incurred operating expenses of $829,506 (2011 - $936,039) and capital expenses of $10,603 (2011 - $1,205) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to eHealth Ontario for the remaining balance of $62,791 ($45,337 for PMO and $17,454 for SPIRE).

11. General and administrative expenses

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

	2012	2011
	$	$
Salaries and benefits	**3,522,153**	3,242,761
Occupancy (Note 12)	**207,850**	205,399
Amortization	**158,851**	149,628
Shared services	**451,995**	359,495
LHIN Collaborative	**50,000**	50,000
Public relations	**105,639**	50,986
Consulting and Project expenses	**183,184**	801,032
Supplies	**45,676**	36,413
Board chair per diem	**42,423**	24,275
Board member per diem	**54,435**	54,017
Board member expenses	**89,251**	49,004
Mail, courier and telecommunications	**67,790**	59,604
Other	**315,610**	154,652
	5,294,857	5,237,266

12. Recovered expenditures

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

This contract expired March 31, 2011. During the prior fiscal year, amounts received for accommodations decreased occupancy expense by $58,200 to $205,399 from $263,947 and is included in the statement of financial activities.

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 30 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 2012 was -$292,146 (2011 - $262,137) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2011. As at 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 comparative figures have been reclassified to conform to the current year presentation

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