South West LHIN

# South West Local Health Integration Network
# Annual Report 2012-2013

Ontario
Local Health Integration Network

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## Message from Jeff Low, Board Chair and Michael Barrett, CEO

It seems like yesterday that we were announcing the launch of our second three-year Integrated Health Service Plan (IHSP) 2010-13; the foundational document that drives all that we do, every initiative that we fund, every partnership that we support. Now, as we get ready to introduce our third IHSP, we take a look at how we fared over the last three years.

Three years ago, we knew the task at hand was enormous, and only with the support of all our health service providers, and the communities we serve, would we be able to move closer to the fully integrated system of care described in our Health System Design Blueprint – Vision 2022.

Just as children on a long road trip might ask "Are we there yet?", so we are often asked about our Vision. The answer: we still have a long way to go, however we have made great strides in bringing organizations together to provide better health outcomes.

Although all the initiatives we support are important, we would like to highlight a few that stand out as truly transformative in a health care system that not very long ago was viewed as inflexible.

The One-number protocol that was developed in the South West LHIN brought together every hospital in our geography to ensure that critically ill patients received the care they need, when they need it, in the right location. The Life or Limb – No Refusal policy was also implemented to ensure that an individual at risk of death or losing a limb would never be turned away for lack of a bed. Indeed, the main premise of this policy is "patient first, bed second". We are particularly proud of this initiative that has proven so beneficial that it is being implemented across the province.

Another area where we have seen significant progress is in wait times. When an individual is ill, injured, or requires surgery a lengthy wait may bring on additional stress. Hospitals in our LHIN have seen great improvements in all areas of wait times – surgical, diagnostic testing, and emergency visits. Although there will always be periods of unanticipated surge in demands for certain services, overall we are moving in the right direction in our approach to reducing wait times in our LHIN.

In November 2012, the Ministry of Health and Long-Term Care announced the creation of Health Links, collaboratives that put the individuals at the centre of their care, supported by a multi-disciplinary team. The first Health Link in the South West LHIN will be in Perth County, with the North Perth Family Health Team as the lead partner. Health Links are being established throughout the province to provide more coordinated health services, particularly for individuals with complex needs.

The South West LHIN eHealth team also implemented SPIRE, a system that links hospital records to family physicians' electronic medical record, so that test results, hospitalization and discharge information is instantly available to the patient's family physician so that appropriate follow-up care can be provided.

Another initiative of note is Access to Care (ATC), an approach focused on supporting people, specifically seniors and adults with complex needs, in their homes for as long as possible, with community supports. The three initiatives under the Access to Care umbrella (*Home First, Rehabilitation and Complex Continuing Care, Adult Day Programs/Assisted Living/Supportive Housing)* help individuals avoid or delay admission to a long-term care home.

This is only a brief sampling of the dozens of initiatives currently underway in the South West LHIN. You will find additional updates throughout this annual report.

As we launch our third IHSP, we are excited about the next three years. Our health care system needs to change so that it is available to our children and grandchildren in a sustainable way. The health service providers of the South West LHIN have partnered with us, and with each other to transform the health care system. We are grateful for their support for without it, transformation would be beyond our reach. We also want to thank the South West LHIN Board of Directors, leadership team, and all the staff for their ongoing work to build a stronger health care system for all the people of the South West LHIN.

# Board of Directors

## Board members as of March 31, 2013

(Please note there are two vacancies as of March 31, 2013)

Jeff Low (London), Chair
February 7, 2011 - February 6, 2014

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

Sheryl Feagan (Goderich)
July 8, 2010 – July 7, 2013

Ron Lipsett (Annan)
July 28, 2010 – July 27, 2013

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

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

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

### Member whose term expired during 2011-12

Linda Stevenson, May 15 2012

The South West LHIN gratefully acknowledges the significant contributions made by Linda during her years of service on the Board. During her two terms, Linda was called upon to fill the role of Acting Chair, as well as Vice Chair and her exemplary dedication and insight made her a key member of the Board of Directors.

# The South West LHIN and its Health Service Providers

The South West LHIN was established in 2005 to plan, fund, and integrate health services in a mixed rural-urban geography that includes the tip of the Bruce Peninsula to the shores of Lake Erie. Our area includes world renowned teaching hospitals such as London Health Sciences Centre, mid-sized hospitals in cities such as Owens Sound, Stratford and Woodstock. We also have over two dozen hospital sites that serve the smaller towns and farm communities throughout our LHIN. Each has a role to play in providing the residents of the LHIN a quality health care system that can be sustained into the future.

A large part of the LHIN's role is to ensure optimal use of all health care resources, including those agencies that provide much needed community-based services. We have recently developed our third Integrated Health Service Plan (IHSP) which will guide our activities and initiatives for the next three years, and is focused on helping people *live healthy, independently and safely at home*.

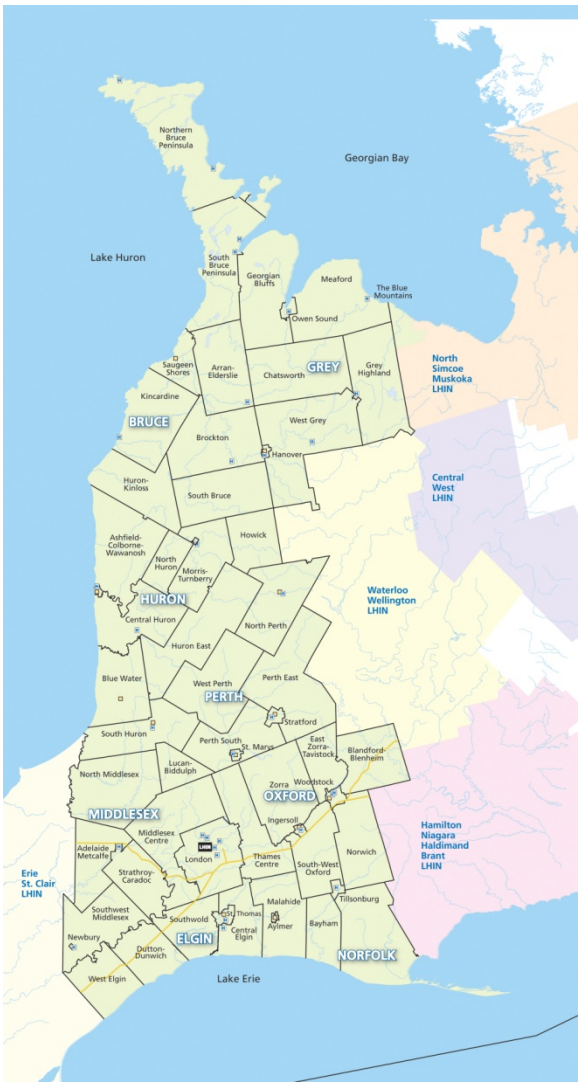
Hospitals in the LHIN provide exceptional acute care for those who are very ill, and our long-term care homes are available for individuals whose care needs can no longer be accommodated in the community. However, for the vast majority of people who require support, those needs can and should be met in their home community. Whether it's in-home care from a personal support worker, or an adult day program for individuals with dementia, these community services are key to the future sustainability of the health care system as they allow earlier discharge from hospitals, prevent re-admissions, and help delay or avoid admission to long-term care homes.

The South West LHIN population receives services from an array of LHIN and non-LHIN funded organizations across the community, long-term care and acute health sectors. Residents rely on these organizations for a variety of needs including home/social support, episodic, chronic and long-term care.

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

- 20 Hospital Corporations (33 sites)
- 78 Long-Term Care Homes
- 60 Community Support Service Agencies
- 38 Mental Health and Addiction Agencies
- 5 Community Health Centres
- 1 Community Care Access Centre

In addition, non-LHIN funded organizations, such as family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency medical services and labs play a critical role in the delivery of primary care services. While these services do not fall under the LHIN's mandate, understanding and partnering with them is crucial to developing a plan for integration and coordination across the health continuum.



## Population Profile

*Source: Environmental Scan*

The South West LHIN is home to 962,500 people; 7.2% of the population of Ontario. London is the largest urban centre (population 100,000+) in the South West LHIN with a population of 366,150, home to approximately 40% of residents. Almost 30% of the South West LHIN population live in a rural area and just over 30% live in small or medium population centres.

Population projections for the South West LHIN suggest that population growth will be slower than Ontario as a whole. By 2015, the LHIN's population will have grown by about 3.5%, compared to 6.2% for the province overall; by 2021 the population is projected to increase by 7.5% (compared to a projected increase of 13% for Ontario overall).

Almost 16% of the LHIN's population is aged 65 years or over. This is up from 14.6% in 2006. By 2016 seniors will account for 18% of the LHIN's population; by 2021 it will be 20.5%. South West LHIN's population is aging slightly faster than the province as a whole.

In 2006, approximately 85% of the LHIN's population reported English as their mother tongue. While 14.8% of the South West LHIN's population were immigrants in 2006, fewer than 2% were recent immigrants, having arrived in Canada between 2001 and 2006. According to 2006 census data, Francophones account for just under 1.5% and Aboriginals 1.4% of the South West LHIN population. Immigrant, Francophone and Aboriginal communities tend to experience difficulty accessing health care services due to cultural and language barriers.

## Socioeconomic Characteristics of the South West LHIN Population

Overall, the LHIN's population is lower than the Ontario average on a number of measures including unemployment rate, education and percentage of low-income residents.

| | South West | Ontario | Ontario Comparison |
|---|---|---|---|
| Unemployment Rate 2011 (age 15+) | 7.6% | 7.8% | |
| Education | | | |
| Without certificate/degree/diploma | 16.6% | 13.5% | 3rd highest |
| Completed post-secondary education | 55.8% | 61.4% | 3rd lowest |
| Living in low-income | 11.1% | 14.7% | |

## Population Health Profile

When developing a strategic plan for the health system, it is important to understand the population's health status, which is likely to influence the health care needs of the population. The prevalence of chronic disease and accessibility of primary care are key concerns among the South West LHIN population.

### General Health

Three out of five South West LHIN residents say they have *very good* or *excellent* health, and three out of four reported *very good* or *excellent* mental health. Although this proportion decreases with age, 44% of those aged 75+ still report very good/excellent health. Approximately 13% of LHIN residents say they usually

experience moderate or severe pain/discomfort, and 30% say they experience activity limitations because of long-term physical or mental health problems. Not surprisingly, prevalence of pain/discomfort and activity limitation increases with age.

The majority, 92%, of LHIN residents report having a regular medical doctor (similar to the provincial average).

## Risk Factors

Approximately one in five South West LHIN residents are smokers and 17% are heavy drinkers (similar to provincial rates). The proportion of smokers and heavy drinkers decreases with age. Over half (56%) of LHIN residents are overweight or obese; significantly higher than the provincial average of 52%. Among LHIN residents age 65-74, 68% are overweight or obese. Half of LHIN residents are physically inactive, and nearly six in 10 report inadequate consumption of fruits and vegetables (consume fewer than 5 servings daily).

## Life Expectancy and Leading Causes of Death

South West LHIN residents have a slightly lower life expectancy (at birth and at age 65) compared to Ontario overall. Ischemic heart disease, lung cancer, cerebrovascular disease (stroke), breast cancer, and cancer of lymph/blood are leading causes of death.

## Chronic Disease

Approximately 38% of South West residents (age 12+) have a chronic condition and 16% have multiple conditions. Prevalence of multiple chronic conditions increases dramatically with age; 45% of LHIN residents age 65-74 and 56% of those age 75+ have two or more chronic conditions. Chronic conditions account for six out of 10 deaths, one out of four acute hospital discharges, and one out of four acute hospital days for LHIN residents. The prevalence of most chronic conditions in the South West is similar to provincial rates as described in the chart below, however mortality and hospitalization rates for all these conditions, except asthma, are higher than provincial rates.

| Condition | South West LHIN | Ontario |
|---|---|---|
| Prevalence (2009-2010), rate per 100, age 12+ | | |
| Arthritis (age 14+) | 18.9 | 17.2 |
| Asthma | 7.5 | 8.4 |
| Cancer | 2.2 | 1.9 |
| COPD (35+) | 4.8 | 4.2 |
| Diabetes | 6.2 | 6.9 |
| High blood pressure | 18.5 | 17.4 |
| Heart disease | 5.1 | 4.9 |
| Suffer from effects of stroke | 1.4† | 1.1 |
| Have a chronic condition | 37.6 | 37.0 |
| Have multiple chronic conditions[1] | 15.6 | 15.2 |

## Primary Care

There are 559 primary care physicians and 66 primary care groups (e.g. family health teams, family health organizations, etc.) in the South West LHIN. Two key provincial programs are improving access: Primary Care Enrollment Model (PEM) and Health Care Connect (HCC) Program.

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

Almost 736,000 South West LHIN residents (78% of eligible residents) are enrolled with a PEM, an increase of approximately 2% over the past year.

The HCC Program, a service that allows people to find a family physician, began in February 2009. Between February 2009 and April 2012, 18,300 LHIN residents have registered with the program and 81% of them have been referred to a family health service provider. In the past year (2011/12) there were 8,900 registrations and 6,600 (74%) were referred. In 2011/12 there were 825 "complex vulnerable" people who registered with HCC (9% of registrants). 69% of them (571) were referred to a family health service provider.

## Health Human Resources Profile

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

### Physicians

From 2006 to 2010, the total number of physicians in South West LHIN increased by 9.9% reaching a total of 1,875 from 1,706. The total number of physician to population rate in South West increased from 182.0 physicians per 100,000 population to 196.9 from 2006 to 2010. The number of family physicians to population rate in South West was similar to the province in 2010 (188.3 per 100,000 population), but had slightly more specialists per 100,000 population.

### Nurses

From 2006 to 2010, the total number of nurses in South West increased by 5.7% reaching a total of 11,901 from 11,260 while the nurse to population rate increased from 1,201.3 nurses per 100,000 population to 1,249.8. Compared to the province, South West had higher RNs, RPNs and NPs rates per 100,000 population in 2010 (95.6 per 100,000 population). The number of NPs in South West increased by almost three-fold (192.0%) between 2006 (50) to 2010 (146).

## Community Engagement

Our communications and community engagement plan focuses on leveraging opportunities and building relationships with our audiences. Continuous engagement with our health service providers, stakeholders and public is an integral part of our process. For 2012-2013, a significant portion of our community engagement activities were focused on getting input from various stakeholder groups on the strategic directions of our Integrated Health Service Plan (IHSP) 2013-2016.

We began in February with the pre-development stage of our IHSP utilizing our Area Provider Tables, Quality Advisory Group and Health System Leadership Council to help determine the process for engagement necessary to the development of our draft IHSP. These discussions were important in ensuring stakeholders were aware of the process we were proposing and their involvement helped shape the final course of action the LHIN took regarding its communications and community engagement strategy.

We then engaged our full roster of stakeholder groups, through workshops and targeted consultations with specific communities, and the public throughout the summer and fall to inform and validate our strategic directions and to learn more about their perspective on future plans for the health system. The full extent of these collaborations and engagements helped us refine and improve the IHSP and the concerns, comments, ideas and issues of providers and the public continued to inform the creation of the final document that will go to the South West LHIN Board of Directors November board meeting and is submitted to the Ministry of Health and Long-Term Care by November 30th.

| Stakeholder Audiences | |
|---|---|
| Aboriginal Steering Committee | End of Life Network |
| Access to Care Core Group | French Language Health Services Advisory Council |
| Area Provider Table – Elgin | French Language Planning entity Board of Directors |
| Area Provider Table – Grey Integrated Health Coalition | Health System Leadership Council |
| Area Provider Table – Huron Perth Providers Council | Hospital/CCAC/LHIN CEO Leadership Forum |
| Area Provider Table - London | Long-Term Care Homes Network Council |
| Area Provider Table - Middlesex | Long-Term Care Homes |
| Area Provider Table - Oxford | Ontario Community Support Assoc District Meeting |
| Board to Board Reference Group | Partnering for Quality |
| Chronic Disease Prevention & Management Network | Primary Care Network |
| Community Health Centres | Quality Advisory Group |
| Critical Care Network | South West Addiction and Mental Health Coalition |

We used a variety of methods to reach a broad cross section of the community in order to raise awareness and provide opportunity for input to our IHSP 2013-2016. These methods and the audiences targeted are listed below:

| Audiences | Communications | Tactics/Tools |
|---|---|---|
| Health Service Providers/ Professionals | South West LHIN website – thorough information continuously updated | 24 Health Service Provider /Stakeholder Meetings |
| | Other websites including health service providers | Web Survey |
| | Posters | Self-Led Group Discussion Guide |
| | Social Media | |
| | Exchange E-Newsletter, August issue | |
| Public/Families | South West LHIN website – thorough information continuously updated | 8 Public Meetings: St. Thomas, Stratford, Wingham, Kincardine, Woodstock, Owen Sound, London – English and Francophone |
| | Other websites including community bulletins | Webcast with information and Q&A |
| | Posters | Web Survey |
| | Social Media | Self-Led Group Discussion Guide |
| | Radio and Newspaper advertising | |
| | Press Releases resulting in media coverage | |
| | Exchange E-Newsletter, August issue | |

## Engaging Our Community

Our engagement sessions included forums with health service providers, community leaders and the public, which invited detailed feedback and input on our draft strategic directions and objectives for the local health system in the South West LHIN.

- 7 Community Sessions
- 1 Francophone Community Session
- 1 Aboriginal Session
- Online survey with 222 respondents

Our engagement will continue through the creation of a Communications and Community Engagement plan for 2013-2015 that will leverage opportunities and develop tactics and tools to engage with all stakeholders and further communicate the strategic directions and implementation of key initiatives.

## Public Meetings

The objectives of these sessions were to:

- Share with the community the vision, mission and values for the South West LHIN
- Update the community on the IHSP 2013-2016
- Identify priorities and strategies for the local health system
- Hear from the community their thoughts and feedback on the proposed IHSP, more specifically regarding the proposed strategic directions and associated objectives

A facilitated workshop approach was used to present a brief overview to participant at each session. Participants were invited to ask questions. Two sets of break-out sessions were then conducted on each of the four strategic directions during each public meeting. These break-out sessions were facilitated by assigned staff or volunteers of the South West LHIN. Feedback from both the Question & Answer session and the break-out sessions were recorded and transcribed for qualitative analysis.

In addition to verbal feedback, participants were asked to complete a one-page feedback/evaluation form on the public meeting.

They were asked to select the most important strategic direction and to provide any further feedback. Finally, there were several evaluation questions regarding the format of the session and the information that was shared with them.

Through the month of September and the first week of October, public meetings were conducted in St. Thomas, Stratford, London (Aboriginal, French and English), Wingham, Kincardine, Woodstock, and Owen Sound. A webcast was also conducted. 178 people in total attended the sessions.

## Francophone Community Engagement

There was one specific public meeting held entirely in French at the École Mgr Bruyère, and one specific stakeholder engagement meeting held with the French Language Health Planning Entity Board of Directors, in addition to the web survey offered in French. There were 24 respondents to the French version of the web survey.

### Who We Heard From

There were 17 attendees of the French language public meeting. Of the 24 French web survey participants, respondents were primarily female (67%) aged between 45-65 (42%). Two-third of respondents reside in the City of London. 9 French Language Health Planning Entity Board of Directors were present at the stakeholder engagement meeting.

### What Participants Told Us

Timely access to family health care is important to them, especially services targeting French seniors in the areas of health promotion and self-management. Coordination between care settings requires increased team work and people knowledgeable about services available in the community. It was felt French Language Services (FLS) provision is often left to goodwill and "paid lip service" only. There is a feeling that there should be consequences when FLS is not provided as per legislation/regulations.

Insufficient number of bilingual health care workers is a concern for the Francophone community. It was felt that people are not identifying themselves as bilingual because there is no incentive to do so (suggested paying more for bilingual language skill) and that there is disincentive (doing more than their regular workload). Recipients of health services also do not identify themselves as French speaking because they have become accustomed to receiving services in English.

It was identified that francophone community services are not funded by the LHINS. In fact, there is concern that a health promotion program will stop when funding by Health Canada ends March 2013.

There is a wish to develop relationships/ partnerships with mainstream Health Service Providers. There is an expressed need to be better informed of challenges facing health services providers. It was suggested that the LHIN share back with the French Language Planning Entity results from its community engagement efforts.

### Conclusion – Francophone Community

The francophone community felt that their health care needs are not different than that of their English counterpart. It is the implementation that may be different – i.e. services offered in French. There is a sense that French speakers are not self-identifying (either providers or recipients of health services). There is a desire for added incentives for Health Service Providers to hire bilingual nurses and to offer these nurses higher compensation for their French language skills. The French Language Planning Entity would like the LHIN to return at a future meeting to share back results of their community engagement efforts in order to better understand challenges facing Health Service Providers.

# Integrated Health Service Plan 2010-2013 – Initiatives and Key Accomplishments

This past year marked the final leg of our IHSP 2010-2013 which continued the implementation efforts of our first IHSP 2007-2010 and worked towards achieving our Blueprint goal of an Integrated Health System of Care by 2022. Aligned with the provincial priorities focused on ED wait times, mental health and addictions, and increased community supports for seniors, the plan defined two strategic directions focused on target populations and services and key enablers.

## Strategic Direction One:
## *Enhance Capacity and Integration of Primary, Specialized and Community-based Care*

The first strategic direction focused on specific populations - seniors and adults with complex needs, people living with mental health and addiction challenges and people living with or at risk of chronic disease(s). Generally, these populations tend to access and use a substantial portion of our health care resources. But they don't always use these resources at the right time, in the right place and by the right provider which often leads to crisis intervention that could have been prevented if early identification, management and supports were in place.

## Strategic Direction Two:
## *Enhance Access and Sustainability of Hospital-based Treatment and Care*

The second strategic direction had two objectives: the first involved challenges accessing emergency services and the second involved challenges accessing medicine, surgical and critical care services. Local and multi-community stakeholders were engaged to initiate processes to develop and implement tailored strategies to meet the communities' needs.

## What We Accomplished – Strategic Direction One

### Seniors and Adults Living with Complex Needs –

Access to Care brought all the partners in the system together with the Home First initiative to help move patients safely out of hospital and into their homes, to support people to live safely and comfortably in the community, to make better use of the health system and improve quality of care for all. Home First was implemented to ensure that when a patient enters the hospital, physicians, hospital staff and South West CCAC work together from the time of admission to get the patient home upon discharge, when possible. As its name implies, Home First believes that home is the preferred destination upon discharge. Once back at home, informed choices about future needs can be made with all of the information and assistance required. Home First actively involves everyone in care decisions.

Within the first year of the program participating hospitals have reported an increase in referrals to the CCAC and as of September 30, 2012 over 206 clients have been discharged with intensive personalized care plans in place, freeing up those much needed beds for patients with acute needs. Once home, only 3% of clients have been readmitted to hospital. Building on those promising results, the program will continue to be implemented across the South West LHIN. Clients are now being screened early in their hospital stay for risk of complex discharge and

are automatically referred to CCAC. Implementation of Home First has meant that fewer people have to wait in hospital for long-term care.

Two other key components of the strategy ensure access to adult day programs and assisted living services (24/7 on-call and scheduled personal support) in key areas of our LHIN and access to complex continuing care and rehabilitation services in hospital.

Mental Health & Addictions - The implementation of a validated standardized common assessment tool (Ontario Common Assessment of Need - OCAN) will help to better identify the needs of people living with mental health and addictions challenges so that they can be better matched with the right services, delivered in the community by trusted care providers. The OCAN tool, coupled with the implementation of the Integrated Assessment Record (IAR), will further benefit clients and care providers by reducing duplication of assessment and improving the sharing of important health information between organizations. The Telemedicine Nursing Resources for Mental Health and Addictions initiative is implementing telemedicine-based services for patient care across the South West LHIN.

Chronic Disease - We have made advancements in primary care and community-based services through application of chronic disease prevention and management best practices. Initiatives like the Chronic Disease Prevention and Management Network, the South West Self-Management Program and Diabetes Education Improvement Project and Partnering for Quality in Chronic Disease Care are in place and working to provide better communications between partners as well as education and access for people living with a chronic disease(s). People now have access to self-management tools and techniques at their fingertips through thehealthline.ca.

Partnership for Health (a three-year initiative focused on diabetes management) reports that 100% of partners indicate there has been enhanced communication between partners, 100% of physicians say having a case manager as part of the care team enhances patient care, 89% say it facilitates timely referrals and 93% say it enhances their knowledge of community resources.

## What We Accomplished – Strategic Direction Two

Emergency Department – Through implementation of Emergency Department improvement initiatives - ED Pay for Results and ED Process Improvement Program significant improvements in wait times have been realized. When compared provincially, the South West LHIN consistently has some of the lowest wait times for Emergency Care. This success has mobilized efforts to sustain the ED improvements and spread the learnings to additional sites within the LHIN. Over the next couple of years, four additional hospitals in the South West LHIN will implement St. Thomas Elgin General Hospital's process improvement and knowledge transfer techniques to leverage the success across the LHIN.

Diagnostic Scans – The South West LHIN led the creation of a sector-wide MRI task team to achieve significant progress in reducing MRI wait times. In the LHIN's first accountability agreement the baseline wait time was 169 days. By April 2012 this was reduced to 50 days through process changes to improve the scheduling and patient flow led by the team's work. Wait times have risen in recent months and as of August 2012 90$^{th}$ percentile wait times have risen to 65 days due to increasing volumes. To address this, the MRI task team has evolved into a LHIN-wide Diagnostic Imaging Task Team to determine the root causes of the wait time

increases and ensure appropriateness of referrals.

Cancer Surgery - Over the past couple of years, the South West LHIN and South West Regional Cancer Program have led a coordinated multi-faceted effort to improve wait times for cancer patients resulting in a significant improvement. . From April 2010 to September 2012 – wait times for 90% of all cancer surgical clients have been reduced by 25 days. 90% of all clients needing cancer surgery now have that surgery completed within 62 days. All hospitals now monitor lists of people currently waiting for surgery and provide feedback to surgeons when someone is getting too close to their wait time threshold. Some hospitals have added more operating room time to care for people who had been waiting too long. For prostate cancer patients, urologists now all use the same checklist to help prioritize surgeries. In addition, we are working with the Erie St. Clair LHIN to ensure that people can receive their care close to home resulting in better use of resources in both Erie St. Clair and the South West LHINs.

Critical Care - In February 2011 the South West LHIN implemented a policy to facilitate the effective referral of critically ill patients (where life or limb is at risk). The policy ensures the most critical patients are transferred to the closest hospital capable of caring for them in an expeditious manner and that access for these patients cannot be denied. To support this policy an 'extramural' physician is on call 24/7 for consultation to provide support to outlying physicians throughout the South West LHIN. The policy has been so successful it has been rolled out provincially.

## We also made progress in…

Francophone Communities – Specific initiatives have been put in place to enhance capacity of primary, specialized and community-based care for the Francophone community including French language training of health service professionals (34) and enhancement of services and supports for French-speaking seniors through the Wraparound program. The Wraparound program was implemented in collaboration with the London InterCommunity Health Centre to help Francophone and other immigrants navigate the health system.

Aboriginal Communities – Specific initiatives have been put in place to enhance availability of and access to services for Aboriginal communities. A $1.2 million investment was made into the Aboriginal Aging at Home initiative to deliver a broad set of services to Aboriginal seniors including chronic disease management and home support. In February 2012 the Oneida First Nation opened the Tsi'Nu:Yoyantle Na'Tuhuwatisni long-term care home.

Additionally, the South West LHIN, in partnership with the Erie St. Clair LHIN, have appointed a Mental Health and Addictions Expert Panel to develop strategies to improve access to care, access to specialists, aftercare and discharge planning along with culturally competent care and supports.

Information and Communication Technology – Thehealthline.ca is an innovative web portal that puts accurate and up-to-date information about health services at the fingertips of consumers and health providers across the South West LHIN. This has now spread across the province. SPIRE (South West Physicians' Interface to Regional EMR) provides a secure electronic interface between hospitals' Electronic Patient Records and participating regional physicians' offices allowing radiology reports, lab results and notes to be delivered electronically instead of by fax. More than half of the LHIN's physicians (400) have subscribed to date.

The connecting South West Ontario (cSWO) Project is in the process of integrating healthcare systems across the Erie St. Clair, Hamilton Niagara Haldimand Brant, South West and Waterloo Wellington LHINs. These four LHINs have formed a cluster working under the direction of the South West Ontario eHealth Oversight Steering Committee. Building on the success and investments made in local, regional and provincial initiatives, cSWO is working closely with stakeholders to address specific local and regional needs to allow electronic patient health information to be seamlessly and securely shared. When it's complete, the project will be comprised of robust, scalable and re-usable building blocks capable of exchanging clinical data for better, timelier and more coordinated care, accelerating the delivery of electronic health records to the populace

# Integration Activities

*The following service integrations were initiated and completed in 2012/13:*

## Huron Perth Addictions and Mental Health Service Organizations New Partnership Agreement

In June 2012, the following Huron Perth health service providers agreed to enter into a new collaborative agreement: Alexandra Marine and General Hospital, Choices for Change, Canadian Mental Health Association Huron Perth Branch, Huron Perth Healthcare Alliance, Phoenix Survivors Perth County and Western Ontario Therapeutic Community Hostel. They are operating under the umbrella of the Huron Perth Addiction and Mental Health Alliance.

The agreement builds on a long history of collaboration between these mental health and addiction service providers through the Huron Perth Mental Health & Addictions Network which has been in place since 1975. Addiction services (Choices for Change) joined the network in 2004. This new agreement was a logical next step in creating more integrated services for clients that have mental health and/or substance abuse problems. Given the future funding challenges likely to be faced by all publicly-funded organizations as highlighted in the recent Drummond report, the new agreement will also help the alliance partners to pursue greater efficiencies by working smarter together.

The objective of this collaborative agreement is to provide easier access to service and support public understanding of a more integrated service system. The new agreement will help the alliance partners to pursue greater efficiencies by working smarter together.

Previously, the clients had multiple numbers to call for help, had to tell their story more than once and agencies are not always able to share information. The Huron Perth Crisisline will be rebranded as the Huron Perth Helpline and Crisis Support. With the new system, someone calling this line at any time and will get immediate help with his or her issue or concern. With the client's permission, the information is passed along to the most appropriate group to call back either that day or the next business day. In the past, the person who needs help had to call an agency after being given contact information. The Helpline and Crisis Support will continue to be the back-up service after hours for the partner agencies.

The benefits and improvements the alliance has implemented include:

- Partners are mutually accountable to each other (and their volunteer boards of directors) for the management and delivery of services;
- There is a single access number under the name Huron Perth Addictions and Mental Health Alliance
- A helpline will assist people find the appropriate services;
- People will be asked for information only once;
- Information is shared between partner organizations to facilitate treatment;
- Partners are also working together to reduce wait times.

Development of the new agreement was partly in response to the South West LHIN's Community Capacity report (2011) for mental health and addictions which recommended a number of strategies for integrating services in Southwestern Ontario.

## Oxford Addiction Treatment Strategy

In July 2012, in line with the South West LHIN Community Capacity and Implementation Project for mental health and addictions, a new

partnership agreement was formed between Addiction Services Thames Valley (ADSTV), Canadian Mental Health Association (CMHA) Oxford County, Woodstock and Area Community Health Centre (WACHC) and Ingersoll Nurse Practitioners-Led Clinic (INPLC) to increase direct treatment capacity and services for those struggling with addiction in Oxford County.

The Collaborative focused on the following elements in order to develop a comprehensive strategy:

1. Prevention, education & support
2. Training & coaching to increase capacity using partners and external resources
3. Development of referral protocols across the county at all stages of treatment
4. Initial assessment, screening & treatment planning
5. Case management and continuing care
6. Community treatment

Changes to the Client Experience – A Client Story:

Before the Collaborative: "Jane" goes to see her physician at the WACHC. During the conversation, it is evident that Jane is concerned with her increasing daily use of alcohol. She has also begun experimenting with prescription drugs. The Children's Aid Society has recently become involved due to concerns of neglect and Jane's partner is threatening to leave the home. She has also missed a great deal of work due to feeling ill during periods of withdrawal. The physician recommends that she see the community health worker for some addition support and resources. Jane makes an appointment to do so. On her second visit to the WACHC, the community health worker suggests that Jane self-refer to ADSTV. Jane calls the London number and is encouraged to attend a group intake on Wednesday morning in London. Jane finds a babysitter for her daughter and asks a friend to drive her to London. She must call in sick again to work to be able to attend the daytime intake. She spends 2 hours at the intake and is given another appointment date for her brief history. Based on this assessment, it is determined that Jane would be appropriate for a group but the group is not available in Oxford. Jane is unable to get to London to attend the group. She is then given the option of one-to-one counselling. Her appointment is in 4 months.

With the Partnership Implemented: Jane sees her physician. He pulls the shared intake group calendar up on his computer. There is a group intake available on a Wednesday evening in Woodstock at the WACHC. Her spouse will be available to watch her daughter and Jane will not have to miss work. The bus route will provide inexpensive transportation. At the intake, Jane reviews her assessment with a local counsellor who is familiar with local services. As Jane is already familiar and comfortable attending the WACHC, she is given the next available appointment the following week with the counsellor there. It is on a Wednesday evening during their extended hours to accommodate Jane's scheduling and childcare issues.

*The following service integrations were initiated in 2011/12 and continued to develop in 2012/13. These are multi-year initiatives and will continue into 2013/14.*

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

The Tier 2 transfer of 15 beds and related ambulatory services to St. Thomas Elgin General Hospital (STEGH) is now planned for September 30, 2013. The transfer was originally scheduled for May 2013 but due to unanticipated construction delays at STEGH a contingency plan needed to be develop by partners to accommodate the move to the new St. Thomas 89 bed Forensic facility in May 2013. The contingency plan includes moving the 15 acute care beds destined for transfer to STEGH to SJHC - Regional Mental Health Care (RMHC) London and relocating the related ambulatory service within the city of St. Thomas for an interim period starting at the end of March until the STEGH site is opened, which is anticipated in October 2013.

The transfer agreement between STEGH and SJHC is nearing completion. STEGH's designation under the Mental Health Care Act of Ontario is in process of being sought through the LHIN, LHIN Liaison Branch and the Ministry of Health.

The STEGH transfer is the fourth of four planned beds and related ambulatory services transfers from SJHC to 4 partner hospitals. The first occurred in November 2010 when 50 beds and related ambulatory services were transferred to Grand River Hospital in Kitchener. The second occurred in November 2011 when 59 beds and related ambulatory services were transferred to Windsor Regional Hospital. The third transfer of 14 beds and related ambulatory services to St. Joseph's Healthcare Hamilton will take place on March 31, 2013. This transfer will complete the fourth transfer. Each transfer has involved the transfer of staff, in-patients and out-patients and financial resources. Formal processes have been completed with each transfer for staff and patients and transfer agreements signed between the two hospitals involved. The final phase of divestment will be completed in June 2014 when the new regional longer-term mental health care 156 bed facility is opened on the London Parkwood site of SJHC

Long stay (length of stay greater than 365 days) patients continue to successful be placed in community settings through a community based care planning process that has resulted in 43 of the overall 70 beds that need to be closed, resulting in permanent closure. As of January 31, 2013 80 long stay patients had been discharged, many being placed in facilities that had existing capacity to accommodate the patient needs, with 6 readmitted and still in RMHC beds. 14 of those patients that also required readmission were stabilized within a few weeks and returned to community placement. Wait time for admission to RMHC has improved, with most referred patients waiting less on average from 3-5 days to admission, demonstrating improved access to care. The South West LHIN continues to invest in community capacity aimed at avoiding hospitalization as prevalence rates for mental health and substance use issues continue to rise.

### 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. During 2012/13, the three hospitals in Oxford County (Woodstock General, Tillsonburg and District Memorial and Alexandra Hospital in Ingersoll) began to work collaboratively to develop a framework for a Joint Services Plan.

Phase I anticipated outcomes include:

- a current state assessment of the three priority areas in context with the services that are available
- data collection and analysis pertaining to the three priority areas (also incl. clear inclusion

and exclusion criteria outlined in the methodology)
- development of recommendations for the integration of the three priority areas, taking into consideration any other individual or regional initiatives that might impact the implementation of recommendations and/or on which timelines will be dependent
- development of a Priority Project Plan including implementation
- an outline of clear accountability for the resulting program(s) or service(s) changes
- In addition to the three priority projects, the Oxford Hospitals recognize the opportunity for greater collaboration and integration regarding the remaining clinical programs/services and non-clinical services; as well as governance functions. In order to make evidence-based decisions to enhance patient care across the County, comprehensive data collection and analysis is required with the assistance of an external consulting firm. Phase Two proposes to conduct the required data collection and analysis with the end goal being the creation of a Joint Services Plan.

Expected date of completion for phase I is May 31, 2013

Phase II desired and anticipated outcomes include:

- a focus on the broader development of a Joint Service Plan
- current state assessment of the remaining programs and services, clinical and non-clinical, including governance
- data collection and analysis pertaining to clinical and non-clinical programs and services (also incl. clear inclusion and exclusion criteria outlined in the methodology)
- recommendations for the integration of clinical and non-clinical programs and services, taking into consideration any other individual or regional initiatives that might impact the implementation of recommendations and/or on which timelines will be dependent, medical health human resource planning and urgent and non-urgent transportation planning
- recommended governance structure of the Oxford Hospitals to implement that will assist the hospitals to assess and evaluate ongoing system capacity issues as they evolve
- prioritization of clinical and non-clinical services for the planning of a service delivery model with goals, deliverables, timelines that are based on the health needs of the residents of Oxford;
- market share realignment (repatriation) from London Health Sciences Centre, St. Joseph's Healthcare, London and other neighboring hospitals as appropriate;
- development of a Joint Services Plan including implementation and clear accountability for the resulting program(s) and/or service(s) changes.

Expected date of completion for phase II is March 31, 2014

### 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 and deliver the services provided by HoL and the new residential hospice bedded service. Planning for the residential hospice began in late 2011/12, continued throughout 2012/13 and will continue into 2013/14 with the residential hospice expected to be open for residents in January 2014. A location has been identified and the name of the new entity is "St. Joseph's Hospice London".

# Ministry-LHIN Accountability Agreement Performance Indicators 2012/13

| PI No. | Performance Indicator | LHIN 2012/13 Starting Point | LHIN 2012/13 Performance Target | Most Recent Quarter 2012/13 LHIN Performance | FY 2012/13 LHIN Annual Result |
|---|---|---|---|---|---|
| Emergency Room/Alternate Level of Care | | | | | |
| 1 | Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution* | 12.40% | 9.46% | 10.03% | 10.51% |
| 2 | 90th Percentile ER Length of Stay for Admitted Patients | 26.23 | 23.75 | 25.03 | 23.80 |
| 3 | 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients | 6.45 | 6.30 | 6.50 | 6.50 |
| 4 | 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients | 3.87 | 4.00 | 3.67 | 3.77 |
| Surgical Wait Times | | | | | |
| 5 | 90th Percentile Wait Times for Cancer Surgery | 82 | 70 | 57 | 59 |
| 6 | 90th Percentile Wait Times for Cardiac By-Pass Procedures | 44 | 49 | 36 | 35 |
| 7 | 90th Percentile Wait Times for Cataract Surgery | 104 | 110 | 141 | 134 |
| 8 | 90th Percentile Wait Times for Hip Replacement | 207 | 178 | 177 | 188 |
| 9 | 90th Percentile Wait Times for Knee Replacement | 253 | 182 | 211 | 215 |
| Diagnostic Wait Times | | | | | |
| 10 | 90th Percentile Wait Times for Diagnostic MRI Scan | 71 | 78 | 60 | 69 |
| 11 | 90th Percentile Wait Times for Diagnostic CT Scan | 26 | 25 | 18 | 20 |
| Excellent Care for All/Quality | | | | | |
| 12 | Readmission within 30 Days for Selected CMGs** | 15.83% | 14.00% | 17.55% | 16.81% |
| Mental Health and Substance Abuse | | | | | |
| 13 | Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions** | 15.30% | 14.50% | 15.28% | 15.52% |
| 14 | Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions** | 27.30% | 23.20% | 26.99% | 30.95% |
| 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)* | 27 | 24 | 24 | 26 |

*FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 - Q3 2012/13) due to availability

**FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 - Q2 2012/13) due to availability

## Performance Results

The following provides greater detail on activities within the LHIN relating to our key Ministry-LHIN Performance Agreement (MLPA) indicators.

The South West LHIN collaborated with health service provider partners from across the health care system to improve performance in 2012/13. Together we have focused on driving change in key areas in order to improve timely access to health services, improve patient/client experiences with the health care system, 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, and the Report on Performance Dashboards covering the MLPA (see South West LHIN Performance Indicators table) and the 2010-13 Integrated Health Service Plan priorities. For updated information on our performance, please visit the Performance section of our website at www.southwestlhin.on.ca.

Overall, for the fiscal year 2012-13, the South West LHIN has achieved good performance results and have been within corridor (met or improved over baseline) for 12 of 15 key MLPA performance indicators.

*Improving Emergency Department Wait Times*
In general, the South West LHIN has some of the lowest emergency department wait times in the province (top 5 across all LHINs). Patients and families are waiting less time for care in our area as performance has improved or is within corridor for all emergency department indicators.

*Improving ALC*
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. Through Home First, 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). In 2012/13, performance on the ALC measure (percent ALC days) has improved by approximately 15% over the rate in 2011/12.

*Improving Access to Surgery and Diagnostic Testing*
Improving access to surgery and diagnostic imaging has also been a priority. In 2012/13, wait times for surgery have improved in the following areas: cancer, cardiac, hip replacement, and knee replacement. Wait times for diagnostic imaging (MRI and CT) have also improved over baseline. A key wait time improvement strategy within the South West LHIN has been to trigger the creation of 'Performance Management Teams' (multi stakeholder learning collaboratives), in order to promote root cause analysis of performance related to key indicators and a shared opportunity to drive improvement through process management. In 2011/12 and 2012/13 Performance Management Teams were launched for Cancer Surgery and Hip and Knee Replacement Surgery.

The time patients wait for cancer surgery has improved by 28% over the past year. In the recent past, the South West LHIN had consistently reported the longest wait times for cancer surgery in Ontario. Within the past year and a half, 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. Our goal this year is to ensure we set up a sustainable reporting, monitoring and improvement process through the newly created Quality Council.

*Opportunities for Improvement*

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 cataract surgery have worsened in the past year. Moving forward the South West LHIN will investigate opportunities for improvement in this area.

Performance has also declined for the following key indicators:

- readmission to hospital within 30 days
- revisits for substance abuse concerns to emergency departments within 30 days

Improving performance in the above noted areas is a key part of our Integrated Health Service Plan 2013 – 2016 and aligns with our ultimate goal of improving 'time that people spend living safely and independently at home'. Key interventions for improvement in these areas include implementation of Health Links, expansion of Partnering for Quality work, and enhancement of crisis and transitional case management support within the South West LHIN.

We have made substantial progress in improvement across many areas this year within the South West LHIN. Our new strategic plan, coupled with the implementation of our Performance Improvement Strategy will allow us to optimize impacts to our health system, and to understand and track progress for improvement. In addition to increased accountability, and increased monitoring and reporting, we will continue to progress our improvement efforts through a pre-emptive and proactive approach.

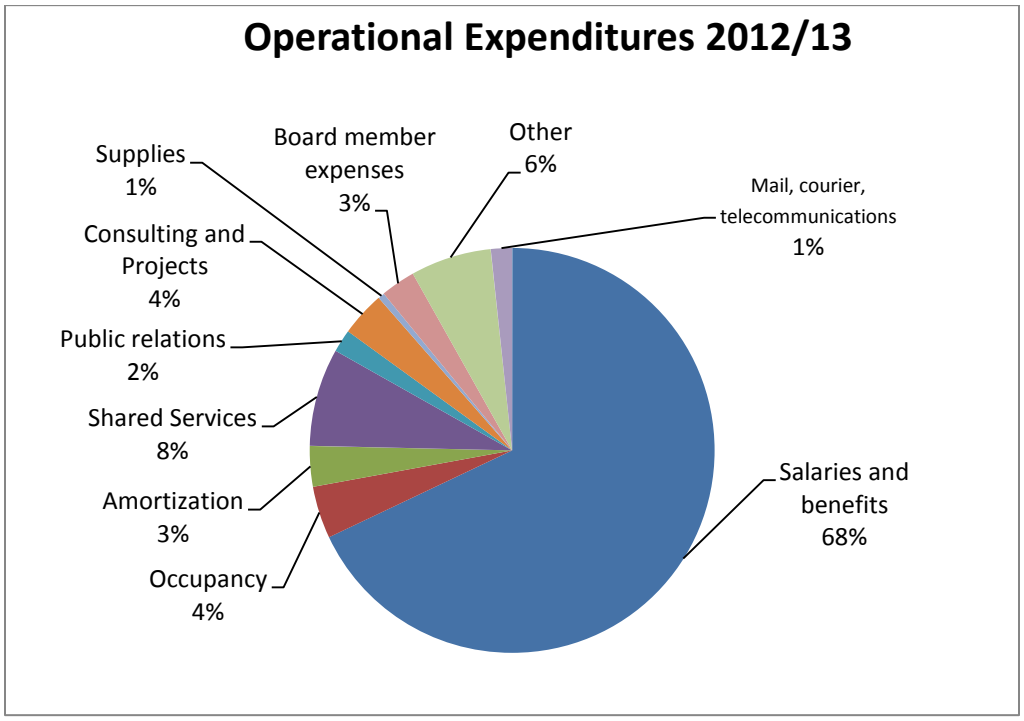
# Operational performance

In 2012/13, the South West LHIN operating budget was made up of two components:

$5.1 million for operations
$2.0 million for special projects

**Operations**

The South West LHIN ended the year with an operating surplus of $54,084. There were surpluses relating to the funding for other special projects. The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure is salaries and benefits with 32 FTEs and 8 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 2012/13 fiscal year were:

| | Funding | Expenditure* |
|---|---|---|
| | $ | $ |
| Aboriginal Planning (Base) | 35,000 | 32,760 |
| French Language Services (Base) | 106,000 | 93,198 |
| Enabling Technologies | 578,560 | 512,356 |
| E-Health SPIRE | 773,833 | 738,968 |
| Critical Care Lead | 75,000 | 74,508 |
| ED Lead | 75,000 | 73,944 |
| Primary Care Lead | 75,000 | 74,889 |
| ER/ALC Lead | 100,000 | 98,245 |
| Diabetes Regional Coordination Centres | 206,632 | 169,265 |
| **Total** | **2,025,025** | **1,868,205** |

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

# South West Local Health Integration Network

# Financial Statements

## March 31, 2013

# South West Local Health Integration Network

March 31, 2013

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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, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

**Management's Responsibility for the Financial Statements**

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

**Auditor's Responsibility**

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

**Opinion**

In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2013 and the results of its financial activities, change in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

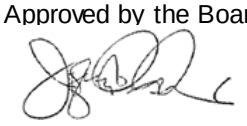
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 22, 2013

# South West Local Health Integration Network

Statement of financial position
as at March 31, 2013

| | 2013 | 2012 |
|---|---|---|
| | $ | $ |
| **Financial assets** | | |
| Cash | **892,912** | 325,816 |
| Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9) | **8,505,822** | 2,025,893 |
| Due from the LHIN Shared Services Office (Note 4) | **17,190** | - |
| Harmonized sales tax receivable | **79,069** | 45,355 |
| Accounts receivable | **3,879** | 16,490 |
| | **9,498,872** | 2,413,554 |
| **Liabilities** | | |
| Accounts payable and accrued liabilities | **795,784** | 308,018 |
| Due to Health Service Providers ("HSPs") (Note 9) | **8,505,822** | 2,025,893 |
| Due to MOHLTC (Note 3b) | **176,111** | 48,082 |
| Due to eHealth Ontario (Note 3c) | **52,319** | 62,791 |
| Due to the LHIN Shared Services Office (Note 4) | - | 7,440 |
| Deferred capital contributions (Note 5) | **262,387** | 267,754 |
| | **9,792,423** | 2,719,978 |
| Net debt | **(293,551)** | (306,424) |
| Commitments (Note 6) | | |
| **Non-financial assets** | | |
| Prepaid expenses | **31,164** | 38,670 |
| Tangible capital assets (Note 7) | **262,387** | 267,754 |
| | **293,551** | 306,424 |
| **Accumulated surplus** | - | - |

Approved by the Board



_____ Director

_____ Director

# South West Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

| | Budget (Note 8) | 2013 Actual | 2012 Actual |
|---|---|---|---|
| | $ | $ | $ |
| **Revenue** | | | |
| MOHLTC funding | | | |
| HSP transfer payments (Note 9) | **2,150,971,662** | **2,190,349,994** | 2,169,260,125 |
| Operations of LHIN | **4,895,719** | **4,873,561** | 5,146,833 |
| Aboriginal Planning (Note 10a) | **35,000** | **35,000** | 35,000 |
| French Language Services (Note 10b) | **106,000** | **106,000** | 106,000 |
| Critical Care (Note 10c) | **75,000** | **75,000** | 75,000 |
| Emergency Department ("ED") Lead (Note 10d) | **75,000** | **75,000** | 62,132 |
| Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10e) | **100,000** | **100,000** | 88,008 |
| Primary Care Lead (Note 10f) | **75,000** | **75,000** | 18,750 |
| Behavioural Support (BSO) (Note 10g) | - | - | 57,000 |
| Enabling Technologies (Note 10h) | **510,000** | **578,560** | 589,397 |
| Diabetes Regional Coordinating Ctr (Note 10i) | - | **206,632** | - |
| E-Health SPIRE & cSWO (Note 10j) | **1,025,400** | **773,833** | 302,900 |
| Amortization of deferred capital contributions (Note 5) | **162,000** | **162,000** | 158,851 |
| | **2,158,030,781** | **2,197,410,580** | 2,175,899,996 |
| Funding repayable to eHealth Ontario (Note 3a) | - | **(34,865)** | (62,791) |
| Funding repayable to the MOHLTC (Note 3a) | - | **(176,111)** | (49,207) |
| | **2,158,030,781** | **2,197,199,604** | 2,175,787,998 |
| Expenses | | | |
| Transfer payments to HSPs (Note 9) | **2,150,971,662** | **2,190,349,994** | 2,169,260,125 |
| General and administrative (Note 11) | **5,057,719** | **4,981,477** | 5,294,857 |
| Aboriginal Planning (Note 10a) | **35,000** | **32,760** | 21,466 |
| French Language Services (Note 10b) | **106,000** | **93,198** | 87,247 |
| Critical Care (Note 10c) | **75,000** | **74,508** | 73,831 |
| ED Lead (Note 10d) | **75,000** | **73,944** | 62,132 |
| ER/ALC Performance Lead (Note 10e) | **100,000** | **98,245** | 88,008 |
| Primary Care Lead (Note 10f) | **75,000** | **74,889** | 16,091 |
| Behavioural Support (BSO) (Note 10g) | - | - | 54,735 |
| Enabling Technologies (Note 10h) | **510,000** | **512,356** | 559,811 |
| Diabetes Regional Coordinating Ctr (Note 10i) | - | **169,265** | - |
| E-Health SPIRE & cSWO (Note 10j) | **1,025,400** | **738,968** | 269,695 |
| | **2,158,030,781** | **2,197,199,604** | 2,175,787,998 |
| **Annual surplus and accumulated surplus, end of year** | **-** | **-** | - |

# South West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

| | **2013** | 2012 |
|---|---|---|
| | **Actual** | Actual |
| | **$** | $ |
| **Annual surplus** | **-** | - |
| Change in prepaid expenses, net | **7,506** | (16,999) |
| Acquisition of tangible capital assets | **(156,633)** | (17,190) |
| Amortization of tangible capital assets | **162,000** | 158,851 |
| Decrease in net debt | **12,873** | 124,662 |
| Net debt, beginning of year | **(306,424)** | (431,086) |
| **Net debt, end of year** | **(293,551)** | (306,424) |

# South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

| | 2013 | 2012 |
|---|---|---|
| | $ | $ |
| **Operating transactions** | | |
| Annual surplus | - | - |
| Less items not affecting cash | | |
| Amortization of capital assets | **162,000** | 158,851 |
| Amortization of deferred capital contributions (Note 5) | **(162,000)** | (158,851) |
| Changes in non-cash operating items | | |
| (Increase) decrease in due from MOHLTC HSP transfer payments | **(6,479,929)** | 35,386,994 |
| (Increase) decrease in due from LHIN Shared Services Office | **(17,190)** | 3,736 |
| Increase (decrease) in accounts receivable | **12,611** | (15,069) |
| (Decrease) increase in Harmonized Sales Tax receivable | **(33,714)** | 20,113 |
| Increase (decrease) in accounts payable and accrued liabilities | **487,766** | (273,223) |
| Increase (decrease) in due to HSPs | **6,479,929** | (35,386,994) |
| Increase in due to MOHLTC | **128,029** | 19,564 |
| (Decrease) increase in due to eHealth Ontario | **(10,472)** | 62,791 |
| (Decrease) in due to LHIN Shared Services Office | **(7,440)** | (191) |
| Increase (decrease) in prepaid expenses | **7,506** | (16,999) |
| | **567,096** | (199,278) |
| **Capital transaction** | | |
| Acquisition of tangible capital assets | **(156,633)** | (17,190) |
| **Financing transaction** | | |
| Deferred capital contributions received (Note 5) | **156,633** | 17,190 |
| Net increase (decrease) in cash | **567,096** | (199,278) |
| Cash, beginning of year | **325,816** | 525,094 |
| **Cash, end of year** | **892,912** | 325,816 |

## 1. Description of business

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

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

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

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

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

The LHIN statements do not include any Ministry managed programs.

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

## 2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

*Basis of accounting*

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

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets 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 tangible capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under “revenue” in the statement of financial activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

*Tangible capital assets*

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

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

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

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

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

*Segment disclosures*

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of 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 public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

## 2. Significant accounting policies (continued)

*Adoption of new accounting standards*

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation*", Section PS 2601 *"Foreign Currency Translation"*, PS 3410 "*Government Transfers*" and Section PS 3450, *"Financial Instruments".* There was no impact of the adoption of these new standards on the financial statements.

## 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 eHealth Ontario.

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

| | | | **2013** | 2012 |
|---|---|---|---|---|
| | **Funding** | **Eligible expenses** | **Funding excess** | Funding excess |
| | **$** | **$** | **$** | $ |
| Transfer payments to HSPs | **2,190,349,994** | **2,190,349,994** | **-** | - |
| LHIN operations | **4,873,561** | **4,819,477** | **54,084** | 10,827 |
| Aboriginal Planning | **35,000** | **32,760** | **2,240** | 13,534 |
| French Language Services | **106,000** | **93,198** | **12,802** | 18,753 |
| Behavioural Support | **-** | **-** | **-** | 2,265 |
| Enabling Technologies | **578,560** | **512,356** | **66,204** | 45,337 |
| E-Health SPIRE | **773,833** | **738,968** | **34,865** | 17,454 |
| Critical Care Lead | **75,000** | **74,508** | **492** | 1,169 |
| ED Lead | **75,000** | **73,944** | **1,056** | - |
| Primary Care Lead | **75,000** | **74,889** | **111** | 2,659 |
| ER/ALC Lead | **100,000** | **98,245** | **1,755** | - |
| Diabetes Regional Coor. Centres | **206,632** | **169,265** | **37,367** | - |
| | **2,197,248,580** | **2,197,037,604** | **210,976** | 111,998 |

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

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Due to MOHLTC, beginning of year | **48,082** | 28,518 |
| Funding repaid to MOHLTC | **(48,082)** | (28,518) |
| Funding receivable from the MOHLTC related to current year activities (Note 3a) | - | (1,125) |
| Funding repayable to the MOHLTC related to current year activities (Note 3a) | **176,111** | 49,207 |
| Due to MOHLTC, end of year | **176,111** | 48,082 |

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

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

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Due to eHealth Ontario, beginning of year | **62,791** | - |
| Paid to eHealth Ontario during year | **(45,337)** | - |
| Funding repayable to the eHealth Ontario related to current year activities (Note 3a) | **34,865** | 62,791 |
| Due to eHealth Ontario, end of year | **52,319** | 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

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Balance, beginning of year | **267,754** | 409,415 |
| Capital contributions received during the year (Note 8) | **156,633** | 17,190 |
| Amortization for the year | **(162,000)** | (158,851) |
| Balance, end of year | **262,387** | 267,754 |

## 6. Commitments

The LHIN has commitments under various operating leases extending to 2018 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

| | $ |
|---|---|
| 2014 | 292,735 |
| 2015 | 254,459 |
| 2016 | 93,101 |
| 2017 | 4,789 |
| 2018 | 4,014 |

## 6. Commitments (continued)

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:

| | $ |
|---|---|
| 2014 | 2,131,943,582 |

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

## 7. Tangible capital assets

| | | | **2013** | 2012 |
|---|---|---|---|---|
| | **Cost** | **Accumulated amortization** | **Net book value** | Net book value |
| | **$** | **$** | **$** | $ |
| Computer equipment | **172,575** | **120,528** | **52,047** | 44,135 |
| Leasehold improvements | **1,588,789** | **1,415,762** | **173,027** | 146,351 |
| Office equipment, furniture and fixtures | **218,003** | **180,690** | **37,313** | 77,268 |
| Web development | **21,998** | **21,998** | **-** | - |
| | **2,001,365** | **1,738,978** | **262,387** | 267,754 |

## 8. Budget figures

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

The final HSP funding budget of $2,190,349,994 is derived as follows:

| | $ |
|---|---|
| Initial budget | 2,150,971,662 |
| Adjustment due to announcements made during the year | 39,378,332 |
| Final HSP funding budget | 2,190,349,994 |

The final LHIN budget, excluding HSP funding, of $7,373,852 is derived as follows:

| | $ |
|---|---|
| Initial budget | 7,059,119 |
| Adjusted eHealth SPIRE reduction | (294,900) |
| Additional funding received during the year | 453,000 |
| Amount treated as capital contributions during the year | 156,633 |
| Final LHIN operating budget | 7,373,852 |

## 9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,190,349,994 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2013 as follows:

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Operation of hospitals | **1,566,756,371** | 1,569,651,483 |
| Grants to compensate for municipal taxation - public hospitals | **451,500** | 451,500 |
| Long term care homes | **299,613,261** | 293,210,720 |
| Community care access centres | **188,487,125** | 179,155,370 |
| Community support services | **39,092,788** | 37,367,473 |
| Assisted living services in supportive housing | **17,490,024** | 17,324,750 |
| Community health centres | **16,979,597** | 15,433,606 |
| Community mental health addictions program | **61,479,328** | 56,665,223 |
| | **2,190,349,994** | 2,169,260,125 |

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2013, an amount of $8,505,822 (2012 - $2,025,893) was receivable from MOHLTC, and was payable to 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 (2012 - $35,000) related to aboriginal planning. The LHIN incurred operating expenses totaling $32,760 (2012 - $21,466). The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,240.

*b) French Language Services*

The MOHLTC provided the LHIN with $106,000 (2012 - $106,000) related to French Language Services funding. The LHIN incurred operating expenses totaling $93,198 (2012 - $87,247). The LHIN has setup a payable to the MOHLTC for the remaining balance of $12,802.

*c) Critical Care Lead*

The MOHLTC provided the LHIN with $75,000 (2012 - $75,000) related to Critical Care initiatives. The LHIN incurred operating expenses totaling $74,508 (2012 - $73,831). The LHIN has setup a payable to the MOHLTC for the remaining balance of $492.

*d) ED Lead*

The MOHLTC provided the LHIN with $75,000 (2012 - $62,132) related to Emergency Department initiatives. The LHIN incurred operating expenses totaling $73,944 (2012 - $62,132). The LHIN has setup a payable to the MOHLTC for the remaining balance of $1,056.

*e) ER/ALC Lead*

The MOHLTC provided the LHIN with $100,000 (2012 - $88,008) related to emergency room management strategy funding. The LHIN incurred operating expenses totaling $98,245 (2012 - $88,008). The LHIN has setup a payable to the MOHLTC for the remaining balance of $1,755.

**10. Programs (continued)**

*f) Primary Care Lead*

The MOHLTC provided the LHIN with $75,000 (2012 - $18,750) related to Primary Care initiatives. The LHIN incurred operating expenses totaling $74,889 (2012 - $16,091). The LHIN has setup a payable to the MOHLTC for the remaining balance of $111.

*g) Behavioural Support (BSO)*

The MOHLTC provided the LHIN with $nil (2012 - $57,000) related to behavioural support planning. The LHIN incurred operating expenses totaling $nil (2012 - $54,735).

*h) Enabling Technologies*

The MOHLTC provided the LHIN with $580,000 (2012 - $600,000) related to Enabling Technologies initiatives. The LHIN incurred operating expenses of $512,356 (2012 - $559,811) and capital expenses of $1,440 (2012 - $10,603) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to the MOHLTC for the remaining balance of $66,204.

*i) Diabetes Regional Coordination Centres*

The MOHLTC provided the LHIN with $338,228 (2012 - $0) related to Diabetes Regional Coordination Centres initiatives. The LHIN incurred operating expenses of $169,265 (2012 - $0) and capital expenses of $131,596 (2012 - $0) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to the MOHLTC for the remaining balance of $37,367. Expenses incurred include the following:

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Salaries | **34,205** | - |
| Operating expenses | **4,792** | - |
| One-time expenses | **261,864** | - |
| Total | **300,861** | - |

*j) eHealth Ontario – SPIRE & cSWO*

The LHIN entered into a transfer payment agreement with eHealth Ontario providing $775,272 (2012 - $302,900) to the LHIN;$730,500 related to Southwest Physicians Interface with Regional EMRs (SPIRE) and $44,772 related to Connecting South West Ontario (cSWO). The LHIN incurred operating expenses of $738,968 (2012 - $269,695) and capital expenses of $1,439 (2012 - $0) 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 $34,865 all related to 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:

| | **2013** | 2012 |
|---|---|---|
| | **$** | $ |
| Salaries and benefits | **3,385,331** | 3,522,153 |
| Occupancy | **206,682** | 207,850 |
| Amortization | **162,000** | 158,851 |
| Shared services | **341,520** | 451,995 |
| LHIN Collaborative | **47,500** | 50,000 |
| Public relations | **90,192** | 105,639 |
| Consulting and Project expenses | **178,194** | 183,184 |
| Supplies | **25,901** | 45,676 |
| Board chair per diem | **52,805** | 42,423 |
| Board member per diem | **38,490** | 54,435 |
| Board member expenses | **47,101** | 89,251 |
| Mail, courier and telecommunications | **84,711** | 67,790 |
| Other | **321,050** | 315,610 |
| | **4,981,477** | 5,294,857 |

## 12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 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 2013 was $278,905 (2012 - $292,146) 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, 2012. As at that time, the plan was fully funded.

## 13. Guarantees

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

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

## 14. Comparative figures

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

**ISSN 1911-2858 June/13 ©2013**

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