South West **LHIN** | **RLISS** du Sud-Ouest

South West Local Health Integration Network
Annual Report 2017-18

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Preface

As crown agencies responsible for planning, integrating, and funding of local health care, as well as the delivery of home and community care, Local Health Integration Networks (LHINs) continue to strive towards ensuring a seamless continuum of high quality care for patients and their families. Local planning and decision-making is the model that the LHINs are built on, and one that values the input of community members, health care professionals and stakeholders.

LHINs operate within an accountability framework made of the Local Health System Integration Act, the Memorandum of Understanding between the Minister of Health and Long-Term Care and the South West LHIN, as well as the Ministry-LHIN Accountability Agreement.

As part of this framework, LHINs are required to submit an Annual Report to the Ministry of Health and Long-Term Care detailing achievements and work being undertaken in the previous fiscal year. This report includes requirements outlined in the guideline documents, as well as audited financial statements for the agency.

This document will outline progress and achievements in the 2017/18 fiscal year. The Ministry of Health and Long-Term Care is required to table the LHIN Annual Report within 60 days of receipt. Once the Annual Report is tabled by the Minister, it ca be released publicly.

Message from Andrew Chunilall, Acting Board Chair and Ron Sapsford, Interim Chief Executive Officer

In a time of significant change across the system, the South West LHIN continues to work alongside its health system partners to improve patient care across the region. While a lot of progress continues to be made, there is still work ahead in creating an integrated, high quality system of care.

On December 7, 2016, Ontario passed the *Patients First Act*. Approving this legislation was a big step in supporting health system transformation work. The Act is about making a system that is more coordinated and focused on patient and community needs to ensure health care resources are being used effectively and efficiently, in the public interest. Implementing Patients First was a significant focus for the LHIN in 2017/18.

To this end, Patients First is reflected in the South West LHIN's Integrated Health Service Plan (IHSP) for 2016 to 2019. The fiscal year 2017/18 marks the second year of implementing a three-year strategic plan that guides the organization in achieving the vision outlined in the *Health System Design Blueprint: Vision 2022*. The IHSP identifies strategic directions and steps required to make the overall vision of an improved and integrated health system a reality. The plan's initiatives and actions position the organization well to deliver on the expectations outlined in the Minister's Mandate letter dated May 1, 2017, including the work ahead with both local and provincial partners to move health system renewal and transformation forward.

Each three-year strategic plan builds on the accomplishments of previous plans and brings the South West LHIN closer to achieving its vision for quality care, improved health and better value. In 2017/18, the LHIN continued to implement initiatives focused on achieving our vision, including:

- The continued expansion of residential hospice capacity, and planning to bring unified solutions to each of the five sub-regions of the LHIN, which will mean more support to palliative patients and their families. This work is key to ensuring that a range of supports are available to enable individuals to die in their place of choice.

- The LHIN was also in the midst of working with partners to pilot an Indigenous Palliative Care Outreach Team in London Middlesex focused on providing culturally safe care to Indigenous people. We know that Indigenous communities experience inconsistent access to services through the mainstream system, creating barriers to receiving palliative

care. This new Outreach team provides an integrated team of practitioners including a traditional healer to offer improved culturally safe and coordinated care to Indigenous people.

- The organization also continues to work in partnership with Indigenous health leaders and communities through the Indigenous Health Committee to co-design A Roadmap for Indigenous Inclusion and Reconcili-ACTION. The Roadmap outlines the process for Indigenous inclusion and consultation to inform our work in improving the health system for patients and their families.

- There are a number of opportunities to improve our mental health care system in our LHIN. The South West LHIN has worked to take a detailed analysis of mental health and addictions access issues in October 2017, and a final report was released with recommendations on improving care. Over the 2017/18 fiscal year, the South West LHIN is now in the process of establishing the partnerships and structures needed to plan and implement strategies to address the report's findings.

- A key element of serving South West LHIN residents is ensuring that Francophone voices are included and supported in our health system. We are in the process of developing a community of practice for bilingual staff focused on creating a supportive online community for future and existing bilingual health and wellness information. The LHIN has also been working to develop online training for LHIN and health service providers to increase awareness of Francophone communities and French language services.

- As part of improving services to South West LHIN Francophones, health and social system partners have been working together to launch a Regional Francophone Community Health and Social Services Hub in June 2018. This hub will be an access point and source of information to help clients with service navigation, as well as awareness of, and participation in, culturally sensitive activities and services.

- Implementation and success of the Connecting Care to Home continues, a local initiative focused on integrating patient care between hospital and home using technology and education as key enablers.

- The South West LHIN has also realigned adult day programs across our LHIN to improve

access to programs where they are needed the most.

- In the 2017/18 fiscal year the first behavioural support transitional unit at McGarrell Place Long-Term Care Home was piloted, a 29-bed unit offering a safe and specialized living environment for those who have responsive behaviours.

In addition to these key initiatives, the South West Community Care Access Centre (CCAC) was integrated into the South West LHIN on May 24, 2017. As a result of this merger, 2017/18 was also heavily focused on establishing the organizational structure, aligning key processes, creating the strategic vision for the new organization, and establishing the overall culture needed to advance our transformation goals.

In transferring the functions and employees of the CCACs to LHINs, our foremost priority has been to keep quality of care front and centre by maintaining the continuity of patient care for individuals and families across the LHIN. The South West LHIN and CCAC have a strong history of collaboration, and have been leveraging the collective expertise throughout this integration to come together as one organization.

The South West LHIN will continue to build on the progress to date, leveraging collective expertise as it moves forward with the critical work ahead. A key part of this work is engaging with communities across our region to build a system that better understands and meets the needs of individuals and families in the LHIN.

Andrew Chunilall
Acting Board Chair
South West LHIN

Ron Sapsford
Interim Chief Executive Officer
South West LHIN

Board of Directors

As of March 31, 2018

Lori Van Opstal (Tillsonburg)
Board Chair
Nov. 6, 2013 - Nov. 5, 2019

Myrna Fisk (London)
Nov. 16, 2016 - Nov. 15, 2019

Jim Sheppard (Kincardine)
Jan. 8, 2018 - Jan. 7, 2021

Andrew Chunilall (London)
Acting Board Chair, Vice Chair
Apr. 11, 2013 - Apr. 9, 2019

Glenn Forrest (London)
Nov. 2, 2016 - Nov. 1, 2019

Leslie Showers (St Marys)
Apr. 20, 2016 - Apr. 19, 2019

Linda Ballantyne (London)
Vice Chair
Oct. 18, 2017 - Apr. 31, 2020

Allan Mackay (Kincardine)
Mar. 21, 2018 - Mar. 20, 2021

Cynthia St. John (London)
Apr. 12, 2017 - Apr. 11, 2020

Jean-Marc Boisvenue (London)
Mar. 1, 2017 - Feb. 29, 2020

Wilf Riecker (Port Stanley)
Nov. 6, 2013 - Nov. 5, 2019

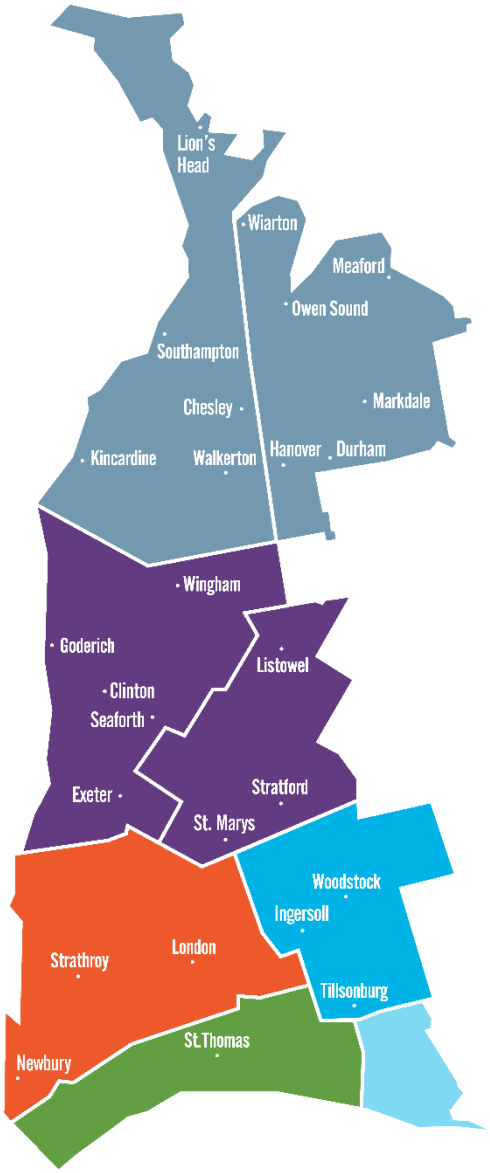
Aniko Varpalotai (Port Stanley)
Oct. 3, 2012 - Oct. 2, 2018

The South West LHIN

Established in 2005, the South West LHIN's region extends from the Bruce Peninsula in the North to Lake Erie in the South, and is made up of both rural and urban communities. LHINs work with providers and communities to determine health care priorities and services required in local communities, reflecting the reality that a community's health needs and priorities are best understood by those familiar with the community.

With the passing of *Patients First* and the integration of CCACs into the LHIN, the LHIN directly provides home and community care services to residents. These services include care coordination, nursing and personal care, allied health, direct nursing, placement, information and referral, and medical supplies and equipment services.

The South West LHIN's work is also focused on the planning, integration and funding of over 180 health service providers including: hospitals, long-term care homes, mental health and addictions service agencies, community support services, and Community Health Centres.



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

- 20 hospital corporations (33 sites)
- 78 long-term care homes
- 5 Community Health Centres
- 52 agencies provide community support services
- 14 agencies provide assisted living supportive housing services
- 22 agencies provide mental health services
- 10 agencies provide addictions services
- 3 agencies provide acquired brain injury services

Together as system partners, we are ready and well-positioned to continue our efforts to improve health care in the South West LHIN. To help guide our continued work, all LHINs produce a three-year plan that outlines our strategic priorities and proposed outcomes. The plan, called the Integrated Health Service Plan (IHSP), will help us to continue enhancing the health system to better meet the needs of patients and families across the region.

There are a number of professionals and organizations that, while they are not LHIN-funded, play an important role in the delivery of care for patients and their families. These system partners include family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency health services and labs. With the introduction of Patients First we continue to build a strong relationship with primary care providers. We rely heavily on the knowledge, advice and work of our Clinical Leads to assist in decision-making. While public health, emergency health services and labs do not have direct accountability to the LHIN, it is also imperative to partner with them to achieve our vision.

Population profile

Understanding the South West LHIN's population demographics and health status, as well as the ability of the health system to meet population needs, plays a key role in improving population health, experience of care and ensuring value for money.

According to the 2016 Census, the South West LHIN is home to over 953,600 people, or 7 per cent of Ontario's population.[1] The population is predominantly urban, with 40 per cent of residents living in large urban centres, and an additional 30 per cent living within a 30-minute drive from an urban centre, known as the "urban commute zone." The remaining 30 per cent live in rural communities.

In 2016, seniors accounted for 19 per cent of the LHIN's population, compared to 16 per cent in 2010. The LHIN continues to have a higher proportion of adults aged 65 years or older compared to the provincial average (17 per cent). By 2025, 24 per cent of the South West population is projected to be made up of seniors aged 65 years and older.

Between 2016 and 2020 the number of residents across the South West LHIN is projected to grow by 2.9 per cent, as compared to 5.3 per cent across the province. The South West LHIN is expected to continue experiencing slower than average population growth over the next 10 years for all age groups.

In 2016, approximately 86 per cent of the LHIN's population reported English as their first language. Francophones accounted for 1.4 per cent of the population. The City of London is currently home to an estimated 8,000 Francophones.

There are five First Nations communities located within the geographic boundaries of the South West LHIN: Chippewas of the Thames First Nation, Munsee-Delaware Nation, Oneida Nation of the Thames, Saugeen First Nation and Chippewas of Nawash Unceded First Nation. The South West LHIN region is located on the traditional territory of the Anishnaabeg. This region has also become the home to the Haudenosaunee and Lenni-Lenape Nations.

The LHIN recognizes that the demographic data on Indigenous populations is limited as Indigenous communities tend to be underrepresented in census data.[2] With this in mind, people who identify as Indigenous (First Nation, Inuit and Metis) account for 2.4 per cent of the LHIN population, with significant numbers living in urban and rural communities across the region. There are several Indigenous health service

[1] 2016 Canada Census.

[2] "Census data limitations for Aboriginal populations include: Undercounting (homeless and mobility), non-participation is common (lack of trust), on-reserve enumeration is incomplete, weakened platform for self-identification (long form to voluntary NHS), data suppression, aggregate data, no data for children." Well Living House - Indigenous population health data collection, management, analysis and use, 2015

organizatons operating across the South West LHIN including the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) with three locations, two Friendship Centres, one Long-Term Care Home, and local cultural and resource centres.

In 2016, 10 per cent of residents in the South West LHIN identified themselves as belonging to a visible minority group and 15 per cent of residents were born outside of Canada. Over the course of the previous two years, communities located across the South West LHIN have welcomed a significant influx of recent immigrants. A total of 2 percent of residents are Canadian newcomers, having arrived between 2011 and 2016, and 28 per cent were comprised of refugee families. The influx of Canadian newcomers is just beginning to become apparent within the LHIN's census data.

Socioeconomic characteristics

In 2016, the median household income in the South West LHIN was $60,037, with 15 per cent of the total population living under the after-tax low-income measure. Approximately 20 per cent of children (age < 18 years) and 12 per cent of seniors (age 65+) were living in low-income households. Education levels in the South West LHIN are below the Ontario average.

Population income profile	South West	Ontario
Unemployment rate (age 15+)	6.4%	7.4%
Education attained (age 25-64): Population with no certificate/degree/diploma	12.7%	10.4%
Population with completed bachelor's degree	21.5%	31.9%
Population living below the after-tax low-income measure [3]	15.0%	14.4%

2016 Canada Census

General health

Asking people what they think about their own health is an important way to monitor health status at the population level, in part because it has been shown to be an accurate predictor of the actual health, future disability, and life expectancy of a population. Six out of 10 residents in the South West LHIN say they have very good or excellent health, and seven out of 10 reported very good or excellent mental health.[4]

[3] DeSalvo, K.B., et al., Mortality Prediction with a Single General Self-Rated Health Question. Journal of General Internal medicine,2006.21: p.267–275.

[4] Canadian Community Health Survey LHINS Sharefile (CCHS), 2015/16.

Population health status

The health status of residents in the South West LHIN is largely comparable to the Ontario population. A total of 40 per cent of the adult population in the South West has one or more chronic conditions (compared to 37 per cent in Ontario), 63 per cent are overweight or obese (61 per cent in Ontario), 19 per cent are daily or occasional smokers (17 per cent in Ontario) and 41 per cent are physically inactive (42 per cent in Ontario).[5]

Prevalence rates of select chronic conditions in the South West LHIN are presented below. The South West LHIN has the second highest prevalence rate of asthma in Ontario, with 9 per cent of the population who are 12 and older, based on self-report; and 5 per cent of the population has chronic obstructive pulmonary disease. Despite their relatively low prevalence, these two chronic respiratory conditions accounted for approximately 12 per cent of all chronic disease-related hospitalizations and 7 per cent of mortality in the South West LHIN in 2013/14.[6] The LHIN also has significantly higher rates of arthritis. The prevalence of arthritis, asthma, diabetes and chronic obstructive pulmonary disease have all increased across the South West LHIN over the past decade.

Prevalence of chronic conditions in the South West LHIN *Rate per 100 people, 2013 (age 12+)*	**South West**	**Ontario**
Arthritis (age 14+)	20.6%	17.3%
Asthma	9.0%	7.5%
Cancer	1.0%	1.9%
Chronic obstructive pulmonary disease (age 35+)	4.8%	4.3%
Diabetes	7.0%	6.6%
High blood pressure	17.5%	18.3%
Heart disease	4.7%	4.8%
Have chronic condition	39.0%	37.3%

Canadian Community Health Survey LHINS Sharefile, 2013/14

[5] Canadian Community Health Survey LHINS Sharefile (CCHS),

[6] Vital Statistics Registry 2011, Ontario Ministry of Health and Long

Life expectancy

People living within the South West LHIN have a lower life expectancy at birth and at age 65 compared to Ontario. Ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases (stroke), and chronic lower respiratory diseases (pneumonia, chronic obstructive pulmonary disease) are the leading causes of death for residents.

Accessing primary care

There are over 620 primary care physicians actively practicing in community settings in the South West LHIN. Eight nurse practitioners provide additional primary care capacity working in two Nurse-Practitioner-Led Clinics. A total of 283 of the regions' primary care physicians practice as part of a team-based practice (e.g. family health networks, family health organizations, etc.) located within the LHIN. In Ontario a total of 2619 working in a team-based practice. There are five LHIN-funded community health centres: Central Community Centre (St. Thomas), London InterCommunity Health Centre (London), Southwest Ontario Aboriginal Health Access Centre (London and Chippewa), West Elgin Community Health Centre, as well as Oxford County Community Health Centre. The five community health centres are expected to serve 24,200 residents, or 2.5 per cent of the total population. A total of 96 per cent of LHIN residents report having access to a regular medical doctor or nurse practitioner.

In 2017, physicians were successfully recruited into high-needs communities located in Grey, Bruce, Oxford and Elgin counties. Recruitment is underway to secure additional primary care resources in Grey Bruce, rural Oxford and South London Middlesex.

Community engagement

The Communications and Community Engagement plan for 2017/18 outlines how the LHIN would attain its engagement goals for the fiscal year. The plan provides the foundation for the objectives and priorities, considers all audiences, manages key information and guides the development of all communications plans and activities throughout 2017/18.

Communications and community engagement form a vital public service where the LHIN has a duty to provide information and listen to the public it serves. This contributes to building a system that better understands and meets the needs of patients, clients and residents in the LHIN. The South West LHIN's core engagements include:

- The Quality Symposium (June 2017)
- Board meetings (held in a different community each month)
- Conferences and forums
- Advisory groups, committees, liaisons
- Targeted engagement for priority audiences around significant South West LHIN or provincial initiatives
- Knowledge transfer webinars

Quality Symposium

The annual Quality Symposium was held on June 1, 2017 in Stratford, Ontario. The event was attended by 440 participants representing a broad range of sectors and system partners.

The theme was "A Quality Journey: Together we are better." Presenters included patient advisor Paula Knight; commentator and health care policy analyst Roy Lilley; CEO of Canadian Centre for Diversity and Inclusion Michael Bach; and founder of Stopgap Foundation Luke Anderson.

Quality Awards were handed out to two local projects to recognize sustainable and ongoing quality improvement initiatives:

- Assess and restore: Improving health outcomes for older adults received the award for the large project category; and
- PINOT: Patients in Need of Teams received the award for the medium/small project category.

International Plowing Match and Rural Expo

The South West LHIN secured an indoor booth at this event in Walton from September 19-23, 2017 to engage with rural LHIN residents. The aim of engagement was to increase public awareness of the South West LHIN in rural communities. Political figures including the Premier and other community leaders were in attendance. Our booth offered handout materials on home and community care related services.

Patient and Family Advisory Committee

The Patient and Family Advisory Committee is a 16-member group made up of patient, family and caregiver partners working to advise, collaborate and co-design an approach to patient engagement in health care planning across our region. The group was launched in October 2017. Over the fiscal year, it has met with established patient and family advisory groups across the South West to gather learnings and inform its work. The group is also focused on creating effective strategies to embrace a strong culture of patient, caregiver and public involvement to support high quality care. Over the 2017/18 fiscal, PFAC members have identified primary drivers to achieve the provincial goal of embracing a strong culture of patient engagement *(outlined in the "Improving the patient experience section")*.

Sub-region Integration Tables

Sub-region Integration Tables representing each of the LHIN's five sub-regions have been developed to focus on partnering with patients, providers and other stakeholder to improve local health care in South West LHIN communities. Sub-region areas include London Middlesex, Elgin, Oxford Norfolk, Huron Perth, and Grey Bruce. All tables had their inaugural meeting in October 2017 and meet monthly. Throughout the fall and early winter of 2017/18, members have been setting priorities to improve the health care system in each sub-region, and have engaged with local system partners on their draft priorities. Over the last fiscal they have been scoping their work for the development of their work plans.

Below are draft priorities by each sub-region identified in 2017/18.

Priority	**Sub-region**
• Improve access to inter-professional resources through partnerships • Improve care journey for complex patients discharged from hospital through improved provider partnerships • Improve access to assisted living and supportive housing through information sharing and accountability • Create shared understanding of current programs and resources to improve the patient experience and journey through the system	Oxford
• Expand and coordinate best practices to create more health care resources • Coordinate mental health and/or addictions service delivery to create more health care resources • Support patients and caregivers throughout their journey • Ensure that individuals are getting culturally sensitive care, specifically the Anabaptist population	Huron Perth

• Create shared understanding of current programs and resources to improve the patient experience and journey through the system • Improve care journey for complex patients discharged from hospital through improved provider partnerships • Spread and coordinate existing care to ensure people are receiving the right care when and where they need it • Use existing resources to ensure patients are receiving culturally safe care • Improved access to specialized resources for seniors who are frail and/or have a number of medical conditions	London Middlesex
• Enable patients to receive the right level of care by home and community care services, supportive housing, assisted living, hospital or long-term care home • Support providers in understanding how to access specialized mental health services	Elgin
• Spread Indigenous cultural safe care in organizations through policy and education tools • Support recommendations from the South West LHIN mental health and addictions capacity report • Improve information sharing and the use of programs/services that support prevention management of chronic conditions	Grey Bruce

Clinical Quality Table

After the Patient First Act, the South West Clinical Quality Table was refreshed in January 2018 to better reflect the future quality agenda of the South West LHIN. The group represents a partnership between the South West LHIN, Health Quality Ontario and key clinical leaders in the region. The table is focused on advancing clinical quality improvement in support of the South West LHIN's Integrated Health Service Plan and Health Quality Ontario initiatives. Over the last fiscal, the table has been working to: improve the delivery of health care to ensure quality, safety and improved patient outcomes; address complex quality of care challenges; develop the measures and process to monitor specific quality indicators; as well as look at evidence based practices for clinicians, patients and providers.

Health System Renewal Advisory Committee

This group had its inaugural meeting in early February 2018 and is focused on advising the South West LHIN on system-wide implementation of Patients First, the Integrated Health Service Plan, as well as future organizational strategic directions. It is directly accountable to the LHIN CEO and represents the cultural, linguistic, and geographic diversity of the South West LHIN. Work during

the 2017/18 fiscal was in its early planning stages with a terms of reference being finalized and the group having its initial meeting.

The Health System Renewal Advisory Committee will work to:

- Champion equitable access to and availability of necessary health care services
- Provide system and operational advice, insight and recommendations to the South West LHIN leadership team and sub-region integration tables
- Provide advice on regional programs and how they interact with sub-regions
- Provide guidance for developing and adopting standardized methods of delivery (e.g. quality based procedures, order sets, clinical pathways, service protocols)
- Identify opportunities and challenges to standardize sub-region processes to support LHIN-wide programs across the LHIN and within sub-regions (e.g. to support seamless transitions of care)
- Share information on the progress/ challenges of individual sub-regions
- Identify change initiatives within sub-regions that should be optimized and spread across all sub-regions e.g. sub-region local performance improvement plans to help achieve primary care goals
- Identify opportunities for collaboration across sub-regions that will improve quality of patient care and equity in patient care
- Advise on resource allocation to decrease variation and increase equity
- Recommend performance measures
- Monitor system level and sub-region performance for progress and variation
- Provide guidance to sub-region integration tables on implementation plans

Engagement with Francophone communities

The South West LHIN is committed to ensuring the effective provision of French language health services by actively engaging and collaborating with its French Language Health Planning Entity (FLHPE) and the Francophone community. The South West LHIN French language coordinator continues to work closely with the FLHPE team to jointly plan and engage with Francophone communities through the Francophone Network Table (Franco-Info) and the dedicated French Mental Health and Addictions Table. In addition, meetings are held regularly to review the Joint Action Plan, discuss progress on projects and activities and plan for broader community engagement activities when needed. The LHIN website describes the ways in which French Language Services are advanced in the South West.

The LHIN continues to work to ensure the French-speaking population has access to services in French. This

includes alignment to the principles of active offer and ensuring the LHIN meets its obligations under the French Language Services Act. During the 2017/18 fiscal year, a current state and transition plan template was developed and used to track progress.

Over the summer of 2017, the LHIN worked collaboratively with the Erie St. Clair/South French Language Health Planning Entity (FLHPE) to ensure Francophone needs were represented in the development of the South West LHIN Sub-region Integration Tables and the Patient and Family Advisory Committee. In addition to including a clear statement in the Committees' Terms of Reference documents related to serving Francophones, the LHIN has strong Francophone representation on both the London Middlesex Sub-region Integration Table, as well as the Patient and Family Advisory Committee.

The South West LHIN has also worked to enhance the extent to which health service providers understand who their clients are, including their linguistic identity, to provide them with the best services possible. Through the Multi-Service Sector Accountability Agreement (MSAA), the South West LHIN will now be asking all community support and mental health and addiction's agencies to work towards using formal mechanisms to identify, track and report annually on the number of Francophone clients served. This information will help with establishing an environment that provides services in the best possible way to meet the cultural and linguistic needs of the population. The information will also be linked with existing health service data and used for health system planning to ensure services are culturally and linguistically sensitive.

Over the 2017/18 fiscal the following engagement initiatives have also been underway:

- The development of a Community of Practice for health service provider bilingual staff focused on creating a positive and supportive online community for future and existing bilingual health and wellness information. This tool is still in its final stages and will be a platform for exchanging tools, best practices, work and training opportunities, as well as recognizing and supporting bilingual health services.
- Work to create an online cultural linguistic competency training for LHIN and health service provider boards and staff to increase their awareness of Francophone communities and French language services.
- The planning to implement a Regional Francophone Community Health and Social Services hub. This pilot project is focused on bringing together a number of health and social service organizations to create a central point of access to information, programs, and

system navigation for Francophone individuals. The pilot is being launched in London Middlesex to start in June 2018.

- The completion of a total of seven videos focused on highlighting Francophone barriers to care. These barriers to care include: lack of meeting Francophone linguistic needs, access issues, information and service navigation challenges, as well as resistance to providing active offer. The videos also highlight success stories.
- The LHIN Board also receives regular French Language Service updates including presentations and education sessions about the LHIN's Francophone population and their needs.

Engagement with Indigenous communities

From a population health and health equity perspective, Indigenous people experience unparalleled health inequities in the health system both provincially and nationally. These inequities are not only unjust and unfair, but avoidable, thus there is an imperative for the LHIN to address these inequities as part of health system transformation to support equitable access leading to improvements in health outcomes. The LHIN continues to work with local Indigenous communities and partners to develop appropriate mechanisms for achieving ongoing and meaningful engagement.

As the system prepared for the period of transition, the LHIN has been deliberate in upgrading the South West Indigenous Health Committee through a re-structuring process. This restructuring aligns the new regional and sub-regional renewal structures with an Indigenous-led, collaborative leadership model, a parallel process designed to ensure that Indigenous communities and health service providers are at the forefront of health system planning. It is through these mechanisms, and by working with Indigenous organizations and leadership, that the LHIN will continue to build and develop a unique plan for implementing strategies and services to improve Indigenous health in the region.

Indigenous people continue to experience health inequities and the resulting disparities cut across almost every major health outcome, health determinant and measures of access. Within the South West LHIN, the Indigenous Health Lead works collaboratively with Indigenous partners and other health service providers to build positive working relationships and identify strategies that will address inequitable access, along with interventions designed to improve cultural safety of health services for Indigenous people.

The South West LHIN is mapping out patient/client, family and caregiver experiences as a method of integrating the Indigenous patient voice into the body of knowledge that guides system-level planning, supporting the design of sub-regional and sector specific priorities. These

experiences seek to combine stories of lived experiences, along with evidence-based data collection obtained through the application of the Health Equity Impact Assessment Tool as an ongoing process to ensure that Indigenous peoples' voices are recognizable and amplified within system planning.

Along with this voice, Indigenous communities and providers are also involved in shaping and advancing Indigenous-specific recommendations across the LHIN's regional and sub-region planning structures. Indigenous leaders have an active role in sub-region integration tables, as well as a central role within the LHIN Leadership table that oversees regional planning. All five Sub-region Integration Tables regularly attend the Indigenous Health Committee meetings to ensure good collaboration and strong Indigenous influence in each sub-region.

In addition, the Indigenous Health Lead supports Indigenous partners in this leadership work, advancing the recommendations made through the South West Indigenous Health Committee, which is responsible for guiding and informing regional Indigenous health priorities.

Over 2017/18, the South West LHIN Board of Directors continued its commitment to working in partnership with First Nations communities to establish mechanisms to engage appropriately at a governance and leadership level. The Indigenous community also continued to inform and drive quality improvement through the Indigenous Clinical Expert Advisory Panel, a working group of the Indigenous Health Committee that meets monthly to advance implementation of system level Indigenous health interventions.

All of these components, along with sub-region, Nation specific engagement and consultation over the last fiscal year continues to frame the development of an Indigenous inclusion roadmap. This roadmap will be instrumental for the LHIN to model the way of Indigenous engagement by demonstrating the importance co-designing culturally-appropriate structures. The enhanced LHIN organization will also improve its own Indigenous Cultural Safety training plan, as well as continue to focus on implementing mitigation and amplification strategies to ensure that Indigenous health is prioritized as a pillar for Patients First.

In 2017/18 the South West LHIN worked with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and other system partners to develop an Indigenous- led Palliative Care Outreach Team focused on meeting the care needs of Indigenous people. In the later part of 2017/18, a pilot outreach team was getting ready to launch in the London Middlesex region. The team is focused on providing 24/7 on-call support to identified Indigenous palliative patients with the aim of offering culturally safe and coordinated care.

Ministry and South West LHIN initiatives

This section will report on initiatives undertaken to advance the priorities set out in Ontario's Patients First Action Plan for Health Care, the South West LHIN Integrated Health Service Plan 2016-19, the 2017/18 Annual Business Plan, and priorities in the Minister's Mandate Letter for the 2017/18 fiscal year.

Transparency and public accountability

Monitoring and reporting performance is important not only to communicate and demonstrate how the LHIN is delivering on home and community care priorities and achieving an integrated health system for all, but also as a sign of our commitment to accountability and transparency to patients and communities.

The South West LHIN Report on Performance tracks progress on four high-level or "Big Dot" measures (focused on longer-term improvement – over the course of multiple IHSPs), and associated indicators selected to demonstrate how we are doing against our current IHSP objectives, Ministry-LHIN Accountability Agreement (MLAA) performance obligations, and additional priorities and goals.

Big Dots Performance Highlights (as of May, 2018):

Big Dot 1	**Self-reported health status**	• The percentage of South West LHIN respondents to the Canadian Community Health Survey reporting their health as "very good" or "excellent" was 60.9 per cent. • By the end of 2018/19, we aim to reach 63 per cent. • This measure will include one more annual update prior to the end of the IHSP 2016-19.
Big Dot 2	**Faster access to care in the community**	• Three components that describe access to key community services make up this Big Dot: wait time for mental health case management, receiving a personal support worker (PSW) visit within five days, and timely access to a primary care provider. • Two of the three component measures showed improvements from previous performance in the most recent quarter and, together, the net result means access to care in the community has 12 per cent improvement from previous performance. • Our goal over three years is to see 20 per cent faster access across these community services.

Big Dot 3	**Satisfaction with Health Care in the Community**	• The percentage of South West LHIN respondents to the Canadian Community Health Survey who reported they were “very satisfied” or “somewhat satisfied” with health care in their community was 88.6 per cent, a small improvement from previous performance. • Over three years, we aim to reach 92 per cent.
Big Dot 4	**Value Realized by Reducing Hospital Visits and Days**	• Reducing readmissions to hospital, reducing unnecessary Emergency Department (ED) use for conditions best treated in primary health care settings, and reducing the rate at which people are hospitalized for ambulatory care sensitive conditions (ACSC) that could be managed in the community represent three components that quantify costs that can be avoided (or value that can be realized) if improvements are made. • Over three years, we aim to realize $11.7 million in cost avoidance. • To-date, worse-than-targeted rates for readmissions, hospitalizations for ACSC, and unnecessary ED use translate into a *cumulative* $5.5 million unnecessarily spent supporting readmissions, hospitalizations, and ED visits over the first half of IHSP 2016-19.

Building healthy South West LHIN communities informed by population health planning

South West LHIN population health approach

The following three key structures were implemented in the South West LHIN in order to advance the goals of the Patients First agenda:

1. Health System Renewal Advisory Committee
2. Sub-region Integration Tables
3. Patient and Family Advisory Committee

In order to support an understanding of population needs at the sub-region and local levels – population and performance profiles were created for each of the South West LHIN Sub-region Integration Tables (Middlesex London, Oxford, Elgin, Grey Bruce, Huron Perth). These profiles enabled Sub-region Tables to debate and define their local priorities. Some examples of sub-region local priorities and how they align with a need to further understand population health are outlined below.

Sub-region	Current priority or challenge	Need to know to support improvement
London Middlesex	***Create a shared understanding of current initiatives and available programs and resources to improve patient experience and flow for patients with mental health and addictions challenges.***	• The population living with mental health and addictions challenges • What conditions are they living with? • Where are they living? • What types of services are available? Where are they located? • What types of services are they accessing?
Elgin	***Enable providers to better understand how to access specialty mental health services, and how to ensure continued and appropriate support in patients' location of choice (i.e. close to home).***	• Where are patients with different mental health and addictions conditions living? • What conditions are they struggling with? • What access to services and choices do they have close to home? • An overlay of sociodemographic, socioeconomic, and housing status
Grey Bruce	***Improve knowledge and utilization/ embedding of programs and services that support prevention and management of chronic conditions as a key priority.***	• Where do people with key chronic conditions live? • What services are available to support them? Where are the services located? • What are the key barriers to accessing services? (i.e. proximity of services, transportation, drug costs, etc.)

Improving the patient experience

Development of the Patient, Family and Caregiver Partner role and launch of the Patient and Family Advisory Committee

Following the passage in December 2016 of the Patients First Act, the LHIN has created new committees with a stronger patient/family/caregiver voice that can advise the LHIN on system-wide priorities and drive change locally.

The South West LHIN created the Patient, Family and Caregiver Partner role with the expectation that these individuals would participate on these new committees. Patient, Family and Caregiver Partners participate in the Sub-region Integration Table meetings and one LHIN-wide regional committee, either the Patient and Family Advisory Committee (PFAC) or the Health System Renewal Advisory Committee (HSRAC).

The South West LHIN PFAC launched on Wednesday October 18, 2017. The Committee has met three times during the past six months.

Creation of the South West LHIN patient engagement plan

The South West LHIN understands that engagement efforts must extend beyond establishing a PFAC and consist of a variety of activities and initiatives to create a patient-centered healthcare system where patients, families and caregivers are partners in their personal healthcare, and are actively engaged in healthcare system design and decision-making. A main focus of PFAC has been co-developing the South West LHIN patient engagement plan that will guide the South West LHIN's approach to involving patients in healthcare planning and delivery.

The South West LHIN has adopted the *Health Quality Ontario Patient Engagement Framework* to guide the LHIN patient engagement approach. PFAC members reviewed the provincial framework including the provincial strategic goal for patient engagement: *"a strong culture of patient, caregiver and public engagement to support high quality health care."*

Over the past 2017/18 fiscal, PFAC members have identified the following primary drivers to achieve the provincial goal of embracing a strong culture of patient engagement:

- Include and engage patients, families and caregivers as valued partners in care of themselves, the people they love, and the broader, inclusive community
- Support and engage healthcare providers to leverage the collective experience, knowledge and

wisdom of patients, families and caregivers
- Cultivate leaders that will champion patient engagement

As part of the patient engagement plan process, the South West LHIN PFAC sought to build strong relationships with health service provider organizational-level PFACs and provincial PFACs. As an input into the LHIN patient engagement plan, Patient, Family and Caregiver Partners met with health service provider organizations' Patient and Family Advisory groups to learn about their patient engagement successes and how they would like to connect in the future with the South West LHIN PFAC. In addition, the LHIN Patient Engagement Team met internally with the various functional areas within the LHIN organization. These meetings have been very valuable and have highlighted current and future patient engagement opportunities within the LHIN organization.

As next steps, PFAC will complete engagement about the South West LHIN patient engagement plan across the South West LHIN, continue to strengthen LHIN PFAC connections to health service provider organizational-level patient and family advisory groups and provincial PFAC groups, and move to action on identified priority areas of focus.

Development of a population health approach in the South West LHIN

Over the past year, a concept for a South West LHIN population health approach has been developed for future implementation. This concept proposes the creation of a sustainable model aligned with the maturity journey envisioned for sub-regions and local planning. The following outlines key objectives of the approach:

1. Leadership to engage key providers and community partners, in order to establish and formalize neighbourhood geographies to support local and regional planning (key local participants recommended include: public health, municipal planning, decision support –and potentially participation of Sub-region leadership).
2. Enable improved shared access to, and sharing of key population health and health-related data at the sub-region and neighbourhood levels, in order to enable collective impact strategies.
3. Increase the capacity of LHIN partners to use a balance of data, local evidence, and community input in their planning and service delivery. The aim would be to support improvement, work with local resource(s), and capacity building for better access to dynamic population health data.
4. Identify priority populations, local and shared system level strategies for

addressing health inequities.

5. Enable capacity of health care practitioners to adopt a population health and health equity approach in their practice.
6. Support key health system partners, and enable/foster population-based improvement at the sub-sub regional (care community) level.
7. Optimize resource capacity, enhance collaboration, leading/best practice sharing, and improvement through implementation of a South West LHIN Regional Decision Support Collaboration (network). Leverage existing provincial resources (including funding, experience, technology, expertise and networks through participation in a pan-LHIN community of practice).
8. Determine potential opportunities to reduce costs associated with access to data sharing among partner organizations.
9. Improve partner confidence by taking on a leadership role to establish and foster robust partnerships with public health, and other key providers/community partners at the regional, and local levels.

Equity, quality improvement, consistency and outcomes-based delivery

Health equity

To succeed in transforming the health care system all health service providers and our communities must be open to innovative and structural changes to our system.

Health equity is a core value in Ontario's health care system and it is recognized that people belonging to certain groups may experience disparities in their health status, access to service and the quality of care they receive.

The Ministry of Health and Long-Term Care continues to emphasize health equity as a foundational requirement for health system change. The Excellent Care for All Act, recognizes that "a high quality healthcare system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focused, and safe" and the French Language Services Act requires French-language services that are available, accessible and of equivalent quality to services offered in English. Applying a health equity lens to existing and emerging health services ensures that we are working to achieve a health care system that all residents can count on regardless of their individual circumstances or where they live. Factors such as gender, race, sexual orientation, immigration status, income and education must be explicitly considered to address systemic

barriers and challenges for certain populations.

Progress and strategies:

- Working alongside health service providers to develop culturally competent Boards and organizations through Continuous Cultural Competency training (including ongoing Indigenous/Aboriginal cultural and linguistic competency training and Francophone cultural competency training) and board/staff development focused on increasing awareness about key equity issues.
- Applying an equity lens to decision-making by developing guidelines to increase the application of the Health Equity Impact Assessment (HEIA) tool, including when developing and accessing health programs and services and for all major financial decisions and integrations at the LHIN. The Health Equity Impact Assessment is a decision support tool helping users to identify how a program, policy or similar initiative will impact populations groups in different ways. HEIA surfaces unintended potential impacts. The end goal is to maximize positive impacts and reduce negative impacts that could potentially widen health disparities between population groups - in short, more equitable delivery of the program, service, policy, etc.

Quality improvement and innovation

Quality Improvement is a catalyst for change needed to achieve quality care, improved health, and better value. Building a culture of quality improvement, developing capacity, and embedding structured improvement methods into change initiatives has been and continues to be an implementation priority for the South West LHIN and health service providers.

The LHIN's efforts align with, complement and link to a number of provincial and international efforts:

- Excellent Care for All Act ensures all Ontarians receive health care of the highest possible quality and value. The Act is based on the principle: The patient is the centre of the health care system.
- Health Quality Ontario is focused on creating greater public accountability; ensuring executives, clinicians and healthcare organizations focus on quality; increasing the patient's voice in shaping the system; and increasing access to health evidence. Health Quality Ontario provides information about health evidence, public reporting and links to a number of provincial quality improvement initiatives and resources.

- Institute for Healthcare Improvement provides a wealth of information and tools about health care improvement approaches including the Triple Aim framework, an approach to health care based on the belief that focusing on three goals at the same time will lead to better health outcomes.

Progress and strategies:

- Working with health service providers to develop a coordinated approach to engage patients and determine experience of care measures.
- Working alongside health service providers to implement best practices (e.g. Quality Based Procedures, Adult Day Program Redesign) and reduce variation within and among organizations to improve outcomes and value for money.
- Working with health service providers to advance quality outcomes for identified priorities and initiatives.
- Encouraging health service providers to embed quality improvement within their organizations through processes such as accreditation and use tools such as the Quality Improvement Enabling Framework. Continue to integrate and standardize improvement tools and templates into the LHIN's project management approach.
- Continuing to acknowledge and stimulate quality improvement efforts through the LHIN's annual quality symposium and awards.
- Working alongside health service providers, using provincial quality improvement learning opportunities (e.g. IDEAS program--Improving and Driving Excellence across sectors).
- Working alongside health service providers to consistently embed patient engagement approaches (e.g. Experience Based Design) to advance quality improvement.
- Providing leadership in establishing shared quality improvement strategies through Quality Improvement Plans across and within sectors to advance key priorities.

Strengthening primary care

Improving access to primary care and ensuring primary health care is strengthened and linked with the broader health care system is a focus of the South West LHIN's 2016-19 Integrated Health Service Plan. In 2016/17 work began in the South West LHIN to implement a multi-year collaborative primary care reform strategy to improve patient access and quality of care.

The core of this work will be connecting and integrating primary care providers with other care providers. There is also a need for dedicated work to respond to the needs of currently under serviced

portions of the LHIN including Indigenous communities.

In 2017, the South West LHIN began implementing the recommendations aimed to support equitable access to primary care that were identified through the *Understanding Health Inequities and Access to Primary Care in the South West LHIN* report which was completed in 2016. The LHIN is working to develop and implement a LHIN-wide strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of each community.

New primary care provider orientation
The program was launched in January and was designed to ensure primary care providers starting practice are aware of the resources available in their communities and how to access them. Sessions have taken place in both the Oxford and Elgin sub-regions and are scheduled for London Middlesex. The program will be spread to the rest of the LHIN by the end of the year.

Primary Care Alliances
A Primary Care Alliance has been established in each sub-region. The meetings of the groups are led by the LHIN Sub-region Clinical Lead and a co-chair that was elected by the membership of the Alliance. The goal of the Alliances is to bring together primary care providers to enable them to begin working and communicating as a cohesive sector so they are able to advocate for and impact practice and system change at local and regional levels. The Primary Care Alliance has also developed a website to facilitate communication and engagement with the primary care sector.

Access to team based care
The Advancing Access to Team Based Care initiative was launched in 2018 and was established in partnership with the Provincial Research Team based out of the University of Toronto Institute of Health Policy Management and Evaluation. The initiative enables equitable access to inter-professional care by connecting primary care providers in the community, and their patients, to care teams through Community Health Centres and Family Health Teams. This work continues to build on the People in Need of Teams (PINOT) program, an integrated and collaborative model piloted by London Inter-community Health Centre. A Practice Facilitator has been hired to champion and support change and improvement processes to enable the adoption of improving access to team-based care practices and operations.

Hospitals and partners

A significant focus of the LHIN's Blueprint is to optimize hospital-based resources in order to build capacity and access to quality treatment and care throughout the LHIN.

Improving patient access and flow remains a key priority in the South West LHIN given challenges that remain with access to inpatient beds

in hospitals. Under the leadership of the Chief Nursing Executive Leadership Forum, the LHIN and all hospital providers in the South West LHIN continue to work together to improve key drivers of patient access and flow.

A holiday surge plan and protocol was again used during the 2017/18 Holiday season where proactive surge planning, a robust communications plan, and triggered triage huddle calls were used to ensure access and flow was maintained when predictable peaks in volume were seen. The process was successful as a result of collaboration between system partners and lower influenza activity in the region over the holiday period.

In 17/18, additional "flex" beds were allocated to a number of hospital sites in the South West LHIN to help alleviate occupancy pressures during influenza season. Please see table below for details on these flex beds.

Site	Number of beds	Date in operation	Timeline
London Health Sciences Centre	33	Open since December 2017	4 months
	5	Open since January 2018	2.5 months
Grey Bruce Health Services	2	February 2018	2 months
	4	November 2017	4 months
St. Thomas Elgin General Hospital	4	December 2017	4 months
Tillsonburg District Memorial Hospital	8	January 2018	2 months
Woodstock General Hospital	4	January 2018	2.5 months
St. Joseph's Health Care – Parkwood	6	November 2017	4.5 months

South West LHIN Musculoskeletal Strategy

The Ministry in partnership with LHINs are working to expand musculoskeletal (MSK) central intake, assessment and management models that have proven their benefit to patients and providers. This will start with hip and knee replacement surgery (for osteoarthritis) and low back pain management in 2018/19. Over time, pathways for all MSK conditions will be integrated into these regional MSK intake, assessment and management models.

Over the 2017/18 fiscal year, the South West LHIN has been working with partners to develop a region specific MSK strategy. Starting in the fall of September 2018, primary care physicians will be referring patients requiring hip and knee replacement surgery and with persistent low back pain to MSK central intake,

assessment and management in our LHIN.

Primary care professionals and patients will be participants in shared-care models. When a patient requires specialist care, you will be able to refer them to one entry point (i.e., a single LHIN fax number or eReferral pathway); an advanced practice clinician will provide assessment and education to patients in a timely manner and connect them to a surgeon or community-based services as appropriate.

The intent of this strategy is to make wait times more transparent and meaningful to the public, providing clear information on how long they can expect to wait at each stage of their assessment and treatment. This new model of care is focused on appropriate assessment and education, and will work to ensure that patients referred to surgeons are likely surgical, while non-surgical patients will be connected to community-based resources.

Home and Community Care

Throughout the 2017/18 fiscal year, home and community care played a critical role in coordinating and delivering services that helped people leave hospital earlier, and stay independent in their homes longer.

Care Coordination Model Evolution

To support the mandate of the LHIN and the *Patients First Act*, the LHIN embarked on a Care Coordination Model Evolution – developing and implementing a plan with input from key stakeholders including health service providers, front line staff, primary care, and patients and families – to ensure smooth transitions of care, ultimately improving care coordination to meet future demands, and to ensure the highest quality patient experience.

Goals of the project include aligning care coordination with clinical best practices and improving care coordination connections and relationships with primary care and other system partners that benefit patients.

This project began in July 2018 and is estimated to conclude in the last quarter of the 2018-19 fiscal year.

Medical Assistance in Dying

With the passage of Medical Assistance in Dying (MAID) legislation in June 2016, and Ontario's MAID Statute Amendment Act coming into force in May 2017, the South West LHIN has responded by implementing systems to support this legislation aimed at providing clarity and legal protection for health care providers and patients navigating medical assistance in dying.

In order to provide the best care to patients, a MAID Navigator role was created to support effective local service coordination, education opportunities focused on best practices related to MAID adoption, and coordinating mentorship opportunities for new providers. This position allows for dedicated engagement with system partners across the South West to implement and improve this level of care.

A single access resource phone line for local primary care partners and health service providers with information about MAID services in the South West LHIN is also in the process of being launched.

Planning and dialogue continues with stakeholders, including service providers, to establish a coordinated and standardized approach for accessing MAID so that end-of-life needs of patients and their families are better met.

Palliative Care Outreach Teams

In alignment with *Patients First*, the South West LHIN implemented community-based interdisciplinary 24/7 Palliative Care Outreach Teams in all rural LHIN sub-regions to support primary care providers with patients receiving end-of-life services at home. Evidence shows that better access to care that meets the complex pain, psychosocial and spiritual care needs of palliative patients improves the likelihood of patients dying in their location of choice, and increases the number of patients dying in a location other than hospital (home or residential hospice).

In 2017-18, 1,007 patients were supported by the teams in Grey/Bruce, Huron/Perth, Oxford and Elgin.

Family-Managed Home Care

In anticipation of the formal introduction of the Family-Managed Home Care program across the province in April, 2018, the South West LHIN began developing the program specifics and design, as well as an implementation plan for the roll-out. While this work was being completed, the LHIN also developed a patient wait list and prioritization tool. With the program aimed at offering a model of care that provides individuals within the four eligible patient groups (i.e. children with complex medical needs, adults with acquired brain injuries, eligible home-schooled children, and patients in extraordinary circumstances) with more choice and control over the care they receive at home. A project lead ensures the perspectives of patients and families are incorporated into program delivery.

Personal Support Services

South West LHIN Home and Community Care experienced capacity challenges in 2017-18 with a shortage in personal support workers (PSWs). This is similar to the experience of many other communities across the province. As one of the single largest elements in Ontario's health workforce essential to providing care to patients, PSW capacity has been a key focus over the past year.

With a goal of ensuring quality care for patients, the LHIN actively worked with local service providers and provincial colleagues to develop strategies to address the capacity challenges. In addition to strategies planned and implemented at a provincial level to build a safe and competent PSW workforce – such as recruitment and retention, education and training, and accountability and oversight – the South West LHIN continues to effect short and long term actions to maintain support for patients and to ensure resources were used efficiently.

Strategies the South West LHIN continue to employ to address the PSW shortage include: partnering with community support service agencies to provide alternate services; engaging service providers to maximize scheduling efficiencies; providing ongoing assessments to ensure PSW services are prioritized to patients with the most critical need; and implementing service standards across all patient populations.

Mental Health and Addictions

Mental health and addictions capacity planning

This project was initiated and endorsed by the South West LHIN to better support hospitals in responding to significant access and flow pressures in Schedule 1 hospitals. A Capacity Plan Steering Committee established and engaged KPMG in June 2017 to:

- Develop evidence-based capacity plan recommendations, based on current state assessment and predictive analytics
- Assist with clinical protocol implementation, including the development of corresponding algorithms for front line staff
- Review data quality (in terms of the accuracy of entries) for the CritiCall Bed Resource Board.

The result was a comprehensive report identifying challenges, gaps and opportunities for improvement to re-design the Mental Health and Addictions system in the South West LHIN. Four streams of work have been identified. The LHIN is now creating the structures and governance to support this work.

Two clinical protocols have been developed: one aimed to improve patient access and flow for inpatient mental health and addiction beds, which is being implemented in Schedule 1 hospitals within the South West LHIN; the other aimed at improving the transitions of care for children and adolescents with mental health emergencies arriving at emergency departments.

London enhanced mental health crisis services - Satellite Crisis Centre

Since 2012, community partners have been working together to develop comprehensive community-based crisis services including 24/7 crisis mobile response, crisis assessment and rapid response transitional case management.

Presently, Emergency Medical Services are not able to bring patients via ambulance to the crisis centre due to legislative requirements resulting in patients being taken to emergency departments instead. While the Ministry of Health and Long-Term Care is working to alleviate these barriers, Canadian Mental Health Association Middlesex and London Health Sciences Centre (LHSC) have partnered to create a temporary crisis centre satellite location at LHSC.

From October 2017 – March 31, 2018 just over 160 people were diverted from the emergency department to the satellite crisis centre. This means that patients are receiving more appropriate care, paramedics spend much less time waiting with patients for needed services, and less people are in waiting rooms.

Innovation, health technologies and digital health

In 2017/18 the South West LHIN continued to advance several key digital health initiatives. Several digital health initiatives have been identified as having the most impact on helping to meet organizational goals, and therefore have continued to be prioritized over the last fiscal year.

Digital health in the South West LHIN – connecting South West Ontario (cSWO)

The cSWO Program is focused on continuing to further the implementation of integrated Electronic Health Records (EHR) across the region. Through the implementation of the cSWO Program Regional Clinical Viewer, ClinicalConnect™, health service providers can securely access patients' electronic health records from across the continuum of care. Important real-time patient information and data for 3.6 million south west Ontario residents is available online for approved health care professionals.

Electronic health records provide quick and easy access to the information that health care professionals need to:

- make proactive decisions,
- improve patient safety,
- reduce duplication, and
- support positive patient experiences.

The authorized users have real-time access to patients' medical information from all acute care hospitals, Local Health Integration Networks' Home and Community Care (LHIN-HCC) services (formerly Community Care Access Centres) and regional cancer programs in SWO, plus various provincial data repositories, including the Ontario laboratories information system, and the recently developed Digital Health Drug Repository.

Electronic Health Records, viewed through ClinicalConnect, are being used by a total of 42,056 users including:

- 2,113 family physicians
- 4,277 specialist physicians
- 11,353 registered nurses
- 9,030 clinical support workers
- 695 nurse practitioners
- 4,314 allied health professions (diagnostic, technical, therapeutic and direct patient care and support services)
- 915 pharmacists
- 3,008 registered practical nurses

eConsult

eConsult is now a provincial program with over 800 specialists available to respond to non-emergency questions through a web based application hosted by the Ontario Telemedicine Network (OTN). The service has proven efficiency with an average response time of less than three days and a significant avoidance of referrals. The South West LHIN has registered over 450 primary care providers (including nurse practitioners together with 55 specialists) from across the South West LHIN. Sub-Region Clinical Leads, OntarioMD and OTN field teams continue to engage providers and promote adopting this tool in the South West LHIN.

Health Link – electronic Care Coordination Plan
In alignment with provincial direction, work is underway in the South West LHIN to enable providers participating in the Health Links approach (to Coordinated Care Planning) access to the Coordinated Care Plan (CCP) in the Client Health Related Information System (CHRIS). Access will enable providers to create, view and edit CCPs. This work will support the sustainability and spread of the Health Links approach to care; enabling a dispersed leadership model and improving patient care and experience.

MyChart – Patient Portal
The MyChart (Regional Patient Portal) will provide a patient-facing portal, so patients will have a comprehensive view of their health information, regardless of where they received care.

The aim of this portal will be to:

- Help patients to become active participants in their own care.
- Greater patient access to a wide array of credible health information, data, and knowledge.
- Patients can leverage tools and information in MyChart to improve their health and manage their diseases.
- Patients can track their diseases in conjunction with their providers, promoting earlier interventions when they encounter a deviation or problem.

MyChart will leverage information collected within ClinicalConnect. ClinicalConnect is a secure, web-based portal that provides physicians and clinicians with real-time access to their patients' electronic medical information from all acute care hospitals. MyChart planning and implementation work has started in 2017/18. It will be deployed in two early adopter sites in South Western Ontario in 2018/19, which include:

- South West LHIN: London Health Sciences' Regional Cancer program, in collaboration with St. Joseph's Health Care London
- Hamilton Niagara Haldimand Brant LHIN: Hamilton Health Sciences' McMaster Children's Hospital (Complex Care, Transition Clinic and Bariatrics)

eNotifications
eNotifications have been running provincially for over four years allowing hospital emergency departments across the province to know in real time if patients presenting in the emergency department is a LHIN Home and Community Care patient. These eNotifications also inform care coordinators in real time, allowing them to investigate and turn off services going to patients' homes until discharged from the hospital. Recently, these same eNotifications have been sent through the provincial Health Report Manager (HRM) solution to participating primary care physicians via their electronic medical record (EMR) systems. Primary Care Physicians can then follow-up with their patients in a timely manner to potentially avoid readmissions to the hospital.

In February 2018, a pilot in Grey County was started to enable Emergency Medical Services (EMS) eNotifications which will help to further improve coordinated care among providers.

Surgical Waitlist Management
A surgical waitlist management system is an electronic, web-based solution that includes:

- Automated reporting to the provincial Wait Time Information System;
- Real-time wait time management in surgeons' offices;
- Real-time business intelligence for surgical waitlist management at all levels of the organization;
- Improved performance management and accountability;
- eScheduling from physician offices; and
- Paperless eBookings.

In 2015/16, the St. Thomas Elgin General Hospital led the first implementation and successful procurement of an electronic system. The evaluation has shown improvements in operating room utilization, same day cancellation rates, and reduced staff time on clerical, booking and data entry. Implementation was also completed by the Huron Perth Healthcare Alliance hospitals and the Alexandra Marine and General Hospital. Expansion work into Grey Bruce Health Services, South Bruce Grey Health Centre and Hanover and District Hospitals continued in 2017/18 with an anticipated implementation in 2018/19.

Coordinated Access/Central Intake
Leveraging the investments in the Surgical Waitlist Management system, the South West LHIN has enabled the use of technology for coordinated access/central intake in support of the Musculoskeletal (MSK) strategy. A common system for Surgical Waitlist Management and coordinated access/central intake helps ensure a seamless flow of information to support of the required processes. The project will start with hip and knee replacement surgery and low back pain management. Over time, pathways for all MSK conditions will be integrated into the regional MSK intake, assessment and management models.

Telehomecare
Telehomecare is an Ontario Telemedicine Network (OTN) project that allows remote monitoring of patients with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure at home. A remote monitoring nurse engages to support patients for remote monitoring, coaching and self-management. The program is part of an integrated care process that involves the primary care provider and associated agencies providing care to the patient. The Telehomecare team continues to hear very positive feedback from the patients about their experience and ability to self-manage their symptoms. The program has noted a 55% reduction in hospital/ED admissions that were sustained three months after discharge from the Telehomecare program. To date, over 800 patients in the South West LHIN have benefited from this program.

Specialist Service Directory
The directory is an online catalogue designed to assist primary care physicians identify appropriate specialist services to make referrals. The electronic directory lists detailed information on sub-specialty services and procedures provided by the specialist including information on how to access these services, referral requirements, and referral forms. The electronic catalogue is hosted and maintained by the SouthWesthealthline.ca. This tool will help minimize rejected referrals and allow for easier and timely access to these services.

Connecting Care to Home (CC2H)
The Connecting Care to Home program will continue to be implemented at London Health Sciences Centre (LHSC) for moderate care needs patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). A total of 315 patients (225 with COPD and 90 with CHF), have completed the care pathway successfully. Recently, we have expanded CHF patient recruitment to Victoria Hospital's Medicine Unit, following our first wave of expansion for COPD patients earlier in the year to Medicine at University and Victoria hospital sites. The South West LHIN continues to spread, sustain and scale the CC2H program across LHSC, working with the Ministry of Health and Long-Term Care and Health Quality Ontario to identify the common success elements with the other integrated care models across the province.

CC2H has helped deliver a superior level of care to patients across the LHIN living with COPD and/or CHF who are admitted to LHSC. In the COPD care pathway, we have seen a reduction in hospital length of stay by 50 per cent, community care length of stay (LOS) reduction of 81 per cent, 30 day post-discharge readmission reductions of 46 per cent, and a total cost reduction of 40 per cent. For the CHF care pathway, the reduction of LOS was not significant; however, the readmission rate for 30 days after discharge reduced by 30 per cent. The CC2H model of care showed a significant increase in patient and caregiver satisfaction and we continue to see interest in surrounding LHINs and hospitals.

The CC2H project team is currently working on enhancing patient recruitment in order to optimize utilization of the resources in the community. The team is reviewing the eligibility criteria and exclusion criteria to increase access for more patients and continues to monitor key performance indicators and metrics. It should be noted that every patient who experiences CC2H is supported by the Health Links approach to Coordinated Care Planning.

Home and Community Care

Activities and progress made on delivering home and community care

On December 7, 2016, Ontario passed the Patients First Act. Approving this legislation is a significant step in supporting health system transformation. The Act is about making a system that is better integrated and focused on patient and community needs to ensure health care resources are used effectively and efficiently, in the public interest. As part of this Act, all Community Care Access Centres (CCACs) across the province were integrated with LHINs. The integration of the South West CCAC and the South West LHIN took place on May 24, 2017.

Throughout the 2017/18 fiscal year, the South West LHIN worked hard to ensure as a newly integrated organization, there was no negative impact to patient care. The year was focused on establishing the organizational structure and aligning key organizational processes, creating the strategic vision for the new organization, as well as cultivating the culture needed to advance Patients First across the South West LHIN. The new LHIN's organizational structure achieved savings of 8 per cent in administrative and management costs.

The South West LHIN and the former CCAC have a strong history of collaboration, and continue to leverage the collective expertise throughout this integration process to come together as one organization.

Local Health System Performance

The Ministry-LHIN Accountability Agreement (MLAA) outlines obligations and responsibilities of both the South West LHIN and the Ministry of Health and Long-Term Care (MOHLTC) and specifies indicators targeted for improvement. The 2015-2018 MLAA reflects alignment with the new government priorities and initiatives including the Patients First Action Plan for Health Care, and transformation activities including: Home and Community Care, Health System Funding Reform (HSFR), Health Links, Comprehensive Mental Health and Addictions Strategy, and Palliative Care.

As of 2015/16, the Ministry shifted to using a single target for each indicator for all LHINs versus LHIN-specific targets. LHINs must report on and demonstrate progress towards achieving the provincial targets for performance indicators and report on and monitor the results of the monitoring indicators.

The subsequent table on page 40 reports on the performance of the South West LHIN on key MLAA measures.

Performance Indicators

Considering both the most recent quarter of data and the 2017/18 annual performance results, the South West LHIN has either met the provincial target or made progress against the 2015/16 results for the following MLAA performance indicators:

- Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services
- 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients
- Percentage of Alternate Level of Care (ALC) days
- ALC rate
- Repeat unscheduled emergency visits within 30 days for mental health conditions
- Readmission within 30 days for selected Health Based Allocation Model Inpatient Grouper (HIG) conditions.

LHIN/provider actions and initiatives that contributed to the improved outcomes include:

- The ED Pay-for-Results (P4R) and Knowledge Transfer (KT) Learning Collaborative have targeted an improvement and investment approach at high volume ED sites to drive improvement in ED metrics. The focus of this work is on improving patient flow (including ED and ALC measures).
- As part of the broader patient flow improvement approach, a Home First Refresh (focused on ALC avoidance and management strategies) has been implemented at London Health Sciences Centre, demonstrating an overall reduction in the number of open ALC cases, and open ALC cases waiting for long-term care. A spread strategy across the South West LHIN is underway to enhance positive impacts.
- The following investments and initiatives have all contributed to the South West

LHIN consistently performing among the top four best LHINs on ALC rates:

- Investments in South West LHIN nursing to support Home First patients;
- Investments to increase access to Assisted Living spaces based on demographic data and demand;
- Support for Behavioural Supports Ontario to provide coordination and expertise in supporting and transitioning difficult-to-serve ALC clients; and
- Support for coordinated access to Complex Continuing Care and Rehabilitation beds.

The South West LHIN has not achieved the provincial target in the most recent quarter for repeat unscheduled emergency visits within 30 days for mental health conditions but did demonstrate a slight improvement over 2015/16 with its 2017/18 annual performance.

Enhancing community capacity through investments in transitional case management and crisis services (including five stabilization beds and 24/7 walk-in access to the Crisis Centre in London) contributed to sustained or slightly improved performance despite increasing pressures and volumes of patients visiting EDs for mental health conditions. Collaborative efforts among community mental health partners to develop a coordinated access model of care have also contributed to the performance during the 2017/18 fiscal year.

A South West LHIN Peer Support strategy (focused on integrating peer support across the LHIN), as well as the development of clinical protocols to guide the utilization and transition between services are expected to have future positive impacts on repeat unscheduled ED visits within 30 days for mental health conditions.

The provincial target for 90th percentile wait time for home and community care in-home services was not met with either the most recent quarter, or the 2017/18 annual result for the South West LHIN and has not shown improvement since 2016/17. The decline in performance aligns with both continued increases in demand for services for complex and chronic clients as well as an exceptionally long wait recorded for a patient that was later attributed to a data quality issue.

Considering both the most recent quarter of data and the 2017/18 annual performance result, the LHIN has neither achieved the provincial target, nor improved, when compared to 2015/16 for the following performance indicators:

- 90th percentile wait time from community for home care services - application from community setting to first home care service (excluding case management)
- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement
- Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were

authorized for personal support services.
- 90th percentile emergency department (ED) length of stay for complex patients.
- Repeat unscheduled emergency Visits within 30 Days for substance abuse conditions

Some of the challenges that may have contributed to these outcomes include:

- The demand for hip and knee surgeries continues to be a challenge for most hospitals despite provincial and LHIN targeted investment/additional volumes allocated to South West LHIN hospitals.
- Increases in complex referrals--especially over the holiday season--have resulted in home and community care not meeting the ambitious 95 per cent targets for home care access within 5 days. The South West LHIN also has e-shift supports, which is not provided by most LHINs. The e-shift services are challenged by staffing shortages and increases in demand for end-of-life palliative patients, especially over the Christmas period.
- There continues to be observed increases in co-occurring mental health and/or substance abuse conditions in patients who frequently visit the ED, exacerbated by both the opioid and crystal methamphetamine crises.

Actions the LHIN has undertaken or plans to undertake to improve performance include:

- As part of the Surgical Wait List Management system planning and regional and organizational data clean is underway to remove duplicate wait list entries to ensure that there is an understanding of the true demand for procedures.
- Based on sustained demand pressures in the South West LHIN, the LHIN has targeted additional investments to support expedited completion of hip and knee replacement surgeries for patients who have been waiting the longest for surgery.
- The Orthopedic Steering Committee has been re-constituted with a short-term focus on access for hip and knee patients including developing better mechanisms to share wait time information by organization and surgeon with primary care providers in the South West LHIN-leveraging lessons learned through implementation in Waterloo Wellington LHIN.
- Though early in implementation, there are a number of interventions that have been implemented in the South West LHIN to improve readmission rates including: Health Links, Telehomecare, an Integrated Funding Model pilot known as "Connecting Care to Home" (CC2H) for chronic obstructive pulmonary disease (COPD) patients, and improving the timeliness of sending discharge summaries from hospitals to primary care physicians. Improvements in readmissions for COPD patients have been

demonstrated over a six month timeframe as a result of CC2H.
- An escalating series of follow-up requirements is initiated with home and community care if it falls outside of its allowed corridor requiring explanation, improvement planning, and further reporting.
- Enhanced home and community care base funding to expand service provision to clients with complex, high-needs as well as for caregiver respite should ease pressures in other areas to allow for a focus on ensuring wait time improvements.
- An Alternate Level of Care (ALC) Avoidance and Patient Flow initiative led by regional Chief Nursing Executives has resulted in task teams seeing improvements in ALC and discharge planning.
- Planning to enhance Behavioural Support Unit (BSU) capacity is underway and will ease ALC pressures once developed.
- Strategies implemented to improve ED revisit rates for mental health conditions referenced above also aim to improve revisit rates for substance abuse conditions.

Monitoring Indicators
Considering the most recent quarter of data, the South West LHIN has demonstrated improvements over 2016/17 for percent of priority 2, 3 and 4 cases completed within access target for cataract surgery and for percent of priority 2 and 3 cases completed within access target for MRI scans.

Though there are no provincial targets, the South West LHIN demonstrated better results than the province for home and community care wait times from application to eligibility determination for long-term care home placements (from a community setting) and home and community care wait times from application to eligibility determination for long-term care home placements (from an acute-care setting).

The South West LHIN's investments in vision care initiatives have focused on clinical outcomes instead of specific improvements in wait times over the past two years, and this could explain the lack of improvement progress. The Vision Care Steering Committee remains in place and it is anticipated that the Committee will continue to work on the recommendations identified in the March 2015 Vision Care Clinical Services Planning report. Wait time improvement opportunities may be prioritized by the Committee.

Though there are no provincial targets, the most recent quarter and the 2017/18 annual provincial rate of emergency visits for conditions best managed elsewhere, and hospitalization rate for ambulatory care sensitive conditions are better than the South West LHIN performance.

Overall, these measures are inherently complex and multi-faceted and thus require cross-sector collaboration to improve. Spreading best practice hospital discharge processes including improving communication between primary health care providers and hospitals, as well as supporting and facilitating the development of Health

Links represent actions the LHIN has undertaken to improve performance.

As we transition into a focus on improvements within sub-regions and Patients First, a greater emphasis on collaboration, integration and shared accountability will enable health service providers across all sectors to better contribute to improvements in these system measures.

SOUTH WEST LHIN MLAA INDICATORS

2017/18 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial				LHIN			
			2015/16 Fiscal	2016/17 Fiscal	Most Recent Quarter	2017/18 Fiscal	2015/16 Fiscal	2016/17 Fiscal	Most Recent Quarter	2017/18 (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.4%	89.9%	87.1%	88.5%	88.9%	91.9%	89.6%	88.9%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.0%	94.0%	96.1%	95.8%	96.2%	93.1%	93.7%	94.0%	94.0%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	30.00	28.00	29.00	21.00	22.00	33.00	30.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	8.00	9.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.97	10.38	11.50	10.75	7.73	7.73	8.90	8.45
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.07	4.15	4.67	4.38	3.62	3.60	4.20	3.90
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	79.9%	78.5%	78.3%	77.9%	68.4%	50.4%	49.1%	47.4%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.1%	75.0%	72.9%	73.7%	68.9%	47.6%	46.3%	44.2%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.5%	15.7%	16.5%	15.2%	9.2%	10.5%	8.5%	8.7%
10	ALC rate	12.70%	13.9%	15.2%	15.5%	15.7%	11.1%	11.7%	12.0%	11.6%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	20.2%	20.7%	21.8%	20.9%	18.0%	18.4%	17.1%	17.7%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	33.0%	32.5%	32.1%	32.3%	23.1%	24.5%	29.6%	26.8%
13	Readmission within 30 days for selected HIG conditions**	15.5%	16.7%	16.7%	16.4%	16.4%	17.2%	17.1%	16.7%	16.9%

2. Monitoring Indicators										
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	88.1%	85.0%	85.8%	83.9%	91.3%	83.6%	84.4%	81.5%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	62.6%	67.6%	73.2%	69.8%	55.6%	66.5%	69.6%	65.8%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.2%	82.1%	85.7%	84.7%	80.3%	84.6%	84.3%	82.4%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	13.00	14.00	14.00	9.00	7.00	8.00	8.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	7.00	4.00	3.00	3.00	3.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	18.47	17.12	4.40	12.06	42.56	41.76	11.29	29.99
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.13	321.18	84.72	243.31	397.79	414.67	105.16	309.33
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.6%	47.4%	46.8%	47.3%	42.3%	42.6%	41.9%	42.1%

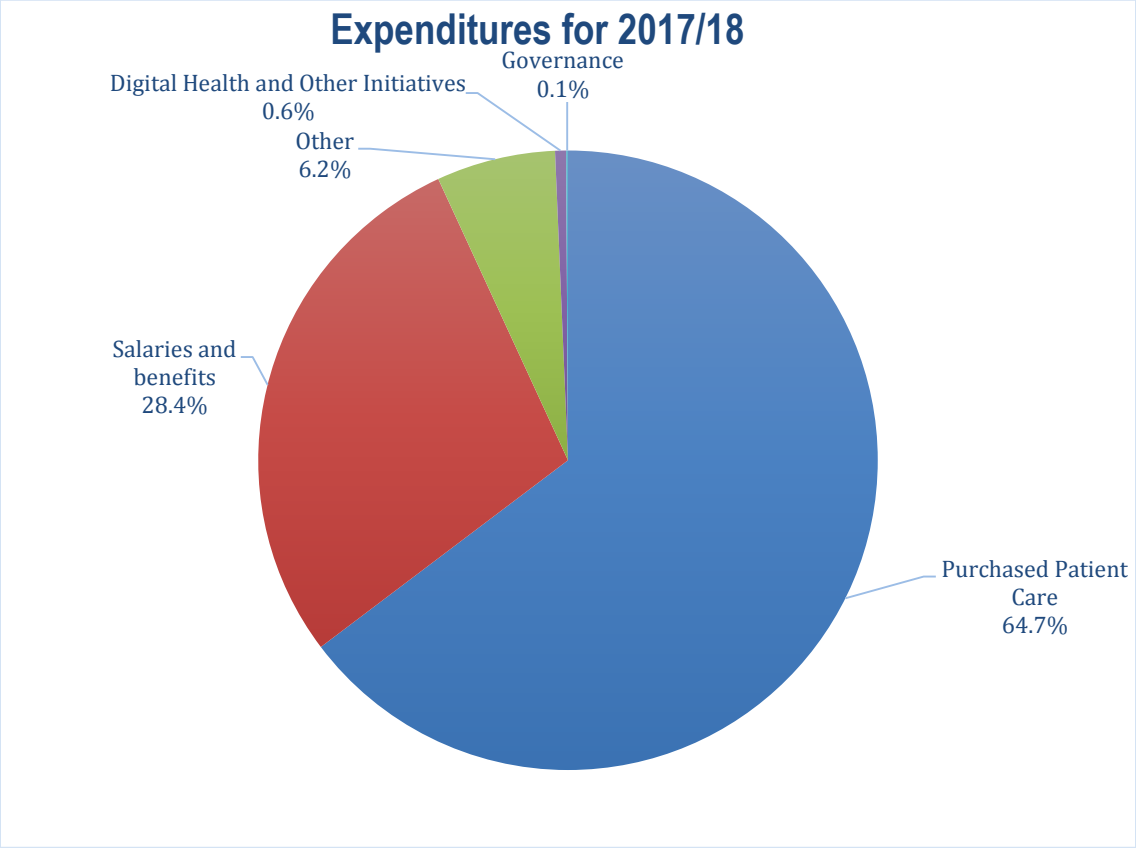
*FY 2017/18 is based on the available data from the fiscal year (Q1-Q3, 2017/18)
**FY 2017/18 is based on the available data from the fiscal year (Q1-Q2, 2017/18)
* Most recent quarter is based on the available quarterly data from the fiscal year (Q3 2017/18)
** Most recent quarter is based on the available data from the fiscal year (Q2 2017/18)
Without other notes, most recent quarter is based on the available data from the fiscal year (Q4 2017/18)

Operational Performance

In 2017/18, the South West LHIN budget was $209.7 million – this includes spending on LHIN Operations, Home Care/LHIN Delivered Services, Admin/Governance, Digital Health and Other Initiatives.

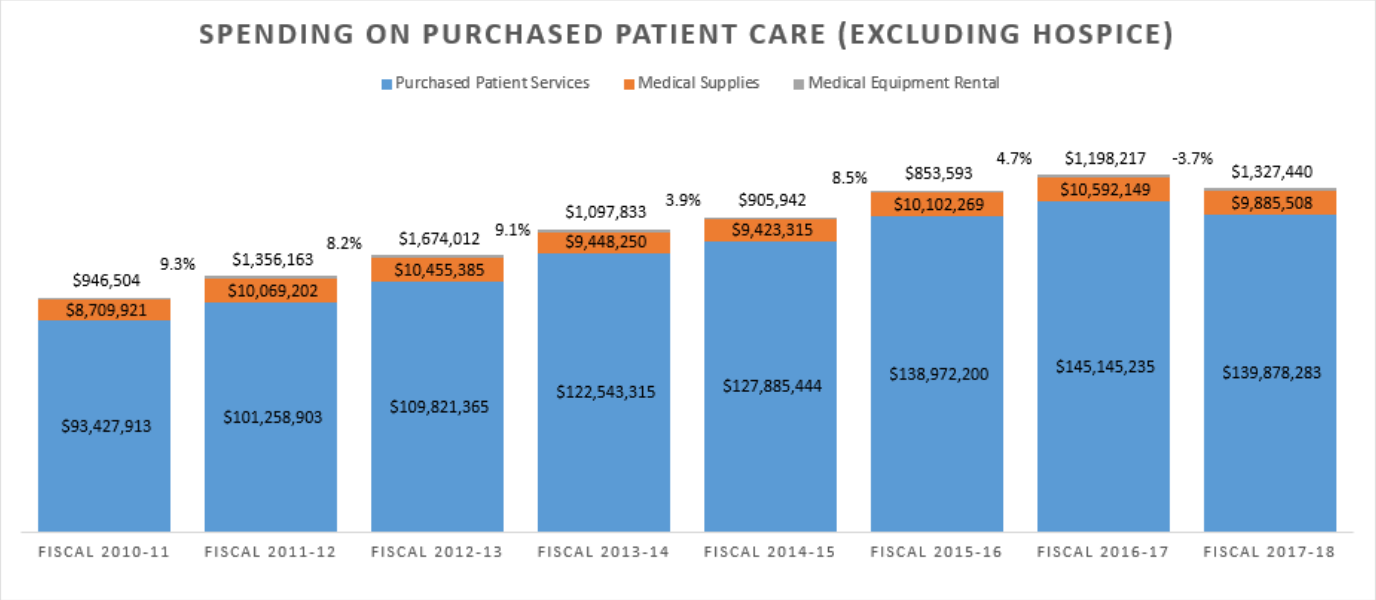
Fiscal Results

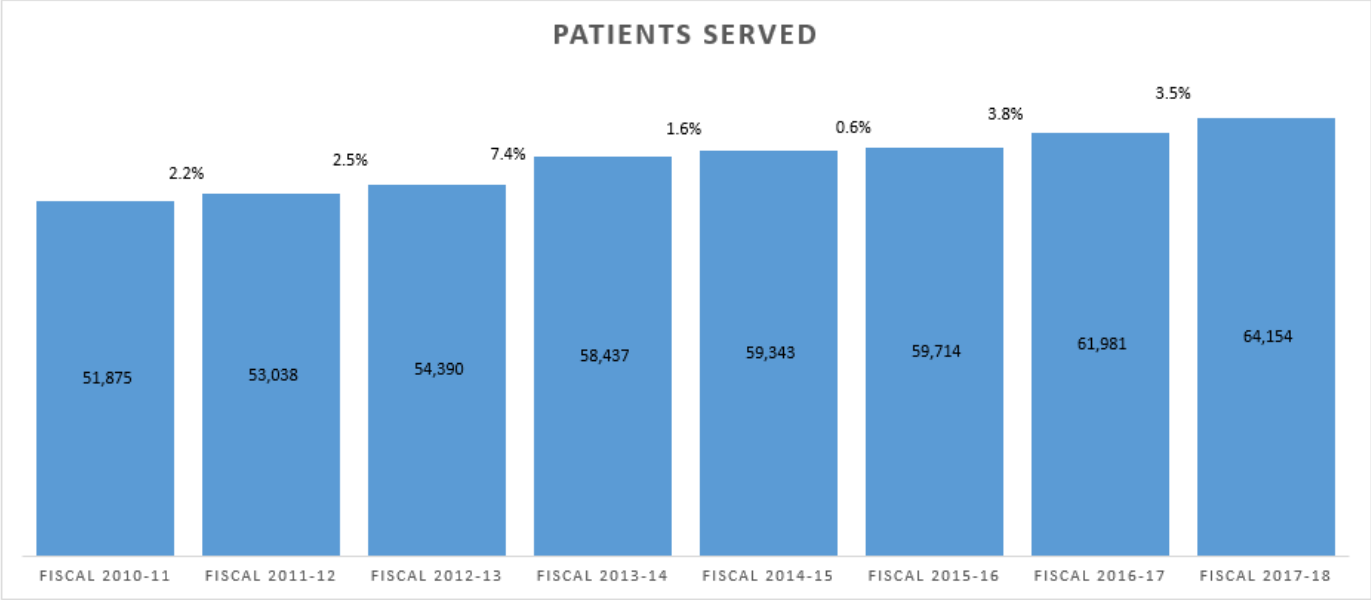
The South West LHIN ended the year with expenditures of $204.2 million and an operating surplus of $2.7 million and restricted program surpluses of $2.9 million. Surpluses are returned to the Ministry of Health and Long-Term Care. The chart below shows five major categories of expenditures for the South West LHIN. The largest expenditure was purchased patient care. Refer below for statistics for 2017/18 and prior years that provide further information on patient care impact and reach.

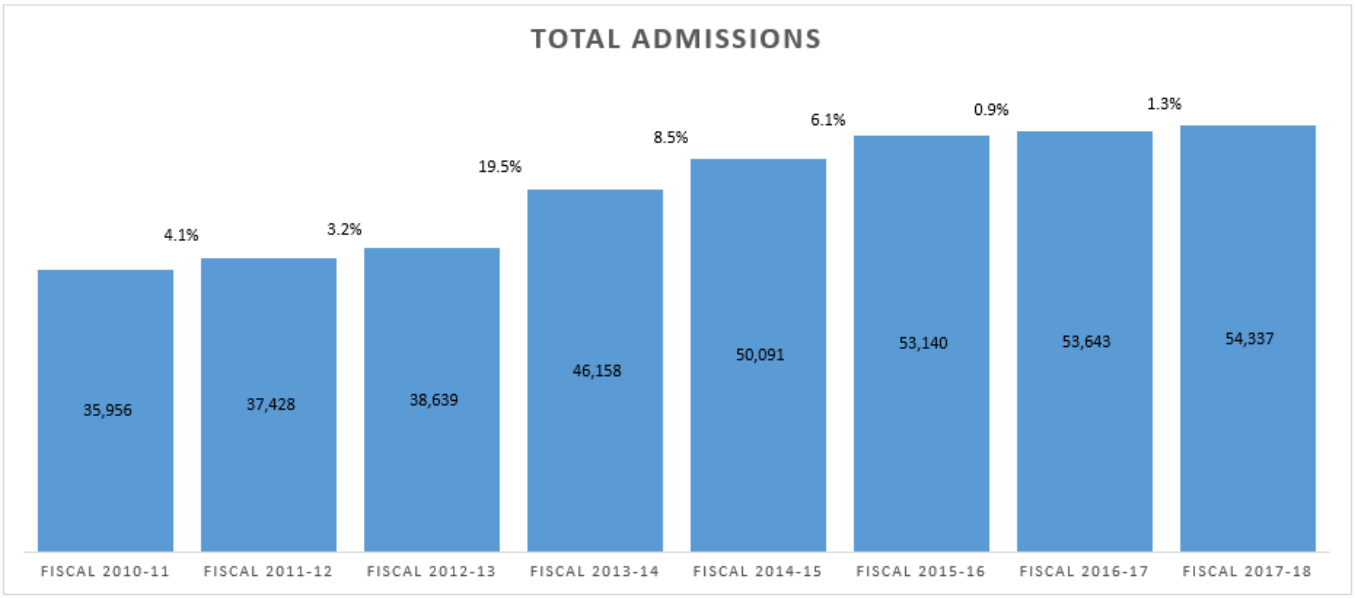


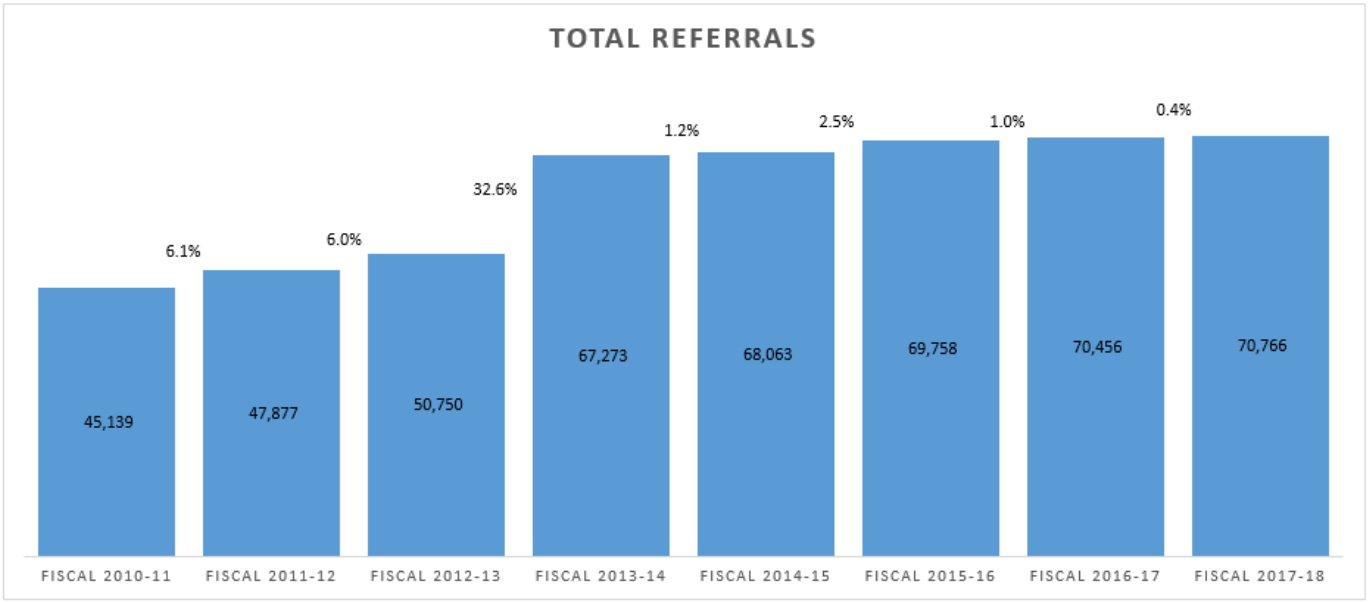
Detailed Patient Care Statistics

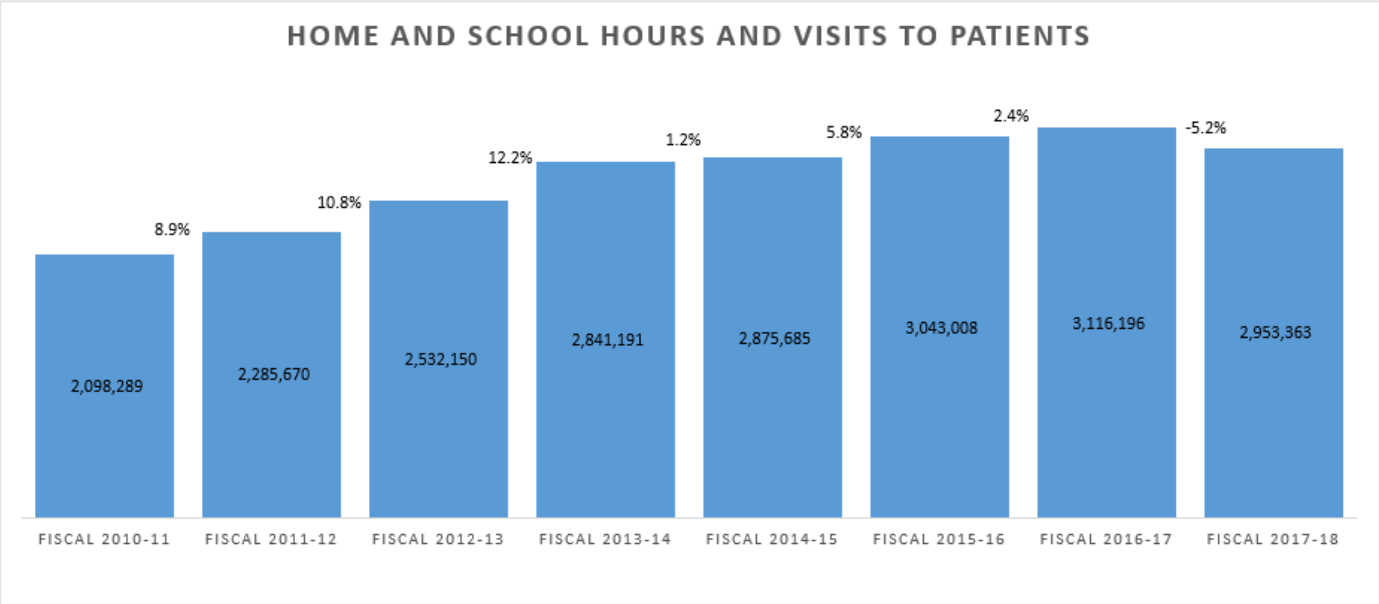
Note that for the purpose of comparability, all of the statistics in the below charts are for the full period April 1, 2017 to March 31, 2018. This includes South West CCAC statistics from April 1, 2017 until merger with the South West LHIN on May 23, 2017 and the new combined South West LHIN from April 1, 2017 until March 31, 2018.





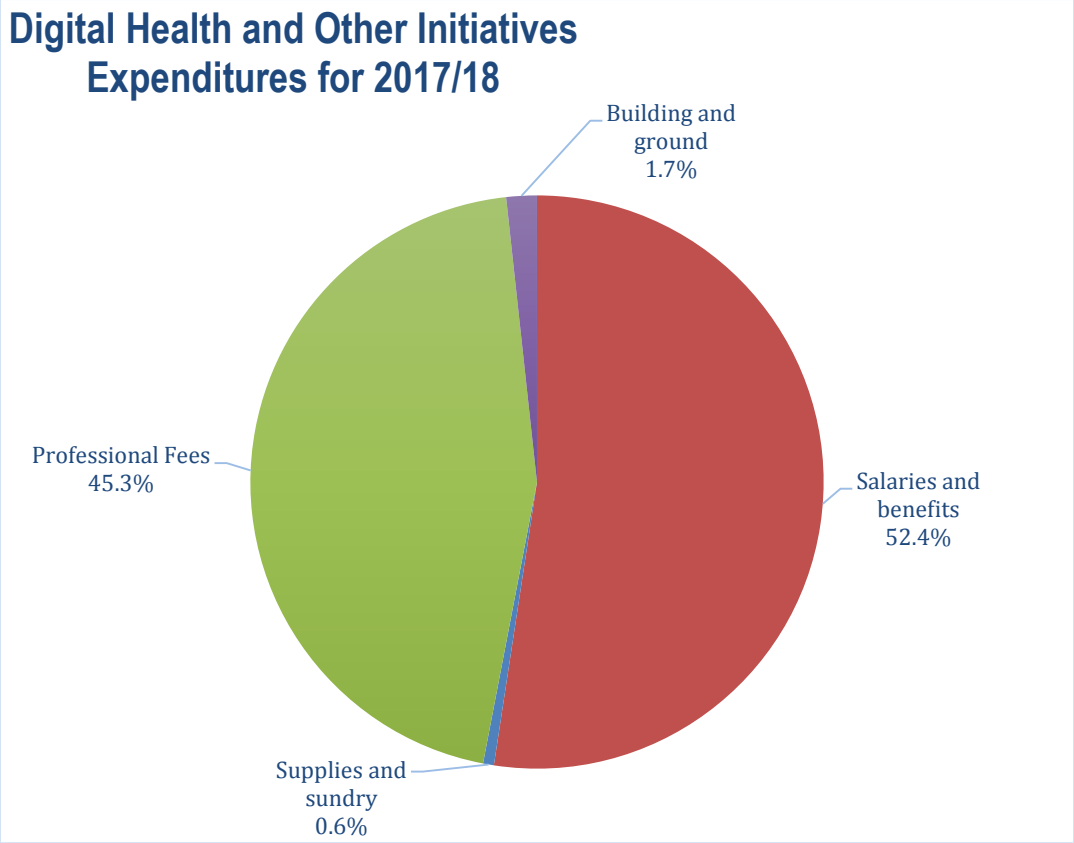

TOTAL ADMISSIONS
4.1%
3.2%
19.5%
8.5%
6.1%
0.9%
1.3%
35,956
37,428
38,639
46,158
50,091
53,140
53,643
54,337
FISCAL 2010-11
FISCAL 2011-12
FISCAL 2012-13
FISCAL 2013-14
FISCAL 2014-15
FISCAL 2015-16
FISCAL 2016-17
FISCAL 2017-18


TOTAL REFERRALS
6.1%
6.0%
32.6%
1.2%
2.5%
1.0%
0.4%
45,139
47,877
50,750
67,273
68,063
69,758
70,456
70,766
FISCAL 2010-11
FISCAL 2011-12
FISCAL 2012-13
FISCAL 2013-14
FISCAL 2014-15
FISCAL 2015-16
FISCAL 2016-17
FISCAL 2017-18



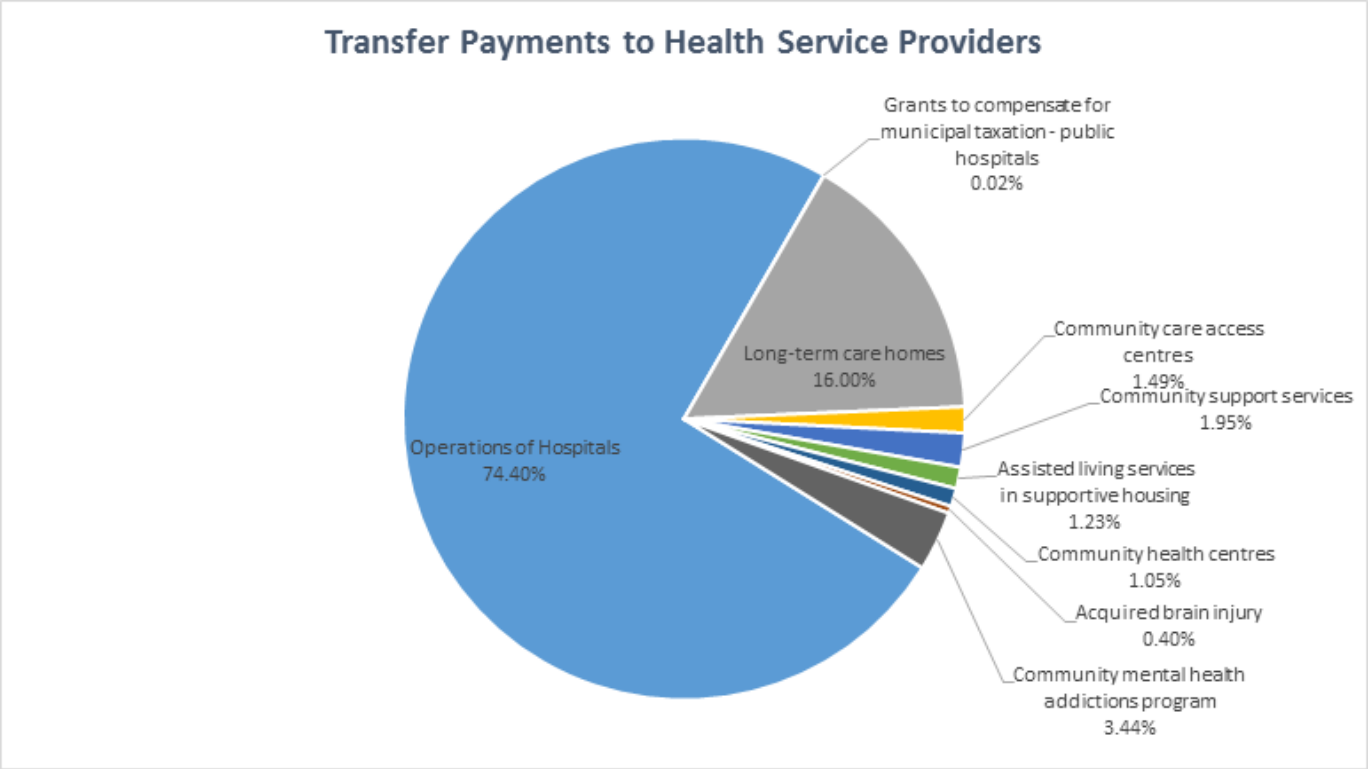
Digital Health and Other Initiatives

The South West LHIN ended the year with expenditures of $1.2 million and a surplus of $344K relating to the funding for Digital Health and other Initiatives. Surpluses are returned to the Ministry of Health and Long-Term Care. The chart below shows the four major categories of expenditures for Digital Health and Other Initiatives.



Initiatives include French Language Services, Aboriginal Planning, Clinical Leads, and Patients First.

Digital Health is the Enabling Technology Integration program. Effective January 31, 2014, the South West LHIN entered into an agreement with three other LHIN's – Erie St. Clair, Hamilton Niagara Haldimand Brant, and Waterloo Wellington. Together with SW LHIN, these are known as the "cluster". The goal is to enable effective and efficient delivery of e-health programs and initiatives within the geographic area of the cluster. The total cluster funding for the year ended March 31, 2018 was $2,040,000. Funding of $1,530,000 was allocated to the other LHINs within the cluster, who incurred eligible expenses of $1,530,000. The South West LHIN incurred expenses of $510,000 relating to project management for enabling technology integration, and these $510,000 in expenses are included in the chart above.


Transfer Payments to Health Service Providers
Grants to compensate for municipal taxation - public hospitals 0.02%
Long-term care homes 16.00%
Community care access centres 1.49%
Community support services 1.95%
Assisted living services in supportive housing 1.23%
Community health centres 1.05%
Acquired brain injury 0.40%
Community mental health addictions program 3.44%
Operations of Hospitals 74.40%

Financial statements of

South West Local Health Integration Network

March 31, 2018

Deloitte & Touche LLP
400 Applewood Crescent
Suite 500
Vaughan ON L4K 0C3
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

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 the South West Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2018, and the statements of operations and changes in net assets, 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 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 the LHIN as at March 31, 2018 and the results of its operations, changes in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 26, 2018

South West Local Health Integration Network

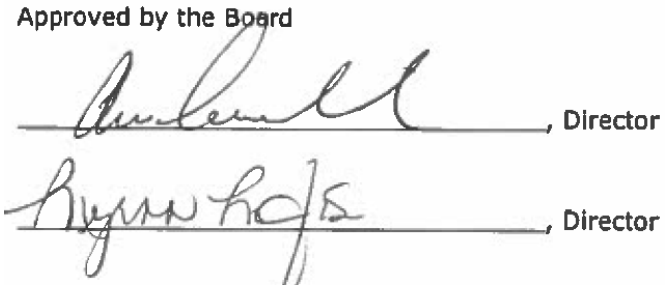
Statement of financial position

As at March 31, 2018

	Notes	2018	2017
		$	$
Assets			
Current assets			
Cash		**33,795,044**	648,278
Due from Ministry of Health			
Long-Term Care ("MOHLTC")		**6,216,698**	7,656,700
Harmonized Sales Tax receivable		**749,387**	32,175
Accounts receivable – other		**559,524**	7,606
Prepaid expenses		**863,448**	8,738
		42,184,101	8,353,497
Capital assets	7	**2,758,535**	44,290
		44,942,636	8,397,787
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**24,192,933**	600,480
Due to Health Service Providers ("HSPs")	15	**6,216,698**	7,656,700
Due to Ministry of Health			
Long-Term Care ("MOHLTC")	4, 15	**11,654,347**	96,317
Current portion of obligations under capital leases	8	**450,746**	—
		42,514,724	8,353,497
Obligations under capital leases	8	**300,518**	—
Deferred capital contributions	9	**2,646,961**	44,290
		45,462,203	8,397,787
Commitments	10		
Net assets		**(519,567)**	—
		44,942,636	8,397,787

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

Approved by the Board



South West Local Health Integration Network

Statement of operations

Year ended March 31, 2018

	Notes	2018 Actual	2017 Actual
		$	$
Revenue			
MOHLTC funding – transfer payments	15	**2,177,164,119**	2,309,811,966
MOHLTC funding – operations and initiatives		**202,344,217**	8,712,912
Interest income		**364,532**	—
Amortization of deferred capital contributions		**1,728,850**	21,618
Other revenue		**1,313,297**	—
		2,382,915,015	2,318,546,496
Enabling Technologies ETI PMO allocated to other LHIN's	5	**(1,530,000)**	(1,530,000)
Total revenue		**2,381,385,015**	2,317,016,496
Expenses			
HSP transfer payments	15	**2,177,164,119**	2,309,811,966
Operations and Initiatives			
Contracted out			
In-home/clinic services		**112,489,356**	—
School services		**6,866,801**	—
Hospice services		**2,898,226**	—
Salaries and benefits		**58,674,067**	5,296,566
Medical supplies		**8,660,433**	—
Medical equipment rental		**1,213,936**	—
Supplies and sundry		**7,307,969**	1,886,346
Building and ground		**2,678,481**	21,618
Amortization		**2,205,514**	
Repairs and maintenance		**1,217,486**	—
		204,212,269	7,204,530
Total expenses		**2,381,376,388**	2,317,016,496
Excess of revenue over expenses before the undernoted		**8,627**	—
Net liabilities assumed on transition	13	**(528,194)**	—
Excess of expenses over revenue		**(519,567)**	—

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

			2018	2017
	Unrestricted	Employee benefits	Total	Actual
	$	$	$	$
Net assets, beginning of year	—	—	—	—
Excess of revenue over expenses before the undernoted	—	8,627	8,627	—
Net liabilities assumed on transition	—	(528,194)	(528,194)	—
Net assets, end of year	—	(519,567)	(519,567)	—

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

South West Local Health Integration Network

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		**(519,567)**	—
Cash received on transition		**23,827,333**	—
Net liabilities assumed on transition		**528,194**	—
Less amounts not affecting cash			
Amortization of capital assets		**2,205,514**	21,618
Amortization of deferred capital contributions		**(1,728,850)**	(21,618)
		24,312,624	—
Changes in non–cash working capital items	12	**8,945,202**	212,925
		33,257,826	212,925
Investing activities			
Purchase of capital assets		**(500,617)**	(22,314)
Financing activity			
Repayment of capital lease obligations		**(451,363)**	—
Increase in deferred contributions		**840,920**	22,314
		389,557	22,314
Net change in cash		**33,146,766**	212,925
Cash, beginning of year		**648,278**	435,353
Cash, end of year		**33,795,044**	648,278

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

1. Description of Business

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

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

The mandate of the LHIN is as follows:

a) 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 kilometres from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with health service providers.

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

   All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

b) Effective May 24, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

2. Significant Accounting Policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOHLTC represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOHLTC are set up as repayable to the MOHLTC at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant Accounting Policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding approved by the MOHLTC to support LHIN managed Health Services Providers and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC in the MLAA. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOHLTC.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC to the Health Service Provider and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds included in the Ministry-LHIN Accountability Agreement.

Adoption of PSAS 3430 – Restructuring transactions

The LHIN has implemented Public sector Accounting Board ("PSAB") section 3430 Restructuring Transactions. Section 3430 requires that the assets and liabilities assumed in a restructuring agreement be recorded at the carrying value and that the increase in net assets or net liabilities received from the transferor be recognized as revenue or expense. Restructuring is an event that changes the economics of the recipient from the restructuring date onward. It does not change their history or accountability in the past, and therefore retroactive application with restatement of prior periods permitted only in certain circumstances. The impact of this policy on the current year is detailed in note 12.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations.

2. Significant Accounting Policies (continued)

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under “revenue” in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Computer equipment	3 years straight-line method
Computer software	3 years straight-line method
Equipment capital lease	Life of lease straight-line method
Leasehold improvements	Life of lease straight-line method
Furniture and equipment	10 years straight-line method
Phone system	5 years straight-line method

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

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 amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in Accounting Policy

As a result of the transition of responsibility for the delivery of certain services related to home care as described above, there has been a significant change in the operations of the LHIN over prior year. As a result of these changes, the LHIN has determined that the adoption of Canadian public sector accounting standards for Government not-for-profit organizations is appropriate. Previously the LHIN followed Canadian public sector accounting standards. The adoption of this policy has no impact on numbers previously reported. The impact of the change is limited to presentation only, and as a result the prior year figures presented for comparative purposes have be reclassified to conform with the current year's presentation.

4. Funding repayable to the MOHLTC

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

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

	2018	2017
	$	$
Due to MOHLTC, beginning of year	**96,316**	61,122
Funding repaid to MOHLTC	**(96,316)**	(55,636)
Funding repayable to the MOHLTC related to current year activities	**9,622,028**	83,354
Funding repayable to the MOHLTC assumed on transition	**2,032,319**	
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities	**—**	7,476
Due to MOHLTC, end of year	**11,654,347**	96,316

5. Enabling Technologies for Integration Project Management Office

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

The South West LHIN is designated the Lead LHIN with this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus, the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2018 was $2,040,000 ($2,040,000 in 2017).

Funding of $1,530,000 ($1,530,000 in 2017) was allocated to other LHIN's within the cluster who incurred eligible expenses of $1,530,000 ($1,530,000 in 2017). The LHIN has set up a payable to the MOHLTC for $nil ($7,476 in 2017).

5. Enabling Technologies for Integration Project Management Office (continued)

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

	2018			2017
	Funding allocated	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Erie St. Clair LHIN	**510,000**	**510,000**	**—**	—
Hamilton Niagara Haldimand Brant LHIN	**510,000**	**510,000**	**—**	—
Waterloo Wellington LHIN	**510,000**	**510,000**	**—**	—
South West LHIN	**510,000**	**510,000**	**—**	7,476

6. Related party transactions

Health Shared Services Ontario (HSSO)

HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long-Term Care.

7. Capital Assets

			2018	2017
	Cost	**Accumulated depriciation**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer equipment	**4,572,985**	**3,872,036**	**700,949**	9,832
Computer software	**2,231,898**	**2,168,350**	**63,548**	—
Equipment capital lease	**2,480,139**	**1,639,287**	**840,852**	—
Leasehold improvements	**5,145,820**	**4,464,482**	**681,338**	—
Furniture and equipment	**5,067,139**	**4,653,845**	**413,294**	34,458
Phone system	**1,342,568**	**1,284,014**	**58,554**	—
	20,840,549	**18,082,014**	**2,758,535**	44,290

8. Obligations under Capital Leases

	2018	2017
	$	$
Equipment lease maturing in April 2019. Monthly combined interest and principal payments of $10,442 plus applicable taxes are required until maturity	127,208	—
Computer lease maturing in September 2019. Annual combined interest and principal payments of $10,948 plus applicable taxes are required until maturity	11,091	—
Computer lease maturing in January 2020. Annual combined interest and principal payments of $27,803 plus applicable taxes are required until maturity	28,166	—
Computer lease maturing in March 2020. Annual combined interest and principal payments of $21,480 plus applicable taxes are required until maturity	21,760	—
Computer lease maturing in March 2021. Annual combined interest and principal payments of $16,554 plus applicable taxes are required until maturity	49,189	—
Computer lease maturing in March 2021. Annual combined interest and principal payments of $2,425 plus applicable taxes are required until maturity	7,205	—
Computer lease maturing in June 2021. Annual combined interest and principal payments of $2,237 plus applicable taxes are required until maturity	6,647	—
Computer lease maturing in July 2021. Annual combined interest and principal payments of $23,017 plus applicable taxes are required until maturity	68,392	—
Computer lease maturing in July 2019. Annual combined interest and principal payments of $4,773 plus applicable taxes are required until maturity	4,483	
Computer lease maturing in September 2019. Annual combined interest and principal payments of $3,458 plus applicable taxes are required until maturity	3,508	—
Computer lease maturing in November 2019. Annual combined interest and principal payments of $1,056 plus applicable taxes are required until maturity	1,071	—
Balance carry forward	328,720	—

8. Obligations under Capital Leases (continued)

	2018	2017
	$	$
Balance brought forward	328,720	—
Computer lease maturing in December 2019. Annual combined interest and principal payments of $4,341 plus applicable taxes are required until maturity	4,404	—
Computer lease maturing in March 2020. Annual combined interest and principal payments of $20,996 plus applicable taxes are required until maturity	40,380	—
Computer lease maturing in June 2020. Annual combined interest and principal payments of $30,591 plus applicable taxes are required until maturity	58,791	—
Computer lease maturing in August 2020. Annual combined interest and principal payments of $103,065 plus applicable taxes are required until maturity	198,073	—
Computer lease maturing in October 2020. Annual combined interest and principal payments of $37,602 plus applicable taxes are required until maturity	72,264	—
Computer lease maturing in January 2021. Annual combined interest and principal payments of $7,074 plus applicable taxes are required until maturity	13,596	—
Computer lease maturing in January 2021. Annual combined interest and principal payments of $2,283 plus applicable taxes are required until maturity	4,387	—
Computer lease maturing in February 2021. Annual combined interest and principal payments of $9,280 plus applicable taxes are required until maturity	17,835	—
Computer lease maturing in March 2021. Annual combined interest and principal payments of $4,304 plus applicable taxes are required until maturity	8,271	—
Computer lease maturing in March 2021. Annual combined interest and principal payments of $2,364 plus applicable taxes are required until maturity	4,543	—
	751,264	—
Less current portion of capital lease obligation	450,746	—
Long-term portion of capital lease obligation	300,518	—

8. Obligations under Capital Leases (continued)

Pledged as security for the above borrowings are the equipment under capital lease. The minimum payments over the remaining terms of the leases are as follows:

	$
2019	470,541
2020	263,534
2021	28,769
Total minimum payment	762,844
Less: amount representing interest	11,580
	751,264

9. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**44,290**	43,594
Capital contributions received during the year	**3,490,601**	22,314
Capital contributions transferred from CCAC	**840,920**	
Amortization of deferred contributions recognized as revenue for the year	**(1,728,850)**	(21,618)
Long-term deferred capital contributions balance, end of year	**2,646,961**	44,290

10. Commitments

The LHIN has commitments under various operating leases extending to 2023 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

	$
2018	1,370,693
2019	1,054,750
2020	928,449
2021	925,950
2022	905,950
Thereafter	268,650

11. Contingencies

The LHIN enters into accountability agreements with Health Service Providers ("HSPs") which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

12. Additional Information to the statement of cash flows

	2018	2017
	$	$
Due from MOHLTC HSP transfer payments	**1,440,002**	5,798,622
Accounts receivable	**(830,117)**	(7,606)
Harmonized sales tax receivable	**262,862**	4,052
Prepaid expenses	**(222,898)**	14,310
Accounts payable and accrued liabilities	**3,402,964**	175,682
Due to Health Service Providers	**(1,440,002)**	(5,798,622)
Due to MOHLTC	**6,332,391**	35,195
Due to LHIN shared services office	**—**	(8,708)
Total change in non-cash working capital items	**8,945,202**	212,925

13. Transition of South West Community Care Access Centre

On April 3, 2017 the MOHLTC made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the South West Community Care Access Centre the ("CCAC"), to the South West LHIN, including the transfer of all employees of the South West CCAC. This transition took place on May 23, 2017. Prior to the transition, the LHIN funded a significant portion of the CCACs operations via HSP transfer payments. Subsequent to the transition date, the costs incurred for the delivery of services previously provided by the CCAC were incurred directly by the LHIN and are reported in the appropriate lines in the statement of operations.

13. Transition of South West Community Care Access Centre (continued)

The LHIN assumed the following assets and liabilities, which were recorded at the carrying value of the CCAC

	$
Assets	
Cash	23,827,333
Accounts receivable	806,677
Statutory government remittances receivable	950,034
Accrued funding due from MOHLTC	8,103
Prepaid expenses	431,990
	26,024,137
Rental, security and benefit deposits	199,822
Capital assets	3,783,459
	30,007,418
Liabilities	
Accounts payable and accrued liabilities	22,854,615
Statutory government remittances payable	1,062,939
Non-vesting sick pay obligation	528,194
Due to MOHLTC	2,032,319
Current portion of capital lease obligations	247,352
Current portion of deferred contributions for capital expenditures	1,798,622
	28,524,041
Long-term capital lease obligations	319,592
Long-term deferred contributions for capital expenditures	1,691,979
	30,535,612
Net liabilities assumed	(528,194)

The Net liability resulting from this transaction is recorded in the statement of operations.

14. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 881 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 2018 was $4,502,622 ($415,822 in 2017) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2017. At that time, the plan was fully funded.

15. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,177,164,119 ($2,309,811,966 in 2017) to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**1,619,917,047**	1,574,467,090
Grants to compensate for municipal taxation – public hospitals	**385,575**	426,600
Long-Term care homes	**348,392,647**	339,024,414
Community care access centres	**32,525,467**	228,637,822
Community support services	**42,447,240**	47,829,870
Assisted living services in supportive housing	**26,882,147**	25,200,322
Community health centres	**22,914,143**	21,705,859
Acquired brain injury	**8,780,344**	—
Community mental health addictions program	**74,919,509**	72,519,989
	2,177,164,119	2,309,811,966

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $6,216,698 ($7,656,700 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

Pursuant to note 13, effective May 24, 2017 the South West LHIN assumed the assets, liabilities, rights and obligations of the South West CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC after the date of transfer.

16. Board costs

The following provides the details of Board expenses reported in the statement of operations and changes in net assets:

	2018	2017
	$	$
Board Chair per diem expenses	**47,631**	61,089
Other Board members' per diem expenses	**77,565**	72,767
Other governance and travel	**55,260**	76,323
Balance, end of year	**180,456**	210,179

17. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

18. Accumulated non-vesting sick pay

The accumulated non-vesting sick pay comprises the sick pay benefits that accumulated but do not vest. These adjustments are not funded by the Ontario Ministry of Health and Long-Term Care.

19. 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.

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Local Health Integration Network
Réseau local d'intégration des services de santé