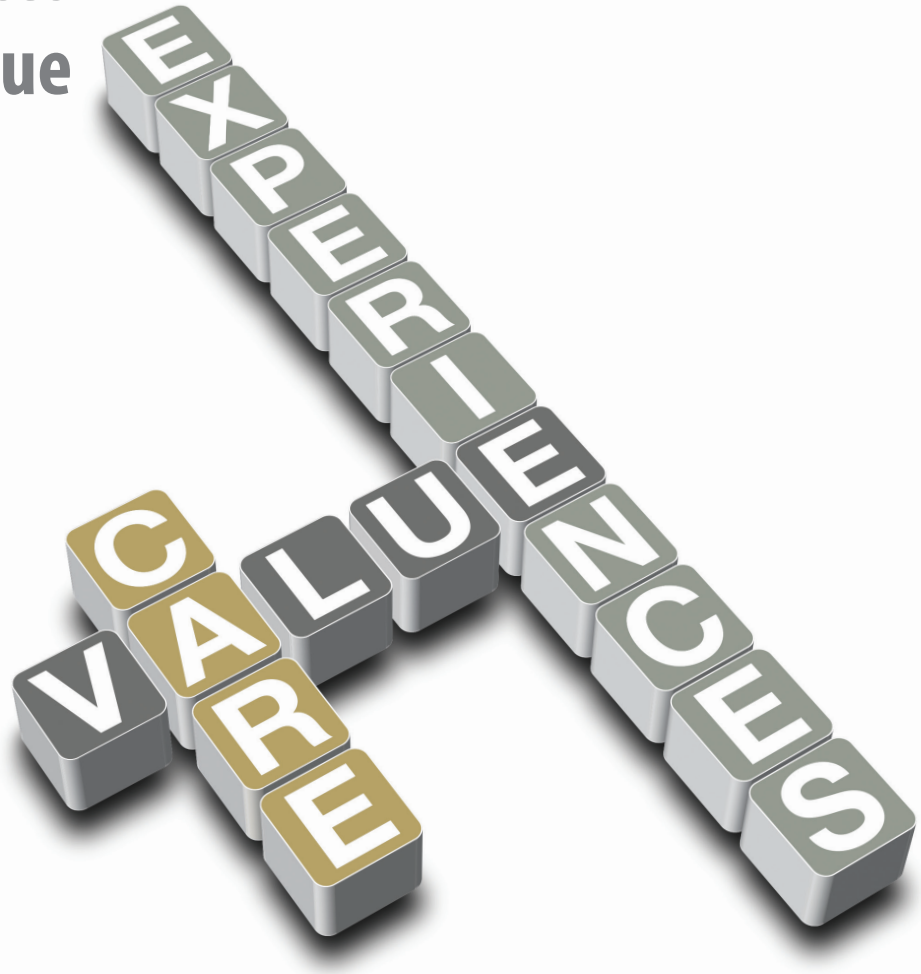
Erie St. Clair **LHIN**
RLISS d'Érié St. Clair
www.eriestclairlhin.on.ca

Better Care
Better Experiences
Better Value



Erie St. Clair Local Health Integration Network

Annual Report 2012-13

For the year ending March 31, 2013

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Table of Contents

ISSN 1911-3269 (Print) Annual report

ISBN 978-1-4606-1921-6 Print

Better care, better experiences, better value
Erie St. Clair Local Health Integration Network
Annual Report 2012-2013

Message from CEO and Acting Board Chair

Even as demands for health care service continue to increase, the Erie St. Clair Local Health Integration Network (ESC LHIN) demonstrates that a focused, evidence-based approach to improving health care throughout the region is working well.

As complex as the planning and implementation of high-quality health care can be, a dedicated team, working on a number of evidence-based initiatives, have one common goal: providing better care, better experiences and better value to the residents of Erie St. Clair.

Good planning starts with a recognition that not everyone uses health care services in the same way or for the same reasons. Better health care starts with understanding the needs of the people we serve. With that knowledge, we can start improving their care and focus our efforts on areas where some of the most life-changing results can be achieved.

Underscoring just how well the ESC LHIN is doing in fulfilling its strategic priorities, consider this: even while people in our region typically face higher rates of health challenges than those in other areas of the province—including diabetes, congestive heart failure, chronic obstructive pulmonary disease and arthritis—our wait times are generally lower.

The system improvements are a testament to the ongoing work of an overall team of 87 health service providers, as well as the ESC LHIN that are helping to guide better health care results. One thing is clear: when we focus on the highest use and highest need areas of health care, as well as ensuring that the needs of all Erie St. Clair residents are met, remarkable things happen.

We invite you to explore how ESC LHIN is making a difference, one provider and one patient at a time.

These are exciting days, and we delight in sharing our progress.

Dr. Mike Hoare
Acting Board Chair

Gary Switzer
Chief Executive Officer

Introduction to the Erie St. Clair LHIN

The ESC LHIN is one of 14 Local Health Integration Networks in Ontario. The LHINs were established in 2006 to manage the planning, integration, performance and funding of the health care system. This responsibility includes services delivered by:

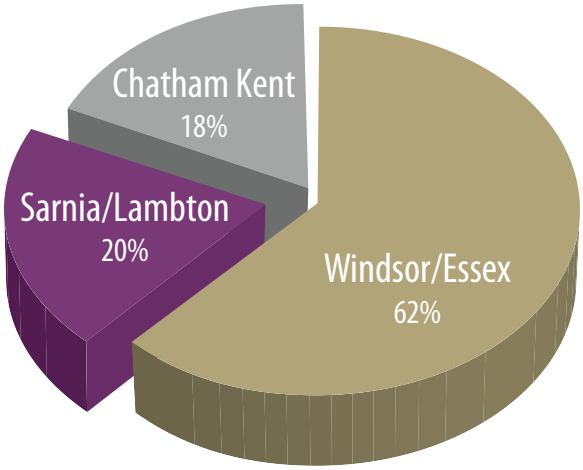
- Hospitals
- Long-term care (LTC) homes
- Community Care Access Centres (CCAC)
- Community support service agencies
- Mental health and addictions agencies
- Community health centres (CHC)

Population Health Profile

The health service needs of Erie St. Clair residents are significantly different from those of Ontario as a whole. Compared to the Ontario average, Erie St. Clair has:

- A higher proportion of seniors
- A lower proportion of individuals in the 25-to-39-year age group
- A significantly higher incidence of overweight and obese individuals
- A slightly higher proportion of individuals with poor lifestyle habits such as smoking, drinking, poor nutrition and inactivity
- Significantly higher rates of chronic conditions such as cardiovascular diseases, cerebrovascular diseases, diabetes, high blood pressure, chronic obstructive pulmonary disease and arthritis
- Significantly higher rates of hospitalization, potential years of life lost, and death due to higher rates of tumours and circulatory disease

Population Breakdown



Erie St. Clair
Immigrants 18.1%
Seniors 15.8%
Francophones 3.3%
Aboriginal peoples 2.4%

ESC LHIN serves approximately 640,000 people in the regions of Chatham-Kent, Sarnia/Lambton and Windsor/Essex. Windsor/Essex comprises 62% of the population; Sarnia/Lambton, 20%; and Chatham Kent, 18%. The population includes immigrants (18.1%), seniors (15.8%), Francophones (3.3%) and Aboriginal peoples (2.4%).

**Note: Not all First Nation communities participated in the 2006 Aboriginal Census. As a result, exact percentages and figures are not available.*

Service Area

The regions of Chatham-Kent, Sarnia/Lambton and Windsor/Essex are independent, each with unique qualities. However, they share many commonalities such as being surrounded on three sides by two of the Great Lakes. The area's urban-rural mix is economically dependent upon the agricultural, petrochemical and automotive industries. Having American neighbours not only influences our local economy and trade, but also impacts the use and perception of health care.

Annual Business Plan

The ESC LHIN Annual Business Plan is the key action document that flows from a three-year strategy for improving health care outcomes—known as the Integrated Health Service Plan.

That strategy highlights several key areas, including:

- Emergency department care
- Alternate level of care
- Chronic disease management
- Mental health and addictions
- Rehabilitation and interventions

The efforts focused on four specific areas within the general category of chronic disease management: Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure, Diabetes and Stroke.

For example, in order to address the 4,570 Emergency Department visits that occurred just a year ago in Chatham-Kent, the ESC LHIN facilitated a comprehensive care path called the Breathe Well COPD Program. This customized program includes an initial assessment with a wide range of options, depending on the needs of the individual. The program launched in Chatham-Kent in February 2013 and will be rolled out region-wide.

Rehabilitation Plan

The ESC LHIN was also successful in developing a strategic plan for rehabilitation services, a key priority area and a critical enabler to lowering the length of hospital stays, as well as improving patient flow and an individual's strength and tolerance for daily living activities.

Recognizing that the current system is fragmented, with both residents and providers struggling to know how to access and best use the system, the new strategic plan focuses on the need for change—driven by growing care demands from an aging population, heightened fiscal concerns and ongoing acute-care pressures.

With the support of the ESC Rehabilitation Advisory Network, the strategic plan will be a framework for helping move people effectively through the health care system, improving their care outcomes and experiences, and ultimately optimizing the abilities, health and quality of life for Erie St. Clair residents.

Initiatives that include improving rehabilitation resources, implementing and adhering to best practices, and supporting self-management will build system capacity to deliver excellent rehabilitation services in hospitals and throughout the community.

Even now, there are signs that leveraging strengths and collaborative approaches lead to better integration of services and a more systemic approach to care delivery.

Telemedicine

With an overarching aim of providing health care closer to home, the ESC LHIN funded 14 full-time equivalent nursing positions, positioned in the communities according to the greatest need.

One example of just how effective the system can be involved a Leamington resident who was not fully aware of all the resources available to help combat an addictions issue. Linked to a Telemedicine nurse, the patient received both an assessment and referral through the Chatham-Kent Health Alliance, all without leaving the community.

When it comes to chronic disease management, Telemedicine also plays an increasingly key role.

In Sarnia/Lambton and Chatham-Kent, both areas where there is a high demand for dermatology specialists, patients can have a snapshot taken of their wound site. The image is then sent to a remotely located specialist who makes a recommendation for treatment.

The Telemedicine model is also being utilized in Chatham-Kent for Children and Youth Services. Through a video conferencing setup, a crisis nurse can link into the Windsor Regional Children's Centre for a near-instant assessment with the appropriate care provider. Knowing if a spot is available and the need exists, the client would then be transported to Windsor for treatment.

Emergency Department Care

No one wakes up in the morning deciding that one of the things they really want to do that day is visit their hospital's Emergency Department. What they do want, if they end up needing urgent care, is to get the care they need as quickly as possible.

Improvement comes when we identify tangible outcomes: how long, for example, it takes to be seen in an Emergency Department and how long, if they are admitted, before patients access a hospital bed.

By putting in place a "pay-for-performance" system that rewards those facilities where extra funding helps further reduce wait times, care continues to get even better. And improvements continue when representatives from various hospitals get together in "network forums" to share what they've learned.

In some Windsor/Essex and Sarnia/Lambton Emergency Departments, physicians assess patient conditions as higher-acute or lower-acute (through a triage process) to improve patient flow.

Still, the ESC LHIN continues to face challenges when it comes to Emergency Department care, including a lack of access to primary care (having no primary-care physician or needing urgent care after hours), the increase in an aging population and higher-than-average rates of chronic conditions (such as arthritis, asthma, diabetes, hypertension, mood disorder and anxiety disorder), all of which tend to increase volumes at an Emergency Department.

While demand is high, a limited supply of Emergency Department physicians continues to put additional pressures on the system, especially when there are few primary care options.

Even for a person needing care, going to the hospital isn't always the best choice. It may be the best choice available to them, but putting in place community resources that will ease the pressure on hospital Emergency Departments, including improving access to nurse practitioners in LTC homes, is another way to improve overall health care.

One notable development is the recruitment of a physician assistant for the Central Lambton Family Health Team in Petrolia, a key role that is helping alleviate pressure on family physicians, especially those who take on regular Emergency Department shifts in addition to caring for a growing roster of patients.

Bluewater Health in Sarnia is already making progress when it comes to reducing the average time visitors spend in the Emergency Department, from the time they first see a triage nurse to when they leave—either to home or to a bed elsewhere in hospital. The hospital last year was able to shave an hour off the average 23 hours a patient spent in the Emergency Department in 2011-12, its baseline year. And plans are in place to keep pushing for even better performance: a 19-hour average target for 2013-14.

Alternate Level of Care

Providing the best care in the best setting for a patient is what Alternate Level of Care is all about.

Reducing the average number of days when a patient receives Alternate Level of Care is a complex challenge, but one that will make a big difference toward the overall quality of the health care system.

In Windsor/Essex, at both Windsor Regional and Hôtel-Dieu Grace hospitals, steps are being taken to improve the processes for discharge planning and policies. And in Sarnia/Lambton, improvements have been made through a combination of adding capacity at Bluewater Health's Complex Continuing Care unit (a more streamlined process for helping patients transition to a LTC facility) and introduction of a Mobile Wellness Team (a March of Dimes partnership) that provides increased Personal Support Worker services to those who need it.

Community Support Services

The "Home First" strategy designed to help people stay in their homes rather than in a hospital, waiting for long-term care or other community options, continued to gain ground, partly the result of additional funding ($4.75 million, a 4% increase) for the Erie St. Clair Community Care Access Centre.

And because getting people from their homes to community-based services is a critical component of the strategy, the ESC LHIN provided vehicle replacement funding of $100,000 to our transportation providers.

But seniors in their homes aren't the only ones in need. Those who care for them often require even a brief rest, and the ESC LHIN provided $270,000 for exactly that purpose. Respite care services in Windsor/Essex and Chatham-Kent are provided by the local Alzheimer Society; in Sarnia/Lambton, two organizations—Lambton Elderly Outreach and the local branch of the Alzheimer Society—share the keenly needed work.

Mental Health and Addictions

The strategic plan for the delivery of mental health services, approved in principle by the ESC LHIN board in December 2012, is now being worked into a multi-year implementation strategy through a task force.

In the meantime, treatment of addictions is underway. Indeed, a number of initiatives identified as priorities by the Ministry of Health and Long-Term Care are proceeding, one being an Emergency Department Diversion Strategy where the Ontario Telemedicine Network and Connex Ontario (which provides help-line services) will provide next-day bookings, easing the pressure on hospital Emergency Departments.

Another program, Behavioural Supports Ontario (BSO), delivers the right care, at the right time and in the right place. BSO enhances the health care services of seniors, their families and caregivers who live and cope with responsive behaviours associated with dementia, mental illness and other neurological conditions. It provides support to those who need it wherever they live, whether at home, in long-term care or elsewhere. As part of this initiative, the ESC LHIN created a Responsive Behaviours Action Plan to redesign the local mental health care system. Among its key elements are the addition of 12 Registered Nurses or Registered Practical Nurses and 18 Personal Support Workers in five LTC lead homes throughout the ESC LHIN.

As in many other situations involving front-line health care, early intervention is often very helpful in the long-term. Such is the case with Windsor's Community Outreach and Support Team, where the Essex County OPP are partnering with Hôtel-Dieu Grace Hospital. Specially trained officers are paired with crisis workers in situations where safety might otherwise be a barrier to care.

A similar program exists in Chatham-Kent where the HELP Mobile Crisis Team, consisting of a plainclothes police officer and a mental health crisis nurse, is ready to intervene when the need arises.

Another example is Caring Connections, a new program created in partnership with Windsor-based House of Sophrosyne, an organization providing addiction recovery programs for women. The ESC LHIN strategy also incorporates the specialized needs of women who face addiction challenges during their pregnancy.

In addition, the ESC LHIN funded an opioid therapist whose services are available through methadone clinics. And in Sarnia-Lambton, development of a withdrawal management service is continuing.

Integration Activities

Integrating health care services throughout the ESC LHIN is an ongoing effort, one that is and will continue to provide better coordinated care, especially in ways that directly touch those who receive the service.

Consider for example the bringing together of some services of three different health care providers in Chatham-Kent. These organizations, the Chatham-Kent Health Alliance, the Community Health Centre and the local office of the Canadian Mental Health Association, are now working actively on a one-site proposal to bring certain activities under one roof. Now approved for funding by the Ministry of Health and Long-Term Care, the new facility is already stimulating a collaborative planning approach with a future integrated service delivery on the near horizon.

While other examples abound, one of the most exciting is in Grand Bend, where two years ago the Community Health Centre was approached

by a hospital outside the ESC LHIN boundary but only a few kilometres away. Today, there are seven joint-management positions at the two facilities, including the CEO.

In Essex and Windsor, following the release of a report by the Windsor Hospitals Study Task Force, the ESC LHIN board supported a new governance model and approved the voluntary integration of both Windsor Regional and Hôtel-Dieu Grace hospitals, notably for the establishment of a new single-site acute care facility, with each of the current hospitals concentrating on their focus of care. For Windsor Regional, that will include all acute care services; Hôtel-Dieu Grace will focus on sub-acute services.

On the transportation front, the Community Support Centre of Essex County is taking the lead in improving and coordinating the activities of five separate agencies, a good first step in improved coordination of transportation services in Windsor/Essex.

Community Engagement

The ESC LHIN took on several key community engagement initiatives last year, each designed to provide a better understanding of the community's health care concerns, as well as making sure the goals of various health care providers are reasonable, achievable and on track.

Among these initiatives were the first steps in developing an Integrated Orthopaedic Capacity Plan (IOCP), including a survey and focus groups, as well as education planning meetings with patients, family caregivers, health care providers, administrators and physicians. The next step in the process of creating the capacity plan is a steering committee that will be established in 2013-14.

The ESC LHIN, preparing for the launch of an early adopter Health Links site, reached out to key stakeholders in an effort to gain support for participation, alignment and standardization of Health Links startups, and to support partnership development.

Other engagement activities with the Primary Care Council, Leadership and Governance Councils, physician engagement in partnership with the Ontario Medical Association, and working with groups to develop standardized care pathways for better treatment of Chronic Obstructive Pulmonary Disease and Congestive Heart Failure.

Francophone Engagement

In a society that values its diversity, the ESC LHIN tries to accommodate Ontarians who are most comfortable speaking French, one of Canada's two official languages.

Flowing from engagement activities facilitated through the French Language Health Planning Entity (FLHPE), a French-speaking nurse has been hired to provide primary health care services to Francophone seniors from the Best Start Hub in the community of Pain Court. This initiative will support Francophone seniors who want to remain in their homes while also helping reduce Emergency Department visits, improve Alternate Level of Care rates and reduce hospital readmissions.

Whether it be long-term care homes for seniors with a French language heritage or other initiatives, access to health care services for those who speak French continues to be a high ESC LHIN priority.

Aboriginal Engagement

Aboriginal communities within the ESC LHIN typically experience higher incidence of chronic health conditions such as diabetes. There are also higher-than-average demands when it comes to areas such as mental health and addictions.

Seeking input from those communities on a formal basis is done through a joint South West (SW) & ESC LHIN Aboriginal Committee that meets quarterly. That group continues to focus on diabetes care and self-management, and the creation of a joint Aboriginal-specific mental health and addiction strategy.

One notable result of efforts to better serve Aboriginal communities is an annual $150,000 investment in a satellite office of the Chatham-Kent Community Health Centre, based on Walpole Island First Nation.

Cultural training for ESC LHIN staff and health service providers is an ongoing activity that supports the engagement process.

eHealth

The ESC LHIN is unique in Ontario for having adopted a hospital-owned shared services organization for all of its eHealth planning and implementation.

That organization, Consolidated Health Information Systems (CHIS), gives health service providers the ability to plan within a regional context while meeting the local needs of its member hospitals.

Taking a regional approach, with most project implementations involving all five hospitals in the ESC LHIN, ensures the continued growth and development of these hospitals as they move forward with regional eHealth initiatives.

With shared-services best practices as a key goal, CHIS has developed new processes and standards that support and demonstrate a commitment to leveraging the joint capacity and expertise of its members.

One example is the adoption of the Medworxx Utilization Management System, which quickly identifies barriers, delays and interruptions to the plan of care. As a result, hospitals experience better patient flow and communication among health care providers.

Another successful eHealth initiative involved agreement among all five hospitals for a system-wide Electronic Health Record and common Hospital Information System. As a first step, the hospitals agreed to adopt a core suite of applications within a single integrated solution.

Finally, as part of the “Connecting South West Ontario” initiative, hospitals in the ESC LHIN will join their neighbouring LHINs in working toward making an individual’s health care information accessible in a timely and secure fashion at any point of care in southwestern Ontario and, ultimately, across the province.

Community Engagement

	Frequency	Format	Content	Outcome
GOVERNANCE	12	Open Board Meetings	Governance of ESC LHIN and other matters.	Open Board meetings are an opportunity for the public to learn about local health care.
	4	ESC LHIN/Health Service Providers (HSP) Leadership Councils	Tri-County Councils with governance representatives from all funded health service providers.	Council improves collaboration among health service provider boards.
	8	Open Mic Board Meetings	Members of the public can address the ESC LHIN Board of Directors in an open mic session.	Relevant issues or questions raised to the ESC LHIN Board and direct engagement with community members.
	8	Board Meeting Highlights	Highlights of information and decisions from open board meeting distributed and posted online.	Increased awareness of Board activities and media coverage of important matters.
PLANNING & INTEGRATION	5	ESC LHIN COPD Working Groups	Provider and stakeholder-based meetings to move the COPD Care Path Model to operational level and begin reporting on overall performance gains and patient outcomes.	Developed a COPD Care Pathway/Integrated Model for Chatham-Kent. To be implemented in Sarnia/Lambton and Windsor/Essex in 2013-14. Established a Crisis Management and After Hours Protocol group.
	1	Congestive Heart Failure (CHF) Windsor	First meeting held in March 2013. Established to advance an integrated CHF care model.	Completed first meeting of the working group, agreed to group goals and objectives, determined group members.
	5	End-of-Life Care Advisory Network	Provider and stakeholder-based networks providing support for system planning, integration, implementation and review.	Aligned regional work with provincial priorities; enhanced access to community-based palliative care; increased capacity; improved integration of palliative care services.
	3	Rehabilitation Implementation Committee		Implemented action items from the Rehabilitation Strategic Plan.
	4	Rehabilitation Steering Commitee		Produced the ESC LHIN Rehabilitation Strategic Plan. Establish the Rehabilitation Implementation Committee.
	4	ESC LHIN Executive Nurse/Clinical Leaders Advisory Council	An opportunity for organizations to share expert advice, leadership and support, enable collaboration, share models of care, and promote best practices with respect to quality and performance improvement.	Shared knowledge, lessons learned, successes and promoted all hospital's hard work.
	7	Mental Health Taskforce	Lead the design and implementation of strategic planning exercises for improving mental health and addictions care in Erie. St. Clair.	Oversaw the initial phases of the strategic plan implementation that included the engagement of consumers, families, mental health care providers and clinical experts.
	5	Primary Care Council	Group focused on Chatham-Kent and COPD.	COPD Pathway developed and implemented in Chatham-Kent, along with a hospital-discharge process to ensure patients are followed up and connected with a primary care provider. This initiative is being expanded into Sarnia/Lambton and then to follow in Windsor/Essex.

Community Engagement (continued)

	Frequency	Format	Content	Outcome
PLANNING & INTEGRATION (continued)	12	IOCP - Administrative meetings, focus groups	Ministry mandate that all LHINs complete an IOCP.	IOCP submitted to the MOHLTC. Formed an ESC LHIN Orthopaedic Steering Committee to work through a regional plan to improve orthopaedic services. Engagement with hospital staff, physicians, administration, out-patient rehab, patients/ caregivers and other key stakeholders to gain insight.
	4	Health Links Initiative	Rolling out Health Links in ESC LHIN.	First Health Link Readiness Assessment was approved for C-K City Centre Model. Business case development to follow. Engaged with the Rapids Family Health Team and Lambton CHC Physicians Group. Engagement with other health service providers for education and discussions on next steps.
	2	Residents First and Behavioural Supports Ontario Forum - joint Health Quality Ontario, ESC LHIN and SW LHIN	Training sessions provided LTC homes with Quality Improvement tools and ways to enhance quality of life for residents. BSO training was also included in the three-day forum.	Since launching these training sessions in December 2010, significant improvements have been seen in the quality of care in LTC homes. Participants also took away best practices in regards to BSO.
PHYSICIANS	1	Ontario Medical Association/ LHIN Engagement Sessions	Provide physicians updates on local health care initiatives and receive feedback.	Local relationships built with physicians and information exchanged to improve access to care.
FRANCOPHONE	4	ESC/SW FLHPE Liaison Committee	To provide a forum for collaboration and ongoing dialogue among the FLHPE, the SW LHIN and the ESC LHIN in order to improve health outcomes for the Francophone population in our regions.	Partners are working collaboratively to improve access to and accessibility of services in French for priority populations, including people with mental health and addictions issues, people living with a chronic disease, in particular diabetes, and seniors and adults with complex needs.
	1	Let's Talk Food Focus Group	A research initiative aimed at understanding the food system in Chatham-Kent and how Francophone residents perceive and value food.	Results created an opportunity to develop an action plan.
ABORIGINAL	7	Local Aboriginal Health Planning Committee	A committee of local aboriginal health care professionals, stakeholders and ESC LHIN staff.	Provided input on engagement, diabetes, mental health and addictions, primary care, and cultural competency and safety.
	1	Joint ESC and SW LHIN Aboriginal Health Symposium	Inclusive health concepts and innovative partnering.	Networking between key HSPs; best-practice, cultural-competency and safety education.
	1	Joint ESC and SW LHIN Aboriginal Mental Health & Addictions Strategy session	One-day planning session between ESC and SW LHIN with Aboriginal community members.	Reviewed, provided content and validated joint LHIN Aboriginal Mental Health & Addictions strategy.
	1	Joint ESC and SW LHIN urban Aboriginal and Métis partners session	Information sharing and planning for urban Aboriginal and Métis communities.	Identified urban Aboriginal and Métis communities' health issues.

Ministry-LHIN Performance Agreement

WHAT IS THE MINISTRY-LHIN PERFORMANCE AGREEMENT (MLPA)?

The MLPA sets out the obligations of the Ministry of Health and Long-Term Care (MOHLTC) and the ESC LHIN to fulfill its mandate to plan, integrate and fund local health care services. Developing and updating this accountability agreement is a collaborative process that defines the relationship between the MOHLTC and the ESC LHIN and helps us strengthen local health care.

REPORT ON MLPA PERFORMANCE INDICATORS CHART

PI No.	Performance Indicator	LHIN 2012-13 Starting Point	LHIN 2012-13 Performance Target	Most Recent Quarter 2012-13 LHIN Performance	FY 2012-13 LHIN Annual Result
The ESC LHIN continues to be a high performer in Emergency Department (ED) wait times, surgical wait times, diagnostic wait times and provider of home care services. ALC rates in Windsor/Essex continue to be high; however, substantial efforts were made in community support services to mitigate hospital pressures. In the future, we expect our integrated strategies to produce significant improvements in reducing emergency re-visits for mental health issues and re-admissions for select clinical conditions.					
Emergency Room/Alternate Level of Care					
The ESC LHIN has made substantial gains for ED length of stay for non-admitted complex clients and for non-admitted un-complicated clients. Improvements/ efficiencies made through Pay-for-Results initiatives, including physician triage, flow teams and LEAN process improvements. The ESC LHIN has higher demand for long-term care than current capacity. A delay in the opening of LTC beds in Windsor has required the ESC LHIN to make alternative investments in community support services, interim LTC beds, convalescent care beds, complex continuing care beds and assisted living services. The ESC LHIN, in partnership with the Erie St. Clair CCAC, has made significant investments in our Home First strategy, making every effort to support seniors to go home safely after a hospital stay, rather than seeing long-term care as the only option. Assess and Restore programs at local area hospitals, along with targeted CCAC and assisted living services, have improved ALC performance and decreased hospital length of stay. End-of-Life Outreach teams have supported people in their wish to die at home, in the comfort of their own surroundings.					
1	Percentage of ALC Days	13.62%	12%	18.5%	15.3%
2	90th Percentile ER Length of Stay for Admitted Patients	24.15	17	25.08	24.18
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.22	6.5	6.9	6.92
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.2	4	3.77	3.85
Surgical Wait Times					
ESC LHIN continues to be in the top quartile for best wait times for cancer surgeries and cataract surgeries.					
5	90th Percentile Wait Times for Cancer Surgery (in days)	40	45	51	44
6	90th Percentile Wait Times for Cardiac By-Pass Procedures (in days)	NA	NA	NA	NA
7	90th Percentile Wait Times for Cataract Surgery (in days)	62	56	86	77
8	90th Percentile Wait Times for Hip Replacement (in days)	155	121	183	182
9	90th Percentile Wait Times for Knee Replacement (in days)	161	130	220	190
Diagnostic Wait Times					
ESC LHIN is one of the top performers for diagnostic MRI & CT scan wait times due to LEAN process improvement initiatives.					
10	90th Percentile Wait Times for Diagnostic MRI Scan (in days)	50	28	27	33
11	90th Percentile Wait Times for Diagnostic CT Scan (in days)	25	26	13	17

PI No.	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter 2012/13 LHIN Performance	FY 2012/13 LHIN Annual Result
Excellent Care for All/Quality					
The ESC LHIN has high chronicity in its residents and yet re-admission rates are better than average. Substantial efforts are being made to implement best practices and track opportunities across sectors for chronic obstructive pulmonary disease, chronic heart failure, stroke and diabetes. Improving transitions to care and enhanced case management are two enablers of this strategy. Improving access to primary care has also improved re-admission rates—as of March 31, 2013, the ESC LHIN's Health Care Connect program had linked 13,325 patients with a primary care provider.					
12	Readmission within 30 Days for Selected CMGs**	14.66%	12.8%	14.81%	15.56%
Mental Health and Substance Abuse					
The ESC LHIN has launched the Adult Mental Health Strategic Plan to improve this indicator and outcomes for residents. An example is our Inner City Model in Windsor where alternatives to the ED are being created for this vulnerable population. The BSO initiative is investing in the capacity for LTC homes to deal with responsive behaviours and, as shown below, has produced promising preliminary successes.					
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	18.73%	16.9%	19.28%	19.32%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	22.7%	17.2%	17.52%	23.22%
Access to Community Care					
ESC LHIN's time to service for home care is one of the best in the province. Given current ALC rates, the CCAC has ensured timely service for home care in an effort to keep people out of hospital and at home where they are most comfortable.					
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) (in days)*	21	19	17	17

**FY 2012-13 is based on most recent four quarters of data (Q4 2011-12 to Q3 2012-13)*
***FY 2012-13 is based on most recent four quarters of data (Q3 2011-12 to Q2 2012-13)*

Operational Performance

The ESC LHIN has once again finished the year with a balanced budget, details of which are in our statement of financial activities. We provide funding for 87 health service providers, including hospitals, community service agencies and LTC homes.

A new Chronic Disease Management (CDM) team was formed during fiscal 2012-13 as a result of the assumption of the previous Diabetes Regional Coordination Centre (DRCC). The CDM team will continue to focus on diabetes and will be responsible for the previous DRCC deliverables.

Four individuals are serving as professional leads for the ESC LHIN:

- Dr. Eli Malus, Critical Care Lead
- Dr. David Ng, Emergency Department Lead
- Dr. Martin Lees, Primary Care Lead
- Paul Audet, eHealth Lead

A number of specific projects received additional funding from the Ministry of Health and Long-Term Care, including:

- Continued support of the French Language Health Planning Entity
- Funding for Aboriginal engagement
- Continued funding support for the Critical Care, Primary Care and Emergency Department Leads

Board of Directors

Director	Position	Location	Tenure
 Dave Cooke	Director / Chair	Windsor	February 7/11 – February 6/14 March 2/11 – February 6/14 (OIC as Board Chair) January 23/13 – (OIC revoked - resignation December 31/12)
 Lynn McGeachy Schultz	Director	Chatham-Kent	January 10/08 – January 9/11 January 9/11 – January 10/14 (2nd Appointment)
 Merilyn (Lyn) Allison	Director	Chatham-Kent	January 13/10 – January 12/13
 Mike Lowther	Director	Chatham-Kent	October 6/10 – October 5/13
 Patrick (Pat) O'Malley	Director	Bright's Grove	October 27/10 – October 26/13 January 9/13 – (OIC revoked - resignation September 30/12)
 Barbara Bjarneson	Director	Windsor	February 9/11 – February 8/14
 Robert (Bob) Bailey	Director	Amherstburg	April 18/11 – April 17/14
 Michael (Mike) Hoare	Director / Vice Chair *Acting Board Chair as of January 1/13*	Grand Bend	May 17/11 – May 16/14 March 22/12 – May 16/14 (OIC as Board Vice Chair)
 Joseph Bisnaire	Director	Windsor	June 2/11 – June 1/14

Management Responsibility Report

The management of the Erie St. Clair Local Health Integration Network is responsible for preparing the accompanying financial statements in conformity with generally accepted accounting principles. In preparing these financial statements, management selects appropriate accounting policies and uses its judgment and best estimates to report events and transactions as they occur. Management has determined such amounts on a reasonable basis in order to ensure the financial statements are presented fairly, in all material respects. Financial data included throughout this Annual Report is prepared on a basis consistent with that of the financial statements.

The ESC LHIN maintains a system of internal accounting controls designed to provide reasonable assurance, at a reasonable cost, that assets are safeguarded and that transactions are executed and recorded in accordance with the ESC LHIN's policies for doing business.

The Board of Directors is responsible for ensuring that management fulfills its responsibility for financial reporting and internal control, and is ultimately responsible for reviewing and approving the financial statements. The Board carries out this responsibility principally through its Finance and Audit Committee. The Committee meets approximately four times annually to review audited and unaudited financial information. Deloitte & Touche LLP has full and free access to the Finance and Audit Committee.

Management acknowledges its responsibility to provide financial information that is representative of the ESC LHIN's operations, is consistent and reliable, and is relevant for the informed evaluation of the ESC LHIN's activities.

Gary Switzer
Chief Executive Officer

Mr. Matthew Little, CMA
Chief Financial Officer

May 13, 2013

Financial statements of

Erie St. Clair Local Health Integration Network

March 31, 2013

Erie St. Clair Local Health Integration Network

March 31, 2013

Table of contents

Deloitte LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
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
Erie St. Clair Local Health Integration Network

We have audited the accompanying financial statements of Erie St. Clair Local Health Integration Network, which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

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

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 28, 2013

Erie St. Clair Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**624,974**	493,712
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 7)	**28,500**	1,463,700
Accounts receivable	**53,316**	218,198
Due from the LHIN Shared Services Office (Note 3)	**-**	2,729
	706,790	2,178,339
Liabilities		
Accounts payable and accrued liabilities	**672,469**	701,947
Due to MOHLTC (Note 10b)	**6,305**	25,205
Due to Health Service Providers ("HSPs") (Note 7)	**28,500**	1,463,700
Due to the LHIN Shared Services Office (Note 3)	**3,398**	-
Deferred capital contributions (Note 4)	**336,404**	33,489
	1,047,076	2,224,341
Net debt	**(340,286)**	(46,002)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	**3,882**	12,513
Tangible capital assets (Note 5)	**336,404**	33,489
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

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

Erie St. Clair Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	2013		2012
	Budget (Note 6)	**Actual**	Actual
	$	**$**	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,050,023,827**	**1,101,919,942**	1,063,512,111
Operations of LHIN	**4,558,900**	**4,231,879**	4,565,173
Emergency Department Lead (Note 9a)	**75,000**	**75,000**	75,000
Critical Care Lead (Note 9b)	**75,000**	**75,000**	75,000
Behavioural Supports Ontario Fund (Note 9c)	**-**	**-**	57,000
Primary Care Lead (Note 9d)	**31,200**	**75,000**	43,750
French Language Health Planning Entities Fund (Note 9e)	**425,500**	**425,533**	425,533
Enabling Technologies (Note 9f)	**510,000**	**784,000**	700,700
Amortization of deferred capital contributions (Note 4)	**25,000**	**72,062**	34,001
	1,055,724,427	**1,107,658,416**	1,069,488,268
Funding repayable to the MOHLTC (Note 10)	**-**	**(69,945)**	(53,379)
	1,055,724,427	**1,107,588,471**	1,069,434,889
Expenses			
Transfer payments to HSPs (Note 7)	**1,050,023,827**	**1,101,919,942**	1,063,512,111
General and administrative (Note 8)	**4,540,100**	**4,303,941**	4,589,726
Emergency Department Lead (Note 9a)	**75,000**	**75,000**	75,000
Critical Care Lead (Note 9b)	**75,000**	**68,695**	71,825
Behavioural Supports Ontario Fund (Note 9c)	**-**	**-**	47,494
Primary Care Lead (Note 9d)	**75,000**	**75,000**	12,500
French Language Health Planning Entities Fund (Note 9e)	**425,500**	**425,533**	425,533
Enabling Technologies (Note 9f)	**510,000**	**720,360**	700,700
	1,055,724,427	**1,107,588,471**	1,069,434,889
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

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

Erie St. Clair Local Health Integration Network

Statement of change in net debt

year ended March 31, 2013

	2013		2012
	Budget (Note 6)	Actual	Actual
	$	$	$
Annual surplus	-	-	-
Prepaid expenses incurred	-	(3,882)	(12,513)
Prepaid expenses expired	-	12,513	-
Acquisition of tangible capital assets	-	(374,977)	-
Amortization of tangible capital assets	25,000	72,062	34,001
Decrease in net debt	25,000	(294,284)	21,488
Net debt, beginning of year	(46,002)	(46,002)	(67,490)
Net debt, end of year	(21,002)	(340,286)	(46,002)

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

Erie St. Clair Local Health Integration Network

Statement of cash flows

year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	72,062	34,001
Amortization of deferred capital contributions (Note 4)	(72,062)	(34,001)
Changes in non-cash operating items		
Decrease in due from MOHLTC	1,435,200	2,867,553
Decrease (increase) in accounts receivable	164,882	(159,571)
Decrease in due from LHIN Shared Services Office	2,729	3,770
Decrease in accounts payable and accrued liabilities	(29,478)	(152,550)
Increase (decrease) in due to MOHLTC	(18,900)	(30,550)
(Increase) in due to HSPs	(1,435,200)	(2,867,553)
Increase (decrease) in due to LHIN Shared Services Office	3,398	(4,386)
Decrease (increase) in prepaid expenses	8,631	(12,513)
	131,262	(355,800)
Capital transactions		
Acquisition of tangible capital assets	(374,977)	-
Financing transactions		
Increase in deferred capital contributions (Note 4)	374,977	-
Net increase (decrease) in cash	131,262	(355,800)
Cash, beginning of year	493,712	849,512
Cash, end of year	624,974	493,712

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

1. Description of business

The Erie St. Clair Local Health Integration Network was incorporated by Letters Patent on June 2, 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 Erie St. Clair Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

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

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

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Municipalities of Essex, Lambton and Chatham-Kent. The LHIN enters into service accountability agreements with service providers.

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

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

The LHIN financial statements do not include any MOHLTC managed programs.

2. Significant accounting policies

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

Basis of accounting

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

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

2. Significant accounting policies (continued)

Government transfer payments

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

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

Deferred capital contributions

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

Capital assets

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

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

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

Office equipment	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

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

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

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

Adoption of new accounting standards

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

3. Related party transactions

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

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

4. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	**33,489**	67,490
Capital contributions received during the year	**374,977**	-
Amortization for the year	**(72,062)**	(34,001)
Balance, end of year	**336,404**	33,489

5. Tangible capital assets

			2013	2012
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office equipment	**619,692**	**478,665**	**141,027**	-
Computer equipment	**209,648**	**142,282**	**67,366**	19,137
Leasehold improvements	**723,110**	**595,099**	**128,011**	14,352
	1,552,450	**1,216,046**	**336,404**	33,489

6. Budget figures

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

The final HSP funding budget of $1,101,919,942 is derived as follows:

	$
Initial budget	1,050,023,827
Adjustment due to announcements made during the year	51,896,115
Final HSP funding budget	1,101,919,942

The final LHIN budget, excluding the HSP funding, of $5,666,412 is derived as follows:

	$
Initial budget	5,675,600
Change in funding from the MOHLTC during the year	340,461
Amount treated as capital contributions made during the year	(349,649)
Final LHIN operations budget	5,666,412

7. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,101,919,942 (2012 - $1,063,512,111) to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2013 as follows:

	2013	2012
	$	$
Operation of hospitals	**697,996,636**	672,534,639
Grants to compensate for municipal taxation - public hospitals	**167,625**	167,625
Long-term care homes	**184,146,983**	179,903,526
Community care access centres	**122,251,743**	121,378,126
Community support services	**18,352,826**	17,267,639
Assisted living services in supportive housing	**8,326,183**	6,887,151
Community health centres	**25,903,474**	24,056,526
Community mental health addictions programs	**10,921,946**	10,079,591
Community mental health programs	**33,852,526**	31,237,288
	1,101,919,942	1,063,512,111

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2013, an amount of $28,500 (2012 - $1,463,700) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of financial activities and are included in the table above.

8. General and administrative expenses

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

	2013	2012
	$	$
Salaries and benefits	**2,950,868**	3,312,882
Occupancy	**286,711**	257,874
Amortization	**72,062**	34,001
Shared services	**393,210**	365,025
Public relations	**62,775**	60,512
Consulting services	**25,144**	148,407
Supplies	**29,334**	35,693
Board Chair per diems	**22,600**	22,400
Board member per diems	**37,375**	37,900
Board member expenses	**58,762**	19,142
Mail, courier and telecommunications	**68,578**	59,719
LHIN collaborative	**47,500**	28,219
Other	**249,022**	207,952
	4,303,941	4,589,726

Diabetes Regional Coordination Centres

The LHIN received funding of $233,355, which is included in the operating expenses of the LHIN, related to the assumption of work plan deliverables for diabetes and chronic disease management planning effective February 1, 2013. Expenses incurred of $233,355 are included in general and administrative expenses in the statement of financial activities and is made up as follows:

	2013	2012
	$	$
Salaries & Benefits	**52,400**	-
Operating expenses	**54,400**	-
One-time expenses	**126,555**	-
	233,355	-

9. Programs

a) Emergency Department Lead

The MOHLTC provided the LHIN with $75,000 (2012 - $75,000) to hire a LHIN representative for emergency department planning. The representative incurred professional advisory services expenses totaling $75,000 (2012 - $75,000).

b) Critical Care Lead

The MOHLTC provided the LHIN with $75,000 (2012 - $75,000) to hire a LHIN representative for critical care planning. The representative incurred professional advisory services expenses totaling $68,695 (2012 - $71,825). Unused funding of $6,305 is repayable to the Ministry of Health and Long-Term Care.

c) Behavioural Supports Ontario Fund

The MOHLTC provided the LHIN with $Nil (2012 - $57,000) to develop programs specifically attributed to behavioural supports as guided by the Ministry.

9. Programs (continued)

d) Primary Care Lead

The MOHLTC provided the LHIN with $75,000 (2012 - $43,750) to hire a LHIN representative for primary care planning. The representative incurred professional advisory services expenses totaling $75,000 (2012 - $12,500).

e) French Language Health Planning Entity

The MOHLTC provided the LHIN with $425,533 (2012 - $425,533) to establish and fund a new entity on behalf of the Southwest and Erie St. Clair LHINs. All funds were expended.

f) Enabling Technologies

The MOHLTC provided $784,000 (2012 - $700,700) to the LHIN. The LHIN had a contract and retained services of the Consolidated Health Information Services ("CHIS") during 2013 and 2012. Unused funding of $63,640 was repaid to the Ministry of Health and Long-Term Care during the fiscal year.

10. Funding repayable to the MOHLTC

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

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

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

			2013	2012
	Funding received	**Eligible expenses**	**Funding excess**	Funding excess
	$	**$**	**$**	$
Transfer payments to HSPs	**-**	**-**	**-**	-
LHIN operations	**4,231,879**	**4,231,879**	**-**	9,448
French Language Health Planning	**425,533**	**425,533**	**-**	-
BSO Fund	**-**	**-**	**-**	9,506
Critical Care Lead Fund	**75,000**	**68,695**	**6,305**	3,175
Primary Care Lead Fund	**75,000**	**75,000**	**-**	31,250
Emergency Department Lead	**75,000**	**75,000**	**-**	-
Enabling Technologies	**784,000**	**720,360**	**63,640**	-
	5,666,412	**5,596,467**	**69,945**	53,379

b) The continuity of the amount due to the MOHLTC at March 31 is as follows:

	2013	2012
	$	$
Due to MOHTLC, beginning of year	**25,205**	55,755
Funding repayable to the MOHLTC related to current year activities (Note 10a)	**69,945**	53,379
Amounts repaid to MOHLTC during the year	**(88,845)**	(83,929)
Due to MOHLTC, end of year	**6,305**	25,205

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 25 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $212,520 (2012 - $216,662) for current service costs and is included as an expense in the Statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2012. At that time, the plan was fully funded.

12. 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 favour 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*.

13. Commitments

The LHIN has funding commitments to health service providers associated with accountability agreements. The LHIN had the following funding commitments as of March 31, 2013.

	$
2014	196,096,645

The LHIN also has commitments under various operating leases related to building and equipment, which will be renewed in accordance with standard lease terms. Minimum lease payments due in each of the next five years are as follows:

	$
2014	196,091
2015	180,794
2016	99,859
2017	-
2018	-

Erie St. Clair **LHIN**
RLISS d'Érié St. Clair
www.eriestclairlhin.on.ca

180 Riverview Drive
Chatham ON N7M 5Z8
519-351-5677
1-866-231-5446
www.eriestclairlhin.on.ca

ISSN 1911-3269 (Print) Annual report.
Erie St. Clair Local Health Integration Network.

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair