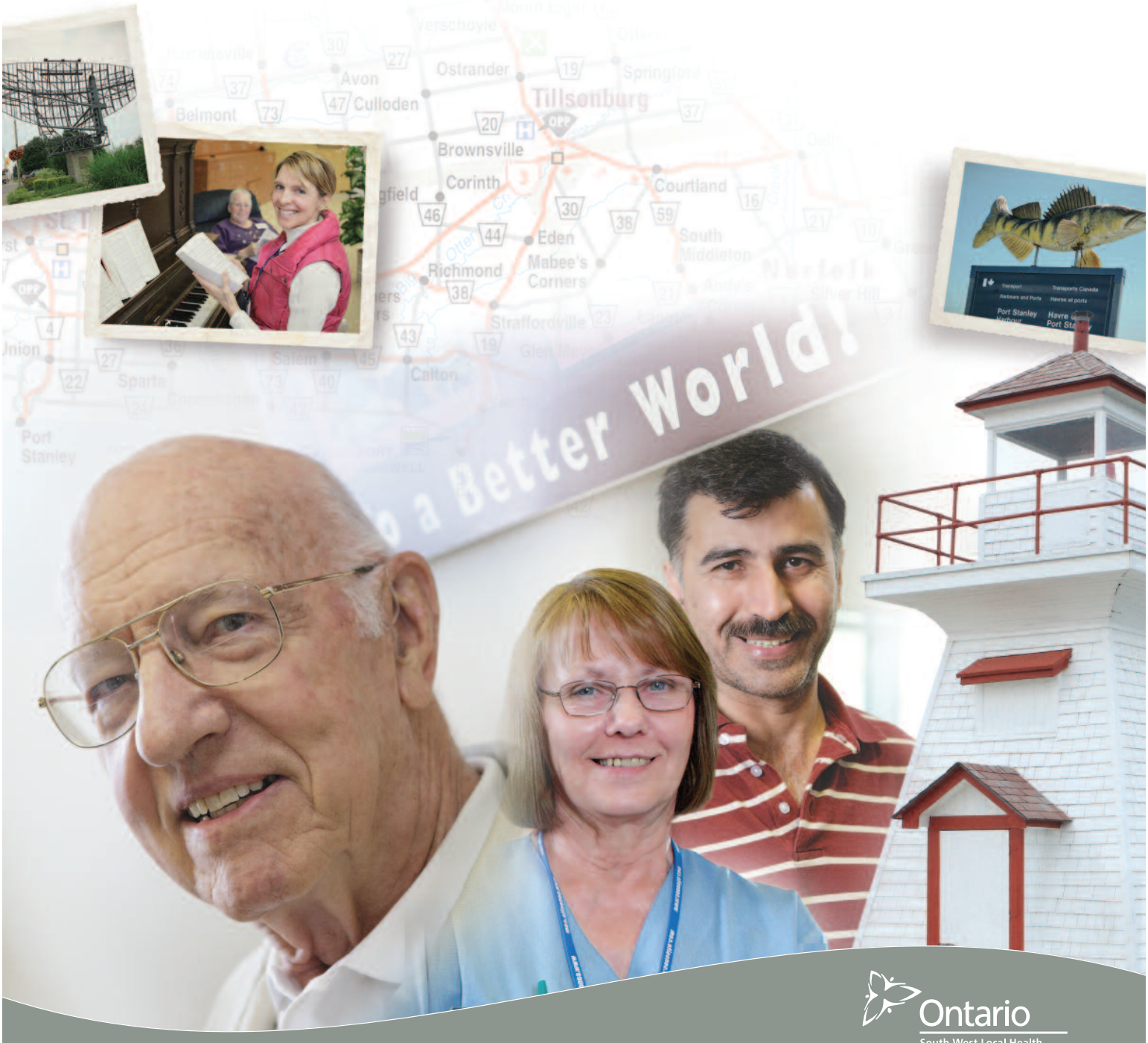
South West **LHIN**

A Healthier Tomorrow

Annual Report 2008-2009



Ontario

South West Local Health Integration Network

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Joint Message from the Board Chair and Chief Executive Officer

The LHINs hit the ground running a little over three years ago and have not slowed since.

Our inspiration comes from our residents who need and deserve a quality health care system and from the providers who are so passionate about their work and give willingly and generously of their time to make sure we are making well informed decisions.

The geography of our LHIN is very large, and we recognize that we must respond to the needs of all our residents whether they are in our rural communities or larger urban centres. Our Board meets regularly in communities across the LHIN to ensure it stays connected with all of our communities. In 2008-09, the Board held meetings in Kincardine, Clinton, Woodstock, Port Rowan, Tavistock and Wingham. Only by getting to know our communities and understanding their concerns are we able to deliver a transformed health care system that is fair, equitable, and sustainable.

In the past year, we have started seeing positive changes that are having a real impact on the day-to-day lives of the residents of our LHIN. Under the provincial Aging at Home Strategy, we have been able to fund programs that help seniors when they are discharged from hospital, or those who need extra help in their home, or perhaps just a ride to get to a medical appointment. We know that our hospitals face great challenges because some of their beds are taken up by people who no longer need hospital services, but are not quite able to go home because they need an alternate level of care, or because they have no one to help them at home. So the LHIN funded a transitional care bed unit at Parkwood Hospital to ease the discharge of patients out of hospital. The success of this and many other programs has made a real difference in people's lives, and in the health care system.

This year we formally adopted a South West LHIN mission and vision and identified the values that we weave into our day to day work (see page 4 of this Annual Report). The mission and vision are used as our reality check. If a particular activity or program cannot be explained in the context of our mission and vision, then we have to seriously question why we would do it at all.

The upcoming year will be exciting. We will be refreshing our Integrated Health Service Plan (IHSP) – it is in this document that we establish the priorities that will guide us for the next three years. The priorities of our IHSP will be informed by the work undertaken in our Health System Design initiative, or "Blueprint" project as it is commonly called. The Blueprint project will take a system level view of health care in the South West LHIN to determine the right services, in the right place, at the right time, by the right provider. As part of the Blueprint, we will be going out to our health service providers, and to the communities of our LHIN to make sure that when it is developed, it is done with the confidence that we have heard the input, issues and concerns from the people we are here to serve. We are planning 17 community engagement sessions across our LHIN in July and September so that residents can have their say. We are also holding symposiums with health care providers, those who are on the front lines and understand the daily challenges faced by our health care system.

There is much work left to be done, but with the input and support of our communities and our dedicated health care providers, we can take another step closer to achieving our vision of 'a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren'.

This report looks back at what we have accomplished in the last year, and we look forward to the work that is already well underway for the upcoming year. On a final note, we would like to acknowledge the passion and dedication of our Board and staff and their tremendous contribution to our success in 2008-09.

Norm Gamble
Board Chair

Michael Barrett
Chief Executive Officer

Board of Directors

Norm Gamble, Chair
June 1, 2008 to May 31, 2011
(second term)

Janet McEwen, Vice-Chair
June 11, 2008 to June 10, 2011
(second term)

Kerry Blagrave, Secretary
June 2, 2008 to June 1, 2011
(second term)

Anne Lake
February 5, 2007 to February 4, 2010
(second term)

John Van Bastelaar
January 5, 2008 to January 4, 2011
(second term)

Dr. Murray Bryant
May 17, 2008 to May 16, 2011
(second term)

Barrie Evans
June 17 2007 to June 16, 2010
(second term)

Ferne Woolcott
June 17, 2007 to June 16, 2010
(second term)

Linda Stevenson
May 16, 2007 to May 15, 2009

Working together... for *A Healthier Tomorrow.*

Our Vision

A health care system that helps people stay healthy, delivers good care to them when they are sick, and will be there for their children and their grandchildren.

Our Mission

The South West LHIN brings people and organizations together to build a health care system that balances access, quality and sustainability.

Our Values

COMPASSION – We appreciate that our actions have real implications for people and communities.

COURAGE – We will make difficult decisions and challenge the status quo when required.

EVIDENCE-INFORMED – Our decisions will be guided by the best available information.

INNOVATION – We will encourage and support new thinking and the sharing of new knowledge.

INTEGRITY – We will act in a fair, consistent and unbiased manner.

TRUST AND RESPECT – We believe in mutual trust and respect.

Board member biographies are available on the South West LHIN website at www.southwestlhin.on.ca

Welcome to the South West Local Health Integration Network (LHIN)

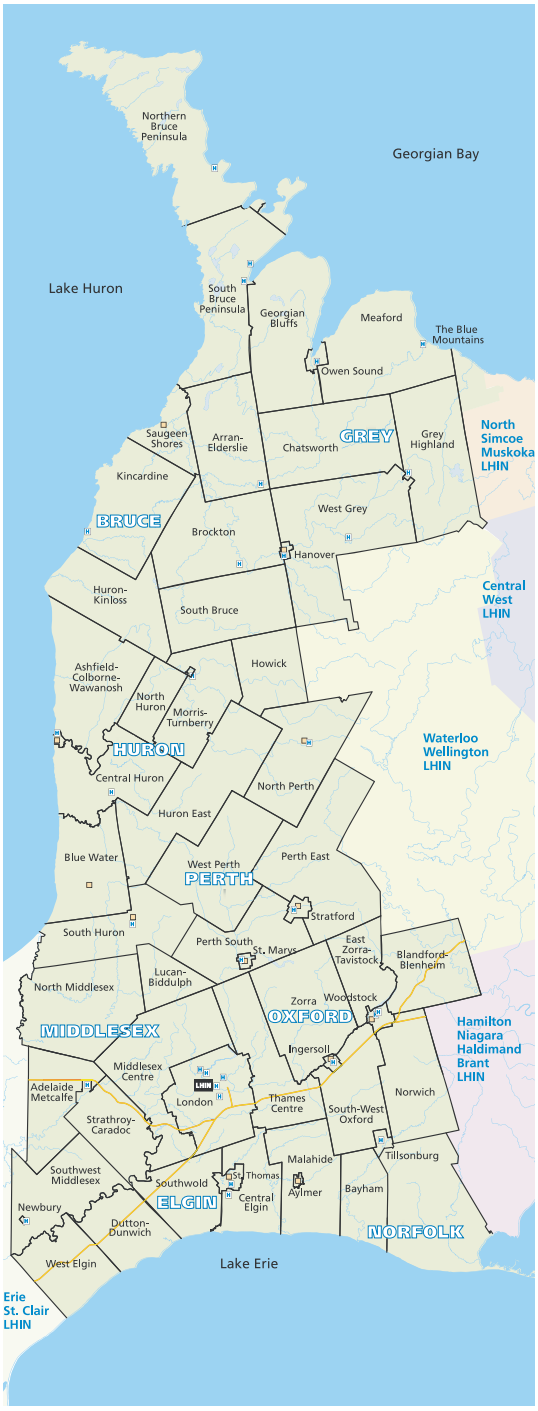
The South West LHIN is a crown agency responsible for planning, integrating and funding more than 150 health service providers across a geography that stretches from Lake Erie in the south to Georgian Bay in the north. From limestone cliffs and sandy beaches to forests, farmland and city streets, the South West is a diverse region. The LHIN is a young organization, guided by a Board of knowledgeable and committed community members.

Our name says it all. The South West LHIN's goal is to ensure that local people help shape their own health system, based on their knowledge of community needs. We believe quality integrated care will be achieved through partnerships to ensure service quality enhancements, optimal resource use, minimal duplication and increased coordination. We are a network of organizations and individuals linked together by a common goal – a system that works.

We all know that our health system faces challenges – an aging population, wait times, shortages in some health professions, limited resources, and more. We also know that there is untapped potential in our communities and among the people within the system.

In 2006, the South West LHIN committed itself to four integration priorities: strengthening and improving primary health care, preventing and managing chronic illness, building linkages across the health care continuum, and accessing the right services in the right place at the right time by the right provider. In addition, two enabling priorities were identified: Health Human Resources, and eHealth. Each initiative we undertake is aligned with these priorities. We are now in the process of identifying the priorities for our next three-year plan that will guide our activities for the period 2010-2013.

The South West LHIN is proud of our vital place in communities from Glencoe, Ballymote and Cape Croker to Vienna, Newbury and Port Stanley. In partnership with the nearly one million people in our region, we are working to make care better for all.



Who are the People of the South West LHIN?

Like the land they inhabit, the people of the South West LHIN are diverse. As we plan for a health system that meets the needs of all people, we keep these facts in mind:

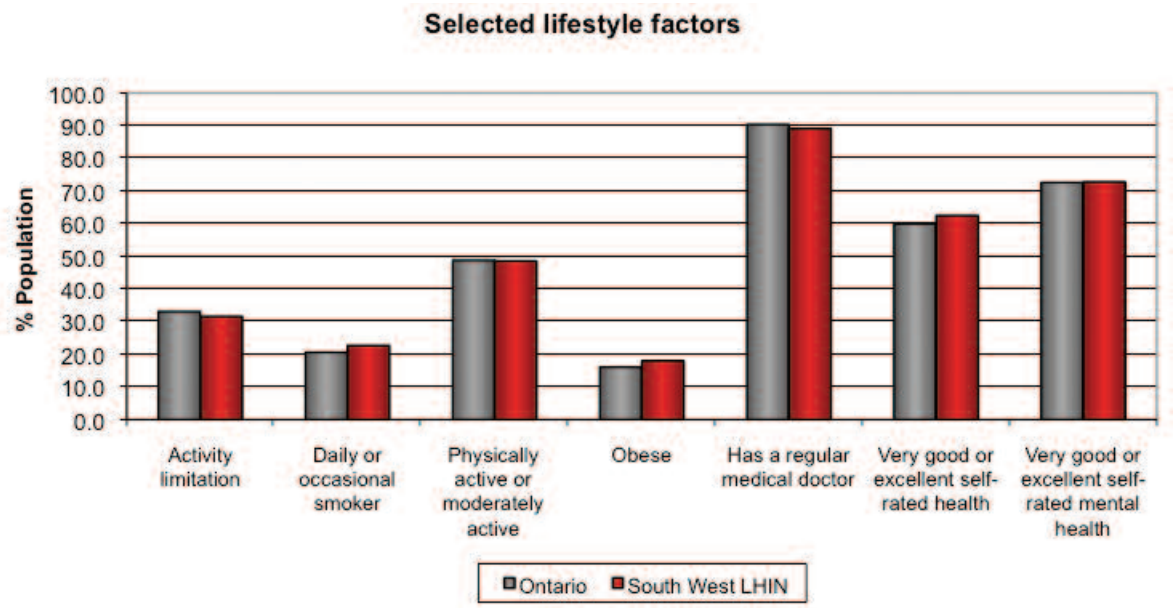
- Of the approximately 900,000 people in the region, most (85%) speak English as their mother tongue. However, French is the mother tongue for more than 11,000 (1.3%). Mother tongue for an additional 7,300 (0.8%) is neither of the official languages.
- 1.4% of people in the South West identify themselves as Aboriginal. This compares with 2% for the province as a whole and represents a significant population with unique health challenges. There are five reserves in the South West with a population of close to 4,500 people. An additional 7,200 Aboriginals live off reserve.*
- The population in the South West LHIN is projected to grow to over 1.1 million by 2017.
- The percentage of the population ages 65+ is 15.2% in the South West LHIN. This compares with 13.6% for the province as a whole. The senior population is expected to grow rapidly in the coming years. **

Population Health Profile for Residents of the South West LHIN***

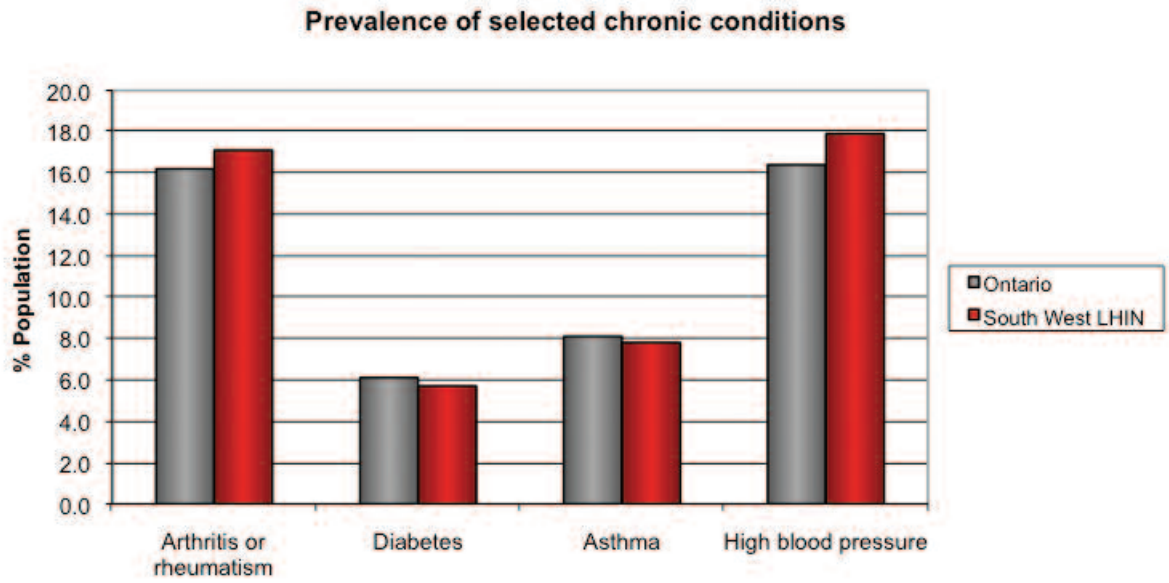
When developing a health care system for the future, it's important to understand today's needs, and the lifestyle factors of today's population which are likely to influence the health care needs of tomorrow. Following are some of the factors, and their prevalence within the South West LHIN, which must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

- Just under two thirds (62.5%) of people in the South West rate their health as very good or excellent. This measure has improved significantly since 2003.
- Although the incidence of diabetes is less than the provincial average, it has increased since 2003.
- 24.7% report alcohol consumption of five or more drinks at one time, at least once a month, compared to the provincial average of 21.1%
- 19.1% of the residents of the South West LHIN report high stress levels in their lives, compared with 22.1% of Ontarians
- 18% of people in the South West are obese
- Compared to the numbers from 2003, currently fewer people in the South West have a regular family physician

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



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



Data Sources: *Indian and Northern Affairs Canada First Nation Profiles and Registered Indian Population by Sex and Residence, 2006. **Ministry of Finance Population Projections, Population Projections by Gender, Age and LHIN of Residence, 2006-2016, Health System Intelligence Project. ***Canadian Community Health Survey, 2007.

Ministry-LHIN Accountability Agreement (MLAA)

The Ministry-LHIN Accountability Agreement (MLAA) clearly defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the South West LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines the responsibilities and obligations of each organization and the respective performance indicators within a pre-defined period of time. The following table outlines indicators measured during the 2008/09.

South West LHIN MLAA Performance Indicators 2008/09

Performance Indicator	Provincial Target	08/09 Annual Provincial Performance	LHIN 08/09 Starting Point	LHIN 08/09 Performance Target	FY 2008/09 LHIN Annual Results[1]	Performance Corridor	LHIN Met Target or Within Corridor
90th Percentile Wait Times for Cancer Surgery[2]	84 Days	62	77	65	88	72-59	NO
90th Percentile Wait Times for Cardiac By-Pass Procedures[2]	182 Days	53	46	45	56	50-41	NO
90th Percentile Wait Times for Cataract Surgery[2]	182 Days	115	109	96	90	106-86	YES
90th Percentile Wait Times for Hip Replacement[2]	182 Days	173	227	200	153	220-180	YES
90th Percentile Wait Times for Knee Replacement[2]	182 Days	205	293	215	204	237-194	YES
90th Percentile Wait Times for Diagnostic MRI Scan	28 Days	97	170	133	132	166-100	YES
90th Percentile Wait Times for Diagnostic CT Scan	28 Days	39	44	34	34	43-26	YES
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)[3,5]	290.76 per 100,000	301.52	305.26	290.00	316.27	319-261	YES
Median Wait Time to Long-Term Care Home Placement -All Placements[4]	50 Days	104	84.00	79.00	90.00	98.75-59.25	YES
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution[3,5]	9.46%	15.46	10.70	9.90	12.25	10.89-8.91	NO
Rate of Emergency Department Visits that could be Managed Elsewhere[3,5]	11.79 per 1,000	5.98	60.27	55.00	59.16	60.50-49.50	YES
Readmission Rates for Acute Myocardial Infarction (AMI) [3,5]	3.80%	3.89	4.37	4.25	4.15	5.31-3.19	YES

LHIN Year End Performance Notes

1. For Wait Time Indicators: Fiscal Year (FY) 2008/09 LHIN Annual Results = Actual Annual Performance Value from Apr 2008 to Mar. 2009. For non-Wait Time Indicators: FY 2008/09 LHIN Annual Results = Averaged performance value over 2008/09 Q1(Apr, May, Jun. 2008), Q2 (Jul, Aug, Sep. 2008) & Q3 (Oct, Nov, & Dec. 2008)
2. For all Wait Time Indicators, if LHIN 08/09 Starting Point is GREATER than Provincial Target, LHIN Year-End Performance will be assessed using Q4 2008-09 Actual Performance Value. For all Wait Time Indicators, if LHIN 08/09 Starting Point is LESS than Provincial Target, LHIN Year-End Performance will be assessed using FY 2008-09 Actual Annual Performance Value.
3. For the four Non-Wait Time Indicators (ALC Days, Readmission rates for AMI, ED Visits, and Hospitalization for Ambulatory Care Sensitive Conditions), LHIN Year-End Performance will be assessed using the average performance values of the first three quarters in 2008/09.
4. For Median Wait-Time to LTC Homes Placement, LHIN Year-End performance will be assessed using FY 2008/09 Actual Annual Performance Value (interim data)
5. 2008/09 Annual Rates are estimated based on Q1-Q3 data.

Definitions

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

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

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

Readmission Rate for Acute Myocardial Infarction (AMI): percentage of unplanned inpatient hospital readmission for AMI or another relevant diagnosis within 28 days of an initial hospitalization for AMI. Reported as a %. Performance Corridor is +/- 25%

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

Rate of Emergency Department Visits that Could be Managed Elsewhere: age-standardized rate per 1000 pop. Of emergency department visits for conditions that may be treated in alternative primary care settings. Reported as a rate per 1000. Performance Corridor is +/- 10%.

As can be seen in the chart, we have met and exceeded most of our performance targets due, in part, to the collaborative efforts and dedication of the Health Service Providers (HSPs) and communities in the South West LHIN.

The results also point to specific areas within the system that are experiencing challenges, particularly percentage of ALC days. For these challenges we are undertaking various initiatives to improve performance. For example, some of the programs currently underway to reduce ALC include:

- Grey Bruce Falls Prevention and Intervention – Increase number of seniors served by the Home Support Exercise Program from the approx. 25 currently served to date. 150 served in year 1;
- Integrated Case Managers in emergency rooms;
- Capacity Building of Community Support Services;
- Adult Day Services / Programs; and
- Supportive Housing and Security Checks.

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

Implementation of our Integrated Health Service Plan

The South West LHIN's first Integrated Health Service Plan (IHSP) was developed after extensive engagement with providers, consumers, community leaders and public. It reflected our best understanding of the key priorities to advance health care integration in the South West. The priorities were:

- Strengthening and improving primary health care
- Preventing and managing chronic illness
- Building linkages across the continuum for all seniors and adults with complex needs
- Accessing the right services in the right place at the right time by the right provider

In addition, two enabling priorities were identified: health human resources, and eHealth.

Since the Plan was created, the South West LHIN has moved forward to bring our vision to life.

The first step, in early 2007, was the creation of nine Priority Action Teams aligned with the priorities. The enthusiastic volunteers on the PATs studied health services in the South West and reviewed best practices from around the world. The PATs' final reports provided high-level strategic directions for each of the IHSP priorities.

These recommendations formed the basis for the next step, the LHIN's focused strategic improvement approach, undertaken during 2008-2009. As part of this approach, the LHIN identified the following system level goals:

- Healthier South West LHIN Community
- Equitable Access to Services
- Quality of Care and Services
- Sustainability of South West LHIN Health System
- Integration of Health Care Delivery

The strategic improvement approach identified more than 40 key initiatives and projects that are aligned to our system level goals and IHSP priority populations and programs.

More recently the LHIN has moved from high-level strategizing to more detailed planning. As we do so, we are focusing on our system level goals, measuring our performance, and practicing continuous improvement. Four LHIN-wide Steering Committees have been established, with representation from all health care sectors, and they are hard at work.

- The Health System Design Steering Committee is working to develop an overall blueprint and implementation plan for health services in the South West. The group is also studying human resource issues in Emergency Departments to identify improvement strategies based on best practices.
- The Best Level of Care and Quality Steering Committee is focused on projects and initiatives that collectively promote the achievement of the three Seniors and Adults with Complex Needs Priority Action Team directions and advance the LHIN's efforts to improve the quality of and access to the range of care available to South West LHIN residents when they need it. The Balance of Care model is being used to study the needs of people waiting for placement in long-term care homes, to understand the resources they would need to remain in the community. The committee is also reviewing the use of standardized tools as well as monitoring the outcomes of the Flo Collaborative projects (to improve the transition from hospital to home), and Aging at Home and Alternative Level of Care strategies.

- The Chronic Disease Prevention and Management Steering Committee is focused on advancing directions from the Chronic Disease and Primary Care PATs to achieve a comprehensive approach to CDPM in the South West LHIN. The committee is working closely with the Ministry of Health and Long-Term Care to implement the Ontario Diabetes Strategy and enhance access to family health care. It is also supporting Partnerships for Health, a project to improve primary care for adults with diabetes. A South West Self-Management Tool Kit for health care practitioners has been developed and an implementation strategy is in the works.
- The eHealth Adoption Steering Committee has just begun its work, providing a conduit for a number of eHealth projects and initiatives to improve access to and quality of care. For example, the Committee will support the North-South Connectivity Project, which will link the London hospitals and Grey Bruce hospitals to provide shared access to patient clinical data in a secure and confidential manner. Other projects include ensuring that the appropriate equipment and infrastructure is in place, supporting the move from paper to electronic lab results, and, as one of the eHealth early adopter LHINs, working with eHealth Ontario to deploy an online diabetes registry.

In addition to the above committees, the South West LHIN, in partnership with Grey Bruce Health Services, London Health Sciences Centre and St. Joseph's Health Care, London established an MRI Task Team to ensure patients of Magnetic Resonance Imaging (MRI) services receive timely, high quality care. The team will serve for a pre-determined period, from December 2007 to March 2010.

In three short and very busy years, the South West LHIN has moved from initial community engagement to detailed plans that are moving us toward a truly integrated health care system. There is much work still to be done, but we are proud of what has been accomplished, and grateful to those who have supported and contributed to the process.

Community Engagement

Community engagement continues to be an integral part of the South West LHIN's activities. Our commitment to building and maintaining a vibrant dialogue with our partners and communities is demonstrated by our four goals of community engagement:

- *Focus on the people who use health care:* We will work in partnership to build a system that places the consumer at the centre and engage with those who are most knowledgeable about heir needs, experience and satisfaction with health care services.
- *Enhance local accountability:* We will enhance accountability by providing opportunities for input into decision-making and fostering a sense of mutual responsibility for achieving goals.
- *Balance Priorities:* We will work to ensure that the full diversity of voices in the community are heard, and to build a shared sense of responsibility for achieving balance among competing priorities.
- *Develop system capacity and sustainability:* We will draw on the knowledge and capacity of our partners to identify needs and to help build sustainable, long-term local solutions.

Who have we engaged?

Between April 1, 2008 and March 31, 2009, the South West LHIN has continued to engage residents, providers, and other partners in our health care system in various ways:

- The provincial Aging at Home Innovations Expo in April 2008, brought together over 500 people from across the 14 LHINs, including health care professionals and residents from across Ontario to share and learn about innovative practices for improving health care delivery for seniors. The South West LHIN took a leadership role, in partnership with the Ministry of Health and Long-Term Care to plan the Expo.
- The Priority Action Teams who were made up of health care professionals, health service providers, and citizens who have a dedicated interest in improving the health care system, completed their work of creating mid- to high level recommendations for the priority areas identified in our 2007-2010 Integrated Health Service Plan. The success of the Priority Action Teams was due to the valuable input, expertise and time from the members.
- The South West LHIN, in partnership with Grey Bruce Health Services, London Health Sciences Centre and St. Joseph's Health Care, London established an MRI Task Team in 2007 to ensure patients of Magnetic Resonance Imaging (MRI) services receive timely, high quality care. This team will serve until March 2010 and met seven times during 2008/09.
- In September, our LHIN hosted a Community Health Centre (CHC) forum with our three developing CHCs and two existing CHCs to share information, build relationships and facilitate partnerships. Participant's included CHC and LHIN Board members, the Executive Directors of the two existing CHCs, LHIN staff, representatives from the Association of Ontario Health Centres and consultants working with developing CHCs.
- In addition to the above, the South West LHIN was involved in the community engagement that the three developing CHCs completed to assist in developing their community engagement plans.
- In October 2008, over 200 leaders from more than 80 community health service providers came together with the South West LHIN to learn about the service accountability agreements and begin completing their planning submissions. At the sessions in October, the South West LHIN had an opportunity to share details about governance, accountability and system level strategies and goals. The sessions aimed to align the importance of the agreements with the direction of the health system.
- In October, in collaboration with the Ontario Medical Association (OMA) division 2, the South West LHIN once again hosted three physician engagement workshops in London, Stratford and Owen Sound. Overall, 84 physicians participated in the workshops. We received positive feedback from physicians who attended and a number of them expressed a desire to keep connected to the LHIN.
- Between January and March 2009, the South West LHIN hosted *A Healthier Tomorrow* webcast series to communicate with our stakeholders on key initiatives. During this time, we broadcasted six webcasts on various key initiatives. We targeted Priority Action Team

members, all advisory groups and steering committees, health service providers and community partners. On average, approximately 150-200 people participated in each webcast. Upon completion of the series, participants evaluated their success. The majority of respondents told us they were satisfied with the series, they felt that it was an effective medium for information sharing, relevant to their work and a valuable use of their time. All six webcasts are archived on our website for future viewing for one year.

- The South West LHIN continues to liaise with three Area Provider Tables – one for each of the three geographic areas (North, Central and South) – made up of health care providers who know and understand their communities' health care needs. The area provider tables play a key role in providing input to various LHIN initiatives as well as leadership to local priorities and initiatives. In the South, we also liaise with the four Geographic Tables and the chairs from each of these tables are represented at the south area provider table.
- The Health Professionals Advisory Committee, representing a wide range of health professionals working in different sectors across the LHIN, provides advice to the LHIN on various matters and initiatives. This committee first came together in July 2008 and met four times prior to the end of the 2008-09 year.

This year we also saw our Board of Directors engage in further Board-to-Board sessions with many of our health service provider boards. These sessions, which precede the monthly board meetings, allow all participants to gain a greater understanding of the responsibilities and accountabilities of the boards and foster shared goals and a spirit of collaboration when dealing with issues and opportunities in our health care system.

The South West LHIN continues to build partnerships through the engagement of our community at all levels. In addition to the activities listed above, our LHIN has engaged with its communities in the following ways over the last year:

- Physician engagement with respect to chronic disease prevention and management
- Monthly hospital and CCAC leadership forums
- Invitational meetings and presentations
- Focus groups
- Surveys – electronic and paper-based

The South West LHIN continues to receive positive feedback on its efforts to engage broadly with providers, partners and the public at large. In addition, the South West LHIN welcomes any recommendations for future engagement activities in order to improve our approaches.

Community engagement can only be successful if approached with a proven methodology that ensures all the elements are carefully thought out and in place prior to engaging. To accomplish this, the South West LHIN has adopted the methodology developed by the International Association for Public Participation (IAP2) to ensure that all engagement activity is planned with a clear definition of audience, method of engagement, desired level of participation, and expected outcomes. In 2008-09, the South West LHIN participated in formal IAP2 community engagement/public participation training hosted by the Champlain LHIN. As a result, a total of 15 participants (two of which were from the South West LHIN), representing 12 LHINs received full certification in Public Participation from IAP2.

Aboriginal Health Initiatives

The Aboriginal Health Lead was hired in partnership with the Southwest Ontario Aboriginal Health Access Centre in September 2008 in assist both the South West and Erie-St. Clair LHINs. This role is to provide insight into Aboriginal community concerns and issues and serve as the primary resource for planning, community engagement and strategic directions with Aboriginal people in the two LHINs.

Over the past eight months the Aboriginal Health Lead has completed several meetings with individual Aboriginal communities, and collectives of Aboriginal organizations (see list below). At these meetings, community leaders spoke about the health services offered in their communities, infrastructure needs, pressing health issues and best practices. An Aboriginal health conference was also planned for the South West LHIN.

Below are the aboriginal communities and organizations in the South West LHIN that have been engaged:

Chippewa of the Thames, Oneida, Saugeen/Cape Croker, Oneida, AGA Mnassged Delaware Nation, London District Chiefs Council, Kettle Point, Chippewa of the Thames, Saugeen/Owen Sound Friendship Center, Muncey Chippewas of the Thames, Kikeewaanikaan Healing Lodge

Next steps will include continued engagement with the aboriginal communities of the South West LHIN, including a planned all-day event that will bring together representatives from all South West First Nations, aboriginal communities, and health care providers serving aboriginal communities, both on and off reserve. It is critical that the South West LHIN listens to the health concerns from these communities who face significant challenges in accessing the right care, at the right time, in the right place, by the right provider.

Our Francophone Communities

The South West LHIN takes very seriously its accountability for managing the health care system and ensuring a sustainable system that meets the needs of all populations now and in the future. Within that context, the South West LHIN continues to recognize the needs and legislative rights of our Francophone community and strives to ensure that services are provided that are culturally appropriate and accessible. Under the province's Aging at Home Strategy, the South West LHIN funded an Immigrant and Francophone Wraparound initiative that provides culturally sensitive and personalized assistance to the immigrant and francophone senior population.

In an effort to engage with the Francophone communities of the South West LHIN, representatives of the Francophone communities meet regularly with the South West LHIN to identify French language services access issues, and develop opportunities to break down barriers faced by our francophone population.

As we move forward with the development of our next IHSP, there are plans to conduct, in French, a focus group session with our Francophone representatives to seek their input into the current state assessment that is being conducted as part of the Health System Design initiative.

Integration in the South West LHIN

The South West LHIN has focused on education and resource development specific to integration during the year 2008/09. A webcast presentation broadcast to a large and varied audience of health care providers throughout the LHIN provided an opportunity to present the legislative aspect of integration activities and explain the roles of HSP boards and management. This webcast included valuable information that will help our health service providers identify and implement integration opportunities.

The presentation allowed for discussion on the interrelationships and roles between the Ministry of Health and Long-Term Care, the LHIN Board and leadership team, and the health service providers. The webcast included a definition of the various types of integration and outlined policies, flowcharts and resources available to help guide health care providers through the integration process. In order to enable reference back to the information presented, this webcast has been posted on the South West LHIN website where it will remain for a full year following the date of presentation.

A resource library of integration documentation has been created on the South West LHIN website.

In addition, Board-to-Board sessions held prior to our SW LHIN Board meetings throughout the geography of the South West, are providing additional opportunities to reinforce this information and provide discussion time. As a result, voluntary integration proposals have started to come forward for the fiscal year 2009-10.

Addressing ER Wait Times and Reducing Alternate Level of Care (ALC) Pressures

Reducing Emergency Room (ER) wait times remains a key priority for the Ministry of Health and Long-Term Care. In support of this priority, the South West LHIN has funded several initiatives to help improve ER wait times and reduce the number of Alternate Level of Care (ALC) patients who are occupying acute care beds in hospitals when the care they require could be more appropriately provided in an alternate setting.

Currently in the South West LHIN, there are a number of initiatives underway that will help ease the demand on ERs and consequently improve the wait time for those who most need the services of an ER. Many of these initiatives have been funded under the provincial Aging at Home Strategy, and the Urgent Priorities Fund. Below is a brief description of initiatives in the South West LHIN that will advance the ministry's ER Wait Times priority.

- Geriatric Emergency Management Nurses (GEM) assess seniors who come to the ER to see if they could be more appropriately treated in another care setting thereby avoiding admission to the Emergency Department;
- Wellness for Seniors including prevention of falls and fractures programs;
- Falls Prevention and Intervention through increase in the number of seniors served by the Home Support Exercise Program;
- Supportive Housing and Security Checks; this initiative is also associated with the prevention of falls/fractures and identification of problems before they require a visit to the ER;
- Integrated Case Managers in ERs to promote early involvement of a Community Care Access Centre (CCAC) case manager in discharge planning and potentially preventing admission;
- Rapid Emergency Management Assessment for Community Transition (REACT); a multi-disciplinary team assessment and supports provided to divert admission of seniors presenting in ER;
- Advanced Home Care Team, which maximizes the utilization of Nurse Practitioners in the community to maintain individuals at home or in long-term care homes;
- Capacity building of Community Support Services to enhance resources available in the community.

Additionally, several initiatives are currently underway to help improve bed utilization to alleviate ALC pressures:

- The "Flo Spread Strategy" improves the movement of patients through the health care system from hospital admission to discharge. It is expanding to include an additional 5 partnerships (hospitals and CCAC) within the South West LHIN. This strategy has provided evidence of decrease in average length of stay and more timely discharges in the original two pilot sites at St. Thomas Elgin General Hospital and Grey Bruce Health Services.
- 20 bed Transitional Care Unit (TCU) at Parkwood Hospital; this collaborative project between the London hospitals and the South West CCAC, is targeted to support patients who would benefit from restorative care in another setting. These patients would otherwise experience long lengths of stay and/or potential discharge to a long-term care home. Preliminary review is indicating a decrease in alternate level of care (ALC) days specifically for the Surgery and Family Medicine programs, and 50% of TCU patients are returning home after their stay in the transitional care unit.
- The Wait at Home program which has benefitted from an increase in the South West CCAC service maximums has provided the opportunity for 53 clients as of the end of February '09, to wait at home for their placement to long-term care homes, rather than in an acute care bed. This has saved approximately 1,263 patient days for hospitals thus far.
- Safe at Home, a South West CCAC Aging at Home program that assists frail seniors through visits with a nurse practitioner and additional nursing and personal support visits focused on medication review and caregiver support, has provided additional support to 353 clients as of the end of February '09. This has saved approximately $5.5 million of what would previously have been hospital-provided care.
- Tillsonburg Community Transition Model; a collaborative partnership between hospital, the South West CCAC, long-term care homes, and community providers to focus on the provision of the most appropriate level of care combining community programs, CCAC services, etc. This has evolved into a truly community driven collaborative with very client focused care in mind.

Other Initiatives to improve health care in the South West LHIN

In addition to the many programs outlined in other sections of this report, the South West LHIN is also supporting initiatives that will not only impact health care in our LHIN, but will also, when fully implemented, improve health care on a provincial level.

The South West LHIN was identified by the Ministry of Health and Long-Term Care as one of 3 LHINs for the first year of implementation of the Ontario Diabetes Strategy (ODS). Consistent with recommendations from our Diabetes and Chronic Disease Prevention and Management (CDPM) Priority Action Teams, we have focused our efforts on ways to increase access to team-based care closer to home and on developing an on-line diabetes registry in conjunction with the Ontario eHealth strategy.

The South West LHIN is well positioned for this work as an early adopter of the provincial Diabetes Registry and as a leader of the Partnerships for Health Project, aimed at promoting better care for adults with diabetes at the primary care level. Being involved in the ODS, the eHealth Diabetes Registry and Partnerships for Health enables the South West LHIN help people living with diabetes receive high quality coordinated care from multiple providers.

The South West LHIN is one of two LHINs identified as an "early adopter" for the province's eHealth strategy. The first major milestone for the strategy will focus on the introduction of a provincial Diabetes Registry, with the longer term goal of the implementation of a comprehensive electronic health record. Other eHealth initiatives include connecting Hospital Information Systems to provide wider access to patient information, sending electronic results to physician electronic medical records and creating a regional repository for all Diagnostic Images.

Operational Performance

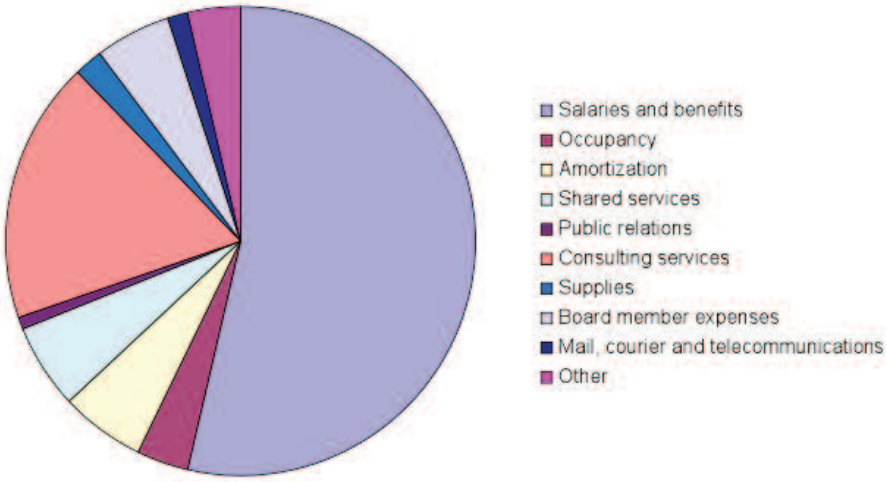
In 2008-09, the South West LHIN Operating actual was made up of two components:

- $5.261 million for Operations
- $0.905 million for Special Projects

The Operating budget includes $35,000 annualized funding for Aboriginal Community Engagement.

Operations
The South West LHIN ended the year with an operating surplus of $35,230. The chart below shows the ten major categories of expenditures for the South West LHIN. Our largest expenditure is Salaries and Benefits with 27 full time staff and 4 staff hired on contract basis for specific projects.

Operational Expenditure



Special Projects
The one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2008-2009 fiscal year were:

	FUNDING	EXPENDITURE
E-Health	$650,000	$650,000
Diabetes	127,500	119,893
Emergency Department Lead	75,000	62,629
Emergency Room/ Alternative Level of Care	33,300	22,666
Nursing Initiative	50,000	50,000
Total	**$935,800**	**$905,188**

Financial Report

Financial Statements of the South West Local Health Integration Network

As at March 31, 2009

Auditor's Report

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto, Ontario M2N 6L7 Canada
Telephone: 416-601-6150
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To the Members of the Board of Directors of the
South West Local Health Integration Network

We have audited the statement of financial position of the South West Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, these financial statements present fairly, in all material respects, the financial position of the South West Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 30, 2009

South West Local Health Integration Network

Statement of Financial Position
As at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**1,254,897**	1,012,184
Due from Ministry of Health and Long-Term Care ("MOHLTC")	**2,113,558**	1,317,520
Accounts receivable	**2,826**	8,515
	3,371,281	2,338,219
Liabilities		
Accounts payable and accrued liabilities	**1,173,998**	808,284
Due to MOHLTC (Note 3b)	**65,842**	209,281
Due to Health Service Providers ("HSPs")	**2,113,558**	1,317,520
Due to the LHIN Shared Services Office (Note 4)	**17,883**	3,134
Deferred capital contributions (Note 5)	**675,415**	959,146
	4,046,696	3,297,365
Commitments (Note 6)		
Net debt	**(675,415)**	(959,146)
Non-financial assets		
Capital assets (Note 7)	**675,415**	959,146
Accumulated surplus	-	-

APPROVED BY THE BOARD

DIRECTOR

DIRECTOR

South West Local Health Integration Network

Statement of Financial Activities
Year Ended March 31, 2009

	Budget (unaudited) (Note 8)	2009 Actual	2008 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,839,002,228**	**1,910,900,828**	1,839,656,949
Operations of LHIN	**5,012,666**	**4,989,934**	3,583,969
E-Health (Note 10a)	**120,000**	**650,000**	275,000
Diabetes (Note 10c)	-	**127,500**	-
Aging at Home	-	-	236,000
Emergency Department ("ED") Lead (Note 10b)	-	**75,000**	31,300
Wait Time Funding	-	-	70,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10d)	-	**33,300**	-
70% Nursing Initiative (Note 10e)	-	**50,000**	-
Amortization of deferred capital contributions (Note 5)	-	**306,463**	226,636
	1,844,134,894	**1,917,133,025**	1,844,079,854
Expenses			
Transfer payments to HSPs (Note 9)	**1,839,002,228**	**1,910,900,828**	1,839,656,949
General and administrative (Note 11)	**5,012,666**	**5,261,167**	3,797,561
E-Health (Note 10a)	**120,000**	**650,000**	275,000
Diabetes (Note 10c)	-	**119,893**	-
Aging at Home	-	-	153,506
ED Lead (Note 10b)	-	**62,629**	25,546
Wait Time Funding	-	-	70,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10d)	-	**22,666**	-
70% Nursing Initiative (Note 10e)	-	**50,000**	-
	1,844,134,894	**1,917,067,183**	1,843,978,562
Annual surplus before funding repayable to MOHLTC	-	**65,842**	101,292
Funding repayable to the MOHLTC (Note 3a)	-	**(65,842)**	(101,292)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

South West Local Health Integration Network

Statement of Changes in Net Debt
Year Ended March 31, 2009

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of capital assets (note 12)	**(22,732)**	(533,685)
Amortization of capital assets	**306,463**	226,636
Decrease (increase) in net debt	**283,731**	(307,049)
Opening net debt	**(959,146)**	(652,097)
Closing net debt	**(675,415)**	(959,146)

Statement of Cash Flows
Year Ended March 31, 2009

	2009	2008
	$	$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**306,463**	226,636
Amortization of deferred capital contributions (Note 5)	**(306,463)**	(226,636)
Changes in non-cash operating items		
Increase in due from MOHLTC	**(796,038)**	(1,317,520)
Decrease (increase) in accounts receivable	**5,689**	(8,515)
Increase in accounts payable and accrued liabilities	**365,714**	324,594
(Decrease) increase in due to MOHLTC	**(143,439)**	101,292
Increase in due to HSPs	**796,038**	1,317,520
Increase (decrease) in due to LHIN Shared Services Office	**14,749**	(60,628)
	242,713	356,743
Capital transactions		
Acquisition of capital assets	**(22,732)**	(533,685)
Financing		
Increase in deferred capital contributions (Note 5)	**22,732**	533,685
Net increase in cash	**242,713**	356,743
Cash, beginning of year	**1,012,184**	655,441
Cash, end of year	**1,254,897**	1,012,184

1. Description of business

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

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

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

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Provider ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

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

2. Significant accounting policies

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

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

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

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

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

The LHIN statements do not include any Ministry managed programs.

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

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

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

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

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

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

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

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

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

3. Funding repayable to the MOHLTC

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

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

	REVENUE	**EXPENSES**	**2009 SURPLUS**	2008 SURPLUS
	$	**$**	**$**	$
Transfer payments to HSPs	**1,910,900,828**	**1,910,900,828**	**-**	-
LHIN operations	**5,296,397**	**5,261,167**	**35,230**	13,044
E-Health	**650,000**	**650,000**	**-**	-
Aging at Home	**-**	**-**	**-**	82,494
ED Lead	**75,000**	**62,629**	**12,371**	5,754
Wait Time Funding	**-**	**-**	**-**	-
Diabetes	**127,500**	**119,893**	**7,607**	-
ER/ALC Lead	**33,300**	**22,666**	**10,634**	-
70% Nursing Initiative	**50,000**	**50,000**	**-**	-
	1,917,133,025	**1,917,067,183**	**65,842**	101,292

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

	2009	2008
	$	$
Due to MOHLTC, beginning of year	**209,281**	107,989
Funding repaid to MOHLTC	**(209,281)**	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**65,842**	101,292
Due to MOHLTC, end of year	**65,842**	209,281

4. Related party transactions

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

5. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**959,146**	652,097
Capital contributions received during the year (Note 12)	**22,732**	533,685
Amortization for the year	**(306,463)**	(226,636)
Balance, end of year	**675,415**	959,146

6. Commitments

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

	$
2010	212,594
2011	207,339
2012	206,561
2013	203,126
2014	198,349

The LHIN also has funding commitments to HSPs associated with accountability agreements.
The actual amounts which will ultimately be paid are contingent upon LHIN funding received from the MOHLTC.

7. Capital assets

	COST	ACCUMULATED AMORTIZATION	2009 NET BOOK VALUE	2008 NET BOOK VALUE
	$	$	$	$
Computer equipment	**65,483**	**51,302**	**14,181**	31,565
Leasehold improvements	**1,366,041**	**842,937**	**523,104**	399,624
Office equipment, furniture and fixtures	**164,652**	**33,855**	**130,797**	122,292
Web development	**21,998**	**14,665**	**7,333**	14,665
Construction in progress	-	-	-	391,000
	1,618,174	**942,759**	**675,415**	**959,146**

Construction in progress in the prior year of $391,000 related to leasehold improvements. These improvements were completed during the current year and are included in leasehold improvements at March 31, 2009.

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of financial activities reflect the initial budget at April 1, 2008. 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 $1,910,900,828 is derived as follows:

	$
Initial budget	**1,893,002,228**
Adjustment due to announcements made during the year	**17,898,600**
Final budget	**1,910,900,828**

The final operating budget of $5,925,734 is made up of the following:

	$
Initial budget	**5,012,666**
Additional funding received during the year	**935,800**
Amount treated as capital contributions during the year	**(22,732)**
Final budget	**5,925,734**

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,910,900,828 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2009 as follows:

	2009	2008
	$	$
Operation of hospitals	**1,424,880,921**	1,386,177,103
Grants to compensate for municipal taxation - public hospitals	**451,350**	451,350
Long term care homes	**235,432,172**	220,743,630
Community care access centres	**148,561,357**	139,286,415
Community support services	**27,838,627**	23,386,594
Assisted living services in supportive housing	**13,067,348**	11,270,977
Community health centres	**7,417,723**	7,054,462
Community mental health addictions program	**53,251,330**	51,286,118
	1,910,900,828	1,839,656,649

10. Separate funding amounts were received by the LHIN from the MOHLTC for specific initiatives.

a) **E-Health:** The E-Health office of the MOHLTC provided $650,000 (2008 - $275,000) to the LHIN. The LHIN had a contract and retained services of the London Health Sciences Centre ("LHSC") during 2008.
b) **ED Lead:** The MOHLTC provided the LHIN with $75,000 (2008 - $31,300) to hire a LHIN representative for emergency department planning. Dr. Lisa Shepherd was selected and remunerated a total of $62,629 through a monthly per diem and expense allowance as described by the MOHLTC. The LHIN has setup a repayable to the MOHLTC for the remaining balance.
c) **Diabetes:** The MOHLTC provided the LHIN with $127,500 related to diabetes management strategy funding. The LHIN incurred operating expenses totaling $119,893 and has set-up a repayable to the MOHLTC for the remaining balance.
d) **ER/ALC Lead:** The MOHLTC provided the LHIN with $33,300 related to emergency room management strategy funding. The LHIN incurred operating expenses totaling $22,666 and has set-up a repayable to the MOHLTC for the remaining balance.
e) **70% Nursing Initiative:** The MOHLTC provided the LHIN with $50,000 related to nurse staffing strategy. The LHIN incurred operating expenses totaling $50,000.

11. General and administrative expenses

The statement of financial activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and benefits	**2,824,036**	2,157,430
Occupancy (Note 12)	**190,509**	264,095
Amortization	**306,463**	226,636
Shared services	**300,000**	299,273
Public relations	**54,169**	83,750
Consulting services	**943,272**	324,640
Supplies	**96,615**	54,244
Board member expenses	**287,334**	190,229
Mail, courier and telecommunications	**65,134**	60,451
Other	**193,635**	136,813
	5,261,167	3,797,561

12. Recovered expenditures

The LHIN has an agreement with the Southwest Community Care Access Centre ("CCAC") to introduce a Chronic Disease Prevention and Management ("CDPM") Project. The CCAC will pay cost of accommodations and initial office set-up on behalf of the CDPM to the LHIN. During the fiscal year 2009, amounts received for initial office set-up decreased capital asset additions and deferred capital contributions by $80,100 from $102,832 to $22,732 and amounts received for accommodations decreased occupancy expense by $84,050 from $274,559 to $190,509.

13. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 22 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 2009 was $208,061 (2008 - $170,673) for current service costs and is included as an expense in the statement of financial activities.

14. Guarantees

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

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

15. Segment disclosures

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

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Ontario
South West Local Health
Integration Network