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South East **LHIN**

Building value...

2009-2010 Annual Report | South East Local Health Integration Network

Ontario
Local Health Integration Network

Ontario

South East Local Health Integration Network

Réseau local d'intégration des services de santé du Sud-Est

Board of Directors

Georgina Thompson (Chair)
First Appointed: 1 June 2005
Term Expires: 8 June 2011

Jyoti Kotecha
First Appointed: 24 March 2010
Term Expires: 24 February 2013

Thomas Rankin (Vice Chair)
First Appointed: 17 May 2006
Term Expires: 16 June 2010

Wynn Turner
First Appointed: 1 October 2008
Term Expires: 31 October 2012

Leslie Benecki
First Appointed: 8 October 2008
Term Expires: 10 July 2011

Margaret Werkhoven
First Appointed: 17 May 2006
Term Expires: 17 June 2010

John Ferguson
First Appointed: 20 June 2007
Term Expires: 19 June 2011

Board members who retired in 2009/10
Gaye McGinn (5 Jan 2006 – 5 February 2010)
John Groves (5 Jan 2006 – 7 April 2010)

Senior Executive

Paul Huras
Chief Executive Officer

Sherry Kennedy
Chief Operating Officer

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2009-2010 Annual Report

From the Board Chair & Chief Executive Officer

On behalf of the Board of Directors of the South East Local Health Integration Network, as well as our entire team, we are pleased to provide our 2009-2010 Annual Report.

We cannot adequately express the appreciation we have for every person working in our local health-care system. This year brought many significant challenges for us; including the achievement of performance targets that would have seemed unreachable just a few short years ago.

Our hospitals and the CCAC have demonstrated leadership through their collaborative work with the LHIN in developing the Clinical Services Roadmap process. The Roadmap, which we will be developing in the upcoming year, will chart the course for hospital-based health care in our LHIN that will have quality, access, and sustainability as guiding principles.

Our community support service agencies have demonstrated their commitment to the health and well-being of our residents and their capacity to meet community need over the past year. We are proving to the rest of Ontario that providing care to our seniors before they find themselves in the emergency room is the most effective way to maintain their health and independence. CSS agencies prove this every day, with every client they serve. Our CCAC has been instrumental in the implementation of home first – which shifts the focus of patients and caregivers towards going home, instead of going to a long-term care home.

Our thanks also go to the staff of our community mental health programs. Over the past year, these agencies have done what others couldn't achieve in a decade. They are successfully placing former long-term mental health patients into appropriately supported community living environments. Beyond the idea it is simply the humane thing to do, it signals the end of an era when institutions were the centre the system. The achievements we've cited here are evidence that the patient is now at the centre of our local health care system.

The residents of south eastern Ontario have been very well served by the people who are the local health care system. It is our intention to use this momentum to innovate and inspire improvements going forward. To employ quality, effectiveness, and sustainability as the building blocks to improved services. And to promote timely and effective interventions at all points in the care continuum in support of health.

On behalf of the Board

Georgina Thompson
Chair, Board of Directors

Paul Huras
Chief Executive Officer &
Secretary to the Board

Overview

South East Local Health Integration Network

Facts & Figures

Population 442,800 (2006) *projected* 489,600 (2010)

Funding $960,628,457 Allocated to health service providers in 2009/10.

Providers

7 Hospitals operating 11 sites

1 Community Care Access Centre (South East)

37 Long-term care homes (1 interim)

Community Agencies

37 Community support service agencies

3 Acquired brain injury programs

3 Assisted living / supportive housing

8 Addictions programs

4 Community Health Centres

19 Mental health programs

Funding by Sector (2009/10)

Operation of Hospitals	$640,350,426
Municipal Tax Grants–hospitals	$190,725
Long-Term Care Homes	$148,948,421
Community Care Access Centre	$92,924,681
Community Support Services	$19,961,270
Acquired Brain Injury	$3,482,522
Assisted Living Supportive Housing	$1,988,446
Community Health Centres	$14,921,421
Community Mental Health	$31,740,708
Addictions Program	$6,119,837
Total Funding Allocated	$960,628,457

Funding by Hospital (2009/10)

Brockville General Hospital	$47,143,550
Hotel Dieu Hospital	$52,436,377
Kingston General Hospital	$270,639,221
Lennox & Addington County General	$18,358,000
Perth & Smiths Falls District Hosp	$32,627,200
Providence Care	$86,597,978
Quinte Healthcare Corp	$132,548,100
Total Funding (Hospitals)	$640,350,426

Community Overview

At 19,473 square kilometers, the South East LHIN is the fourth largest local health integration network by geographic area. We serve approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area.

The LHIN geographic area includes the communities bounded by towns of Brighton and Cardinal from east to west, and from Prince Edward County to just north of Lake St Peter from north to south (sees Figure 2). LHIN geographic areas were determined based on where residents primarily received their care. 96% of all South East LHIN residents obtain care

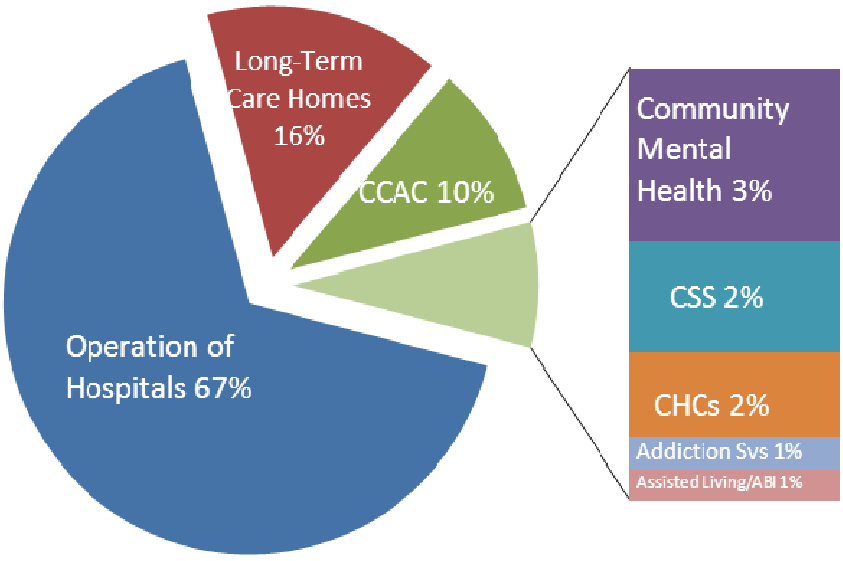


Figure 1: Percentage funding distribution by sector 2009/10

from local health service providers.

Accountability and responsible health system management

LHINs were developed with accountability as a core value. *The Local Health System Integration Act, 2006* specifies the powers of the LHIN Board to make decisions regarding the local health system, within the provisions of the *Act* and under the stewardship of the Ministry of Health and Long-Term Care. The LHIN is required to engage in consultations with its communities as part of its strategic planning and priority setting cycles. Decisions of the LHIN must be made in full consideration of the public interest.

Every three years, LHINs develop their Integrated Health Service Plan (IHSP) – which defines our strategic objectives for the local health system. The IHSP provides a framework for the LHIN and our health service providers to ensure that time, effort and resources are appropriately aligned.

Each LHIN has an Accountability Agreement between itself and the Minister of Health and Long-Term Care. That agreement specifies the obligations of both parties, as well as identifies areas where the ministry wants to see improvement. Performance indicators, along with multi-year targets, are set out in this agreement, and the results are reported publicly, through this report and other means.

As a Crown Agency, the LHIN is fully responsible for following Directives from the Province of Ontario regarding allocation of funding, operational spending, tendering for third party services, hiring, and other policies that are directed towards Ontario's agencies, boards and commissions.

The Chief Executive Officer of each LHIN has quarterly meetings with senior ministry officials to brief them on the impact of the LHIN's activities, highlighting successes as well as opportunities for greater improvement.

The LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions taken by the LHIN are directed by our Board. Our CEO provides monthly updates on operational activities, reports on performance indicator results, and provides updates on our progress towards achieving our IHSP priorities.

Within this accountability framework, the South East LHIN Board has set in place four corporate strategic goals:

Build a true system of integrated health care that optimizes the use of resources

Build awareness and understanding of the mandate of the LHIN and its health system management role

Be a knowledge-based organization

Be an effective organization that is credible, professional and responsive.

LHIN Board members, executive, and staff are fully briefed on our accountability relationships and are required to incorporate these requirements of these relationships into their work activities.

As important and necessary as these formal accountabilities are, they do not directly speak to our most important accountability – to the residents who live within our geographic area.

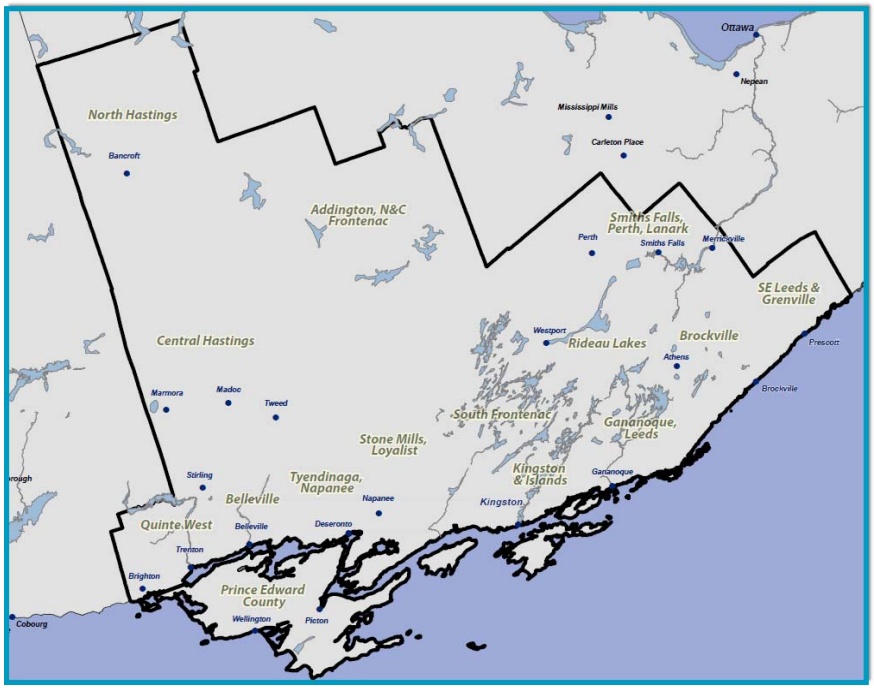


Figure 2 Map of the South East Local Health Network Area

The Board and staff of the South East LHIN are also residents of this community. We share the vision of an accessible and sustainable health care system expressed by residents.

Being accountable is more than reporting the right numbers. In the South East LHIN, it means making decisions that will have positive impact on the quality and sustainability of the health system. It means making things work better, and doing what makes sense.

Meeting provincial standards

The South East LHIN has worked diligently with its health service providers to ensure that provincial standards of care are met by addressing local health-care needs. We have been innovative so that our engagement with our communities was significant and meaningful, allowing us to develop an approach that reflected community input. We have looked beyond Ontario's borders to find models, programs and processes that have been proven to provide services more efficiently and effectively, or which help people avoid typical — but preventable —reasons for accessing the health care system. Our objective is to enhance and evolve the local health care system to ensure it meets, and continues to meet, the needs of our residents.

Maturity Assessment

Over 2009/10, the Ministry of Health and Long-Term Care's Health Audit Service Team conducted maturity assessments of Ontario's 14 LHINs. The assessments were intended to provide the ministry with an evaluation of the competency and capacity of the LHINs after three years functioning as local health system managers.

The South East LHINs assessment was very positive, ranking our LHIN as a 'mature' organization. The definition means that the South East LHIN demonstrated having systems, processes, and procedures in place that met provincial policy, were fair and equitable in their application, and demonstrated understanding of our role.

Major accountability projects

As part of our mandate, the South East LHIN has undertaken a number of projects that support our accountability relationships, priorities for change at a health systems level, or improve our overall understanding of the local health care system. In 2009/10, the LHIN engaged in several projects of this type.

Regional Capacity Assessment and Projection (ReCAP)

To ensure that our work was aligned with our strategic and operational goals, the LHIN developed a regional, population-based projection of residents' health care use. The Regional Capacity Assessment and Projection (ReCAP Project) took a comprehensive look at the current and future needs of our residents and then projected that need over a five year period. The project also looked at the capacity of health service providers to meet projected population need over the same period. ReCAP data provides the LHIN with the means to efficiently plan for future services, and to ensure our providers are planning to meet anticipated health service needs. This data driven approach to health systems planning is new to Ontario, but is proving itself to be a valuable part of local health systems management.

Clinical Services Roadmap

In 2009/10, the South East LHIN, together with its hospitals and the CCAC, began discussions on how clinical services could be realigned to improve efficiency, improve access, and reduce service duplication. Traditional approaches to clinical services realignment would have the decisions of 'who does what' made by the LHIN, with the provider being told what their role would be afterward.

We knew we could do better than this. We have brought our hospitals and the Community Care Access Centre to the table and asked them to work with us to create a regional health services plan that makes sense to the hospitals and the CCAC, the LHIN, and to our residents. We are calling this process the Clinical Services Roadmap, as we will collectively be drawing the map from where we are to where we want to be.

Community Services Back Office Project

As part of our accountability agreements with community providers, each are participating in an exercise to determine what core administrative services could be combined and shared through a common 'back office'. The intent of the project is to determine how much could be saved by the system by, for example, having a single payroll system, or a common bookkeeping office. Phase I of this project, which involved an assessment of what back office services could be shared was completed in 2009/10. Phase II, the development of options for a back office approach, is under development.

Shared Support Services of Southeastern Ontario (3SO)

3SO is a collaboration of the South East LHIN hospitals to create a shared back office for purchasing and procurement services. 3SO, employing staff who are expert in procurement, leverage the purchasing power of all the hospitals, allowing hospital management to direct their attention to their core business of patient care.

Boards Working Together (Collaborative Governance)

From the beginning of the LHINs in late 2005, the SE LHIN has communicated with its provider Boards' Chairs and Members. These informal early meetings led to the South East LHIN Board appointing a formal Collaborative Governance Development Team (CGDT) in 2007.

The CGDT has representation from each service sector (addictions services, community care access centre, community health centres, community support services, hospitals, long-term care, and mental health) as well as

members from the academic health sciences, primary health care and public health sectors. The CGDT was established to provide advice to the LHIN on how to engage at the governance level and how to promote boards to work together to achieve greater alignment with the LHIN's objectives.

Since 2007, on the advice of the CGDT, our Board has held a series of governance working sessions each year. Hosted throughout our geographic area, these sessions have focused on areas which the CGDT felt would engage board members and contribute to the advancement of LHIN priorities. Sessions have included:

The role of an HSP Board in a LHIN environment

The SE LHIN health system

Integration – definitions, types, purpose, opportunities

Governance Tool Kit

Role of HSP Boards in contributing to the SE LHIN's Priorities for Change

The CGDT has also conducted a formal evaluation of how well the LHIN has engaged our providers' boards and how well we have fostered collaboration among our providers' boards. The evaluation, consisting primarily of a survey of our providers, was very positive. The working sessions were well received and the sense among surveyed providers was that this approach had potential to grow and further improve the potential for collaborative opportunities.

In addition, our Board Chair leads a monthly meeting of the chairs of the LHIN's hospitals and CCAC. Overall, our Board is demonstrating the engagement of HSP boards as a valuable enabler of integration and advancing our priorities.

Looking ahead

Our providers have demonstrated the capacity to meet the challenge of providing a high quality, accessible and sustainable system. The past three years have demonstrated the capacity and responsiveness of the local health care system to make real change. Using the foundation of our IHSP1 achievements, we will advance the local health care system further with plans to reduce unnecessary hospitalizations, reduce health-care acquired infections, develop and refine regional approaches to care, and embed quality as a core deliverable of the local health care system.

Report on IHSP1

2007-2010 Integrated Health Services Plan

The South East LHIN's first Integrated Health Services Plan (IHSP1) was approved by our Board of Directors in October, 2006. In preparing that plan, we conducted extensive research on the health of our residents to find out what health care services they used. We talked to Ontarians who live in the communities we serve to gain their views about the local health care system. We asked what was good about health-care locally and what could use improvement. We also asked what the future local health-care system should look like. Finally, we consulted with our providers to gain their perspective of the local health-system's strengths, opportunities for improvement and generally how well they saw the system meeting people's needs.

The outcome of this research was IHSP1, and the twelve *priorities for change* that directed the LHIN's activities from 2007/08 through 2009/10. A full copy of IHSP1 is available at www.SouthEastLHIN.on.ca

We are very proud of the accomplishments that our health service providers have made, and that we have achieved collectively over the past three years. The results speak to the dedication and commitment of every health-care provider in this LHIN, as well as to all the administrative, operations, and support people behind them.

One of the concerns raised in health-care is that there is so much change, people just can't keep up. We think our results tell a different story. Change for change sake is not sustainable. However, change that fits with a vision of success is sustainable. Change linked to a clearly articulated goal, with a way to measure progress towards that goal, can energize people.

There is nothing stagnant about health-care. Medical discoveries have not slowed down over the last 20 years. Surgical residents today are not learning the same techniques and approaches that their teachers learned. Everything in health-care is changing all the time. The LHIN's role is to ensure that change is focused on what is important to the health-care needs of our residents now and in the future. IHSP1 told us that the system was, largely speaking, doing what it was supposed to do. Our job in IHSP1 was not to create a new local health-care system, but to 'renovate' the existing one.

Our report on IHSP1 is listed by each priority for change, and a summary of key activities and results achieved for those priorities.

Improving access to specialized medical care

Participants in community engagement sessions felt that there was inadequate access to medical specialists and specialized diagnostic services (like magnetic resonance imaging (MRI) and computer assisted tomography (CT)). Inadequate access to a primary health care provider was thought to be a factor in this situation.

The LHIN will work with providers to enhance the recruitment of necessary additional medical specialists and subspecialists.

Activities supporting this priority

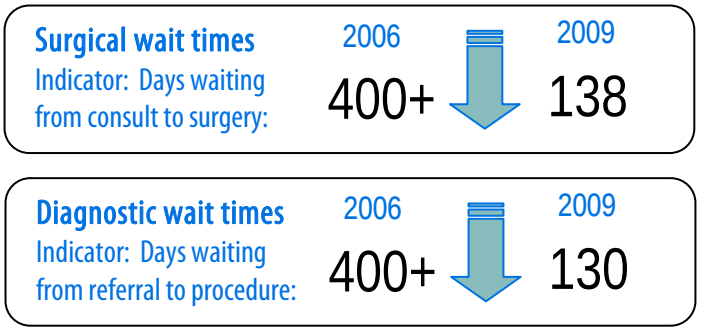
Wait List Management: The South East LHIN has maintained the requirement of hospitals providing services funded under Ontario's Wait Time Strategy to audit their wait lists to ensure that anyone waiting longer than 180 days was re-assessed.

Education: The LHIN provided education to our hospitals and through the hospitals to area surgeons, about the importance of reducing wait times.

Directed funding: The LHIN re-allocated funding within the fiscal year to ensure that hospitals that could perform more surgeries had the resources to provide them.

Short Stay Orthopaedic Unit: The South East LHIN funded one of the first short stay units providing total hip and knee replacements in Ontario. Hotel Dieu Hospital launched the program in December 2009 with 105 procedures.

Electronic referral: Kingston orthopaedic surgeons submitted a proposal to create an electronic referral system for family doctors, to improve the time from specialist referral to consultation. The system would do this by incorporating education and patient pre-screening. Development began in 2009/10 and will continue into 2010-11.



Results

Waits for total hip and knee replacements dropped from an average of 22 months to an average of nine months within 90 days in 2008.

Lengths of stay have dropped as a result of the short stay unit (from an average of six days to an average of two days) since program inception, with no increase in clinical complications.

For specific results, please see page 25.

Improving access to mental health services

Our first IHSP identified difficulty accessing mental health services at all points across the continuum of care. Of particular concern were crisis care services outside our larger urban centres. Smaller community emergency departments were the primary venue for crisis care, and relied on telephone access to psychiatrists and crisis team support. Admitting those with acute mental health problems was reported as being difficult.

Finally, accessing ambulatory care and community support services for those with long-term mental health issues (psycho-geriatric, child and adolescent, and concurrent disorders) were identified as being difficult

Particular attention will be paid to developing and implementing models to ensure access to appropriate and timely mental health care and addiction services for residents of the more remote parts of the LHIN.

Activities supporting this priority

Transitioning long-stay mental health patients to community living: The LHIN is committed to the principle that people with mental health issues should only receive institutional care when necessary, and should be provided the opportunity to live in their community when their condition is stable. Both Providence Care and the former Brockville Psychiatric Hospital have been working with community agencies to transition long-stay mental health patients to community settings.

Acute Mental Health: In Brockville, Kingston, and Belleville, acute mental health services are being reviewed programmatically as part of the respective hospital's functional program planning. In each case, mental health beds are being moved into new facilities within the foreseeable future. The hospitals are working to ensure that the care models being designed represent current clinical best practice. The results of these activities will ensure appropriate use of the acute mental health beds with strong community supports systems for those with mental health challenges.

Psycho-geriatric outreach: Several of our hospitals have investigated ways to support elderly patients staying at home, or in a long-term care home, where dementia or other psycho-geriatric issues pose challenges to family. This work continues.

Queen's University: Queen's University is working with hospitals in the LHIN to recruit psychiatry residents into the South East. By providing research, education, and varied clinical environments, the university hopes to increase the cadre of specialists in the region.

Results

Over 70 acute mental health beds in the South East LHIN have been or are in the process of being redeveloped to ensure that care for mental health patients is provided in modern facilities that support current clinical best practice.

The LHIN is supporting the development of community-based psycho-geriatric services that focus on minimizing institutionalization.

Improving access to addictions services

Problems accessing services for those with addictions were reported as being significant. Individuals with addictions often have to leave their home community to access care. Outside of urban centres, no local withdrawal management or detoxification options are available. Transportation is difficult to obtain or prohibitively expensive. Medication management presents issues due to a shortage in primary health care providers. Supportive housing, which could attenuate many of these concerns, has been identified as inadequate.

Particular attention will be paid to developing and implementing models to ensure access to appropriate and timely mental health care and addiction services for residents of the more remote parts of the LHIN.

Activities supporting this priority

Common Intake and Assessment: Addiction counseling service providers across the LHIN have been working in geographically relevant groups to develop common intake and assessment protocols for clients who need their services, or a combination of both addictions and mental health services.

This 'no wrong door' policy ensures that clients who need services can be assessed by any one of several service providers, and that this assessment and intake is sufficient for service provision at a partner agency.

This level of coordination is particularly important for clients with both addictions and mental health concerns, as very often the treatment of one of the issues is ineffective without treatment of the other.

Addiction supportive housing: The Ministry of Health and Long-Term Care proposed to fund 48 supportive housing beds for addiction services within the LHIN. The LHIN prepared a plan that would have the beds regionally allocated, but with the ability to redeploy the beds based on population need. In 2009/10, the LHIN had expected to be funding agencies to operate 32 of the 48 beds. Unfortunately funding from the Ministry has not yet been granted.

Results

These projects have only recently been launched, but the LHIN anticipates that the alignment of intake and assessment will improve access and the quality of services provided to those with addiction issues.

Improving access to rehabilitation services

Inpatient physical rehabilitation has a much lower utilization rate in the South East LHIN than in other parts of Ontario. The reason for this appears to be problems accessing this level of care within the LHIN.

This lower utilization is compounded by an identified lack of access to community physical rehabilitation services. Providers have indicated that the demand for publically funded in-home or inpatient rehabilitation exceeds the available supply, forcing wait lists for these services.

Supply of these services appears to be limited both financially and by a lack of rehabilitation practitioners within the LHIN; particularly in our smaller communities. The lack of providers is evident in both public and private practice venues.

The SE LHIN will investigate the dimensions of the apparent deficit in rehabilitation services and develop strategies to increase capacity.

Activities supporting this priority

Discharge Link*:* This program provides physical rehabilitation services to recently recovered stroke survivors. Discharge Link was launched in February 2009 to provide enhanced community-based rehabilitation services for stroke survivors at home and in long-term care homes. Since the program started, it has taken on 145 clients – with approximately 25% of new clients having just been discharged from hospital as a result of their stroke. Discharge link lets stroke survivors leave hospital sooner and begin their healing and recovery at home with family.

Expansion of rehab services: With the increased number of total joint procedures within the LHIN, access to physical rehabilitation services has been supported through additional funding for community-based physiotherapy. Additionally, Providence Care continued to provide post-operative rehabilitation services for more complex patients receiving total joint replacements to ensure the best possible clinical outcomes, improved quality of life, and reduce the risk of clinical complications or hospital readmissions.

Physical Activation Programs: Several of our hospitals have started providing rehabilitation programs for seniors who have lost some physical capacity during the course of a hospital stay. The programs are designed to restore physical capacity in these individuals to enable them to return to independent living at home rather than be admitted to a long-term care home. These programs are being supported with physical activation programs for seniors admitted to hospitals, to minimize any loss of physical capacity while in hospital.

Results

The LHIN anticipates seeing a reduction in the number of patients designated as requiring an alternate level of care, fewer referrals for long-term care, and better clinical outcomes for total joint replacements and stroke recovery.

Improving access to transportation to and from health care services

Land ambulance services across the LHIN were identified as being well provided for emergency transportation. However, transporting patients between facilities when the patient is critically ill, but stable, presents an ongoing challenge.

Non-urgent transportation to and from health care providers was identified as a significant challenge in all communities where public transportation was not an option. Where public transport is not available; other options are reported as prohibitively expensive. This includes transportation between hospitals for specialized treatment and diagnostic services, both for non-urgent but necessary and urgent interventions.

Non-urgent wheelchair and stretcher accessible transport are not available in most communities.

The SE LHIN will develop plans to improve access to transportation for care.

Activities supporting this priority

HSP Transportation Forum: The health service providers within the LHIN who have a role in providing transportation for residents met twice in 2009/10 to advise on how transportation could be improved. A working group of these providers, including area land ambulance services, are working with LHIN staff to create a transportation framework that will guide improvements.

Health Vans: The South East LHIN was provided with seven passenger vans to provide transportation to and from health care appointments. The LHIN target for increased utilization was 10,700 one way trips per year. One van was taken out of service in 2009/10 due to a vehicle accident. The remaining six vans have been put into service by our partner agencies to ensure they were used to best advantage. By employing the vans on longer-haul trips and transferring larger groups of patients, the hope is that we improve services while not overburdening the volunteer drivers who support these transportation programs. The LHIN has not yet met the total number of additional trips required when receiving the vans. However, we believe that not achieving this target is offset by the longer distances travelled in this region.

Results

The LHIN has seen increased access to volunteer based transportation services in the LHIN, as well as increased access to handicapped accessible transportation services.

Improving the availability of long-term care services

Long-term care home placements and complex continuing care placements were identified as being in short supply. 60% of patients waiting for an alternative level of care were waiting for a placement in one of these two venues. There was also a high number of clients waiting for these placements in the community. The ratio of people waiting for admission to these placements compared to beds available is the third highest in Ontario, and is increasing.

Other long-term care options, including retirement residences and geared-to-need supportive housing were also identified as being in short supply across the LHIN.

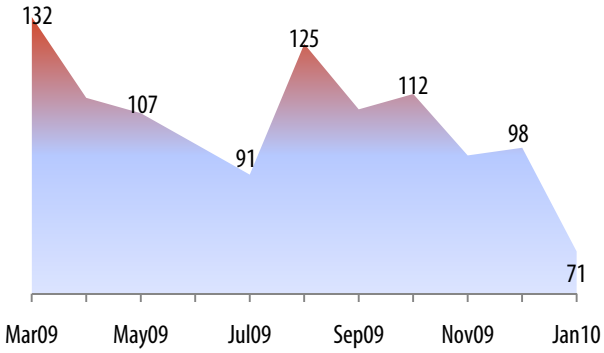
SE LHIN will develop a plan to realign current capacity to better meet the needs of the population and/or to increase the capacity of one or more long-term care modalities.

Activities supporting this priority

Wait List Management: The Community Care Access Centre was directed to review and reassess the eligibility of all clients on the waiting list for long-term care placement. This resulted in a reduction of over 200 clients from the wait list for long-term care.

SMILE: Since the SMILE program was launched over two years ago, the wait list has dropped by an additional 482 clients. Accounting for reductions due to ineligibility, death, or other circumstances (captured through the CCAC review) the remaining reductions are attributed to the SMILE program providing the right level and combination of home-based services to reduce reliance on long-term care.

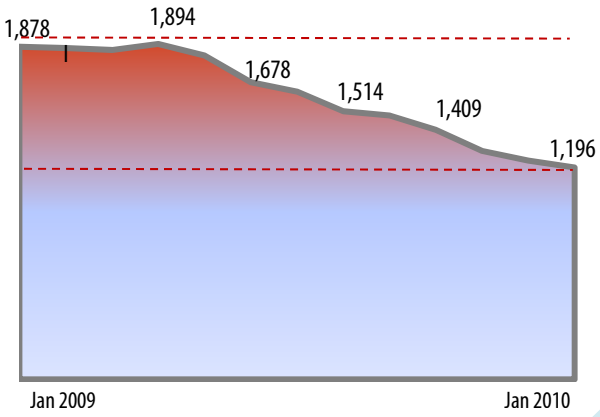
Figure 3: Median Days to Long-Term Care Placement



Results

Over 2009/10, the median days to Long-Term Care Placement dropped from 132 days to 71 days, or 46%. The number of clients waiting for Long-Term Care placement dropped from 1,878 to 1,196, or 36%. 2009/10.

Figure 4: Clients waiting for Long-Term Care Placement



Making the movement of patients between different health care organizations and professionals easier

Integration of services and service provision along the continuum of care is especially important for the large number of people with chronic diseases in the LHIN. This approach improves the quality of care by minimizing disruptions in service; resulting in better quality of life and improved health.

Participants in the community engagement and stakeholder consultation process stressed the importance of improving the 'hand-off" of patients between providers.

Standardization of processes and sharing of patient information were seen to be key to improving integration.

The LHIN will work with providers to identify and adopt best practice models for eliminating barriers and improving the flow of patients along the continuum of care.

Activities supporting this priority

Integrating information systems: Two projects were completed in 2009/10 that improved the seamless transition of care between providers by leveraging information technology. Information technology systems between two Family Health Teams and their nearest hospitals has provided family doctors with real-time access to hospital charts, clinical notes, diagnostic reports and specialist consults. Where implemented (Kingston and Belleville) this has resulted in significant reduction of administrative burden for family physicians (57% reduction in hard-copy reporting, 24 to 72 hour reduction in report turnaround times), who are now acting on current information instead of chasing after dated reports.

Standardized Assessment: Community Support Service Agencies started training to adopt the interRAI community health assessment tool (interRAI-CHA). Use of standardized community assessments will enable consistent evaluation and determination of required services, improved knowledge and understanding of the clients being served in the community, and the ability to quantify the impact of services on clients' lives. It also supports a shared understanding of levels of care, and client need among health service providers, which improves clinical decision making. Projects like this are a necessary step towards the development of an electronic health record.

Improved coordination of care: Work done as part of our aging at home strategy has improved the dialogue and cooperation between hospital discharge planners, CCAC case coordinators, and community service support case coordinators within the LHIN. Over the last three years, an increase of 45% in referrals to CSS agencies has been observed.

Results

These examples are early indicators that improved communication, leveraged through technology or through better understanding of roles, can improve cooperation, access, and patient care.

Developing better communication between the South East LHIN and local aboriginal communities

Canadian studies of First Nations health care have consistently shown that First Nations populations have reduced life expectancy and poor health status compared to the general Canadian population. The LHIN needs to develop and implement a framework for ongoing dialogue with the First Nations and off-reserve First Nations communities within the LHIN.

Aboriginal Community Health Services and Engagement Activities

The LHIN made it a priority to develop better communications with Aboriginal communities within our LHIN as a first step to determining their needs for health services, and how best to support these needs. Aboriginal people represent 2.8% of those living in the South East LHIN (not counting the Mohawks of the Bay of Quinte who did not take part in the census).

The South East LHIN has worked to build cordial and supportive working relationships with Aboriginal leaders with the intent of building trust between the LHIN and Aboriginal communities so that we can support the health care needs of this population.

Activities in support of Aboriginal Community Health Services

Our activities in 2009/10 focused on improving relationships as a means to creating awareness and trust between the LHIN and Aboriginal communities. This included identifying opportunities where the LHIN could offer assistance to Aboriginal communities in their efforts to ensure appropriate access to care.

In November 2009, our Board Chair and staff representatives attended a cultural awareness session at the invitation of the Métis Nation of Ontario (MNO) in Bancroft. The session provided the LHIN with information about the Métis people and their issues accessing services. The Métis Nation of Ontario is completing a health survey of their people in 2010-11. The results of this survey will inform further discussions on how the LHIN may provide assistance.

Aboriginal Community Health Services

This following is a listing of the services identified to the LHIN as Aboriginal Community Health Services. This list should not be taken as exhaustive, as new programs and services are made available regularly.

Katarokwi Native Friendship Centre (Kingston)
◊ Aboriginal Healing and Wellness Program
◊ Life Long Care Program
◊ Aboriginal Community Mental Health
◊ Aboriginal Healthy Babies/ Healthy Children Program
◊ Aboriginal Prenatal Program
◊ Nokomis Early Years Literacy Program
◊ Program for Early Parent Support (PEPS)
◊ Mother Earth Play Group
◊ Meals to Make/ Meals to Take, Nutritional Bingo, craft classes
◊ Sweat lodges, community feasts, First Nations awareness workshops, drum circles, drum making classes
Métis Nation of Ontario

◊ Transportation ◊ Visiting – Social, safety and hospice ◊ Caregiver Support ◊ Service Arrangement / Coordination / Case Management ◊ Mental Health Services (in partnership with Providence Care) ◊ Telemedicine services (in partnership with Keewaytinook Okimakanak Telemedicine (KOTM) and the Ontario Telemedicine Network) ◊ Diabetes awareness, gambling awareness, Aboriginal Healing and Wellness Strategy, and the Aboriginal Healthy Babies Healthy Children Program
Mohawks of the Bay of Quinte
Community Support Services ◊ Activities of daily living support (transportation, meal programs, home maintenance, security programs, day programs, homemaking and personal support) ◊ Home and community care (nursing) *Aboriginal Healing and Wellness* ◊ Shelters ◊ Aboriginal Healthy Babies Health Children *Community Health Centre* Health Services with a focus on health promotion and disease prevention ◊ Immunizations ◊ Health information and education ◊ Patient & health advocacy as needed; referrals ◊ Peri-natal classes (moms-in-waiting program, nutrition, breastfeeding) ◊ Communicable disease follow-up and information ◊ Diabetes education and testing ◊ "Good Food" and "Good Lunch Box" programs ◊ Drop in Clinics Tuesdays and clinics at the Elders Lodge ◊ Registered Dietitian services. ◊ Chiropody
Kingston and Quinte West Community Health Centres
• Nurse Practitioner positions (pending)
Kingston General Hospital
KGH serves as the tertiary care referral centre for the Weeneebayko Health Ahtuskaywin, located at James Bay.

LHIN staff attended a similar session sponsored by the Katarokwi Native Friendship Centre (KNFC). The LHIN was able to support the Centre by providing them with funding through the Aboriginal Health Transition Fund Ontario Adaptation Plan. LHIN staff had frequent contact with the KNFC during the implementation of the project, which was completed at the end of the fiscal year.

Our Board Chair and CEO have regular meetings with the Chief and Council of the Mohawks of the Bay of Quinte (MBQ). These meetings provide an opportunity to improve relationships and create awareness. LHIN staff also met with MBQ representatives to develop a plan for improved access to primary health care. Based on these meetings, the LHIN was able to secure and provide funding for a Nurse Practitioner for the Mohawks of the Bay of Quinte, based out of the community health centre in Napanee. The LHIN continues to work to obtain ministry approval for a second position to be funded, based out of the Quinte West community health centre (when that centre is opened).

Improving access to health care services in French

There is a reported lack of health professionals who can provide services in French. This may be a barrier for francophones living in the South East LHIN which may affect the quality of health services and the health of francophone residents.

Francophone Community Health Services and Engagement Activities

A lack of French speaking health professionals was identified in our first IHSP as presenting a significant barrier to accessing care for francophone residents in the South East.

In May 2009, the Province of Ontario designated the City of Kingston under the *French Language Services Act*. This designation required provincially funded agencies to develop plans to provide services in both of Canada's Official Languages.

The South East LHIN has actively sought input from the francophone community on their health care needs. We have used the information obtained through formal community engagement exercises as well as through regular meetings with community groups to inform *Reaching for Excellence*, as well as providing this information to those health service providers who serve the francophone community.

Since the City of Kingston's designation under the *French Language Services Act* (FLSA) in May 1, 2009, the LHIN has worked with health service providers and planners to ensure effective implementation plans were developed. The LHIN has focused planning of our providers on building capacity to provide French language services through resource sharing.

The South East LHIN was able to secure bilingual staff to provide services within our offices. Two positions within the LHIN are designated as bilingual, and we have three staff people who are able to provide services in either English or French.

Health Service Providers Designated to provide French Language Services in Kingston
◊ Kingston General Hospital
◊ Hotel Dieu Hospital
◊ Providence Care (including Providence Manor for long-term care)
◊ Frontenac Community Mental Health Services
◊ Options-for-Change
◊ Salvation Army Harbour Light
◊ Community Care Access Centre
◊ Victorian Order of Nurses
◊ Seniors Association Kingston Region
◊ Hospice Kingston
◊ Mental Health Support Network South Eastern Ontario
◊ Canadian National Institute for the Blind
◊ The Canadian Hearing Society – Kingston Region
◊ Alzheimer Society of Kingston
◊ Sexual Assault Centre Kingston

Figure 5: Agencies affected by the FLSA designation

Key community engagement activities

Monthly inter-ministerial meetings with community members prior to Kingston's designation

LHIN facilitated meetings with health service providers to provide assistance as they implemented their French Language Services Plans

LHIN staff attended the Annual General Meeting of association canadienne-française de l'Ontario

Bilingual LHIN staff were present at all ENGAGE 2009 sessions, including a session held specifically for francophones

LHIN staff attended a provincial francophone conference to explore better practices to further French language health services

Improving access to primary health-care

Access to primary health care services was identified as a priority issue in all parts of the LHIN, with the exception of Prince Edward County. The reported cause of this issue was an inadequate number of family physicians within the geographic area.

We will focus on further developing integrated, multi-disciplinary models of primary care.

Activities supporting this priority

Health Care Connect: Healthcare connect is a provincial service, conceived and developed in the South East LHIN, that provides a means for Ontarians to obtain a primary health care practitioner without canvassing all local physicians.

Primary Health-care Council: The South East LHIN established our Primary Health Care Council two years ago. The Council is charged with the responsibility of advising the LHIN on how best to build a system of primary care. It is comprised of primary care providers from across the LHIN, and led by the Chair of the Department of Family Medicine at Queen's University, Dr. Glenn Brown

Community Health Centre Satellite: The Kingston CHC opened its satellite at its interim location in downtown Napanee in 2009/10. The CHC satellite provided medical services and nursing support only, given the close quarters of the interim site. The LHIN Board has endorsed the location of a permanent site in the downtown core to the Ministry.

Primary Health Care Support: The LHIN was consulted by the Ministry and made recommendations with respect to new Family Health Team in Northbrook and new nurse practitioner-led clinic in Belleville

Results

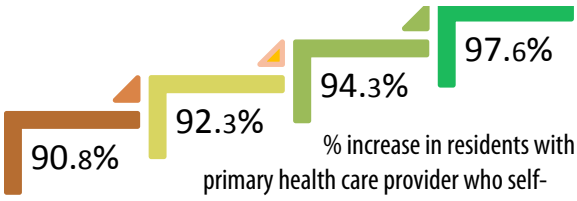
In 2007, approximately 80% of Ontarians living in the South East LHIN did not have a primary health care provider. In 2009, 96% of Ontarians in the South East LHIN who wanted a primary health-care provider had one.

Access to primary care
Indicator: % of residents with primary health care:

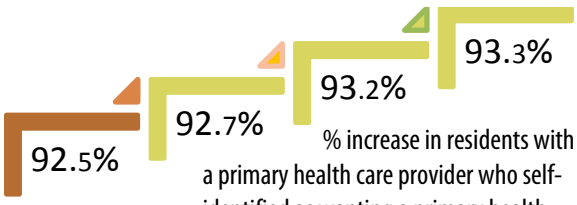
2006: 90.8%

2009: 97.6%

Health Care Connect: A demonstration of local ideas making both a local and provincial impact



% increase in residents with a primary health care provider who self-identified as wanting a primary health care provider in the **South East LHIN**



% increase in residents with a primary health care provider who self-identified as wanting a primary health care provider in **Ontario**

Moving ahead with the development and use of electronic health information systems

In a 2005 report prepared by the Ontario Hospital Association, it was suggested that hospitals in the South East LHIN are relatively less prepared for electronic sharing of patient information than other providers in Ontario. This was confirmed through stakeholder consultation. Other agencies are apparently no better prepared for electronic sharing of patient information. Most health service providers indicated the need for an electronic patient record to make current patient information available to all providers. Without such a tool, there will be duplication, inefficiencies and potential errors. The use of electronic health records would also be of particular benefit in the management of patients with chronic diseases.

The SE LHIN will work with providers to implement an integrated strategy for acquiring and deploying e-health technologies within the LHIN

Activities supporting this priority

Secure electronic mail: The SE LHIN has partnered with eHealth Ontario to provide secure e-mail technology and infrastructure to our health service providers. Use of the secured One Network is allowing health service providers to simplify referrals and scheduling. Over 267 sites are now connected through the One Network. 61 HSPs have deployed One Mail (secure email through the One Network) for healthcare with over 9,420 users registered.

Diagnostic Imaging: South East LHIN hospitals have now moved to electronic storage and retrieval of diagnostic images (like x-rays, CT scans, and MRI scans) through Hospital Diagnostic Imaging Repository Services. Electronic storage and retrieval of diagnostic images is a necessary step towards having an electronic health record. In early 2010/11, all South East LHIN hospitals will have the ability to share diagnostic images with other hospitals in Ontario.

Clinical Document Repository (CDR): Collaborating with eHealth Ontario and the Champlain LHIN, the South East LHIN is developing an electronic document repository for clinical records. The CDR will initially hold traditional 'paper' hospital reports, like discharge summaries and specialist consult notes. Hospitals and community primary health care providers will have access to the repository, which will allow family doctors to find and retrieve clinical documentation for their patients at any time. Once the hospital-based information has been uploaded, the repository may be expanded to include reporting from community agencies, like the CCAC.

Results

The South East LHIN is advancing e-health technology and supporting health provider adoption of this technology to ensure its effective deployment.

Developing a regional health human resources plan

The availability of sufficient and qualified health care workers across numerous disciplines and occupational groups is one of the leading issues for the South East LHIN. Until recently, no appropriate systems or structures existed to support human resource planning and development at the national, provincial or local level. Most participants in the stakeholder consultation sessions felt that the LHIN should take a leadership role in developing an overall health human resources plan for the region.

SE LHIN will develop a model for the most effective and efficient deployment of health human resources in the different sub-areas of the LHIN

Activities supporting this priority

The LHIN acknowledges the support and collaboration on the projects of HealthForceOntario (HFO), the provincial agency responsible for health human resources recruitment.

Inventory of physicians in the South East LHIN: As part of the ReCAP project, the LHIN and HFO prepared an inventory of all practicing physicians within the LHIN. This enabled ReCAP to evaluate current and future capacity within primary health care.

Health Professions Database: The Ministry's Health Human Resources Policy Branch is creating a database that once populated, the database will provide standardized, consistent and comparable demographic, geographic, educational, and employment information on all of the regulated allied health professionals in Ontario. This database will reflect information from 20 health regulatory Colleges. This database will be available sometime in 2010.

Health 'extender' role implementation: Physician assistants have been introduced and are working in Brockville General Hospital Emergency Department, Quinte Health Care (Trenton Memorial Site Emergency Department), and the Family Health Teams in Gananoque, Kingston, and Brighton. We have already seen a very positive impact with the physician assistants in our emergency departments. The additional assistance has increased morale in the departments and having these professionals on staff has contributed to the recruitment of new physicians to the area.

Nursing 70% Full Time Initiative: The South East LHIN was one of three LHINs working with the ministry on strategies to increase the number of nurses working full time to 70%. A toolkit for achieving higher proportion of nurses employed full-time is now a regional resource for our health service providers.

Results

The LHIN continues to build a solid infrastructure of knowledge and competency with respect to the current and future health human resources requirements of our LHIN, in the context of provincial initiatives and expanded health practitioner roles.

Community Engagement

Report on Activity

The majority of our community engagement activity in 2009/10 was directed towards seeking input for *Reaching for Excellence*, the South East LHIN's second Integrated Health Services Plan. That engagement campaign, ENGAGE 2009, is described in greater detail below.

In addition to consultations to inform the *Reaching for Excellence*, the LHIN undertook to engage our residents, providers and other stakeholders through the following venues:

Hospital Service Accountability Agreement Community Engagement Survey – designed to ensure that our engagement with residents was relevant, meaningful and would advance the LHIN's corporate strategic objectives.

October 2009: Health Service Provider Board Community Engagement Sessions (LHIN sponsored).

August 2009: Public Notice of Proposed Regulations under the Local Health System Integration Act, 2006 regarding Aboriginal Community Engagement.

February 2009: LHIN Launches ENGAGE 2009.

ENGAGE 2009

The LHIN's ENGAGE 2009 Community Engagement Campaign was one of the most innovative and intensive community engagement activities to occur in Ontario. It created an informed dialogue between the LHIN and those with a stake in the local health care system. ENGAGE 2009 began in late January with a meeting of our over 130 of our health service providers at a kick off meeting to review the result of ReCAP. ReCAP data will allow providers to identify opportunities to support the LHIN's priorities for development over the coming three years.

Provider input, along with ReCAP data, was advanced to ENGAGE 2009's second stage – a special citizen's reference panel comprised of 36 Ontarians, selected randomly from across the LHINs geographic area. Additionally, LHIN staff hosted community open houses in each of the LHIN's 15 sub-LHIN planning areas.

The South East LHIN's IHSP2 Priorities for Development

Developing a system of primary health care
Enhancing a culture of patient-centred care

Improving mental health and addictions services capacity

Developing regional program management

Improving access to emergency room care

Reducing the incidence and prevalence of Alternate Level of Care

Implementing the Ontario Diabetes Strategy

Furthering access through e-Health

Expanding culturally and linguistically sensitive health-care services

Advancing System improvement through boards working together

The results of ENGAGE 2009 were then cross-referenced with the quantitative data obtained through ReCAP. LHIN staff were then able to align projected need with residents' priorities The result was *Reaching for Excellence*, the South East LHIN's second IHSP (IHSP2) and its priorities for development, which build upon the foundation of IHSP1.

Working together for better results

Addressing provincial priorities in the South East

The South East LHIN works collaboratively with the Ministry of Health and Long-Term Care to address government priorities. The primary focus for 2009/10 was to reduce the times people waited in Emergency Rooms (or Departments) (ER), and reduce the number of people who wait in hospital for an alternate level of care (ALC).

Understanding the Emergency Room – Alternate Level of Care Relationship

At a surface level, the relationship between Emergency Department volumes and discharging patients from hospital is quite clear. Assuming full occupancy, for every new patient to be admitted, another patient needs to be discharged. When the LHIN started to consider this problem, we were more interested in knowing about the patients who were coming to the ER, being admitted and why they had trouble going home after their hospital care was completed.

The LHIN used known demographics, clinical data, and information provided by front line staff to develop a profile of the type of patient that would most likely come to the Emergency Department, be admitted even though their condition was not immediately life threatening, and would very likely be referred for placement in a long-term care home.

The typical ER/ALC patient would likely be:

Over the age of 75

Living alone, or the primary caregiver for a spouse who could not take care of him/herself

Recently experienced the death of a spouse / loved one / primary care giver

Diagnosed as having at least one chronic disease (like congestive heart failure, diabetes, etc)

Recovering from a recent change health status

Each of these characteristics speaks to a single event or combination of factors that render a senior unable to cope with their life circumstances. Once that occurs, an adverse event – from slipping and falling to dehydration – will result and a trip to the emergency department is now a reality.

Figure 6 shows two general paths that a senior's life could take in the event that there is a change in health status. The blue path assumes that supports are available and in place that will reduce the risk to the senior of experiencing a risk to their health. Studies completed in Denmark have suggested that provision of home support services can reduce the demand on long-term care by up to 30%.

The red path shows a more typical pattern for seniors today, and explains why hospitals are seeing increased pressure on beds due to admissions from the emergency department and alternate level of care.

1 *A senior experiences an adverse event and is taken to Emergency Department*

2 *Examination of the patient may or may not reveal the actual cause of their problem. If it is not discovered, the senior will enter a cycle of repetitive visits to the ER with varying symptoms, all based on an underlying inability to perform instrumental activities of daily living*

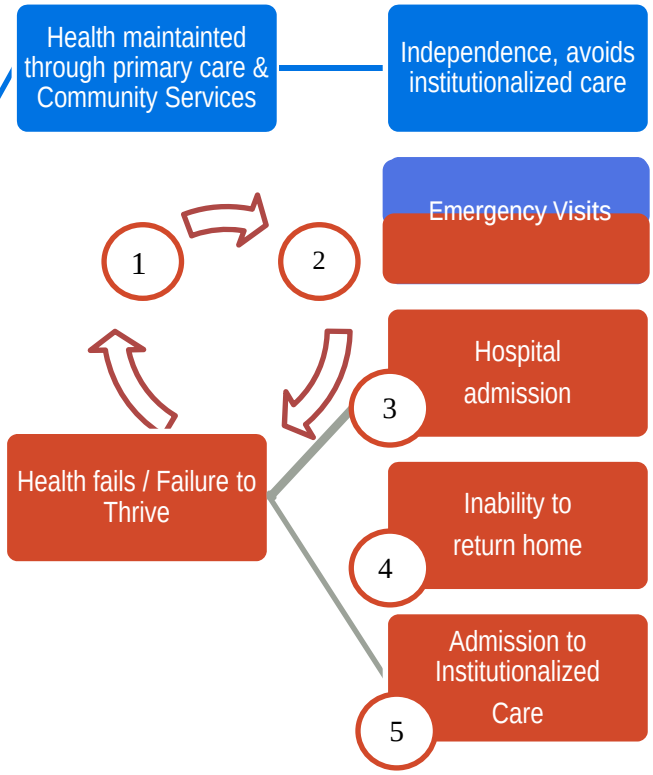
Eventually the senior will be sufficiently debilitated and admission to the hospital is felt to be the only reasonable course of action. The senior will be treated symptomatically for the presenting diagnosis

3 *For each day of bed rest, an average person can lose between 1% and 5% of muscle. This is not usually an issue for the majority of us, but for a senior who was barely able to manage before hospital admission, a six day stay could be the difference between coping and not coping.*

4 *When the senior is assessed for discharge, it will be discovered that they are not capable of performing their instrumental daily living activities. As a result, the senior will be referred for long-term care home placement*

5 *Because there are no available beds in long-term care homes, the senior will have to wait in the hospital until the alternate level of care becomes available*

Figure 6 Impact of Health Status and Supports on Seniors



The South East LHIN ER/ALC Strategy

The ER/ALC strategy implemented by the LHIN addresses each of the boxes, or decision-points in the diagram.

Health maintained through primary care and community services: CCAC, CSS, and the SMILE Program. Combined, they can provide a web of care for seniors.

Emergency visits: Early identification of frail elderly by Emergency Room Staff is made and a referral for community home support services assessment provided.

Hospital Admission: Directed programming to maintain / restore physical capacity to support a discharge home. Other programs are geared to support culture change and make the focus of discharge 'to home'. Programs include home first and home at last.

Business process redesign: Operational improvements for higher throughput.

Managing LTCH wait list

Part of our strategy was to ensure that the wait list for placement in long-term care accurately reflected the demand for these beds. The South East CCAC conducted a review of clients waiting on the list and was able to reduce the list by approximately 200 clients.

Over the past two fiscal years, the number of clients waiting for a long term care bed dropped by 632 clients. Beyond the wait list review, we attribute the reduction of 432 clients to the SMILE program, described below.

SMILE

Seniors Managing Independent Living Easily (SMILE) is a project unique to the South East LHIN. It allows the SMILE coordinating agency to provide services in addition to CCAC and CSS services. If there is no local service provider, SMILE will pay for the provision of those services to whomever the client wishes to employ.

Emergency Department Waits

Wait times in our emergency departments have shown modest improvement over 2009/10. The longest waits are in the larger hospitals in the LHIN. Kingston General Hospital has shown good results through implementation of their ER performance improvement plan as well as through process improvement done through the Ministry's Pay for Results program. The ministry recently added Quinte Health Care to both of these programs, and the hospital is currently preparing for their implementation.

The LHINs strategy to improve wait times is a combination of reducing reliance on ERs, as well as improving how well ERs operate. As can be seen, the number of visits to the ER for the general population as well as those 75 years of age and older, are trending down. Reducing the people who visit the ER allows doctors and nurses time to care for those in greatest need.

Figure 7: ER Visits in the South East LHIN

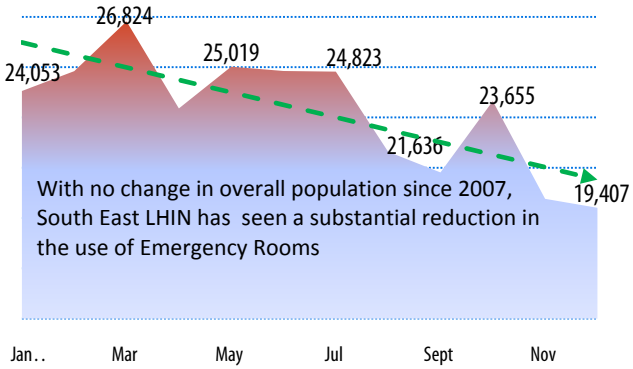
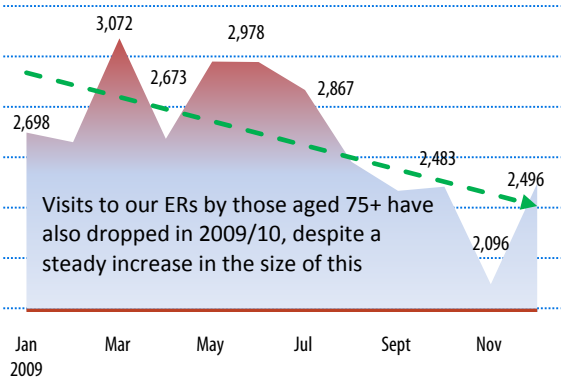
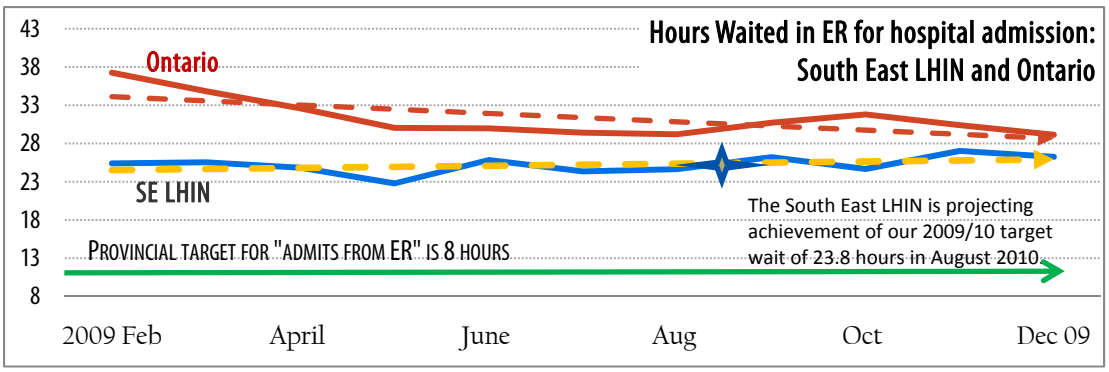


Figure 8: ER Visits by Aged 75+ South East LHIN



Patients waiting for admission from the Emergency Department still have long waits before an in patient bed is made available for them. As can be seen, this is a province-wide issue.

Figure 9: ER Waits, South East LHIN / Ontario



Alternate Level of Care – Improving access to post-hospital care options

Figure 7 shows what percentage of hospital beds were occupied by patients who could have been discharged from the hospital if appropriate services had been available in the community. Working with our hospitals, Community Support Services, and the Community Care Access Centre, the LHIN has been able to improve the flow of patients out of hospital by reducing the number of people waiting for long-term care placement, reducing the median wait for that placement, and implementing programs that let people go home to wait for placement.

Home First

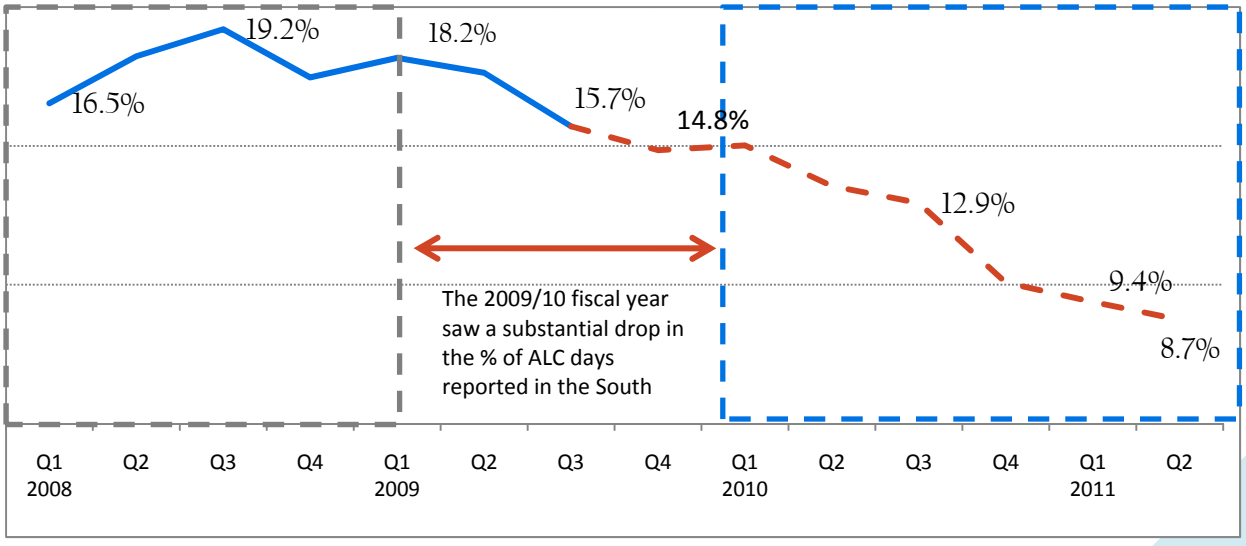
Home first is about letting seniors go home after a hospital stay who would otherwise be designated as requiring an alternate level of care. It represents a different way of thinking for the health system. In the not so distant past, many of the patients who are going home after their hospital treatment would instead be waiting in the hospital for a long-term care home bed to become available. When launched at QHC, the hospital saw a significant drop in the number of patients being designated as ALC. By improving access and intensity of community services, the "home first way" QHC was also saw a reduction in unnecessary hospitalizations. What's more, more than half of the seniors who went home base the home first philosophy are still at home. This has reduced the demand for long-term care home beds, which will improve the ability for those who need that level of care to get it sooner.

Discharge Link

Discharge Link was launched in February 2009 to provide enhanced community-based rehabilitation services for stroke survivors at home and in long-term care homes. Services provided through this program are described on page 10.

Overall, the South East LHIN's integrated ER/ALC strategy is intended to meet Ontario's targets for wait times and access while meeting local health care needs. We are already seeing the positive results after just a few months of projects under the strategy being launched. We expect even greater results going forward.

Figure 10: % ALC Rates 2008 - 2011 (projected)



The South East LHIN reviews, on a quarterly basis (or more frequently if a performance issue arises), a number of performance indicators – including financial and operational performance – with Health Service Providers (HSPs) partially or fully funded by the LHIN. These indicators are specified within the signed Service Accountability Agreements between the LHIN and each HSP.

In addition to these indicators the LHIN is responsible for performance indicators included in the Ministry LHIN Accountability Agreement (M-LAA). The current M-LAA requires the LHIN to report on the 11 performance indicators summarized below. This page reports the indicators provided by the Ministry to the LHIN. The following pages provide a description and relevant facts associated with the indicator results for 2009/10.

SOUTH EAST LHIN MLAA Performance Indicators
FY 2009/2010 - May 14, 2010

PI #	Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10	FY 2009/10	LHIN Performance Target - 2009/10	Performance Corridor - Higher Value	Performance Corridor - Lower Value	Used Performance Value - FY 2009/10	LHIN Met Target - Within Corridor (YES/NO)
1	90th Percentile Wait Times for Cancer Surgery [1.1]	Access	84	63	48	62	47	54	51	55	60.50	49.50	51	YES
2	90th Percentile Wait Times for Cataract Surgery [1.1]	Access	182	117	90	104	95	100	97	117	128.70	105.30	97	YES
3	90th Percentile Wait Times for Hip Replacement [1.1]	Access	182	187	132	160	151	138	146	182	200.20	163.80	138	YES
4	90th Percentile Wait Times for Knee Replacement [1.1]	Access	182	222	145	174	141	130	148	182	200.20	163.80	130	YES
5	90th Percentile Wait Times for Diagnostic MRI Scan [1.1]	Access	28	116	111	93	74	70	95	90	112.50	67.50	70	YES
6	90th Percentile Wait Times for Diagnostic CT Scan [1.1]	Access	28	48	26	28	23	28	27	31	38.75	23.25	28	YES
7	Median Wait Time to Long-Term Care Home Placement -All Placements [2.1]	Integration	50	142	112	118	151	71	111	120	150.00	90.00	111.00	YES
8	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution [2.2]	Integration	9.46%	17.37%	18.17%	17.63%	15.78%	17.20%	17.22%	13.00%	14.30%	11.70%	17.22%	NO
9	Proportion of Admitted patients treated within the LOS target of ≤ 8 hours [1.1]	Access	90.00%	55.00%	60.00%	61.44%	58.19%	45.24%	57.40%	57.00%	57.00%	55.00%	57.40%	YES
10	Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III [1.1]	Access	90.00%	87.00%	87.70%	87.55%	88.32%	87.34%	87.72%	89.00%	89.00%	88.00%	87.72%	NO
11	Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours [1.1]	Access	90.00%	87.00%	89.29%	89.07%	88.79%	89.07%	89.06%	88.00%	88.00%	88.00%	89.06%	YES

Data Timeframe Definitions

1. Wait Time & ER LOS Indicators:

1.1 FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr 2009 to Mar. 2010.

2. Non-Wait Time Indicators:

2.1 LTCH Placement Indicator:- FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from Apr 2009 to Mar. 2010.

2.2 ALC Indicator:- Q4 %ALC days is estimated based on Q1, Q2, & Q3 2009/10 Data. FY 2009/10 LHIN Annual Results are also estimated based on Q1-Q4 2009/10 Data.

3. Used Performance Value - FY 2009/10

3.1. For all 90th Percentile Wait Time Indicators, IF LHIN 20009/10 Starting Point is GREATER than Provincial Target, LHIN Year-End Performance will be assessed against Q4 2009/10 Actual Performance Value.

3.2. For all 90th Percentile Wait Time Indicators, IF LHIN 2009/10 Starting Point is LESS than Provincial Target, LHIN Year-End Performance will be assessed against FY 2009/10 Actual Annual Performance Value.

3.3. For Percentage of ALC Days, and Median Time to LTC Home Placement, the LHIN's performance will be assessed against the LHIN results available in Q4 for the fiscal year (i.e. data for 2009/10 Q1, Q2 and Q3).

3.4. For the 3 ER LOS indicators, LHIN Year-End Performance will be assessed against LHIN performance the full fiscal year. (FY 2009/10 Actual Annual Performance Value).

Target Assessment

YES = LHIN Met Target / Within Corridor

NO = LHIN Did Not Meet Target / Not Within The Corridor

LHIN Commentary on Performance Indicator Results

Cancer Surgery Wait time *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor	Result	
		84	63	48	62	47	54	51	55	60.5 / 49.5	51	Met

The improvement of waits for selected cancer surgeries is fully credited to the hard work and dedication of the leadership, clinical, and care teams of the Southeastern Ontario Cancer Centre.

Cataract Surgery Wait time *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor	Result	
		182	117	90	104	95	100	97	117	128.7 / 105.3	97	Exceeds

Cataract surgeries demonstrated the most profound reductions in waits in the South East LHIN. In 2007, the wait between surgical consultation and procedure was over 300 days. These waits dropped to 117 days at the beginning of the 2009/10 fiscal year. The remaining reduction was seen in 2009/10.

During that year, Ontario launched the "wait time guarantee" for cataract procedures. Residents who could not obtain cataract procedure in their own LHIN within a specific timeframe, would have the service provided elsewhere in the province. No one in the South East LHIN needed to use the guarantee.

Hip Replacement Surgery wait time *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor	Result	
		182	187	132	160	151	138	146	182	200.2 / 163.8	138	Exceeds
Knee Replacem't **Surgery wait time** *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor	Result	
		182	222	145	174	141	130	148	182	200.2 / 163.8	130	Exceeds

The South East LHIN has made tremendous progress in reducing waits for total joint replacement surgeries. In the current fiscal year, this was primarily due to the implementation of a short-stay surgical unit at Hotel Dieu Hospital in Kingston. In 2009/10, the hospital was able to provide an additional 107, procedures. In addition to these procedures increasing capacity, because Hotel Dieu is primarily an ambulatory care centre, they do not experience the same backlog pressures as other hospital with respect to admissions of urgent or emergent patients, or patients waiting for an alternate level of care.

Diagnostic MRI Wait Time for scan *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor		Result	Met
		28	116	111	93	74	70	95	90	112.5	67.5	70	

Diagnostic MRI waits were reduced largely due to the launch of a new MRI at Quinte Health Care. Results for diagnostic MRI scans would have been better, but health human resource issues at some sites prevented operation of the MRIs at optimal capacity. Strategies have been developed by the hospitals affected, including training of additional staff and expansion of operating hours, to ensure that targets continue to be met or exceeded.

Diagnostic CT Scan Wait time for scan *90th %ile wait (days)*	Access	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor		Result	Met
		28	48	26	28	23	28	27	31	38.8	23.3	28	

CT Scan waits are now at the provincial target. The LHIN anticipates these results will be maintained or improved with the launch of a new CT Scanner at Perth and Smiths Falls District Hospital in Summer 2010.

Long-Term Care Home Placement *Median wait (days)*	Integration	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor		Result	Met
		50	142	112	118	151	71	111	120	150	90	111	

The reduction in waits for placement in long-term care is due to a review of the wait list by CCAC to confirm eligibility and that those on the list still wanted to be considered for LTCH placement. Additionally, the SMILE program (see page 27) has allowed approximately 400 seniors to defer or remove themselves from the LTCH wait list, as they are now able to manage for themselves at home.

Alternate Level of Care *% of ALC days by LHIN*	Integration	Goal Target	LHIN Start	Fiscal Year 2009-10 Q1	Q2	Q3	Q4	YE	2009/10 Target	Performance Corridor		Result	Not Met
		9.4%	17.4%	16.6%	17.5%	15.7%	17.2%	17.2%	13.0	14.3%	11.7%	17.4%	

The South East LHIN's self reported percentage of ALC days is lower than the result calculated by the Ministry of Health and Long-Term Care. The Ministry calculated the fourth quarter and year-end results based on averaging the quarterly results. This would be an appropriate proxy measure under normal circumstances, but in this circumstance, the LHIN has implemented home first. The success of home first in our first test hospital was substantial, showing a 65% decrease in the number of patients who were designated as requiring an alternate level of care. Home first is now being implemented LHIN-wide, and the LHIN fully anticipates that the results will be similar in effect. As a result, the Ministry calculated year-end result is not indicative of current or future performance. The year-

end result reported here is the LHIN's estimate of our year-end result based on data collected from our hospitals. Please see figure X (page 24) for the LHIN's projected ALC results, based on the success of home first and other initiatives under our integrated ER/ALC strategy.

Admits from ER		Goal Target	LHIN Start	Fiscal Year 2009-10					2009/10 Target	Performance Corridor		Result	
				Q1	Q2	Q3	Q4	YE			57%		
Admitted within 8 hours	Access	90%	55%	60.0%	61.4%	58.2%	45.2%	57.4%	57%		55%	57.4%	Not Met
Treated in LOS <8 hours													

The South East LHIN continues to make progress on this important access point to the health-care system. Our results in 2009/10 were not as dramatic as gains made in other areas. This is due primarily to the complexity associated with bed management within hospitals and the fluctuating demand from the emergency departments for inpatient beds. Our integrated ER/ALC strategy will, over time, improve the situation as projects like SMILE and Home First are designed to reduce the pressure on emergency departments and to expedite discharge from hospital. Going forward, the LHIN is investigating what the average occupancy rate within hospitals should be in order to accommodate transfers from the ER.

High acuity ER patients treated within targets		Goal Target	LHIN Start	Fiscal Year 2009-10					2009/10 Target	Performance Corridor		Result	
				Q1	Q2	Q3	Q4	YE			89%		
<8(CTAS-II), <6(CTAS III)	Access	90%	87%	87.7%	87.6%	88.3%	87.3%	87.7%	89%		88%	87.7%	Not Met

Low Acuity ER patients treated within target		Goal Target	LHIN Start	Fiscal Year 2009-10					2009/10 Target	Performance Corridor		Result	
				Q1	Q2	Q3	Q4	YE			NA		
<4(CTAS IV/V)	Access	90%	87%	89.3%	89.1%	88.8%	89.1%	89.1%	88%		88%	89.6%	Met

The South East LHIN was within 0.3% of our performance corridor for High Acuity Patients and above our performance corridor for Low Acuity Patients seen in the Emergency Department. It is important to note that over the course of the year, the LHIN has performed consistently below the performance corridor (exceeding our target range). Continued improvements in emergency department efficiency projects ongoing at Kingston General Hospital and recently begun at Quinte Health Care will ensure targets are met as we move forward.

Funding Allocation

Total: **$5,546,569**
Base: **$4,711,569**
Project: **$ 835,000**

South East LHIN management administered an allocation of $5,546,569 in fiscal year 2010. The allocation is comprised of the LHIN's total corporate operational budget of $4,711,569, along with special ancillary project-based funding totalling $835,000.

Ancillary Project-based Funding

The LHIN received special funding for projects supporting Ministry of Health and Long-Term Care health system priorities, and LHIN Integrated Health Services Plan Priorities for Change. These projects included:

- e-Health Project Management Office†
- Performance Lead, Emergency Room / Alternative Level of Care Strategy†
- Emergency Department Physician Lead†
- Aboriginal Community Engagement
- Aboriginal Health Transitions Fund
- Ontario Diabetes Strategy

† A Ministry of Health and Long-Term Care condition of funding is the selection of an individual to lead this project. Project leads are provided with work space within the LHIN offices.

2009/10 Audited Financial Statements

An external audit was conducted by Deloitte & Touche LLP in April 2010. A copy of the auditor's report is provided in the following section of this document. The results of the audit for the 2009/10 fiscal year were very positive. The South East LHIN ended the fiscal year in a balanced financial position.

Statutory Compliance – *Ontarians with Disabilities Act, 2001*

Pursuant to direction from the Accessibility Directorate of Ontario, the South East LHIN implemented staff training on the requirements of the *Ontarians with Disabilities Act*, developed an Accessibility Plan for the LHIN, and reported on our compliance to the Directorate. The LHIN has met its obligations under statute and has ensured that Ontarians with disabilities have access to our facilities, services, and information made available to the public.

Financial statements of

South East Local Health Integration Network

March 31, 2010

South East Local Health Integration Network

March 31, 2010

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Auditors' Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the statement of financial position of the South East Local Health Integration Network (the "LHIN") as at March 31, 2010 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 East Local Health Integration Network as at March 31, 2010 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, 2010

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**975,076**	1,011,618
Accounts receivable	**-**	1,788
Due from the LHIN Shared Services Office (Note 5)	**1,895**	-
	976,971	1,013,406
Liabilities		
Accounts payable and accrued liabilities	**854,148**	1,016,982
Due to MOHLTC (Note 3)	**128,747**	5,895
Due to the LHIN Shared Services Office (Note 5)	**-**	16,697
Deferred capital contributions (Note 6)	**289,421**	292,545
	1,272,316	1,332,119
Net debt	**(295,345)**	(318,713)
Non-financial assets		
Prepaid expenses	**5,924**	26,168
Capital assets (Note 7)	**289,421**	292,545
	295,345	318,713
Accumulated surplus	**-**	-

Approved by the Board

Georgina Thompson, Board Chair

John Ferguson, Director and
Audit Committee Chair

South East Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**905,077,193**	**960,628,457**	905,077,193
Operations of LHIN (Note 3)	**4,619,185**	**4,667,028**	4,384,082
e-Health (Note 4a)	**425,000**	**600,000**	425,000
Emergency Department (Note 4b)	**75,000**	**75,000**	75,000
Aboriginal Initiative (Note 4c)	**15,000**	**15,000**	15,000
Aboriginal Health Transitions Fund Initiative (Note 4d)	**-**	**20,000**	24,450
ER/ALC Initiative (Note 4e)	**100,000**	**100,000**	33,300
Ontario Diabetes Strategy (Note 4f)	**25,000**	**25,000**	-
70% Full Time Nursing Initiative	**-**	**-**	50,000
Amortization of deferred capital contributions (Note 6)	**-**	**47,665**	54,605
	910,336,378	**966,178,150**	910,138,630
Expenses			
Transfer payments to HSPs (Note 9)	**905,077,193**	**960,628,457**	905,077,193
General and administrative (Note 10)	**4,619,185**	**4,657,862**	4,438,687
e-Health (Note 4a)	**425,000**	**567,499**	425,000
Emergency Department (Note 4b)	**75,000**	**57,227**	74,330
Aboriginal Initiative (Note 4c)	**15,000**	**15,000**	15,000
Aboriginal Health Transitions Fund Initiative (Note 4d)	**-**	**20,000**	24,450
ER/ALC Initiative (Note 4e)	**100,000**	**100,000**	33,000
Ontario Diabetes Strategy (Note 4f)	**25,000**	**9,253**	-
70% Full Time Nursing Initiative	**-**	**-**	50,000
	910,336,378	**966,055,298**	910,137,660
Annual surplus before funding repayable to the MOHLTC	**-**	**122,852**	970
Funding repayable to the MOHLTC (Note 3A)	**-**	**(122,852)**	(970)
Annual surplus and closing accumulated surplus	**-**	**-**	-

South East Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2010

	2010	2009
	$	$
Annual surplus	**-**	-
Acquisition of capital assets	**(44,541)**	(235,103)
Amortization of capital assets	**47,665**	54,605
Change in prepaid expenses	**20,244**	20,327
Decrease (Increase) in net debt	**23,368**	(160,171)
Opening net debt	**(318,713)**	(158,542)
Closing net debt	**(295,345)**	(318,713)

South East Local Health Integration Network

Statement of cash flows

year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**47,665**	54,605
Amortization of deferred capital contribution (Note 6)	**(47,665)**	(54,605)
Changes in non-cash operating items		
Decrease (increase) in accounts receivable	**1,788**	(1,750)
Decrease in prepaid expenses	**20,244**	20,327
Decrease (increase) in due to the LHIN Shared Services Office	**(18,592)**	14,828
(Decrease) increase in accounts payable and accrued liabilities	**(162,834)**	331,178
Increase (decrease) in due to MOHLTC	**122,852**	(482,989)
	(36,542)	(118,406)
Investing transactions		
Acquisition of capital assets	**(44,541)**	(235,103)
Financing transactions		
Capital contributions received (Note 6)	**44,541**	235,103
Net decrease in cash	**(36,542)**	(118,406)
Cash, beginning of year	**1,011,618**	1,130,024
Cash, end of year	**975,076**	1,011,618

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 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 East 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 ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2010.

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 is home to over 482,000 people, which encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. 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 losses in the book value of assets.

2. Significant accounting policies (continued)

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 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. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as 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

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the 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.

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

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized, on a straight line basis, over their estimated useful lives as follows:

Office Equipment	5 years
Computer equipment	3 years
Leasehold improvements	Life of lease
Web developments	3 years

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

2. Significant accounting policies (continued)

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 disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

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

3. Funding repayable to the MOHLTC

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.

In accordance with the accounting policy related to deferred capital contributions (Note 2) the LHIN has recognized the amortization of deferred capital contributions of $47,665 (2009 - $56,605) as revenue. This has resulted in an increase to the overall LHIN Operations revenue as shown in the table below. LHIN Operations base funding for 2010 after adjustments was $4,711,569 as detailed in Note 8.

A. The amount repayable to the MOHLTC is made up of the following components:

			2010	2009	
	Revenue	**Expenses**	**Surplus**	Surplus	Total due to MOHLTC
	$	**$**	**$**	$	$
Transfer payments to HSPs	**960,628,457**	**960,628,457**	**-**	-	-
LHIN operations	**4,714,693**	**4,657,862**	**56,831**	-	56,831
E-Health	**600,000**	**567,499**	**32,501**	-	32,501
Emergency department initiative	**75,000**	**57,227**	**17,773**	670	18,443
Aboriginal initiative	**15,000**	**15,000**	**-**	-	-
Aboriginal health transitions Fund initiative	**20,000**	**20,000**	**-**	-	-
ER/ALC Initiative	**100,000**	**100,000**	**-**	300	300
Ontario Diabetes strategy	**25,000**	**9,253**	**15,747**	-	15,747
	966,178,150	**966,055,298**	**122,852**	970	123,822
Aging at Home (relates to prior year)	**-**	**-**	**-**	4,925	4,925
	966,178,150	**966,055,298**	**122,852**	5,895	128,747

3. Funding repayable to the MOHLTC (continued)

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

	2010	2009
	$	$
Due to MOHLTC, beginning of year	**5,895**	488,884
Funding repaid during the year	**-**	(488,884)
One-time funding repayable to the MOHLTC	**66,021**	5,895
LHIN Operations funding repayable to MOHLTC	**56,831**	
Due to MOHLTC, end of year	**128,747**	5,895

4. a) e-Health Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $600,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan. Unspent funds, amounting to $32,501 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	**322,040**
Consulting services	**12,834**
Travel	**16,236**
Meeting expenses	**14,006**
Other	**202,383**
	567,499

b) Emergency Department Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $75,000 from the MOHLTC. These funds were used toward initiatives in support of the strategic Emergency Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan "Priority for Change". Unspent funds, amounting to $17,773 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	**52,505**
Travel	**4,682**
Meeting expenses	**36**
Other	**4**
	57,227

c) Aboriginal Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $15,000 from the MOHLTC. These funds were used toward planning and engagement with the Aboriginal community in support of the Integrated Health Services Plan "Priority for Change".

	$
Expenses	
Other	**15,000**
	15,000

4. (continued)

d) Aboriginal Health Transitions Fund Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $20,000 from the MOHLTC. These funds were provided through the Federal Government to provinces and used to support implementation of the approved project under the Aboriginal Health Transitions Fund Initiative.

	$
Expenses	
Other	**20,000**
	20,000

e) ER/ALC Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $100,000 from the MOHLTC. These funds were used in support of the ER/ALC Strategy.

	$
Expenses	
Salaries and benefits	**100,000**
	100,000

Actual expenditures incurred as part of the ER/ALC Initiative activities were in excess of the $100,00 funding provided by the MOHLTC. The total of actual expenses is $140,215. The deficit has been funded through LHIN Operations base as follows:

	$
Expenses	
Salaries and benefits	**28,670**
Travel	**7,524**
Meeting expenses	**1,692**
Other	**2,329**
	40,215

f) Ontario Diabetes Strategy Initiative

During fiscal 2010, the South East LHIN received funding in the amount of $25,000 from the MOHLTC. These funds were used in support of the MOHLTC directive on the Ontario Diabetes Strategy. Unspent funds, amounting to $15,747 at year end, are repayable to the MOHLTC.

	$
Expenses	
Other	**9,253**
	9,253

5. Related party transactions

LHIN Shared Services Office (LSSO)

The LSSO is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO 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 from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Collaborative (LHINC)

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;
- 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 Ministry of Health and Long-Term Care.

LHINC is a division of Toronto Central LHIN and as such is subject to the same policies, guidelines and directives as the Toronto Central LHIN.

6. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**292,545**	112,047
Capital contributions received during the year	**44,541**	235,103
Amortization for the year	**(47,665)**	(54,605)
Balance, end of year	**289,421**	292,545

7. Capital assets

			2010	2009
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office equipment	**313,983**	**54,313**	**259,670**	237,340
Computer equipment	**69,567**	**63,187**	**6,380**	6,963
Leasehold improvements	**116,854**	**93,483**	**23,371**	46,742
Web development	**21,500**	**21,500**	**-**	1,500
	521,904	**232,483**	**289,421**	292,545

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $960,628,457 is made up of the following:

	$
Initial HSP funding budget	**905,077,193**
Adjustment due to announcements made during the year	**55,551,264**
Total HSP funding budget	**960,628,457**

The total operating budget of $4,711,569 is made up of the following:

	$
Initial budget	**4,619,185**
Additional funding received during the year	**92,384**
Total budget	**4,711,569**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $960,628,457 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2010	2009
	$	$
Operation of Hospitals	**640,350,426**	605,347,505
Grants to compensate for Municipal Taxation - Public Hospitals	**190,725**	188,475
Long Term Care Homes	**148,948,420**	138,338,261
Community Care Access Centres	**92,924,681**	89,228,091
Community Support Services	**23,443,792**	20,035,925
Assisted Living Services in Supportive Housing	**1,988,446**	1,944,690
Community Health Centres	**14,921,422**	13,512,469
Community Mental Health Addictions Program	**37,860,545**	36,481,777
	960,628,457	905,077,193

10. General and administrative expenses

A. The Statement of Financial Activities presents expenses by function. The following classifies general and administrative expenses by object, as follows:

	2010	2009
	$	$
Program based		
Salaries and benefits	**3,214,628**	2,960,329
Consulting and LHIN-based projects	**94,381**	226,555
	3,309,009	3,186,884
Shared Services	**362,714**	300,000
Collaborative	**12,286**	-
Other (details listed below)	**343,509**	241,860
Occupancy	**152,006**	163,071
Office equipment and supplies	**143,261**	188,053
Board per diem	**165,752**	149,042
Public relations	**69,180**	99,816
Mail, courier and telecommunications	**52,480**	55,356
	4,610,197	4,384,082
Amortization	**47,665**	54,605
	4,657,862	4,438,687

B. The breakdown of "Other" general and administrative expenses listed in the table above are:

	2010	2009
	$	$
Training and development	**94,498**	57,811
Travel	**159,673**	160,242
Recruitment	**16,662**	5,330
Insurance	**16,319**	16,281
Other miscellaneous	**56,357**	2,196
	343,509	241,860

C. The total expenses related to governance is as follows, and are included in the expenses listed in Note 10A above:

	2010	2009
	$	$
Board chair per diems	**89,250**	82,075
All other per diems	**76,502**	66,967
Total per diems	**165,752**	149,042
Other governance related costs	**115,464**	135,335
	281,216	284,377

11. 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 2010 was $250,426 (2009 - $232,948) 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 of December 31, 2009. 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 commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next two years are as follows:

	$
2010	**56,626**
2011	**130**
	56,756

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2010 the LHIN had signed Accountability Agreements with all Hospitals and Community Agencies for the next two years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

Reference

Acronym & Figures Tables

Acronyms

AAH	Aging At Home
ABP	Annual Business Plan
ACFO	Association canadienne-francais de l'est de l'Ontario
ACTT	Assertive Community Treatment Team
ALC	Alternate Level of Care
CCAC	Community Care Access Centre
CCHS	Canadian Community Health Survey
CHA	Community Health Assessment
CHC	Community Health Centre
CHRA	Citizens' Regional Health Assembly
CMH CAP	Community Mental Health Common Assessment Project
EASIER+	Eldercare Access Strategy in the Emergency Room – Plus
EMS	Emergency Medical Services (Land Ambulance)
ER / ED	Emergency Room / Emergency Department
HFO	HealthForce Ontario
HSP	Health Service Provider
HSRC	Health Services Restructuring Commission
IHSP	Integrated Health Services Plan
KGH	Kingston General Hospital
LHIN	Local Health Integration Network
LHSIA	*Local Health care system Integration Act, 2006*
LTC	Long-Term Care
LTCH	Long-Term Care Home
Ministry	Unless otherwise specified, the Ministry of Health and Long-Term Care
M-LAA	Ministry-LHIN Accountability Agreement
M-SAA	Multi-sector Service Accountability Agreement
MOHLTC	Ministry of Health and Long-Term Care
OMA	Ontario Medical Association
PMO	Project Management Office
ReCAP	Regional Capacity Assessment and Projection
ROHCG	Royal Ottawa Health Care Group
SMILE	Seniors Managing Independent Living Easily
WTS	Ontario's Wait Times Strategy

Figures

Ontario
Local Health Integration Network