South East **LHIN**

# Integrated Health Care for Local Communities

## 2015/16 Annual Report

ISSN 1920-3748

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# Letter from the Board Chair and CEO

On behalf of the South East LHIN Board of Directors and staff, we are pleased to present our Annual Report for 2015-16. This report highlights our LHIN's activities, accomplishments and financial information for 2015-16. It also chronicles the third and final year of the journey mapped out in our 2013-16 Integrated Health Service Plan, *Better Integration, Better Health Care.*

2015-16 was a year of significant progress for health care in the South East. It was a year in which, more than ever, health care in Ontario was informed by a shared determination to put patients first. This province-wide commitment has been enthusiastically embraced by the South East LHIN, and was reflected in many of our activities and achievements over the past year.

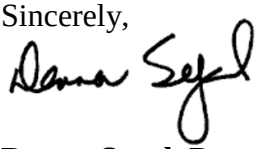
Specifically, the Addictions and Mental Health Redesign undertaken by our LHIN began entering the implementation phase in 2015-16. This bold redesign aims to address many of the issues that have traditionally plagued addictions and mental health systems, and we are now well on our way to delivering what we are calling the Ideal Individual Experience to clients in this region.

From mental health to seniors care, our commitment to patients is clear and profound. We worked very hard in 2015-16 to support seniors with an interest in maintaining their independence and continue living at home through our Seniors Managing Independent Living Easily program and Home First. Great potential can already be seen for the future with our Assisted Living initiative. In addition, seniors and other complex patients are receiving more efficient service and better follow-up care after being discharged from hospital, thanks to the South East Health Integrated Information Portal.

An ongoing focus this past year, as it has been in every year since our LHIN was created, was better integration. A great example of these activities is the Health Care Tomorrow - Hospital Services Project, which is a dynamic collaboration between our LHIN and this region's seven hospital organizations, the Community Care Access Centre, and Queen's University Faculty of Health Sciences. We are working together to make it easier for patients to get care, when they need it, here in the South East, while responding to the financial challenges facing our health care system across the province. It is just one of the ways in which we are helping facilitate inter-agency collaboration and joint strategic planning in support of better patient care.

As always, we have been supported in our work by this region's health providers and administrators, and we have been guided by the many patients and patient groups with whom we have engaged and consulted. We would like to thank all of them, and also express our deep gratitude to the staff of this LHIN, who come to work every day determined to make a positive difference for the patients in our region.

Sincerely,



**Donna Segal**, Board Chair

**Paul Huras**, CEO

## Board of Directors

The South East Local Health Integration Network (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 Chief Executive Officer (CEO) operationalizes strategic directions established by the Board and provides updates on our progress towards achieving our IHSP priorities through monthly reports on operational activities and key performance indicator results.

**Donna Segal (Chair)**
Appointed: 21 December, 2012
Reappointed: 21 December, 2015
Term Expires: 20 December, 2018

**Andreas von Cramon (Vice-Chair)**
First Appointed: 28 April, 2010
Term Expires: 27 April, 2016

**Dave Samson**
First Appointed: 4 May, 2011
Term Expires: 7 May, 2016

**Lois Burrows**
First Appointed: 21 November, 2012
Reappointment: 18 November, 2015
Term Expires: 17 November, 2018

**Janet Cosier**
First Appointed: 1 February, 2013
Term Expired: 31 January, 2016

**Maribeth Madgett**
First Appointed: 10 December, 2014
Term Expires: 9 December, 2017

**Chris Salt**
First Appointed: 5 January, 2015
Term Expires: 4 January, 2018

**Brian Smith**
First Appointed: May 6, 2015
Term Expires: May 5, 2018

**Jack Butt**
First Appointed: June 17, 2015
Term Expires: June 16, 2018

## The South East LHIN Strategic directions

**The South East LHIN Board of Directors has set in place four corporate strategic directions to guide decisions:**

1. **To build a true system of integrated health care that optimizes resources**
2. **To build understanding of the role of the South East LHIN in the development and management of a regional system of integrated patient-centered care in collaboration with Health System Providers**
3. **To build a functional integrated health information system that supports better health care services and healthier citizens**
4. **To demonstrate leadership as a knowledge-based organization that is credible, professional, proactive and responsive**

# INTRODUCTION

Ontario's 14 Local Health Integration Networks, or LHINs, were established in 2005 to manage the planning, funding and integration of the province's health care system. The creation of LHINs reflected a growing understanding that the province's health system needed to be more responsive to local needs and priorities. As the name Local Health Integration Network implies, LHINs have a mandate to bring about better integration between providers, amongst health care organizations, and across sectors.

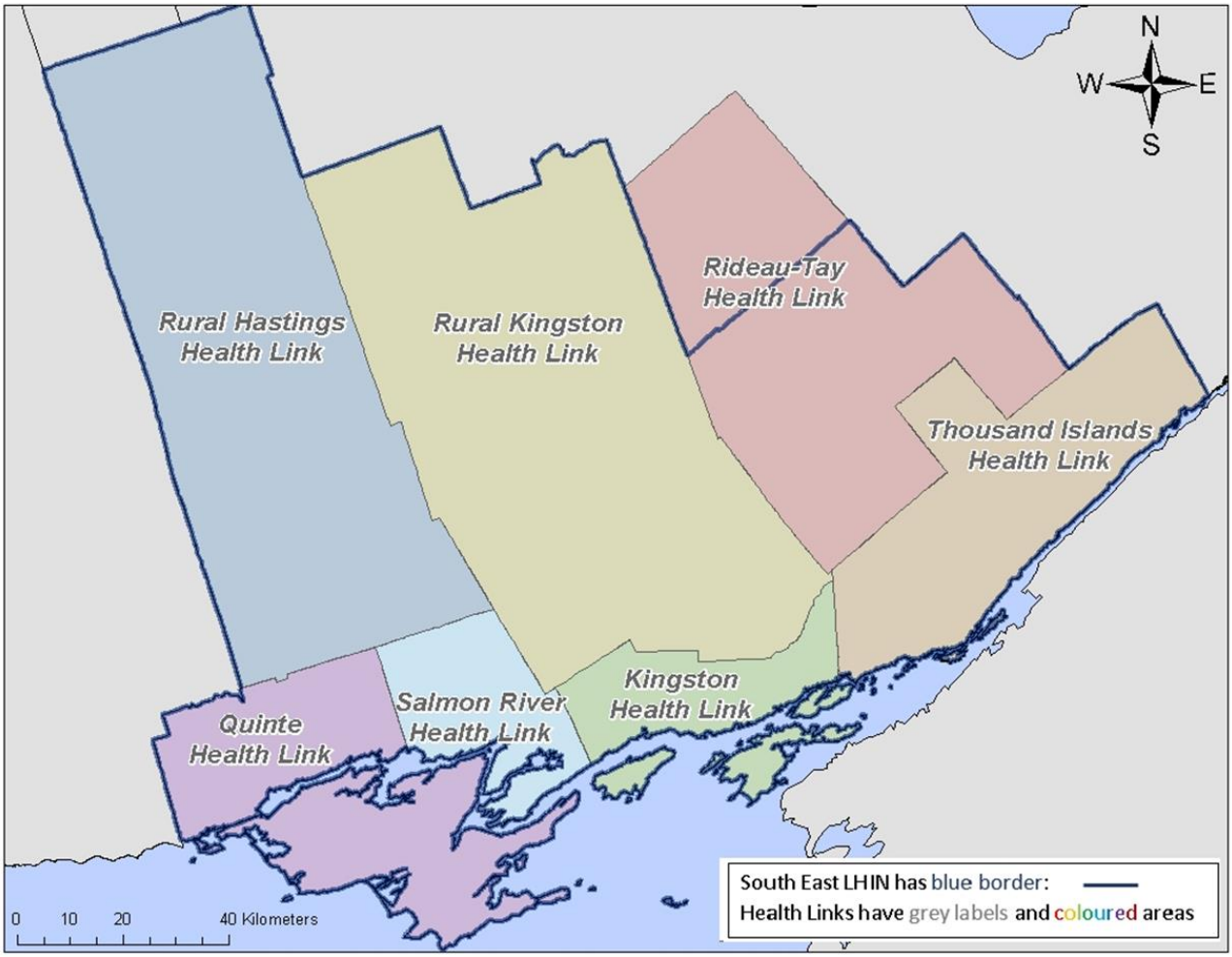
Every three years, LHINs are required to produce Integrated Health Service Plans, or IHSPs, which outline their broad priorities for health care in their regions. 2015-16 was the third and last year covered by the South East LHIN's third IHSP, which was entitled *Better Integration, Better Health Care*. In addition to IHSPs, LHINs also produce Annual Business Plans, which could be considered road maps that lay out the ways and means by which LHINs can complete the health care journeys described in their Integrated Health Service Plans.

This annual report – *Integrated Health Care for Local Communities* – looks back on a year in which our LHIN made significant progress towards the achievement of our goals of improving integration and care in South Eastern Ontario.

# THE SOUTH EAST LHIN COMMUNITY OVERVIEW

Our LHIN spans the Highway 401 corridor, from Brighton and Quinte West in the west through Belleville and Kingston to Brockville and Prescott in the east. The region includes the towns of Bancroft, Perth and Smiths Falls. Geographically, our LHIN is the largest in Southern Ontario, encompassing the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac Counties, the bulk of Leeds and Grenville United Counties and portions of Lanark and Northumberland Counties.

Historically, the South East LHIN has utilized subLHIN geographies for planning purposes. However, since the introduction of the Health Links initiative in 2013, planning efforts have been focused on the seven new Health Links geographic regions identified in the map below.



## The South East LHIN Population

As of 2014, the South East LHIN was home to almost 495,000 people – about 3.6% of Ontario's overall population, making us the third smallest LHIN in terms of population. However, the South East LHIN had the highest proportion (21%) of adults aged 65+. By 2026, that proportion of seniors is expected to have risen to 28% of the LHIN's population. The 65-74 and 75+ age groups are also projected to grow in all our Health Link regions during this period. The Rideau-Tay and Rural Hastings Health Links are projected to have the highest percentage of the population aged 65+ in 2026 (35% and 34%, respectively).

The highest annual growth rate for those 65-74 in the next five years is projected to be in Salmon River (3.5% annual growth), and the highest rate for those 75+ will be in Salmon River and Rural Kingston (both 4.8%). In contrast, the younger age groups will generally see negative growth in each Health Link, except the Kingston Health Link where there will be minimal growth (just over 1% annually) in the 0-19 and 20-44 year age groups.

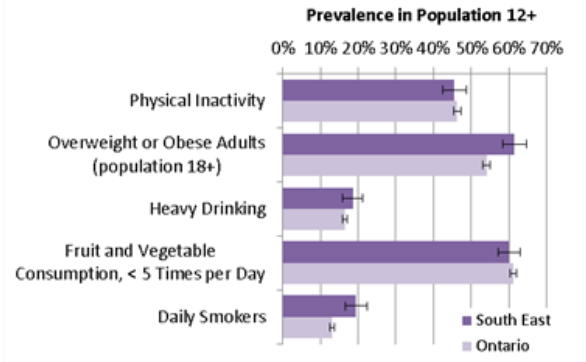
Overall, the projected annual growth rate in the South East LHIN between 2016 and 2021 is estimated to be 0.5%. Salmon River and Kingston Health Links will have a slightly higher annual growth rate at 1% during this period.

The South East LHIN is expected to pass the half million population mark sometime in 2017.

## Population Health Profile

The South East LHIN scores relatively high on prevalence rates for a number of illness and injury risk factors. As shown in Figure 1, the Canadian Community Health Survey (CCHS) for calendar years 2013-14 shows that rates of overweight or obese adults and daily smokers were both higher in our LHIN than the rest of the province as a whole. Most LHIN residents reported not consuming enough fruits and vegetables, and approximately 20% were heavy drinkers. Additionally, nearly half of the population reported being physically inactive in their leisure time. These rates were similar to the province as a whole. However, the population in the South East LHIN also scored higher than average on such positive indicators as receiving an influenza vaccination and having a regular medical doctor.

Figure 1: Self-reported prevalence of various health behaviors, South East LHIN and Ontario, calendar years 2013-2014.

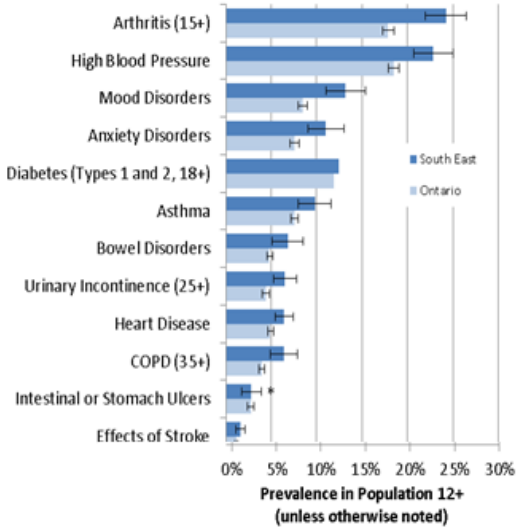



In terms of health status, a higher than average proportion of South East LHIN residents reported being limited in certain activities because of a physical condition, mental condition, or health problems in 2013-14. Additionally, approximately 10% of LHIN residents reported that their health was fair/poor, while eight percent reported that their mental health status was fair/poor. The proportion of residents who reported

fair/poor mental health status has increased slightly since 2005. In terms of self-perceived stress, the South East LHIN had similar rates of high life and work stress compared to the province as a whole.

Our LHIN also has higher than average rates of certain chronic conditions, as shown in Figure 2. These include arthritis, high blood pressure, mood disorders, anxiety disorders, type 2 diabetes, urinary incontinence, and COPD. This is in part due to the older average age in the South East LHIN. While rates of chronic conditions in older adults (65+) in the South East LHIN are slightly higher than the provincial average, they are not significantly different. The prevalence rates for most chronic conditions in the South East LHIN have appeared to increase over time.

Figure 2: Self-reported prevalence of various chronic conditions, South East LHIN and Ontario, calendar years 2013-2014.




Notes: Data with asterisk: Interpret estimate with caution due to high sampling variability. Diabetes prevalence is as of April 2013.

## Health Care Investments

In fiscal year 2015-16, the South East LHIN was assigned a budget of $1,108,268,201 with which to meet the specific needs of our population through this region's Health Service Providers (HSP). Figure 4 (below) shows the proportion of funds allocated to each health care sector in the South East LHIN.

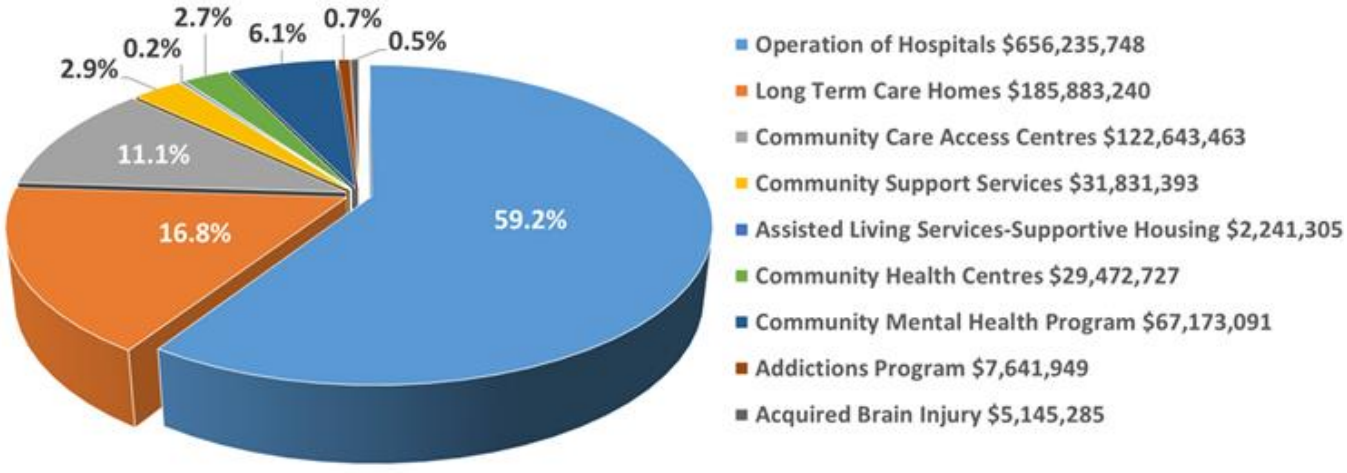
In fiscal year 2015-16, health service providers delivering care in the South East region included:

- 7 Hospital Corporations – operating 12 sites
- 1 South East Community Care Access Centre (CCAC)
- 5 Community Health Centres (CHCs) – operating 8 locations (5 main sites and 3 satellites)
- 30 Long-Term Care providers operating 4,050 beds in 37 facilities
- 27 Community Support Services Agencies (CSS)
- 10 Addictions and Community Mental Health providers of service which comprise the three newly established entities

During the last fiscal year, our LHIN relied on 86 Service Accountability Agreements (SAAs) and related performance assessments to appraise the performance of these agencies. By focusing on and addressing any performance issues, we are developing a regional healthcare system that not only provides high quality services but also is sustainable for years to come.

The South East LHIN reports annually on its use of public funds and the success of meeting health care provincial goals and objectives.

Figure 4: 2015/2016 Percentage of Funding Allocation by Health Sectors




# SOUTH EAST LHIN PRIORITIES

In February 2015, Ontario's Minister of Health and Long-Term Care, Dr. Eric Hoskins, released an updated Action Plan for Health Care called *Patients First: Action Plan for Healthcare*. This plan reinforced the province's determination to make the needs of patients the absolute focus of the health care system, and ensured that putting patients first would be a powerful theme in Ontario health care for many years to come.

***Patients First: Action Plan for Healthcare*** **focuses on four key objectives:**

1. **Access:** Improve access – providing faster access to the right care

2. **Connect:** Connect services – delivering better coordinated and integrated care in the community, closer to home

3. **Inform:** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health

4**. Protect:** Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come

The South East LHIN is committed to advancing all of these objectives, through official plans tailored to address our specific priorities for the delivery of health care within this region. As noted above, those plans are our three-year Integrated Health Services Plan, and our Annual Business Plan. Our LHIN's third IHSP, for which 2015-16 was the final year, established three key priorities for better integrated health care in South East Ontario. Those three priorities were as follows:

**Priority 1 –** *Developing a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care*

Integration has been a primary focus of the LHIN for more than a decade. We know that both quality and sustainability in health care depend on the cooperation and shared vision of everyone involved in the planning and delivery of health services. Integration is also a key enabler of putting patients first, as it encourages providers across the health spectrum to work together to meet the needs of patients. The South East LHIN has identified several significant initiatives will help us improve system integration. These include:

- Health Links
- Strong hospitals
- Addictions and Mental Health Services
- Information System and Enabling Technologies

**Priority 2 –** *Improving the patient experience with a focus on the transition points in care*

Transition points in health care are in many ways the occasions when patients are at their most vulnerable. They are being moved either from one provider to another, or from one setting to another, and these moves can frequently cause uncertainty and anxiety. In certain cases, they can also result in patients falling through the cracks, or their needs being either misunderstood or overlooked. Our efforts to improve the patient experience at these transition points have focused on areas such as better integrated addictions and mental health services and better care for seniors.

**Priority 3 –** *Focusing on the unique health care needs of Aboriginal and Francophone populations*

We know that Ontario's Aboriginal and Francophone populations have specific needs and face challenges to accessing care that the rest of Ontarians do not. We take our responsibility to help them meet those needs and overcome those challenges very seriously, and we continue to work with providers and the Aboriginal and Francophone communities to ensure that everyone in our LHIN can receive health care that is accessible and culturally appropriate.

Figure 5: Alignment of the South East LHIN's initiatives with Ontario's Action Plan for Health

# MINISTRY-LHIN INITIATIVES

## Health Links

Health Links are a model of health care delivery that seeks to improve care for patients living with multiple and complex conditions by supporting a strong partnership between and amongst providers and organizations. Across the South East LHIN, seven Health Links have brought health service providers and other partners together to identify patients with complex needs, enhance the delivery of health care for these individuals, and improve their health outcomes.

The success of the Health Links model is the result of health service providers collaborating to create coordinated care plans for their shared patients, and ensure they have access to primary care. Four South East LHIN Health Links have been able to reliably track data and report on measures related to acute hospital care, and their research confirms that once a coordinated care plan is implemented, patients with complex needs experience fewer hospital admissions and readmissions, as well as fewer emergency department visits.

## Decreased Acute Hospital Utilization

### Pre-post coordinated care planning (CCP) comparison

| Measure | Rural Hastings Health Link | Thousand Islands Health Link | Quinte Health Link | Kingston Health Link |
|---|---|---|---|---|
| **# emergency dept. visits** | ↓ 85.0% | ↓ 47.0% | ↓ 39.4% | ↓ 29.2% |
| **# acute care hospital admissions** | ↓ 80.0% | - | ↓ 49.2% | - |
| **# hospital 30-day readmissions** | ↓ 94.0% | - | ↓ 55.6% | - |
| **Length of stay (days)** | - | - | - | ↓ 22.8% |
| **Urgent care visits** | - | - | - | ↓ 42.6% |
| **Data description**<br>• **# patients**<br>• **# mths pre & post CCP implementation** | 103 patients<br>12 mths pre & 9-12 mths post | 49 patients<br>6 months pre & post | 72 patients<br>12 mths pre & post | 126 patients<br>6 mths pre & post |

In 2015-2016, a total of 1,183 patients with complex needs had a coordinated care plan implemented and all of these individuals were attached to a primary care provider. To date, the cumulative total patients with complex needs with a coordinated care plan in the South East has reached 2,361. To date, Health Links have achieved 82% of their target.

Our LHIN conducted an evaluation of the seven Health Links in the fall of 2015. That evaluation indicated that Health Links are showing progress towards their anticipated short-term and long-term outcomes, including:

- Increased patient-centered care
- Improving patient experience overall
- Improving the provider experience overall
- Strengthening communication/relationships between health care providers

(Reference: Evaluation of the Health Links in the South East LHIN, September 2015)

## ED Wait Times and ALC Pressures

Many patients form their opinions about the quality of their hospitals after a trip to the Emergency Department (ED). They are not wrong to do so. There is a clear correlation between the success a hospital has dealing with Alternate Levels of Care (ALC) pressures and ED wait times. If hospital resources are being consumed by patients who should be receiving care out in the community but cannot easily access this care, bottlenecks ensue and ED wait times increase. On the other hand, if hospitals are able to transition patients out into the community where they can receive the kind of care they need most, bottlenecks are avoided and ED wait times are lowered. When proper access to and flow through an emergency department is timely and successful, the public becomes confident that the healthcare system is functioning well, and also has more efficient access to ED care, when they need it.

### Table 2: Change in ED Wait Times noted from Calendar Years 2014 to 2015

| Pay for Results Hospital | ED LOS – admitted patients | ED LOS – non-admit patients | ED LOS – non-admit non-complex patients | Time to Physician Initial Assessment | Time to Inpatient Bed |
|---|---|---|---|---|---|
| **KGH** | Reduced by 36 min | Reduced by 42 min | Reduced by 12 min | No change | Reduced by 72 min |
| **QHC – Belleville** | Reduced by 108 min | No change | Increased by 30 min | Increased by 12 min | Reduced by 66 min |
| **QHC – Trenton** | Increased by 420 min | Reduced by 12 min | Reduced by 18 min | Reduced by 24 min | Increased by 360 min |

Source: Data obtained from ER Pay For Results program through Access to Care – ER Analytics, Cancer Care Ontario.

### System-Wide Patient Flow Strategy

The South East LHIN patient flow strategy focuses on diverting clients from the emergency department if their care needs can be met elsewhere – reducing their length of stay in the hospital, and ensuring that they receive appropriate community supports once discharged from hospital. The strategy starts with identifying clients that are at risk, as well as "tipping points" in the health and well-being of seniors. The strategy then identifies ways to assist these patients in maintaining independent living at home, reducing the kinds of illnesses or injuries that would require the use of EDs or admission to hospital.

In 2015-16, we continued working to develop and refine our patient flow strategy, focusing on three main areas of improvement:

- Reducing Inflow into the Hospital
  - ED Wait Time Performance & Capacity Management
- Intrafacility Flow
  - Admissions & Inpatient Patient Flow
  - Prevention/Care for ALC Patients
- Out flow - Transitions of Care

### ER Wait Time Management

Understanding and evaluating patients who visit Emergency Departments has helped the South East LHIN manage and improve system wide patient flow. We know that prolonged ED wait times reflect a backlog in the overall hospital patient flow system. Understanding this, we have supported initiatives focused on improving internal ED process, such as rapid assessment process and clinical decisions units, and we are working to improve overall hospital performance along with hospital and community capacity.

The Predicted Discharge Process would be an example of an effective initiative supported by this LHIN. Through the Pay for Results program, patient flow initiatives are focused on complex chronic disease community management, improving access to post-acute settings along with the implementation of a high risk screening tool to ensure high risk clients are identified early in their hospital visit. In this way, they can be linked with appropriate resources within the hospital to avoid prolonged hospitalization and linked with community support services so they can return home promptly with adequate support to remain at home.

**Senior Friendly Hospital**

The "Senior-Friendly Hospital" (SFH) philosophy continues to be a major component of the South East LHIN's senior care work plan. All hospitals within the South East have resurveyed their SFH actions plans, with many focusing their efforts on reducing functional and physical decline and early detection of delirium.

Four of the seven hospitals in the South East have participated in the SFH action plan (Accelerating Change Together In Ontario) developed and supported by the Regional Geriatric Program of Ontario. Learning from this initiative will ensure that older adults receive optimal care within acute care settings.

### Admissions and Inpatient Flow

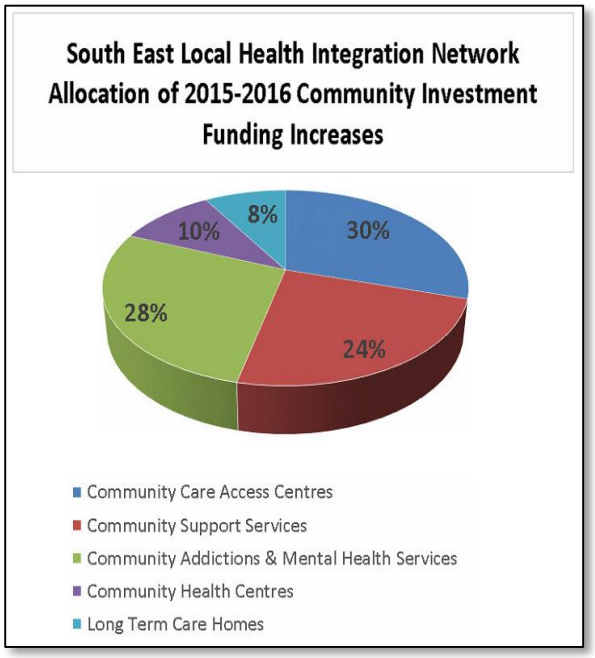
Our LHIN continues to work with health service providers in this region to improve admission and inflow. The idea is for every organization to try to identify those patients who are most at risk for repeat hospital visits, long hospital stays or poor outcomes if no immediate action is taken to help them transition to supportive care settings. Initiatives such as the High Risk Screening Tool, chronic disease clinics, and improved coordination between community services are reducing hospital admissions and revisits, while standardized discharge planning processes and tools are improving patient flow throughout organizations.

### Prevention/Care for ALC Patients

The South East LHIN continued working with local providers this past year to reduce the number of ALC days in our hospitals. When patients remain in a hospital bed after their acute treatment is completed, they are designated as ALC patients, and every day they stay in hospital is an ALC day. Part of the solution for reducing ALC days is to ensure that when possible, patients are cared for in the community or at home.
For those patients who do in fact require hospitalization, every effort must be made to ensure that they can return home as soon as possible. The ongoing focus on Senior-Friendly Hospital practices, adoption of the Home First philosophy, use of convalescent care beds and Behavioural Short Stay Transition Units along with Nurse Led Outreach Teams have all contributed to the prevention of ALC in the South East.

### Discharge and Transition of Care

The South East LHIN continues to endorse and support the work of a LHIN-wide peer to peer patient flow working group, which has developed and implemented standardized policies and protocols to reduce barriers to patient flow practices across the LHIN. In addition, over this past year the working group created an 18 month Patient Flow action plan with initiatives directed at three key areas: Inflow, Intraflow and Outflow.




## Home and Community Services

Much of the health care focus in the past several years, both in Ontario and specifically in the South East, has been on the improvement of home and community services. As noted above, this is a big component of reducing ED wait times and ALC Days. At the core, it is about improving the very kind of care that seniors and other frail, high-needs patients need most – the care that is delivered at home and in the community.

Over the last four years, the South East CCAC has noted a more than 100 per cent growth in the number of high-needs patients. In response to this situation, investments by our LHIN have enhanced the CCAC's capacity to support and care for these patients, and to continue to alleviate hospital

pressures. The main goal of the funding is to reduce wait times for frail patients by increasing access to in-home personal support services. Guided by the Ontario Government, the South East CCAC has established a five-day maximum target standard for service initiation for high needs clients. This standard aims to address existing wait times between discharge and the initiation of support services, and to reduce the number of patients that are designated as Alternate Level of Care (ALC) in an acute care setting waiting for long-term care placement.

### Seniors Managing Independent Living Easily (SMILE)

The South East LHIN continued its efforts in 2015-16 to create additional capacity within the Seniors Managing Independent Living Easily (SMILE) program. This program offers support to frail seniors who are at risk of losing their independence, with the goal of increasing the length of time that they can remain at home. The program offers:

- Support with everyday activities
- Personalized care plans with annual budgets matched to individual need
- Access to a core basket of services
- The option of having the help of a care coordinator
- A choice in who comes to their home to provide services
- Flexibility as to when services will be provided and how

Our LHIN continuously appraises the SMILE program's impact by tracking data and measuring the program's success in reducing avoidable hospital admissions and/or Emergency Department visits. Based on a recent evaluation, we have identified a number of continuous improvement opportunities in collaboration with the agency that operates SMILE in the South East region). Many of these opportunities are already in the process of being implemented or are under development.

### Home First

The Home First philosophy supports frail seniors who want to return home following an acute-care hospital stay, rather than being sent to a Long-Term Care Home (LTCH). Through an integrated discharge planning process, patients at high risk of being designated as ALC are being identified earlier to avoid the physical and cognitive decline that can accompany a lengthy hospital stay. This process also helps avoid inappropriate ALC designation or delays in discharge.

In the early part of last year, senior leaders in the South East undertook a redesign of the Home First philosophy in response to increasing ALC rates. This redesign is now underway, and includes standardizing the discharge process, as well as providing standardized messaging.

### Assisted Living

There may come a point when people who want very much to maintain their independence and remain at home simply cannot do so without help. It was with those people in mind that two years ago, our LHIN invested in the implementation of the Assisted Living Services for High-Risk Seniors (ALSHRS) program.

The goal of this program is to address the needs of high-risk seniors who can live at home but who require the availability of personal support and homemaking services on a 24-hour basis. The effectiveness of this

model has been confirmed in other parts of the province. The services provided under this program include:

- Personal Support Services such as help with dressing and personal hygiene, assisting with mobility, monitoring medication use and other routine activities
- Homemaking services including shopping, housecleaning, and meal preparation
- Security checks or reassurance services including visits to assure client health or safety
- Care Co-ordination including regular and ongoing communication with Community Care Access Centres, Community Support Service agencies, Community Social and Recreational Services, Community Primary Health Care Professionals

Under the existing investment, the ALHRS program supports approximately 120 clients with significant needs across the three hubs in the South East (Belleville, Brockville and Kingston). In all three areas, the goal of providing access to more intensive community supports for the targeted seniors has been achieved. Every indication suggests that additional investment is required for assisted living services in the region.

As part of the second phase of the ALSHRS implementation, the South East LHIN is in active conversation with other municipalities (Hastings and the United Counties of Leeds and Grenville in particular) about developing designated assisted units in municipal buildings.

### Acquired Brain Injury (ABI)

For more than a decade, our LHIN has been working with members of the Napanee community, Pathways to Independence, the Canadian National Ski Team alumni, and the community to develop community-based supportive living residences, which maximize independence and quality of life for people living with ABIs. This is an especially important issue in this region as it has been recognized that we do not have the same level of resources that are available elsewhere in the province to provide community-based services to people with ABIs.

In 2015-16, all of the work that we have undertaken with our partners began to pay off. In August 2015, the first of two planned ABI residences in Napanee opened its doors and is now home to six people with an ABI. The development of the second residence, known as the Lenadco site, was approved by the Ministry of Health and Long-Term Care to proceed with construction in September, 2015. This facility will be able to accommodate up to six people living with an ABI. Work on the development of this site has been initiated and it is anticipated that it will begin accepting residents in the coming year.

### Physiotherapy and Falls Prevention

Falls among older adults continue to be a major concern in the South East, with more than 7000 visits to the Emergency Department occurring in 2014-2015 as the result of a fall, which is the second highest rate among all LHINs. This past year, our LHIN continued to work with Public Health, the Centre for Studies in Aging and Health and other service providers to enhance access to high-quality physiotherapy, exercise and falls prevention classes, and ensure a fair and equitable distribution of these services. Work included hosting a stakeholder engagement

session to identify gaps in service and needs among key stakeholder groups, the formation of a multi-sectoral leadership group, and identification of core pillars, as well as aims and objectives, for a regional strategy. The pillars include:

- Public awareness and education
- Assessment and management
- Service navigation and system integration
- Engagement and advocacy
- Provider skill development and education
- Evaluation and quality improvement

More than 6,100 episodes of physiotherapy care for seniors and eligible patients were delivered in clinics across the South East. Moreover, approximately 6,000 clients with mobility issues received in-home physiotherapy services, while enhanced access to one-on-one physiotherapy continues for all long-term care residents with assessed need. In addition, exercise and falls prevention classes were delivered at more than 175 locations to more than 5,000 seniors across the South East.

### Behavioural Supports Ontario

Behavioral Supports Ontario (BSO) is a provincial initiative created in 2012 to enhance services for elderly people with complex behaviours due to dementia, mental health issues, or other neurological conditions. BSO enhances and leverages the existing service system and promotes integrated service delivery through interdisciplinary mobile teams based around the region. These teams are able to respond around the clock to calls from long-term care homes that need their support and expertise.

Over the last year, the South East LHIN has worked with Providence Care to overcome certain challenges that have been identified within the existing BSO model of care. One of the strategies, intended to build capacity in long-term care homes, involved a three day "High Performing Teams" education and training workshop. All long-term care homes and the BSO team came together to learn best practices in the management of challenging behaviours, as well as to learn from one another's experiences.

Also this past year, Quinte Health Care (QHC) opened the Behavioural Support Transition Unit and has successfully begun treating and transitioning clients with challenging behaviours into both the community and long-term care. The South East LHIN continues to work with QHC and the long-term care sector to better understand how challenging behaviours can be managed and how transitions can be improved across the system.

### Thrive

In 2012, the Ontario Government allocated funding for the LHINs to leverage existing services and address opioid addiction in their communities. Our LHIN responded by developing Thrive, an addiction treatment and ancillary services program for pregnant and parenting women who are opioid dependent. Developed in partnership with the Community Health Centres (CHC) sector, Thrive is a regional program that aims to increase the capacity of addiction treatment services, and to ultimately produce positive health and social outcomes for these women and their newborns, infants and children.

Thrive services are provided by Kingston CHC, Belleville and Quinte West CHC, as well as Upper Canada Family Health Team, who each serve a geographic catchment area with a significant proportion of this high-risk population. In addition, a Community Peer Support component was added to the program this past year to improve coordination of services for individuals and

support their journey toward wellness and recovery.

### Expanding Culturally & Linguistically-Sensitive Health Care Services

The South East LHIN is committed to ensuring there is appropriate access to care for both the French and the Indigenous communities of Southeastern Ontario. The LHIN engages both communities and health service providers working with them in discussions to plan, develop, and enhance the provision of health care services.

## Mental Health and Addictions Services

Improving the Mental Health and Addictions services that we offer is a significant focus for the South East LHIN. There are few branches of health care more challenging and complex than this one. For many years, we have heard from patients and others about concerns they have with the mental health and addictions system. Those concerns include:

- Duplication of services
- Duplication of assessments (need for clients to repeat their story multiple times)
- Difficulties transitioning between providers
- Difficulty accessing services
- Insufficient volume of services to satisfy demand
- Stigma often faced in accessing these and other health services

In response to these concerns, we launched our Addictions and Mental Health Redesign in 2013.

### AMH Redesign

The Addictions and Mental Health (AMH) Redesign aims to address many of the issues traditionally faced by clients seeking help for addictions and mental health challenges. As an outcome, the redesign is intended to achieve what we are calling the Ideal Individual Experience for clients and their caregivers.

One of the first steps in redesigning the system was to integrate it in order to make it more efficient and responsive. In April 2015, the region's seven addictions and mental health agencies amalgamated, forming three main geographic agencies providing common pathways and processes. This will result in fewer clients falling through the

**Ideal Individual Experience**

The Ideal Individual Experience is what our system must provide for clients and their families. It is our vision of the client journey throughout his or her life and throughout the continuum of care. During this journey, clients and their families will:

- Be able to travel across the system and know exactly what to expect from one care provider to the next
- Be able to obtain the information they need, when and where they need it
- Have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support
- Have access to Intentional Peer Supports
- Have access to Intentional Peer Supports
- Not have to repeat their stories to several different providers
- Experience shorter wait times
- Benefit from a system where there is no longer any stigma attached to mental health
- Have access to a common basket of services, regardless of where they live in our region

cracks as they transition from one provider or resource to another.

Since the amalgamation, the three agencies, Acute Schedule 1 Facility hospitals, specialty hospitals and specialty agencies have been working diligently to develop implementation plans and begin operationalization of the overall redesign. The work has included:

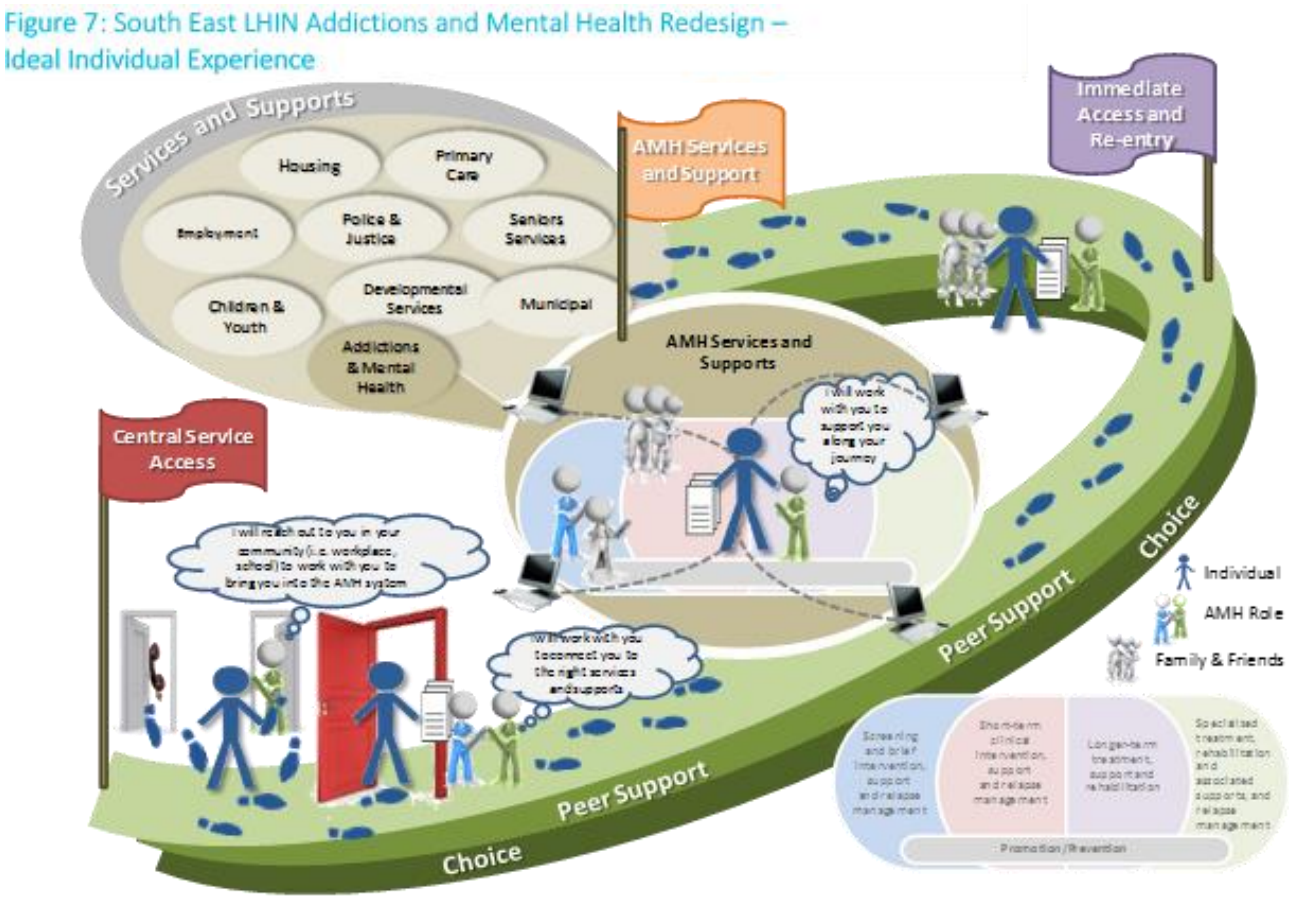
- The development of a Regional Back Office for the three agencies
- Centralized intake and waitlist systems for each of the geographic regions
- A core training, competency and performance plan for the community agencies

The finalized implementation plans were completed on April 15th, 2016, with operationalization already beginning to occur in several areas.

### AMH Redesign Community Engagement Efforts

The redesign of addictions and mental health system is guided, first and foremost, by the needs of clients and their families. Over the past three years, we have engaged with hundreds of providers, stakeholders, clients and caregivers to ensure that their voices have been represented in the design and

Figure 7: South East LHIN Addictions and Mental Health Redesign – Ideal Individual Experience



implementation of the Ideal Individual Experience through the redesigned system of Addictions and Mental Health.

In addition, a leading group of partners with representation from the three AMH Agencies, Peer Support South East Ontario, Providence Care Hospital and Queen's University, have worked together since April 2015 in what is being called the Strategic Alliance. This body will be responsible for supporting stakeholder and client engagement, the monitoring of performance, planning of services and adherence to the Redesign vision and the Ideal Individual Experience.

Our LHIN will continue to work with the Strategic Alliance to ensure that conversations, recommendations, feedback and insights continue to be heard and integrated into the implementation process. The importance of understanding the client perspective and experience will continue to be a central focus of all community agencies, hospitals, the Strategic Alliance and the South East LHIN.

**eHealth 2.0**

The Ministry of Health and Long Term Care is updating its existing eHealth strategy to ensure that electronic technology supports health system transformation in a sustainable, measurable way, while maximizing value of existing assets. This past year our LHIN supported the Ministry's development of a new provincial eHealth strategy by assisting with facilitation of stakeholders and participating in consultations as requested.

## E-Health - Enabling Care through Technology

Electronic technology is now one of the central pillars supporting today's health care systems. Consequently, the implementation of initiatives to support information flow is a critical part of the South East LHIN's mandate. These technology projects aim to support quality improvement initiatives as well as facilitating collaboration with better information and data sharing among all regional stakeholders and practitioners.

Last year the South East LHIN invested time and resources in the development of the following enabling technologies:

- South East Health Integrated Information Portal (SHIIP)
- Regional Hospital Information System Regional Collaboration Space
- Eastern Ontario Clinical Document Repository (EO CDR)
- Ontario Lab Information System
- Eclipse Project Management System
- ED-CCAC Notification System

### South East Health Integrated Information Portal

The South East Health Integrated Information Portal (SHiiP) is a tool providing real-time feedback as well as summarized data to help track and plan care of individual patients. As a portal, SHiiP can help identify patients needing additional care and follow-up after being discharged from hospital. Once a high-risk patient has been identified, the health care team can be activated within the

local Health Link to support the patient's needs. SHiiP can provide clinicians with real time patient information, electronically – at the point of care.

In 2015-16, several milestones were reached in the deployment of SHiiP across South East Ontario. These include:

- Formulation of privacy and data sharing frameworks as well as a Privacy Impact Assessment
- Contribution of data to the SHiiP portal by acute care hospitals in the South East
- Technical proof of concept validation
- Initiation of SHiiP governance model including a SHiiP Clinical Working Group
- SHiiP is now in use in primary care and hospital sites in the South East region

### Eastern Ontario Clinical Document Repository

Electronic clinical document repositories are, as the name implies, a storage repository for patient information. Replacing the old system of paper reports that were sent to health care providers by courier or fax, they help ensure effective use of clinical time, enable efficient workflows, eliminate paper-based processes and support the rapid incorporation of evidence-based practices into care delivery. Once a patient is discharged from the hospital, his or her discharge summary and diagnostic imaging reports are provided directly to health care providers' office records.

The Eastern Ontario Clinical Document Repository (EOCDR) was built using eHealth Ontario published standards. eHealth Ontario participated as a member of the steering committee, reviewed the architecture for compliance with the provincial standards, and supported the procurement efforts.

During 2015-16, integration of all South East hospitals with EOCDR was achieved. All hospital sites are now live and fully connected, uploading documents for transmission to Physician EMRs. The repository has also been leveraged for other projects in the region.

### Regional Privacy Capacity Project

The South East LHIN initiated the Regional Privacy Capacity Project this past year to work towards the development of regional privacy and standard through the identification of LTCH privacy and business needs of Primary Care, Community and Social Services, the Community Care Access Centre, Addictions and Mental Health, and Public Health. The project objectives are:

- To increase privacy knowledge and privacy program capacity to enable more effective public health information sharing
- To focus on privacy program development, implementation and management.
- The formalization of a regional privacy program through the creation of the RPAG (Regional Privacy Advisory Group).

This year, training through workshops and resource development has been completed as well as formal initiation of the RPAG.

### Regional Hospital Information System

A Hospital Information System (HIS) is a comprehensive and integrated IT tool which is used to manage the medical,

administrative, and financial aspects of hospital services. To drive efficiencies and savings in both capital and operational costs, local hospitals within the South East LHIN are cooperating on a new level to converge their separate systems into a consolidated common one. Once complete, the new system will result in the use of common data standards across the region, as well as simplification of shared access to patient records across the participating sites.

In 2015-16, our LHIN began working towards the following key outcomes, in line with the province's HIS Renewal Strategy:

- Commitment to support Ministry direction on clustering technology through fostering regional partnership opportunities
- Re-use of existing HIS technology
- Emergence of appropriate hub hospital leadership

### Emergency Department CCAC Notification System

The South East Emergency Department (ED) CCAC Notification System is a joint initiative of the South East CCAC, the South East LHIN, Kingston General Hospital, and Hotel Dieu Hospital. Designed to establish a two-way gateway between ED and CCAC information systems, this system integrates CCAC and hospital patient and admission information to better inform both clinicians and CCAC case managers when patients visit the ED.

The ED CCAC Notification System reduces the time lost when CCAC staff go to homes only to find out their clients are at the hospital. It also increases awareness, collaboration, and communication between CCAC and South East hospitals so discharged patients are offered more coordinated care on discharge to prevent avoidable readmissions.

### cNEO (Connecting Northern and Eastern Ontario)

The primary goal of the Connecting Northern and Eastern Ontario (cNEO) project is to provide Health Service Providers with timely access to patient health information from across the continuum of care. The South East LHIN has been working collaboratively with Kingston General Hospital to plan, establish and deploy integrated Electronic Health Record services with the cNEO program.

Notable activity that has taken place in fiscal 2015/2016 includes:

- Clinical Viewer Development – delivery starting with OLIS data to early
- Adopters (KGH has 250 current users)
- Infrastructure development to enable ONE ID federation/adoption
- Plan for and Initiate transition to provincial CDR platform

### Ontario Lab Information System

The Ontario Lab Information System (OLIS) connects hospitals, community laboratories, public health laboratories and practitioners to facilitate the secure electronic exchange of laboratory test orders and results. It will contribute to fundamental improvements in patient care by providing practitioners with timely access to laboratory results that is needed at the time of clinical decision making. This past year saw several hospitals in the South East begin testing and uploading to the system.

### Eclipse Project Management System

Eclipse is a cloud-based tool that helps users visualize a portfolio of health care projects, make decisions about priorities and understand resources utilization. The system supports project management by offering a collaborative platform and providing easy access to all interested parties, so health care professionals can maintain and manage simultaneous projects from the planning to implementation phase with both internal and external partners.

The Eclipse Project Management System has been fully endorsed by the South East LHIN. To ensure the optimal use of Eclipse for managing health care-related collaborative projects, the LHIN has initiated a current state assessment of Eclipse use in the region to better understand benefits, limitation, and alignment to a more comprehensive strategy of project management amongst all health sectors.

### Regional Collaboration Space

To enhance information sharing amongst cross-organizational teams, the South East LHIN makes regional collaborative spaces available to them. These collaborative spaces are internal regional tools meant to improve efficiency and effectiveness, and support health care projects, as well as sharing information amongst multiple providers and stakeholders. This project started in 2014 with a needs assessment and it quickly progressed to support several existing projects. The needs assessment showed that collaboration spaces are best used in a local capacity as a project document repository.

### Health Links & Care Coordination Tool (CCT)

As noted above, Ontario is improving care for seniors and others with complex conditions through Health Links. The Health Links program provides an opportunity to leverage IT/IM investments in support of more effective, sustainable, high quality care – specifically a care coordination tool (CCT).

The CCT will enable secure messaging between providers in a patient's care team and will allow members of the care team to create, maintain and share coordinated care plans. In time, the CCT will be more fully integrated with patient Electronic Health Records and point-of-care systems, providing different options for patients to access their coordinated care plans.

The South East LHIN will actively participate in a provincial evaluation of Health Links CCTs, as well as continue to support Health Links currently using the tool.

## Integration Activities – Implementation of Sector Wide Integrations

Much of the health care focus, in the LHIN and in many other jurisdictions, has moved from the acute care sector into the community. This is not because the work that hospitals do has somehow become less important, but rather because of our understanding that in order to achieve the best possible societal health outcomes, we need a fully integrated system of care that prevents serious illness, offers alternatives to the ED in the community, reduces the need for hospital admissions and lessens the duration of patient stays. The key concept in all of that is integration.

### Health Care Tomorrow Hosptials Project

A focused effort on hospital sustainability was launched in 2014 via the Health Care Tomorrow – Hospital Services Project. Working together with the seven hospitals in the LHIN, Queen's University, and the South East CCAC, the South East LHIN has been

exploring options for improving hospital services across the region. The project focus is the development of a sustainable system of integrated care that best meets the needs of patients, now and into the future. Every phase of the Hospital Services project includes engagement with health care providers and the public. Planning for the project is unfolding in several phases.

In fall of 2014, more than 200 stakeholders participated in a visioning day to help define the vision for hospital service. It was identified that the project's goal was to improve access to high quality care through the development of a 'Sustainable System of Integrated Care'.

Early in 2015, several working groups were created to start the first phase of the project, which consists of identification of potential opportunities to achieve the overarching project vision in each of the following areas:

- Business functions (administration, finance, human resources, information technology, etc.)
- Diagnostics and therapeutics (imaging, laboratory, pharmacy services, etc.)
- Clinical services (Complex Chronic, Elective Care, Urgent/Emergent Care, and Tertiary/Quaternary Care)

By August 2015, the Hospital and the LHIN Boards had provided approval to progress on the development of some of the business cases in June 2016, with the remaining business cases to be developed in the fall. The business cases have been developed based on the contributions of regional executive leaders, functional experts and front-line managers/staff. Opportunities have been identified to save money, while still improving service and quality care for the region. A shared service governance model with services councils is in development with capability to provide oversight for both business services clinical support services such as Lab, Diagnostic Imaging and Pharmacy.

### Resource Matching and Referral

Resource Matching and Referral (RM&R) is a standardized referral information pathway that matches patients with the earliest available services that meet their individual care needs. RM&R is about improving care, reducing emergency department wait times and enhancing access to care. It improves workflow and communication during the referral process, and supporting patients as they transition to the next stage of their care journey.

In the South East LHIN, RM&R information standards and referral pathways are implemented in a wide range of settings including acute and post-acute care settings, as well as community settings. Using leading practices, RM&R helps partners manage patient flow from acute care facilities back to their home or to post-acute care facilities, reducing or postponing the need for admission to a LTCH.

All Provincial RM&R referral forms and pathways have been implemented within the South East LHIN. These pathways include:

- Acute to CCAC for in home services
- Acute to CCAC for Long Term Care Home placement
- Acute to Rehab and Complex Continuing Care beds

Throughout the implementation, lessons learned are shared amongst providers to continue the refinement of the process in the future.

### Early Detection, Timely Care for High-Risk Seniors

This concept is a simple one – early detection results in timely care. The focus for ED staff, therefore, is to identify high risk and frail elderly patients, so assessments can be made of the community home support services they'll need once they are discharged from the ED. If, instead, they end up being admitted to hospital, the early identification will have led to an inpatient assessment that will activate a care plan to prevent functional or cognitive decline.

Discharged hospital high-risk clients are put in touch with an Integrated Community Assessment Referral Team (iCART), who assesses clients from CCAC, SMILE and Community Support Services. Care is coordinated through this integrated team, whose members share assessments and care plans to avoid duplication of services, client confusion and to ensure the client is visited appropriately to diminish anxiety, prevent social isolation, and avoid their seeking help through the ER for non-acute care needs.

This past year, five of the hospitals within the South East have implemented this initiative to improve overall integration of care and patient's experience. Already, more than 2000 seniors have been identified as being high risk. Of those identified, 1500 were existing home and community supported clients who had service plans updates and approximately 350 were new clients identified as needing home and community supports.

### Health System Funding Reform

2015-16 was the third year of Ontario's Health System Funding Reform (HSFR). The release of the HSFR funding for fiscal 2015-16 (based on 2013-14 actual expense and activity) presented significant challenges for hospitals in the South East. Overall, hospital funding was reduced by $17.4M.

The South East LHIN continues to work closely with our hospitals to ensure there is a thorough understanding of the new funding system. Regular performance meetings are held with each hospital during which results are reviewed against actual costs and clinical activity to ensure that they are making progress towards closing the gap in services where actual cost exceeds what was expected.

South East LHIN staff will continue to develop and utilize various HSFR tools made available by the Ministry to support the analysis and forecasting of results. As well, LHIN staff will continue to build internal expertise in Health System funding reform in order to provide the leadership and advice to hospitals, with specific emphasis on:

- Becoming more efficient and serving more patients with existing resources
- Improving clinical coding
- Increasing the HBAM Expected Unit Cost (increased volume/higher acuity)

### Wait Times for Surgical and Diagnostic Imaging Procedures

The South East LHIN continues to work with hospitals to review existing processes, identify and address data quality issues, reallocate volumes as deemed appropriate across hospitals, and identify potential options for performance improvement. This is accomplished through formal regional work associated with the Local Partnership working group, quarterly meetings with hospitals, and specific LHIN staff-led initiatives. As an example, one of the LHIN's current focuses surrounds process improvements for MRI, designed to address longer wait times and addressing coding

anomaly and wait list management for Hip and Knee replacement surgeries. It is expected these initiatives will result in performance improvements in the 2016-17 fiscal year.

# PROVINCAL INITIATIVES AND PROGRAMS

### Chronic Disease Prevention and Management

Our LHIN's approach to chronic disease prevention and management (CDPM) is informed by more than 40 cross-sector stakeholder engagements. The goal is to develop a patient-centred approach to ensuring that effective, accessible and integrated services are available in our communities. In particular, the mandated oversight for the adult and paediatric diabetes programs was aligned so that a more regional focus on quality improvement and adopting best practices could be realized. There has also been a consistent increase in the number of clients served in community programs. A Diabetes Stakeholder Networking Day was organized this past year to bring diabetes educators together for education and networking opportunities. Health Links continue to integrate chronic disease work into primary care teams, including the High Risk Foot Care Initiative which has grown over the last year and been supported with educational opportunities.

### Hospice Palliative Care

The South East LHIN continues to promote the provincial vision for hospice palliative care (HPC), and align our HPC work in this region with the report, Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action. Accomplishments in 2015-16 include the following:

- Completion of integration of current community hospice service agencies with a partnering CSS agency or hospital partner
- Development of a tactical plan for community respite to optimize existing resources and identify gaps for future initiatives
- Implementation of the finalized 2015-18 work plan begun, with the development of priority working groups and the development of a communication engagement strategy
- Continued support for the Nurse Practitioner-Palliative Program to enhance continuity of clinical care coordination across all sectors

Future work of HPC will support the proposed directions of the Ontario Palliative Care Network, which was officially launched in March 2016.

# COMMUNITY ENGAGEMENT

Community engagement is a core value of the South East LHIN as well as a legislated responsibility.

All community engagement activities aim to include the input of stakeholders in the planning and decision-making processes. By ensuring the voices of the patients, community members, health care providers, as well as leadership and governance members are heard and by working collaboratively with local stakeholders, more creative and responsive solutions can be developed – which will lead to better results for both Ontarians in the South East and for the health care system.

The South East LHIN continues to engage and collaborate with primary care and health services professionals to continually inform the LHIN regarding opportunities to support high quality and integrated care across the care continuum.

## Primary Care & Health Links

The South East endorses the widespread view that a strong primary care system is foundational to influencing better care and patient outcomes for the whole system, and our work this past year has reflected this view.

Starting in April 2015, the LHIN expanded the capacity of the Primary Care Physician LHIN Lead (PCPLL) role by contracting three physician leads, where there had previously only been one, to cover the eastern, central, and western geographies of the region. The PCPLLs have been instrumental in engaging, promoting and sustaining system level initiatives to improve outcomes for patients such as Health Links, improving immunization uptake, and promoting options for primary care coverage over holidays. The expanded PCPLL coverage allowed for the primary care perspective to be shared across the LHIN in various venues such as the South East Community and Hospital Executive Forum (SECHEF), Health Care Tomorrow – Hospital Project planning tables, Addictions and Mental Health Redesign, internal planning tables, and sharing with their peers in the region. The PCPLLs provide leadership for the South East's Primary Health Care Council which continued to meet quarterly throughout 2015-2016.

All seven Health Links in the South East continue to be led by primary care organizations. Providing regional leadership, primary care supported ongoing relationship building among partners, implementation and evaluation of Health Links, the uptake of coordinated care planning for patients with complex needs, and enabling better access to care.

In September 2015, the South East LHIN held its 8th successful annual Primary Health Care Forum. The theme of the event was primary health care and system transformation. Accredited by the Ontario College of Family Physicians and by the Canadian College of Health Leaders, the Forum provided a venue for primary care providers and others to learn and share information about how information technology, health links, quality

improvement, equity, access, and patient engagement are transforming the health care system. The event was fully subscribed with approximately 250 participants, including HSPs from all sectors, patients and caregivers.

### Health Professional Advisory Committee

The Health Professional Advisory Committee (HPAC) is a multi-disciplinary committee helping the LHIN in carrying out its responsibilities by providing advice on how to better achieve patient-centered health care. The South East LHIN seeks the HPAC support and feedback to enlighten current initiatives.

### Healthcare Tomorrow – Hospital Services Project

As noted earlier, the Hospital Services is exploring opportunities for shared hospital services and new or expanding partnerships. The overall project goal is to improve access and patient care in southeastern Ontario from the following organizations:

- Brockville General Hospital
- Hotel Dieu Hospital
- Lennox and Addington County General Hospital
- Kingston General Hospital
- Perth Smiths Falls District Hospital
- Providence Care
- Quinte Health Care
- South East Community Care Access Centre
- Queen's University Faculty of Health Sciences
- South East Local Health Integration Network

The project is deeply dependent on understanding and responding to the needs and priorities of patients. To that end, it is supported by the voice of the Regional Patient Advisory Council (RPAC), consisting of 24 members from current Hospital Patient Advisory Council's and the broader community. The Council includes patients and family members interested in discussing and testing ideas related to the future of hospital services across the south east region. These patient advisors are a critical component of the Health Care Tomorrow – Hospital Services project. They help bring the patient experience and perspective to all discussions.

## Aboriginal and Francophone Communities

### Aboriginal Engagement

As always, the South East LHIN worked hard in 2015-16 to maintain an ongoing process of engagement and communication with Indigenous communities in our region. This engagement focused on understanding and reflecting Indigenous communities' perspective on projects such as the AMH Redesign, Health Care Tomorrow, and other strategic initiatives.

The LHIN supported an education session on Indigenous Cultural Competency (ICC) that was offered in partnership with Providence Care. The session aligned with our commitment to person-centred care and treating the people we serve with respect and dignity, specifically considering the indigenous communities within the South East LHIN. This day-long training was offered in Belleville Brockville, and Kingston.
These sessions provided health service professionals and leaders with an opportunity

to learn about indigenous issues in an environment that is authentic, supportive and safe. The goal of the ICC training is to further develop individual competencies and promote positive partnerships.

As emphasized in our current Integrated Health Service Plan (IHSP4), the LHIN is committed to addressing the unique health care needs of indigenous peoples in our region.

More than 70 per cent of South East LHIN staff and 50 per cent of board members have received this training. This work enabled the South East LHIN and HSPs to advance health care priorities and improve health outcomes for this population.

### Francophone Engagement

In carrying out our community engagement activities, the South East LHIN has an obligation to engage the French Language Health Planning Entity, the Réseau des Services de Santé en Français de l'Est de l'Ontario, also known as "Réseau". According to the Accountability Agreement signed between the South East LHIN and the Réseau, all parties have to develop and implement a Joint Annual Action Plan. Each year, this plan focuses on several objectives, including strengthening the Francophone community participation and engagement to health services planning activities.

As the result of the past year, the French Language Citizens' Advisory Committee members continued to build their knowledge of the LHIN's ongoing projects. These quarterly sessions were aimed at enabling the Committee to provide guidance, feedback, and suggestions on the manner in which the development of French language health services can best serve francophone residents throughout the South East.
Our collaborative approach to continuous improvement has led us to develop a three-year strategy that will be implemented in the coming years. The strategy's approach is centered on the Francophone patient's experience, and aim to increase the active offer of services in French.

The LHIN also engaged the Francophone community with regards to its strategic plan, through bilingual open houses and an online survey, and a focus group. The results of these engagements has helped to inform the development of the IHSP4.

In 2015-16, the South East LHIN participated in health care professional networking activities which aim to foster informal ties, collaboration, knowledge of existing services in French and experience sharing between French-speaking health care professionals, while promoting organizational leadership in the provision of health services in French.

In an effort to further support the development of services in French by the identified health service providers in the designated area of Kingston, the South East LHIN provided funding to three hospitals in this area to organize a joint event intended specifically for the Francophone community. This event was a great opportunity for hospital representatives not only to create relationships with this community, but also to present the work that is taking place in each organization regarding the development of services in French.

Two members of the Regional Patient Advisory Council (RPAC), created by the LHIN to help inform the Health Care Tomorrow – Hospital Services project, are from the Francophone community, ensuring that the francophone patient perspective is being articulated.

## Public and Patients

### Regional Patient Avisory Committe

As noted earlier, the purpose of the Regional Patient Advisory Council (RPAC) is to bring together patients and family members to discuss and test ideas related to the future of hospital services across the South East region. The RPAC members provide their knowledge and experience to help shape patient-centred hospital services in the South East region.

The RPAC is currently serving in an advisory capacity to the HCT-Hospitals Services Project providing input on matters that impact the experience of patients and their families across the South East region (within the mandate of the South East Local Health Integration Network).

In 2015-16 the South East LHIN also sought feedback and engagement with RPAC related to the Patients First proposal and other MOHLTC initiatives related to the future of healthcare.

### Health Care Tomorrow (IHSP 4)

Comprehensive community engagement took place in the spring of 2015 to support our fourth Integrated Health Services Plan (IHSP 4). All engagement activities were conducted collaboratively with local hospitals with a view to improve patient experience, quality, and sustainability in a regional model of health care. The importance of community services in this process was not lost as they are recognized as key contributors to the development of the local health system.

Community engagement for the IHSP 4 provided multiple opportunities for the public and other partners to get involved. Public input into decision-making is of great value and the LHIN and health service providers committed to meaningful engagement regarding system future planning and to inform the development of options for the project. Community engagement activities included:

- Outreach to provincial and municipal leaders to inform and increase knowledge and awareness about the project
- Governance to governance education sessions to increase knowledge and understanding about the ongoing conversation
- Staff engagement to inform and create awareness and understanding about the project activities
- Public web engagement with specific questions
- Additional opportunities for dialogue were offered to public and health service providers through ‘open houses’

### Patients First

On December 17, 2015, the ministry released Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario, a discussion paper that outlines proposed changes for the health system. The proposed structural changes would see Local Health Integration Networks assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning.

In February, 2016, the South East LHIN invited feedback from Health Service Providers, patients, caregivers, and members of the general public through a variety of opportunities – including an online survey and in-person engagement sessions. Engagement was also ongoing through many of our working groups and stakeholder committees. All input received has been

consolidated and submitted to the Ministry of Health and Long-Term Care to help inform next steps in building a high-performing health system that is more responsive to local needs, is better connected and integrated, drives quality and performance, and enhances transparency for providers and patients, clients and their families.

## Governance

The South East LHIN Board of Directors continues to maintain proactive contact with the general public, local communities as well as with health services providers and organizational leaders through the holding of monthly open board meetings and regular board to board discussions.

The South East LHIN Board of Directors is maintaining and building strong and collaborative partnerships with other boards to support the LHIN goal to build, improve, and sustain health services for the region and local communities.

### Collaborative Governance and Community Engagement Committee

The committee continues its work toward achieving the South East LHIN's vision of a patient-centered health care system that provides seamless and integrated experience for patients and their families along the continuum of care. In its more recent efforts, the Committee has held annual governance excellence workshops for the regional community of health service providers, in order to encourage the development and implementation of collective governance-led integration initiatives.

The committee continues to place an emphasis on integrating patient pathways, strengthening communications, and building collaborative health system leadership within local communities.

# PERFORMANCE INDICATOR REPORT

The Ministry-LHIN Performance Agreement sets out the obligations of the MOHLTC and the South East LHIN to fulfill its mandate to plan manage and fund local health care services. Developing and updating this accountability agreement is a key component of the relationship between the MOHLTC and the LHIN and helps us strengthen our local health care.

| Indicator | Provincial | | | | LHIN | | |
|---|---|---|---|---|---|---|---|
| | Provincial target | 2014/15 Fiscal Year Result | Most Recent Quarter | 2015/16 Result (year-to-date) | 2014/15 Fiscal Year Result | Most Recent Quarter | 2015/16 Result (year-to-date) |

## Access to Health Care Services

The 90th percentile wait time for in-home CCAC services is slightly below the provincial target of 21 days and well below the provincial average of 30 days. Indicators for the percentage of patients receiving nursing or personal support visits within 5 days of authorization are new MLAA indicators. The CCAC has focussed effort on enhancing the identification of clients, improvements in monitoring service requests and care coordinator education to improve timely support for clients needing these services.

Patient flow remains a challenge across many hospitals in the South East and this contributes to Emergency Room (ER) Length of Stay (LOS) beyond the provincial targets. The 90th percentile LOS for complex patients is well below the provincial average though the relatively high LOS of those patients admitted to hospital remains the primary challenge. The Alternate Level of Care population across hospital settings is a key contributor to the patient flow issues across the LHIN. The ALC rate documents the burden of ALC on hospital operations with over 19% of inpatient hospital days accounted for by ALC patients. Targeted improvements have been documented – both institution-specific and region-wide - and action plans developed to address patient flow across the system.

Performance on the percentage of cases completed within the recommended wait times for diagnostic procedures are below provincial targets – though performance for MRI scans is the highest across the province. Similarly, though performance for CT scans is modestly below the provincial target, the South East LHIN has the second highest percentage of cases performed within the recommended wait times. The coding of hip and knee prioritization across South East LHIN hospitals varies fundamentally from provincial norms. Performance is the past year is difficult to assess and efforts are underway to correct this coding discrepancy.

A complete redesign of Addiction and Mental Health services across the LHIN has moved through the planning phase and on to implementation over the past year. Three new agencies present the opportunity for improved coordination of comprehensive service for the AMH patient population. It is anticipated that system-wide improvements in service delivery will benefit the patient population and improve related performance metrics.

| | Indicator | Provincial | | | | LHIN | | |
|---|---|---|---|---|---|---|---|---|
| | | Provincial target | 2014/15 Fiscal Year Result | Most Recent Quarter | 2015/16 Result (year-to-date) | 2014/15 Fiscal Year Result | Most Recent Quarter | 2015/16 Result (year-to-date) |
| 1 | Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services* | 95.00% | 85.39% | 86.55% | 85.28% | 86.84% | 86.54% | 84.86% |
| 2 | Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services* | 95.00% | 93.71% | 93.21% | 93.66% | 92.70% | 92.06% | 91.19% |
| 3 | 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)* | 21 days | 29.00 | 29.00 | 30.00 | 23.00 | 20.00 | 20.00 |
| 4 | 90th percentile emergency department (ED) length of stay for complex patients | 8 hours | 10.13 | 10.48 | 9.97 | 9.47 | 9.20 | 8.90 |
| 5 | 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients | 4 hours | 4.03 | 4.28 | 4.07 | 4.28 | 4.43 | 4.35 |
| 6 | Percent of priority 2, 3 and 4 cases completed within access target for MRI scans | 90.00% | 41.75% | 40.37% | 38.41% | 54.47% | 84.56% | 63.06% |
| 7 | Percent of priority 2, 3 and 4 cases completed within access target for CT scans | 90.00% | 77.77% | 74.08% | 74.60% | 89.17% | 84.36% | 84.63% |
| 8 | Percent of priority 2, 3 and 4 cases completed within access target for hip replacement | 90.00% | 81.51% | 79.63% | 79.97% | 55.82% | 50.91% | 60.17% |
| 9 | Percent of priority 2, 3 and 4 cases completed within access target for knee replacement | 90.00% | 79.76% | 78.18% | 79.14% | 61.35% | 63.07% | 66.27% |
| 10 | Percentage of Alternate Level of Care (ALC) Days* | 9.46% | 14.35% | 14.15% | 14.16% | 15.40% | 14.42% | 15.02% |
| 11 | ALC rate | 12.70% | 13.70% | 14.12% | 13.98% | 17.11% | 18.86% | 19.19% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 12 | Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions* | 16.30% | 19.62% | 20.33% | 20.28% | 21.94% | 24.33% | 22.13% |
| 13 | Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions* | 22.40% | 31.34% | 33.39% | 33.42% | 24.86% | 22.39% | 28.80% |
| 14 | Readmission within 30 days for selected HIG conditions** | 15.50% | 16.60% | 16.62% | 16.51% | 16.23% | 17.56% | 16.75% |
| | **Monitoring Indicators** | | | | | | | |
| 15 | Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery | 90.00% | 87.02% | 86.56% | 88.03% | 88.47% | 82.14% | 83.64% |
| 16 | Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery | 90.00% | 96.01% | 94.00% | 95.00% | 98.07% | 100.00% | 99.00% |
| 17 | Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery | 90.00% | 91.93% | 87.37% | 88.09% | 90.95% | 76.96% | 84.43% |
| 18 (a) | CCAC wait times from application to eligibility determination for long-term care home placements: from community setting** | NA | 14.00 | 15.00 | 14.00 | 13.00 | 15.00 | 15.00 |
| 18 (b) | CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting** | NA | 8.00 | 7.00 | 8.00 | 7.00 | 6.00 | 7.00 |
| 19 | Rate of emergency visits for conditions best managed elsewhere per 1,000 population* | NA | 19.56 | 4.58 | 12.86 | 41.11 | 10.24 | 27.71 |
| 20 | Hospitalization rate for ambulatory care sensitive conditions per 100,000 population* | NA | 320.78 | 80.87 | 235.64 | 460.80 | 126.45 | 358.51 |
| 21 | Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge** | NA | 46.09% | 45.55% | 46.58% | 42.72% | 40.72% | 41.80% |

*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)
**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)

# SOUTH EAST LHIN OPERATIONAL PERFORMANCE ANALYSIS

The South East LHIN Corporate Operations, received and managed a total of $6.4M in funding for the 2015-16 fiscal year.

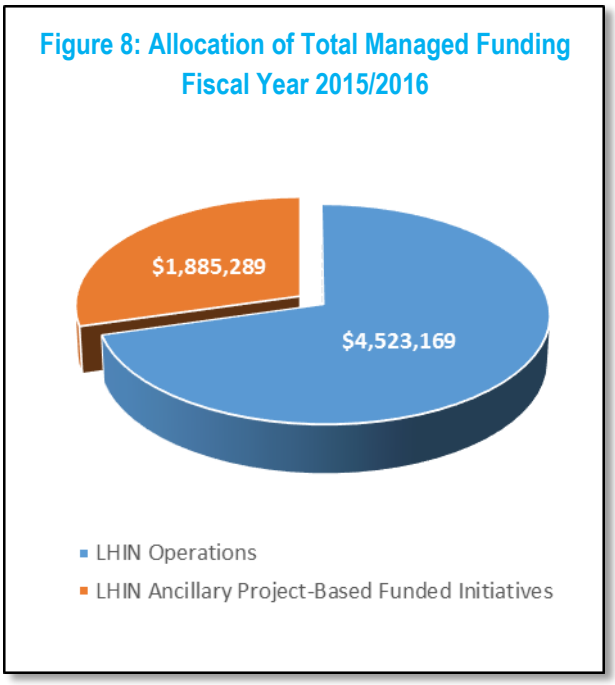
### Ancillary Project-Based Funding

Included in the total above was special funding for projects to support various MOHLTC health system priorities. Figure 8 shows the Allocation of the total funding between LHIN operations and ancillary project-based initiatives.

Ancillary project-based funding is used to support human resources required to achieve the initiatives. These resources are co-located at the South East LHIN office facility. The following is a list of all initiatives and projects that are included in the $1.9 M:

- Enabling Technologies Project Management Office
- Chronic Disease Management & Diabetes Strategy
- Emergency Room/Alternative Level of Care Strategy
- Emergency Department Initiative

Figure 8: Allocation of Total Managed Funding Fiscal Year 2015/2016




- Aboriginal Community Engagement Initiative
- French Language Services Initiative
- Critical Care Initiative
- Primary Care Initiative

# 2015/16 AUDITED FINANCIAL STATEMENTS

An external audit was conducted by Deloitte LLP in April 2016. A copy of the auditor's report, along with audited financial statements & notes disclosures are provided in the following section of this document. The results of the audit for the 2015/2016 fiscal year were very positive, with no errors or mis-statements noted.

Financial statements of

# South East Local Health Integration Network

March 31, 2016

# South East Local Health Integration Network

March 31, 2016

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# Independent Auditor's Report

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

We have audited the accompanying financial statements of the South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

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

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

**Auditor's Responsibility**

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

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

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

**Opinion**

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2016, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 30, 2016

# South East Local Health Integration Network

Statement of financial position
as at March 31, 2016

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| **Financial assets** | | |
| Cash | **768,724** | 848,841 |
| Accounts receivable (Note 3) | **41,503** | 54,955 |
| | **810,227** | 903,796 |
| **Liabilities** | | |
| Accounts payable and accrued liabilities (Note 4) | **555,248** | 662,232 |
| Due to Ministry of Health and Long-Term Care (Note 5b) | **115,146** | 70,605 |
| Due to the LHIN Shared Services Office (Note 7) | **23,035** | 11,109 |
| Deferred capital contributions (Note 8) | **207,222** | 236,879 |
| Obligations under capital lease (Note 16) | **176,022** | 206,836 |
| | **1,076,673** | 1,187,661 |
| Net debt | **(266,446)** | (283,865) |
| Commitments (Note 15) | | |
| **Non-financial assets** | | |
| Prepaid expenses | **59,224** | 46,986 |
| Tangible capital assets (Note 9) | **207,222** | 236,879 |
| | **266,446** | 283,865 |
| **Accumulated surplus** | **-** | - |

Approved by the Board

Donna Segal - Board Chair

Chris Salt - Finance and Audit Committee Chair

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

# South East Local Health Integration Network

Statement of operations
year ended March 31, 2016

| | Budget (Note 10) | 2016 Actual | 2015 Actual |
|---|---|---|---|
| | $ | $ | $ |
| **Revenue** | | | |
| MOHLTC funding | | | |
| HSP transfer payments (Note 10, 11) | **1,081,634,683** | **1,108,268,201** | 1,118,513,373 |
| Operations of LHIN (Note 5, 10) | **4,543,169** | **4,490,774** | 4,481,243 |
| Project Initiatives | | | |
| Enabling Technologies | **510,000** | **510,000** | 510,000 |
| Emergency Department | **-** | **75,000** | 75,000 |
| Aboriginal Initiative | **15,000** | **15,000** | 15,000 |
| ER/ALC Initiative | **100,000** | **100,000** | 100,000 |
| French Language Services Initiative | **106,000** | **106,000** | 106,000 |
| Critical Care Initiative | **-** | **75,000** | 75,000 |
| Primary Care Initiative | **-** | **75,000** | 75,000 |
| Chronic Disease Management (Note 6) | **948,254** | **929,289** | 948,254 |
| Amortization of deferred capital contributions (Note 8) | **-** | **62,052** | 120,018 |
| | **1,087,857,106** | **1,114,706,316** | 1,125,018,888 |
| Funding repayable to the MOHLTC (Note 5a) | **-** | **(44,541)** | (70,605) |
| | **1,087,857,106** | **1,114,661,775** | 1,124,948,283 |
| Expenses | | | |
| Transfer payments to HSPs (Note 11) | **1,081,634,683** | **1,108,268,201** | 1,118,513,373 |
| General and administrative (Note 12) | **4,543,169** | **4,552,376** | 4,596,395 |
| Project Initiatives (Note 6) | | | |
| Enabling Technologies | **510,000** | **510,000** | 510,000 |
| Emergency Department | **-** | **42,499** | 42,000 |
| Aboriginal Initiative | **15,000** | **14,859** | 15,000 |
| ER/ALC Initiative | **100,000** | **100,000** | 100,000 |
| French Language Services Initiative | **106,000** | **106,000** | 106,000 |
| Critical Care Initiative | **-** | **72,000** | 72,000 |
| Primary Care Initiative | **-** | **75,000** | 72,631 |
| Chronic Disease Management | **948,254** | **920,840** | 920,884 |
| | **1,087,857,106** | **1,114,661,775** | 1,124,948,283 |
| **Annual surplus and accumulated surplus, end of year** | **-** | **-** | **-** |

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

# South East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2016

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| **Annual surplus** | - | - |
| Acquisition of tangible capital assets | **(32,395)** | (61,926) |
| Amortization of tangible capital assets | **62,052** | 120,018 |
| Increase in prepaid expenses, net | **(12,238)** | (8,753) |
| Decrease in net debt | **17,419** | 49,339 |
| Net debt, beginning of year | **(283,865)** | (333,204) |
| **Net debt, end of year** | **(266,446)** | (283,865) |

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

# South East Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| **Operating transactions** | | |
| Annual surplus | - | - |
| Less items not affecting cash | | |
| Amortization of tangible capital assets | **62,052** | 120,018 |
| Amortization of deferred capital contributions (Note 8) | **(62,052)** | (120,018) |
| Changes in non-cash operating items | | |
| Accounts receivable | **13,452** | (6,894) |
| Prepaid expenses | **(12,238)** | (8,753) |
| Accounts payable and accrued liabilities | **(106,984)** | 48,514 |
| Due to MOHLTC | **44,541** | 1,676 |
| Due to the LHIN Shared Services Office | **11,926** | 6,469 |
| Due to Champlain LHIN | - | (4,346) |
| | **(49,303)** | 36,666 |
| **Capital transaction** | | |
| Acquisition of tangible capital assets | **(32,395)** | (61,926) |
| **Financing transactions** | | |
| Increase in deferred capital contributions (Note 8) | **32,395** | 61,926 |
| Repayment of obligations under capital lease | **(30,814)** | (29,314) |
| | **1,581** | 32,612 |
| Net change in cash | **(80,117)** | 7,352 |
| Cash, beginning of year | **848,841** | 841,489 |
| **Cash, end of year** | **768,724** | 848,841 |

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

## 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 a Performance Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

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 based on where residents primarily received their care (98% of all South East LHIN residents obtain care from local health service providers). The LHIN 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 500,000 people and has a geographic area which spans 19,473 square kilometers; the South East LHIN is the fourth largest geographic local health integration network. The LHIN serves 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 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.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("Performance Agreement"), 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. 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, 2016.

The LHIN statements do not include any Ministry managed programs.

## 2. Significant accounting policies

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

*Basis of accounting*

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

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

**2. Significant accounting policies (continued)**

*Government transfer payments*

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

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. 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 expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

*Tangible capital assets*

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

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

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

| | |
|---|---|
| Office equipment | 5 years |
| Computer equipment | 3 years |
| Infrastructure/Web developments | 3 years |
| Leasehold improvements | Life of lease |

*Segment disclosures*

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

### 3. Accounts receivable

At March 31, 2016 the LHIN has accounts receivable of $41,503 (2015 - $54,955) which represents HST receivable $39,478 for the last quarter of the fiscal year, and CPP overpayment $2,025.

### 4. Accounts payable and accrued liabilities

At March 31, 2016 the LHIN has accounts payable and accrued liabilities of $555,248 (2015 - $662,232). This amount represents accounts payable trade of $268,639 (2015 - $250,619), and accrued liabilities $286,609 (2015 - $411,613).

### 5. Funding repayable to the MOHLTC

In accordance with the Performance Agreement, 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 as revenue ("funding received"), the amortization of deferred capital contributions of $62,052 (2015 - $120,018), and has deferred 2016 funding used for the acquisition of capital assets of $32,395 (2015 - $61,926). This has resulted in an increase to the overall LHIN Operations revenue as shown in Note 5(a) below:

| | **2016** | 2015 |
|---|---|---|
| | **$** | $ |
| LHIN Operations base funding | **4,523,169** | 4,543,169 |
| Less: Amounts deferred related to acquisition of capital assets | **(32,395)** | (61,926) |
| LHIN Operations Revenue (Statement of operations) | **4,490,774** | 4,481,243 |
| Add: Deferred revenue from capital contributions | **62,052** | 120,018 |
| LHIN Operations Funding (Note 5a) | **4,552,826** | 4,601,261 |

(a) The amount repayable to the MOHLTC is made up of the following components:

| | **Funding received** | **Related expenses** | **2016 Excess funding** | 2015 Excess funding |
|---|---|---|---|---|
| | **$** | **$** | **$** | $ |
| Transfer payments to HSPs | **1,108,268,201** | **1,108,268,201** | **-** | - |
| LHIN operations | **4,552,826** | **4,552,376** | **450** | 4,866 |
| Emergency department initiative | **75,000** | **42,499** | **32,501** | 33,000 |
| Aboriginal initiative | **15,000** | **14,859** | **141** | - |
| ER/ALC Initiative | **100,000** | **100,000** | **-** | - |
| French Language Services Initiative | **106,000** | **106,000** | **-** | - |
| Critical Care Initiative | **75,000** | **72,000** | **3,000** | 3,000 |
| Primary Care Initiative | **75,000** | **75,000** | **-** | 2,369 |
| Chronic Disease Management | **929,289** | **920,840** | **8,449** | 27,370 |
| Repayable directly to MOHLTC | **1,114,196,316** | **1,114,151,775** | **44,541** | 70,605 |
| Enabling technologies, repayable to MOHLTC through Champlain LHIN | **510,000** | **510,000** | **-** | - |
| | **1,114,706,316** | **1,114,661,775** | **44,541** | 70,605 |

## 5. Funding repayable to the MOHLTC (continued)

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

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Opening balance | **70,605** | 68,929 |
| Funding repaid during the year | **-** | (68,929) |
| One-time funding repayable to MOHLTC | **44,091** | 65,739 |
| LHIN Operations funding repayable to MOHLTC | **450** | 4,866 |
| Closing balance | **115,146** | 70,605 |

## 6. Operations of LHIN - Ancillary Funded Project Initiatives

The LHIN received funds for various initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Salaries and benefits | **1,391,142** | 1,372,973 |
| Professional services | **180,972** | 186,000 |
| Shared services | **82,368** | 73,736 |
| Accommodations | **63,765** | 69,532 |
| Public relations | **36,256** | 20,117 |
| Supplies | **17,650** | 48,663 |
| Mail, courier and telecommunications | **7,434** | 5,005 |
| Other | **61,611** | 62,489 |
| | **1,841,198** | 1,838,515 |

### Chronic Disease Management (CDM)

Initial funding $948,254 with in-year reduction of 2%. The CDM operational expenses are included above and are as follows:

| | Budget 2016 | Actual 2016 | Actual 2015 |
|---|---|---|---|
| | $ | $ | $ |
| Funding | **948,254** | **929,289** | 948,254 |
| Salaries and benefits | **772,209** | **768,232** | 759,104 |
| Others | **176,045** | **152,608** | 161,780 |
| | **948,254** | **920,840** | 920,884 |

## 7. 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 are 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; and
- LHINC is an 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.

*Enabling Technologies for Integration Project Management Office*

In fiscal 2014, the LHIN entered into an agreement with the Champlain, North East and North West LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Office for its Cluster and related expenses. During the year, the LHIN received funding from the Champlain LHIN of $510,000 (2015 - $510,000).

## 8. Deferred capital contributions

| | **2016** | 2015 |
|---|---|---|
| | **$** | $ |
| Balance, beginning of year | **236,879** | 294,971 |
| Capital contributions received during the year | **32,395** | 61,926 |
| Amortization for the year | **(62,052)** | (120,018) |
| Balance, end of year | **207,222** | 236,879 |

## 9. Tangible capital assets

| | Cost | Accumulated amortization | 2016 Net book value | 2015 Net book value |
|---|---|---|---|---|
| | $ | $ | $ | $ |
| Office equipment | **425,379** | **412,931** | **12,448** | 5,799 |
| Computer equipment | **177,243** | **165,220** | **12,023** | 20,005 |
| Leasehold improvements | **407,537** | **224,786** | **182,751** | 211,075 |
| | **1,010,159** | **802,937** | **207,222** | 236,879 |

## 10. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the Statement of Operations reflect the initial budget at April 1, 2015. 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 $1,108,268,201 is made up of the following:

| | $ |
|---|---|
| Initial HSP funding budget | **1,081,634,683** |
| Adjustment due to announcements made during the year | **26,633,518** |
| Total HSP funding budget | **1,108,268,201** |

The total operating budget of $4,523,169 is made up of the following:

| | $ |
|---|---|
| Initial LHIN Operations Budget | **4,543,169** |
| Adjustment (Reduction) | **(20,000)** |
| Total LHIN Operations funding budget | **4,523,169** |

## 11. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,108,268,201 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Operation of Hospitals | **656,045,023** | 675,888,668 |
| Grants to compensate for Municipal Taxation - Public Hospitals | **190,725** | 190,725 |
| Long-Term Care Homes | **185,883,240** | 182,055,536 |
| Community Care Access Centres | **122,643,463** | 121,141,263 |
| Community Support Services | **36,976,678** | 35,252,773 |
| Assisted Living Services in Supportive Housing | **2,241,305** | 2,179,046 |
| Community Health Centres | **29,472,727** | 28,781,915 |
| Community Mental Health Addictions Program | **74,815,040** | 73,023,447 |
| | **1,108,268,201** | 1,118,513,373 |

## 12. General and administrative expenses

(a) The Statement of Operations presents expenses by function. The following classifies general and administrative expenses by object, as follows:

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Program based | | |
| Salaries | **3,410,658** | 3,344,467 |
| Consulting and LHIN-based projects | **17,618** | 22,500 |
| | **3,428,276** | 3,366,967 |
| Shared services | **309,098** | 277,926 |
| Collaborative | **37,698** | 50,929 |
| Other (Note 12b) | **193,002** | 222,747 |
| Accommodations | **201,101** | 194,052 |
| Office equipment and supplies | **106,262** | 154,224 |
| Board per diem | **75,600** | 53,125 |
| Public relations | **84,599** | 106,688 |
| Mail, courier and telecommunications | **54,688** | 49,719 |
| | **4,490,324** | 4,476,377 |
| Amortization | **62,052** | 120,018 |
| | **4,552,376** | 4,596,395 |

(b) The breakdown of "Other" general and administrative expenses listed in the table above are:

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Training and development | **66,970** | 92,551 |
| Travel | **118,399** | 122,561 |
| Recruitment | **2,234** | 595 |
| Insurance | **5,399** | 7,040 |
| | **193,002** | 222,747 |

(c) The total expenses related to governance is as follows, and are included in the expenses listed in Note 12(a) above:

| | 2016 | 2015 |
|---|---|---|
| | $ | $ |
| Board chair per diems | **23,625** | 19,775 |
| All other per diems | **51,975** | 33,350 |
| Total per diems | **75,600** | 53,125 |
| Other administrative costs | **28,000** | 21,425 |
| Total governance expenditures | **103,600** | 74,550 |
| Overhead - salaries, benefits, accommodations and shared services | **142,735** | 140,333 |
| Total governance related costs | **246,335** | 214,883 |

(d) The total occupancy and shared service costs are reduced from actual expenses in Note 12(a) above, due to partial cost sharing with ancillary funded projects for project staff that utilize office space and or shared services during the year.

## 13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf 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 2016 was $303,353 (2015 - $298,188) 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, 2015. At that time, the plan was fully funded.

## 14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in 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*.

## 15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building lease as follows:

| | $ |
|---|---|
| 2017 | 224,064 |
| 2018 | 224,064 |
| 2019 | 224,064 |
| 2020 | 224,064 |
| 2021 | 205,392 |
| Thereafter | - |
| | 1,101,648 |

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2016, the LHIN had signed Performance Agreements with all Hospitals and Community Agencies for the next one to three years dependent upon the specific sector. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

## 16. Obligations under capital lease

The LHIN has a lease under the provision of capital lease of leasehold improvements. The cost of this lease is included in equipment and the related liabilities are included in long-term debt to reflect the effective acquisition and financing of these items. The lease on the building expires in February, 2021.

**16. Obligations under capital lease (continued)**

The present value of future minimum rentals is as follows:

| | $ |
|---|---|
| 2017 | 40,456 |
| 2018 | 40,456 |
| 2019 | 40,456 |
| 2020 | 40,456 |
| 2021 | 37,084 |
| Future minimum lease payments | 198,908 |
| Less: amount representing interest | (22,886) |
| Present value of future minimum rentals | 176,022 |

Remaining principal payments required on this long-term debt for the next five years are as follows:

| | $ |
|---|---|
| 2017 | 32,390 |
| 2018 | 34,048 |
| 2019 | 35,789 |
| 2020 | 37,621 |
| 2021 | 36,174 |
| | 176,022 |

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