South East **LHIN**

Integrated Health Care for Local Communities

2016/17 Annual Report

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Ontario
Local Health Integration Network

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Letter from the Board Chair and CEO

On behalf of the South East Local Health Integration Network (LHIN) Board of Directors and staff, we are extremely pleased to present our Annual Report for 2016-17. This report highlights our LHIN's activities, accomplishments and financial information over the past fiscal year. It is important to note that 2016-2017 was also the first year for our fourth Integrated Health Services Plan (IHSP4), *Health Care Tomorrow – Putting Patients First*, which chronicles our goals and achievements as we begin our three-year journey as mapped out in that plan.

As the title indicates, our IHSP4 is very much a commitment to patients, not only in making their needs an absolute priority, but involving them in the major decisions surrounding their health care. Most of the significant activities this past year reflect that commitment, and two in particular serve as excellent examples – the first of those is our Older Adult Strategy (OAS), which we launched this past year in order to meet the needs of a steadily aging population.

The OAS is designed to ensure that existing resources are being used appropriately, and as efficiently as possible, and that any new resources are targeted to the right services and supports to serve an older population and their caregivers. In creating the OAS, we were dependent on extensive engagement and consultation with experts, health care stakeholders, and community leaders. Perhaps of most importance, we consulted with more than 400 patients across our region in order to ensure that the strategy met their needs and reflected their priorities.

Another example of our commitment to patient engagement is our continued work on the Health Care Tomorrow - Hospital Services project, which has been consistently informed by the Regional Patient Advisory Council. This dynamic collaboration between our region's seven hospital corporations, home and community care services (formally Community Care Access Centre), Queen's University Faculty of Health Sciences and our LHIN began in 2014. We have maintained our focus throughout this work on developing a sustainable system of integrated care that best meets the needs of patients, while ensuring greater operational efficiencies – now and in the future.

The OAS and the Hospital Services Project are just two examples from a year in which our LHIN made great strides towards building an integrated health care system that puts patients first. During this time we also worked towards achieving a level readiness for implementation of *Bill 41, Patients First Act, 2016*, as well as the creation of sub-regions, and preparations for system transformation as LHINs take on a new and expanded role home and community care service delivery and primary care accountability. We continued to make progress on our Addictions and Mental Health Redesign, and our Health Links continue to set the standard for coordinating care from different providers to ensure the best possible results for patients.

All in all, 2016-17 was an extremely successful year for health care in our region. Throughout this annual report you will learn more about those initiatives, as well as numerous other projects on which we have focused our efforts on with a common goal of improving our local health care system for all residence in the south east.

For this and so much more, we thank the many people at the South East LHIN for their hard work and commitment, and we thank all the health care providers for the outstanding way in which they have collaborated on behalf of their patients.

We are committed to helping achieve a more integrated, equitable health system that meets the diverse needs of our population in the south east region and across the province. We will continue engaging with partners, the Ministry, patients, families and caregivers across our region, in support of local planning efforts, as this is an essential component to being able to achieve success and continue building upon the many positive foundations we have established in 2016-17.

Sincerely,

Chris Salt, Acting Board Chair

Paul Huras, CEO

Board of Directors

The South East LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions made by the LHIN are directed by our Board. Our Chief Executive Officer (CEO) operationalizes the strategic directions established by the Board, and provides updates on our progress towards achieving our IHSP4 priorities through monthly reports on operational activities and key performance indicator results.

Board Members – Fiscal Year 2016-17

Donna Segal (Chair)
First Appointed: December 21, 2012
Term Expires: December 20, 2015
Second Term: December 21, 2015
Resignation: June 26, 2017

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

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

Lois Burrows
First Appointed: November 21, 2012
Term Expired: November 20, 2015
Second Term: November 18, 2015
Term Expires: November 17, 2018

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

Chris Salt
First Appointed: January 5, 2015
Term Expires: January 4, 2018
Vice-Chair Appointment: November 28, 2016

Brian Smith
First Appointed: May 6, 2015
Term Expires: May 5, 2018
Vice-Chair Appointment: March 1, 2017

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

Jean Lord
First Appointed: January 11, 2017
Term Expires: January 10, 2020

David Vigar
First Appointed: February 2, 2017
Term Expires: February 1, 2020

Annette Bergeron
First Appointed: March 1, 2017
Term Expires: February 28, 2020

The South East LHIN Strategic directions

The Board of Directors has set in place four corporate strategic directions, guiding decisions to:

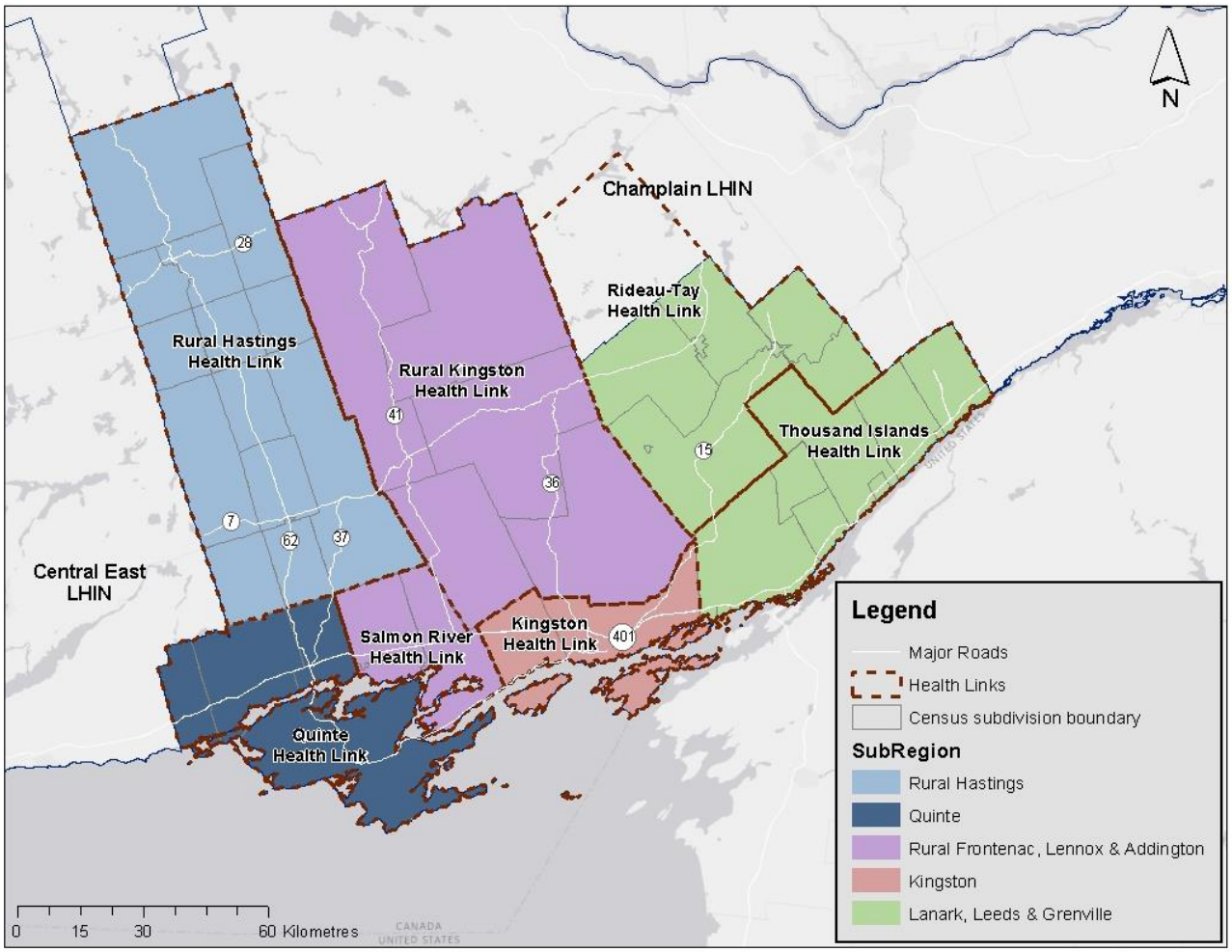
1. Build a true system of integrated health care that optimizes resources;
2. Build understanding of the role of the South East LHIN in the development and management of a regional system of integrated patient-centered care in collaboration with Health System Providers;
3. Build a functional integrated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

The South East LHIN Community Overview

The South East 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, and includes the towns of Bancroft, Perth and Smiths Falls.

This is the largest of the southern Ontario LHINs, encompassing the areas of Hastings, Prince Edward, Lennox and Addington and Frontenac Counties, the bulk of Leeds and Grenville United Counties, and portions of Lanark and Northumberland Counties. Historically, the South East LHIN has used subLHIN geographies for planning purposes.

However, with the introduction of the Health Links initiative in 2013 and the adoption of sub-regions in 2017, planning efforts will now be focused on the new geographic areas identified in the map below.



The South East LHIN Population

As of 2015, the South East LHIN was home to approximately 495,000 people. This accounts for 3.6 per cent of the population of Ontario, making this the third least populous LHIN. At 21 per cent, the South East LHIN had the highest proportion of adults aged 65 years and older amongst all LHINs in 2015. By 2026, the 65-74 and 75 years and older age groups are projected to have grown in all sub-regions, and those aged 65+ are expected to account for 28 per cent of the LHIN's population.

The Lanark, Leeds and Grenville and Rural Hastings Sub-Regions are projected to have the highest percentage of the population aged 65+ in 2026, with both at 34 per cent. The highest annual growth rate for those 65-74 in the next five years is projected to be in Rural Hastings, with 2.7 per cent annual growth, and the highest rate for those 75+ is in the Rural Frontenac, Lennox & Addington Sub-Region, at 4.5 per cent annual growth. By contrast, the younger age groups will generally experience negative growth in each Health Link and Sub-Region, except for Kingston where there will be minimal growth, at just over one per cent 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 per cent. Kingston will have a slightly higher annual growth rate at one per cent during this period.

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

Population Health Profile

Demographics
As noted above, the South East LHIN has an older population. This has a number of implications. We are able to predict that the number of people in this region living with chronic conditions will increase. Hand in hand with that increase, of course, will be a growing need for services and care coordination. We know there will be more demand for long-term care and assisted living, as well as palliative and end-of-life services. Finally, because older adults tend to rely on community support services, demand in that area will also increase in the years to come.

Health Behaviors, and Health Status
As of 2013, which is the most recent Canadian Community Health Survey, only three in five people in the South East LHIN report being in very good or excellent health. This is similar to the provincial average. Moreover, many people exhibit behaviours that will likely result in health issues. Almost half of our population is physically inactive, and more than half the people in the south east region do not consume enough fruits and vegetables. Also, 20 per cent of our residents are daily smokers, and 20 per cent report heavy alcohol use. This LHIN has some of the highest rates in the province for many chronic conditions.

Obesity
A quarter of the adult population in the South East LHIN was classified as obese in 2013-14. This rate was significantly higher than the provincial rate of 19.2 per cent.

Chronic Conditions
The South East LHIN also has high rates of certain chronic conditions compared to other areas of the province:

- **Arthritis:** 24.3 per cent reported having arthritis in calendar years 2013-14, compared to the provincial rate of 17.9 per cent.
- **High Blood Pressure:** 22.8 per cent reported having high blood pressure in 2013-14, a rate that has steadily increased in the past ten years. The 2013-14 South East LHIN rate was

significantly higher than the provincial rate of 18.5 per cent.

- **Diabetes:** The prevalence of adults with diabetes (types 1 and 2) was 12.4 per cent as of April 2013. This was similar to the provincial rate of 11.9 per cent and has increased slightly from 10.6 per cent in April 2009.
- **Asthma:** About one in 10 (9.8%, 95% CI 8%-11.6%) South East LHIN residents reported having asthma in 2013-14. This rate continues to be significantly higher than the provincial rate of 7.6 per cent (95% CI 7.2%-8%).
- **Chronic Obstructive Pulmonary Disease (COPD):** In 2013-14, the rate of COPD in our LHIN was 6.4 per cent, much higher than the provincial rate of 4.0 per cent.
- **Anxiety Disorders:** In both the South East LHIN and Ontario, rates of anxiety disorders have increased over time. In 2013-14, 11 per cent of South East LHIN residents reported having been diagnosed with an anxiety disorder. This rate was significantly higher than the provincial rate of 7.6 per cent.
- **Mood Disorders:** In this LHIN, the prevalence of mood disorders such as depression, bipolar disorder, mania or dysthymia has steadily increased over the last 10 years, from 6.8 per cent in 2003, to 13.2 per cent in 2013-14. Rates for Ontario have also increased but not as much as the South East LHIN rate.

Health Care Investments

In fiscal year 2016/17, the South East LHIN was assigned a budget of $1,139,922,236 for the provision of health care services, through our 73 Health Services Providers (HSPs), to meet the specific needs of our population. The table below shows the proportion of funds allocated to each health care sector in the South East LHIN.

In the past fiscal year, HSPs delivering care in the South East region included:

- Seven Hospital Corporations – operating 11 sites, providing a range of acute care, complex continuing care, rehabilitation, and mental health services.
- One Community Care Access Centre.
- Five Community Health Centres – operating eight locations (five main sites and three satellites).
- Eight Addictions and Mental Health agencies.
- 30 Long-Term Care providers operating 4,050 beds in 37 facilities.
- 22 Community Support Services agencies.

In 2016-17, our LHIN relied on 73 Service Accountability Agreements (SAAs) and related performance assessments to monitor and appraise the performance of these agencies. We report annually on our use of public funds and our success in meeting provincial health care goals and objectives.

This focus on quality and accountability is allowing us to develop a regional healthcare system that not only provides world class services but will also be sustainable for years to come.

South East LHIN Allocation of 2016-2017 Community Investment Funding Increase		
Sector	**Allocation by Sector**	**% of Total Allocation**
CCAC - Level of Care Framework, Caregiver Respite	5,080,100	75.00%
Community Support Services	1,164,267	17.19%
Community Addictions & Mental Health Services	279,133	4.12%
Community Health Centres	250,000	3.69%
Total Allocation of Community Investment Funding Increase by Sector	**$6,773,500**	**100.00%**

Ministry-LHIN Priorities and Initiatives

Ministry Priorities

In 2015, Dr. Eric Hoskins, Minister of Health and Long-Term Care, released the *Patients First: Action Plan for Health Care*. It was a bold reaffirmation of Ontario's commitment to putting people and patients first by improving their health care experience and their health outcomes.

This plan focused on four key objectives, which together establish a framework for the next phase of health care system transformation in Ontario. Those objectives are:

Access: When Ontarians are sick or injured, they want fast access to care. This objective is all about improving patient access to the right kind of help, whether from a family doctor, nurse-practitioner, pharmacist or a number of different care providers.

Connect: It is increasingly important that the home and community care sector be able to meet the needs of patients, particularly seniors, and people suffering from chronic disease. This objective is all about delivering better coordinated and integrated care in the community, closer to home**.**

Inform: We know that health care is more than just treating people when they are sick. It is also about helping people live a healthier life and avoid getting sick in the first place. It is about creating a culture of health and wellness. This objective is all about supporting people and patients by providing them with the education, information, and transparency they need to make the right decisions about their health.

Improving the health care experience through an integrated and patient-centred continuum of care

Protect: The point to universal health care is that it belongs to the people who fund it and depend on it for their health and the health of their children. Ontario's health care system belongs to Ontarians, and we must ensure that it is always there for them. This objective is all about protecting our universal public health care system by making good evidence-based decisions on value and quality, so that we can sustain the system for generations to come.

LHIN Priorities

The South East LHIN is committed to advancing all of the objectives of the Action Plan, through plans that reflect the specific needs of patients and communities in this region, and our specific priorities for the delivery of health care. Our LHIN's fourth IHSP covers the years 2016 to 2019. It established three overarching priorities for how we can achieve better integrated health care in south east Ontario. Those three priorities will guide the work we do and define the direction for our region's health care system. They are as follows:

Achieving better patient outcomes through more equitable access to quality care

In order to achieve equitable access to quality care, we need to ensure that we have a fair distribution of resources based on the needs of patients. Fair distribution does not mean equal distribution, as that is not what patients need. What patients need, and expect, is that they will receive the services they require, when they require them.

Integration and patient-centred care are flip sides of the same health care coin, and they

have come to define the kind of care that Ontario, and LHINs, are committed to delivering. They enable a continuum of care that wraps the system around the needs of the patient, with providers and health organizations working together towards one common goal, which is to bring about the best possible outcome for that patient. The South East LHIN is working to build integrated, patient-centred and sustainable regional health care system that supports healthy people in healthy communities.

Working with partners towards the achievement of an accountable, high-performing health care system

The keys to integration are cooperation and collaboration in the delivery of care. We work with our health care partners across the region to achieve exactly that. We know that in order to build the kind of high-performing health care system that patients and residents need and deserve, we must bring together and work with a wide variety of HSPs, stakeholders and communities. That requires creating a collaborative culture where all partners are involved in the decisions that affect the health care system in our region.

Key Initiatives

Health Links

Health Links were launched in 2013, and have been extremely successful in our LHIN and across the province in bringing together providers and health organizations to work as a team in the best interests of patients and their families. Health Links are a perfect example of integration and patient-centred care. There are seven Health Links in the South East LHIN – collaborative networks that are primary care-led and include a diverse group of health and social services organizations aiming to improve care coordination and transitions between services for patients with complex needs.

In the past four years, Health Links have continued to maintain their momentum and make gains. As of Q4 2016-17, Health Links partners implemented a total of 3,733 coordinated care plans for patients with complex needs. Care coordinators and system navigators reported that the Health Link approach is well received in the field, and care coordination/system navigation approach has spread to other sectors such as home and community care, and addictions and mental health.
hospitals, public health, addictions and mental health, and home and community care.

Primary Care Renewal

It is widely accepted that the foundation of a high-peforming health care system is a strong, robust primary health care sector. Not only do primary health care providers care for their patients directly, they are also able to connect them to the rest of the health care system, whether that be for tests, treatments or specialist consultations.

In late 2016, the Ontario legislature passed the *Bill 41, Patients First Act, 2016*, intended to help patients and their families obtain better access to a more local and integrated health care system, improve the patient experience, and deliver higher-quality care. A major feature of *Patients First* is a renewed focus on primary care. As part of that, LHINs are now responsible for creating a more integrated service delivery network of primary care providers and inter-professional health care teams who will work with other partners, including

Primary Care in the South East LHIN

In our region, primary health care is delivered through a variety of models involving family physicians, nurse practitioners, and other allied health professionals, situated in doctors' offices, family health teams, community health centres, nurse practitioner-led clinics, or other family health organizations.

With our expanded mandate, the LHIN will continue to treat primary care as the foundation of the health care system. Working with health care providers, we will ensure comprehensive care by creating sub-region plans to improve access to primary care physicians, nurse practitioners, and inter-professional primary health care providers. We will also develop and implement a plan, with input from primary care providers, patients, caregivers and partners, that embeds or closely connects care coordinators and system navigators in primary care to facilitate smoother transitions of care between home and community care and other health and social services, as required.

Over the past year, our LHIN began laying the groundwork for this shift in primary care culture. We made engagement with primary health care partners a priority. The ninth Primary Health Care Forum took place in October 2016, focusing on leadership, engagement and transformation. Plans are already underway for the 10th Anniversary of the Forum, *"Celebrating our Gains. Mapping our Future,"* which will be held in October 2017. Moreover, the Primary Health Care Council, in place since 2008, is undergoing renewal to align with the implementation of the *Patients First* legislation.
We will continue to working closely primary health care providers to plan services, undertake health human resource planning, and improve patient access to interprofessional primary health care.

Emergency Department Wait Times and Alternate Level of Care Pressures

Alternate Level of Care (ALC) is a system classification that occurs within acute inpatient, mental health, rehabilitation, and chronic or complex care environments. When a patient occupying a bed in any of these classifications could actually be served in a community setting, he or she is said to be contributing to ALC days.

System-Wide Patient Flow Strategy

The South East LHIN 18-month Patient Flow Strategy was originally launched in 2015-16 to align with Ontario's *Action Plan for Health Care*, and ensure patients receive the care they need when and where it is most appropriate.

This past year, we re-launched the plan to address system-wide patient flow issues. The plan focuses on diverting patients from Emergency Departments (ED) if their care needs can be met elsewhere, reducing the length of stays in the ED and hospital, ensuring patients receive appropriate community supports when discharged from hospital, and reducing ALC days by decreasing the amount of unnecessary time patients remain in hospital beds.

Hospital Patient Flow Dashboard

Every month, EDs across the LHIN submit a report on patient flow to the LHIN. Those reports are also shared with the ministry. As a result, information is always available about how patients are accessing EDs, making it easier to manage the flow.

High-Risk Screening Tool (iCART)

The Integrated Community Assessment and Referral Team (iCART) uses the provincial high-risk screening tool, within the Emergency Room (ER) and throughout the hospital to identify older adults who are at risk of repeat ER visits and/or becoming ALC. If a patient is identified as being at risk, a collaborative team consisting of home and community care, the SMILE program, and a Regional Care Coordinator (RCC) review the file to determine if the patient could benefit from services in the community. Older adults receive an in-home visit and a coordinated care plan is developed to help them remain in their homes as long as possible.

Seniors Managing Independent Living Easily (SMILE)

SMILE is a long-term functional support program for frail and elderly seniors most at risk of premature institutionalization to receive help with activities that are essential to daily living, allowing them to remain in their homes.

Home First Refresh

In 2016-17, there was a dedicated effort across our region to review and refresh the Home First philosophy in hospitals. All hospitals had previously adopted the philosophy, but there was variation across the region in the extent to which the concept was embraced. With the refresh, the focus was on transitioning Home First from a program/initiative to an overarching philosophy that permeates throughout the hospital. The focus, always, is to find ways of getting people home safely instead of having them become ALC or sending them to LTC.

ALC Resource Matching & Referral

The ALC Resource Matching & Referral Business Transformation Initiative (ALC RM&R BTI), continued its success this past year, helping us move patients out of acute facilities and into more appropriate environments, including acute to rehab, acute to complex continuing care, and acute to either long-term care or homecare for their ongoing care.

ED Wait -Times – Performance and Capacity Management

In 2016-17, the South East LHIN continued working collaboratively with EDs across the region to improve both patient flow and health outcomes. The South East LHIN ED Clinic Lead is the clinical resource for EDs, ensuring that our LHIN is able to monitor ED capacity. Understanding how, when and why patients are accessing the ED has helped our LHIN improve system-wide patient flow.

In addition to efforts focusing on improved monitoring, the South East LHIN continued to support initiatives to strengthen hospital performance, as well as hospital and community capacity management. Pay-for-Results program initiatives with Kingston General Hospital and Quinte Health Care focused on expanding and reorganizing staffing as part of ED teams, as well as creating new areas of triage for rapid assessment to assist with patient flow for all categories, ensuring clients receive appropriate care and resources.

ED Patient Flow for Addictions and Mental Health

In 2016-17, our South East LHIN made significant improvements in the area of repeat visit rates to the ED for mental health and substance abuse conditions. In Q1 2016-17, the 30-day repeat ED visit rate for substance abuse conditions was at 25.8 per cent. In Q3, it was at 21.2 per cent, ranking first in the province. In Q1 2016-17 the 30-day repeat visit rate to the ED for mental health conditions was at 21.9 per cent. In Q3, it was at 19.5 per cent.

These improvements can be directly related to the implementation phase of our Addictions and Mental Health Redesign.

Specifically, we made improvements in access to emergency room diversion case management, implemented coordinated care plans in collaboration with Health Links and improved transition planning between hospital and community programs. The situation was also helped by improved flow in community agency programs and investments into services such as clinical counselling.

Home and Community Services Investments

In 2016-17, the Ontario Government provided the South East LHIN with $6.7 million in additional funding to support home care and community services in our region. This funding allowed us to better support home care for more frail seniors and expand the caregiver respite services. We were able to provide focused funding to increase regional capacity for attendant care services and community-based care giver respite programs, as well as continue to invest in improvements to mental health supports as part of Addictions and Mental Health Redesign efforts.

The South East LHIN Allocation of 2016-2017 Community Investment Funding Increase table on Page 8 of this report provides a breakdown of how the increase was shared among providers to enhance the provision of services in the region.

Older Adult Strategy

As noted earlier, the population of the South East LHIN is the oldest in Ontario. We have a large number of people living with chronic conditions, and that number is going to increase. It is an inescapable fact that our aging population will require more and improved care going forward. That is why, this past year, our LHIN developed an Older Adult Strategy (OAS) to ensure the LHIN is positioned to meet the health care needs of an increasingly older population over the next 10 years. In developing the OAS, we engaged and consulted with more than 400 patients, HSPs and key experts in the field of older adult health and policy.

The South East LHIN's OAS is inspired by a clear vision, driven by two overriding objectives, and informed by five distinct themes. The vision of the OAS is *"Realignment and development of a health care system in the South East LHIN to better meet the needs of older adults in our region now and into the future."*

The OAS positions our LHIN to achieve this vision by supporting two objectives:

1) Ensuring that resources currently available are being used appropriately and as efficiently as possible; and
2) Ensuring that any new resources are targeted to the right services and supports to serve this population and their caregivers.

The following five themes will inform our priorities:

1) Wellness and functionality of the Older Adult in the community will be promoted and preserved.
2) Caregiver well-being will be enhanced.
3) The care experience for the client or patient will be improved.
4) There will be targeted upstream interventions that will contribute to the early identification of high risk older adults.
5) There will be support for older adults affected by dementia, behavioral supports and addictions and mental health issues.

The implementation of the OAS aligns with *Patients First*, IHSP4 priorities, the commitment of the MOHLTC to invest $750 million into community support care, and many LHIN initiatives such as Health Links, Assisted Living for High Risk Seniors, improved Dementia Care, Behavioural Supports Ontario (BSO) strategies, and Regional Care Coordination.

The OAS proposes a population-based Balance of Care model of health care for the continuum of low to high needs patients, clients and caregivers. It will be coordinated, accessible, and equitably distributed across the region. Stressing cross-sector partnerships, it leverages existing and new resources to provide more upstream interventions to shift the "tipping point" along the continuum of need and care to support aging safely and independently at home.

The OAS will be implemented over nine years, beginning in 2017. The plan will be executed in three year cycles and will align with the IHSP process. Each plan will describe the sub-projects and initiatives that will be undertaken during the three-year term, and the anticipated impact of these sub-projects and initiatives on the OAS vision.

The first three years of the implementation plan will focus on several interconnected regional outcomes identified by clients, patients, caregivers and experts, as being critical to an effective model of health care for older adults:

- The creation of a clearly defined, publically funded basket of common core services across the region. These would include supports for patients, clients and caregivers to help them age in place, including:
    - Home maintenance and repair;
    - Meals on wheels;
    - Volunteer transportation;
    - In-home respite;
    - Adult day services; and
    - Foot care.
- Increase Assisted Living services, particularly in more rural settings. This will provide the right care for client and caregiver in the community, alleviating the downstream substitution of more expensive and inappropriate care options, such as hospitalization and premature long term care placement. Evaluation of current initiatives and review of new opportunities, particularly for rural and Indigenous communities, has commenced. New initiatives will be implemented in years one and two of the three year cycle.
- A standardized, clearly defined coordination of care system for older adults and caregivers that takes a holistic person-centred view of social and health status to co-create a plan of care and service for the patient's journey along the aging continuum.
- Improved dementia and behavior supports services. This is in progress.
- Create a strategy with Community Support serving agencies over three years to address the issue of people "aging out" of the informal care system.

There are committed funds of $500,000.00 for the implementation of the OAS. Any additional funding requirements identified would be sought through the LHIN's Business Planning Proposal (BPP) process in future years.

Assisted Living Services for High-Risk Seniors

In almost every community, there are a number of people, usually seniors, who are more likely to require institutional services such as acute and long-term care. The goal of the Assisted Living Services for High-Risk Seniors (ALSHRS) program is to help these seniors maintain their independence and remain in their homes for as long as possible, without being prematurely institutionalized in a hospital or Long-Term Care Home.

The South East LHIN currently directs less investment towards assisted living than any other LHIN. However, this assisted living initiative broadens the scope of services that are available in this region.

Assisted Living Services for High-Risk Seniors

The ALSHRS program addresses the needs of high-risk seniors who can live at home but require the availability of personal support and homemaking services on a 24-hour basis. These services include:

Personal Support Services: These include dressing, personal hygiene, assisting with mobility, assisting and monitoring medication use, and other routine activities of living.

Homemaking services: These include shopping, housecleaning, and meal preparation.

Security checks or reassurance services: These include visits to assure client health or safety. These services shall be provided to address the individual needs of clients based on their clinical condition or environment.

Care Coordination: This includes regular and ongoing communication with community care access centres, community support service agencies, community social and recreational services, and community primary health care professionals.

In 2016-17, additional capacity was added to the ALHRS so that there are now 45 clients in each of Brockville and Belleville, as well as 90 clients in Kingston. These hubs have been created to ensure that there is a maximum 15 minute response time and to maximize efficiencies of program staff.

Hastings County also has signed an agreement to allocate up to 10 units from their social housing on Bridge Street in Belleville for ALHRS clients. This partnership will ensure that low income seniors will have access to the services that they need.

Discussions have started with Leeds and Grenville to establish a formal partnership in the Brockville area, as well.

Regional Integrated Fall Prevention and Management

Falls among older adults are always a concern, and that is as true in our LHIN as it is elsewhere. There were more than 7,000 ED visits in 2014-15 that were a result of a fall – that is the second-highest rate among all LHINs.

In 2014, our LHIN initiated a collaboration with Hastings Prince Edward Public Health, Kingston, Frontenac and Lennox and Addington Public Health, and the Leeds, Grenville and Lanark District Health Unit. The objective was the creation of a regional fall prevention strategy. Following engagement with primary care, hospitals and long-term care, as well as strategic planning, the strategy was unveiled in June 2016.

The goal of the strategy is to reduce the incidence, impact and severity of falls and fall-related injury among older adults in the south east Ontario. This will be achieved through five strategy pillars including:

1) Public Awareness and Education;
2) Assessment and Management;
3) Service Navigation and System Integration;
4) Engagement and Advocacy; and
5) Provider Skill Development and Education.

Key achievements for 2016-17 include promotion of November as Fall Prevention Month through a unified social media campaign, the development of a fall prevention and management microsite on the South East HealthLine, and completion of our environmental scan on education opportunities related to falls and fall risk factors. A review of best practice assessments for community, in collaboration with Queen's School of Rehabilitation, was also conducted.

Enhanced Long-Term Care Home Renewal Strategy

Many older long-term care homes (LTCH) have design features that make it difficult for them to meet the growing needs of long-term care residents. Many LTCH, therefore, are now required to redevelop to a new standard by 2025. In our region, approximately 1,965 beds, 49 per cent of the total number of beds in the South East LHIN need to be redeveloped. This represents 25 of our 37 homes. Currently, these homes are at various stages of the redevelopment process, although none of the beds have been approved for operation to date.

This past year, the LHIN submitted a business case with recommendations on the reallocation of 78 LTC beds that have been temporarily out of operation due to a Picton home closure in 2012. This business case was accepted in principle, subject to specific terms and conditions, and the Ministry has now initiated its reallocation process. Once redevelopment is complete, these 78 beds will restore the LTCH bed capacity in our region to a total of 4,106.

French Language Accessibility and Culturally Appropriate Care

French Language Strategy

The South East LHIN is committed to ensuring there is appropriate access to care for the Francophone community of Southeastern Ontario. Our LHIN regularly engages the community and health service providers, working with them to plan, develop, and enhance the provision of health care services.

The first year of the three-year French Language Strategy (FLS) commenced in 2016, and was developed in collaboration with the South East LHIN, the Champlain LHIN, and the French Language Health Planning Entity: Le Réseau. The strategy focuses on the active offer, information on health services and performance of FLS through the following components:

- To determine the needs for health services in French
  - In the FLS annual reports that HSPs have to submit to the LHIN, the bilingual capacity was collected across the region and analyzed. The findings of the analysis will help to better plan for services in French, in showing resources and gaps
  - Our LHIN continued to implement a pilot project with Kingston Health Science Centre that adds two questions about the linguistic variable to identify Francophones for better planning. At this point the questions have been implemented and data is being collected. Our LHIN has already received a few semesters of data, and has elaborated a preliminary analysis and focused on the correction of data collection flaws
- Plan the active offer of services in French
  - The LHIN kept supporting identified organizations by providing funding opportunities for FLS projects and through a collaboration with the Réseau
  - The LHIN continued to engage the committee of Francophone citizens
- Performance of services in French
  - This year again performance measures about FLS were included in the accountability agreements of identified HSPs

To date, more than 96 per cent of all funded HSPs have submitted their FLS annual report to the LHIN, and additional reports are still expected to be submitted before an analysis of the results be conducted.

Indigenous Care

The South East LHIN is committed to engaging with our Indigenous communities across the region. Our goal is to build and strengthen our relationships with First

Nations, Inuit and Métis communities, and we believe that with time and through a co-leadership and engagement model, we will improve the health and well-being of all the Indigenous peoples living in the south east.

This past year, our LHIN's Indigenous Lead met with members of the Mohawks of the Bay of Quinte to conduct a prioritization exercise, which identified their immediate priorities for health care and any critical gaps that might exist. This included feedback on how best to remain engaged with the community and maintain relationship moving forward.

In addition, a session on palliative care was held with the Palliative Care Lead, the Indigenous Lead and local community members, to seek feedback on the proposed regional palliative care strategy from a First Nation, Inuit and Métis perspective. This session included community members from a variety of First Nations communities, as well as members from the Métis Nation. Finally, our LHIN allocated more than 150 seats to regional HSPs for Indigenous Cultural Safety training. These eight to 12-hour sessions were targeted at raising cultural literacy, and encouraging participants to reflect on their own beliefs and values in light of their recent education via the program.

Addictions and Mental Health Services Redesign

Launched in 2013, the Addictions and Mental Health (AMH) Redesign aims to address many of the issues that clients seeking help for addictions and mental health challenges have told us they were facing when accessing care. In particular, feedback from clients reflected concerns with:

- Duplication of services;
- Duplication of assessments, or multiple story telling;
- Difficulties in transitioning between providers;
- Difficulty in accessing services;
- Insufficient volume of services to satisfy demand; and
- Stigma often faced in accessing these and other health services.

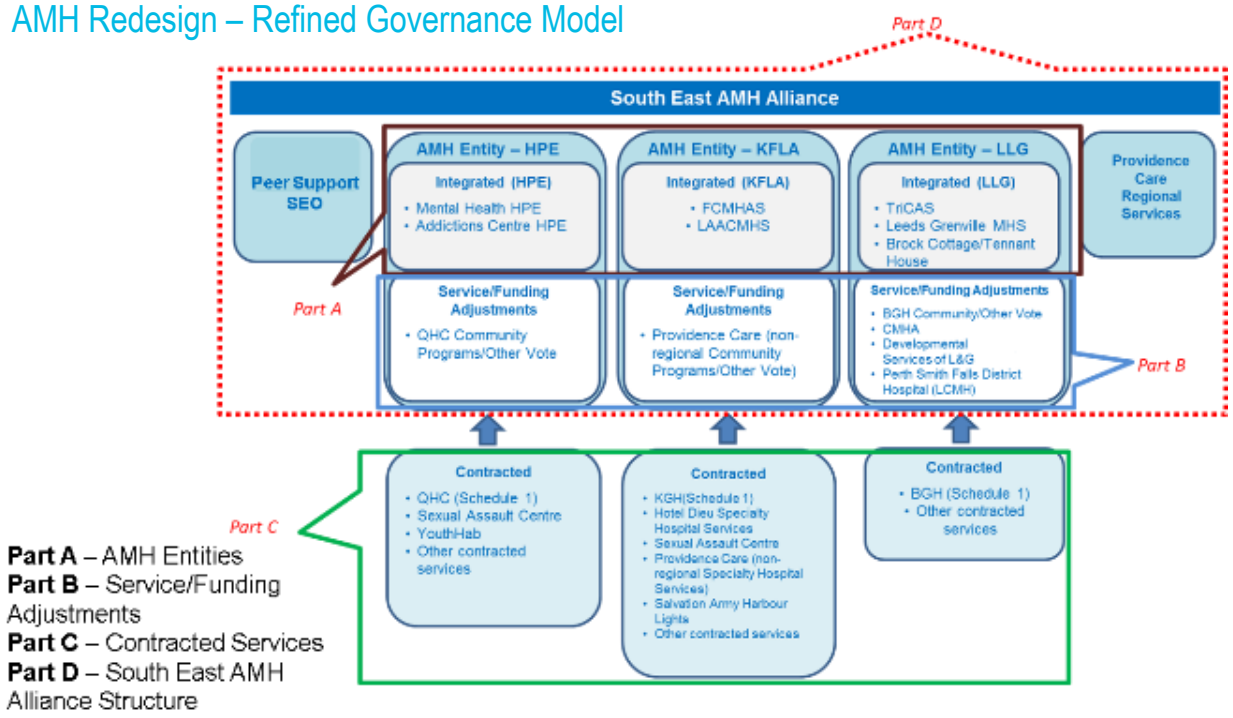
In collaboration with stakeholders, providers, clients and caregivers, the South East LHIN has engaged in a significant redesign of these services, working to achieve the 'Ideal Individual Experience' for clients and their caregivers.

Since the official agency amalgamations on April 1, 2015, 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 core components of the Part A and Part C of the Redesign (please see attached diagram on Page 19).

To be able to develop robust implementation plans for Part A, the three community AMH agencies formed a series of working groups that identified the following objectives:

- 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;
- A drill-down of the Common Basket of Services and an implementation plan for alignment and gap identification; and
- The implementation of one electronic client record platform.

AMH Redesign – Refined Governance Model



Part A – AMH Entities
Part B – Service/Funding Adjustments
Part C – Contracted Services
Part D – South East AMH Alliance Structure

The finalized implementation plans were completed on April 15, 2016, and operationalization is already beginning to occur in multiple areas. Specifically, the unified electronic client record platform was completed in June, 2016. Modeling and a robust toolkit for the Centralized Intake and Waitlist structure has been completed, and implementation is expected to begin in September 2017. Standardization and alignment of Case Management and Clinical Counseling functions will begin implementation in the fall of 2017.

The South East LHIN has worked with the three AMH Agencies, Acute Schedule 1 Facility hospitals, specialty hospitals and specialty agencies to implement Part C. This development of contracts will enable the full continuum of AMH care to be owned by the three AMH Agencies. The contract development was finalized in August, 2017. Two specialty community agency contracts were signed in September, 2017 and all Acute Schedule 1 contracts were signed by March, 2017. The Tertiary Hospital contract is expected to be finalized and signed by the fall of 2017.

The Strategic Alliance, a leading group of partners with representation from the three AMH Agencies, Peer Support South East Ontario, Providence Care Hospital and Queen's University, has been in operation since April 2015. This Alliance has developed and signed a Memorandum of Understanding which defines their role, their principles and their trajectory for planning and oversight of the new AMH system. The Alliance is responsible for supporting stakeholder and client engagement, performance monitoring, planning of services and adherence to the Redesign vision and the Ideal Individual Experience. This past year, the Strategic Alliance finalized the memorandum of understanding, worked with Dr. Brian Rush to develop a Metrics Framework to monitor performance of the AMH system, and has established a process for populating sub-committees that will provide information and direction to the Strategic Alliance.

Enabling Care through Technology

Increasingly, health care providers and organizations depend on robust electronic technology to collect, store, and manage all of the critical health information on which they, and their patients, depend. This past year, the South East LHIN invested time and resources in several enabling technologies intended to increase efficiency and improve patient care.

Regional Privacy Capacity Project

Our LHIN initiated the Regional Privacy Capacity Project in 2015, in order to develop a regional privacy and standard through the identification of Primary Care, CSS, home and community care services, AMH, Public Health, and LTCH privacy and business needs. The project focus is to increase privacy knowledge and privacy program capacity, and enable more effective sharing of personal health information.

In the past year, we have made significant progress in increasing privacy and security maturity amongst HSPs. We developed baseline metrics to support measurement of progress through the regional privacy capacity building work, and adapted provincial privacy and security standards to meet local needs in supporting priorities such as ConnectingOntario, South East Health Integrated Information Portal (SHIIP) (SHIIP) and eNotification.

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. In 2012, the hospitals in the South East LHIN agreed to work together to better integrate the provision of care and services across all hospitals through development of a regional HIS.

Currently, our region is getting closer to having a functional HIS. There is shared commitment amongst hospital and LHIN CEOs, and their executive, clinical, and technology streams to support a shared set of HIS clustering goals, and to work towards the completion of HIS clustering financial/value based analysis. In addition, an HIS business case is being developed to guide any procurement decision. The value base analysis will constitute the clinical ROI portion of the costing model for HIS renewal in the South East. In Q4 of 2017-17, clinical stakeholders were engaged to identify site specific and regional clinical priorities that will support value generation through HIS investment.

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. By establishing a two-way gateway between ED and CCAC information systems, the ED CCAC Notification System will integrate CCAC and hospital patient and admission information to better inform both clinicians and CCAC case managers when patients visit the ED while receiving support service from the CCAC.

This system will increase efficiency in use of resources, and increase awareness, collaboration, and communication between CCAC and south east hospitals so discharged patients are offered more coordinated care on discharge to prevent avoidable readmissions.

ConnectingOntario

The ConnectingOntario project will plan and implement a provincial electronic health record aligned with eHealth's Blueprint and standards. The primary goal of the project is to provide HSPs with timely access to personal health information from acute, home and community care. With reliable and secure electronic health information, HSPs will have more comprehensive

information to deliver better and more coordinated patient care. LHINs are working collaboratively to plan, establish and deploy integrated Electronic Health Record (EHR) services with the ConnectingOntario program and service delivery partners. Technical development of this platform still continues.

Ontario Lab Information System

The Ontario Laboratories Information System (OLIS) is a province-wide, integrated repository of tests and results. When it is complete, 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. OLIS is a corner stone information system that connects hospitals, community laboratories, public health laboratories and practitioners to facilitate the secure electronic exchange of laboratory test orders and results. As of this past year, all hospitals in our region are contributing lab results to OLIS. The only outstanding area is microbiology, where some work remains before Providence Care is able to contribute those results.

Eclipse Project Management System

Eclipse Project Management System (Eclipse PPM) is a cloud-based tool that helps users visualize the portfolio of health care projects, make decisions about priorities and understand resource utilization. The system supports project management by helping health care professionals manage simultaneous projects from the planning to implementation phase, along with internal and external partners. The Eclipse PPM has been fully endorsed by the South East LHIN, and we have initiated an assessment of Eclipse PPM use throughout the region to better understand its benefits and limitations.

This past year, we distributed a project management capacity survey to many regional health service providers, seeking to understand the maturity of project management processes within the acute, home and community care, AMH and Long-Term Care (LTC) sectors. The survey revealed wide variation in project management maturity and processes within and across all sectors. The survey also revealed very little awareness of the Eclipse PPM tool, indicating there is still a good deal of work to be done.

Regional Collaboration Space

We know it is extremely important that organizations in our region are able to share information easily, which is why our LHIN makes regional collaborative spaces available to cross-organizational teams in the South East. These collaborative spaces are internal regional tools meant to support health care projects, and improve efficiency and effectiveness in the sharing of information amongst multiple providers and stakeholders.

The project began with a need assessment in 2014, and has quickly progressed to support several existing projects. There is currently significant demand for regional collaboration SharePoint sites, and so a strategy is in development.

Health Links Care Coordination Enabling Technologies

As previously explained, Health Links are bringing health providers together to work as a team to improve care for patients with high needs, often seniors. This collaborative model depends on electronic technology for its success, and across Ontario, the Health Links program has provided an opportunity to leverage IT/IM investments in support of more effective, sustainable, high quality care. Specifically, the focus has been maintaining and sharing patient records, as well as the Health Links Coordinated Care Plans (CCPs), drawn up by the teams of providers for their patients.

Going forward, there will be third-party comparative evaluation of CCT as well as other major care coordination solutions implemented across the province, in order to ensure that they keep meeting the needs of patients and providers.

South East Health Integrated Information Portal

The South East Health Integrated Information Portal (SHIIP), is a secure web-based portal that enables health care providers to share patient data in real time, or near real-time, including hospital emergency department and acute care visits. The portal incorporates and connects information from existing technology assets, facilitating the identification of complex/high-needs patients, helping to inform clinical decision and care planning to enhance patient experience.

SHIIP can identify groups of patients requiring additional health supports and care – specifically patients with complex or high cost health needs. It also facilitates performance monitoring and quality improvement efforts throughout the health system. It supports collaborative, multi-agency care processes as opposed to exclusive single provider processes, and thus supports the Health Links model of care. Currently, SHIIP receives data from acute hospitals, community support services, and addictions and mental health services. Additional data contributions from the home and community care sectors are forthcoming.

SHIIP increases system productivity with improved access to coordinated care and ease of transitions between providers for patients, eliminating duplicated tasks and the number of forms required for clinicians to complete.

Integration Activities

Integration has been at the heart of this and every other LHIN's activities for more than a decade. This is due to the widespread acknowledgement that health care systems need to pull together to wrap care around the needs of patients. Health care systems need to focus on providing better care in the community to lessen the strain on hospitals, as well as prevent serious illness through more proactive care. Overall, health care systems, in other words, need to be better integrated. The following are some initiatives, aimed directly at integration, which we have been pursuing in the past year.

Providence Care

The opening in spring 2017 of Providence Care's new site is a perfect example of what we mean by integration in health care. Providence Care Hospital is one of the first hospitals in North America to fully integrate long-term specialized mental health care with physical rehabilitation, complex care and palliative care in one building. All patients, no matter their diagnosis, have access to the same therapy spaces, recovery services, and private inpatient rooms.

Health Care Tomorrow – Hospital Services Project

The Health Care Tomorrow - Hospital Services (HCT – HS) project, which was launched in 2014, explores opportunities for shared hospital services and new or expanding partnerships. The overall 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 (prior to Patients First transition)

- Queen's University Faculty of Health Sciences
- South East Local Health Integration Network

The focus of the project is to explore ways in which all partners can work together to better integrate the acute care system in south east Ontario. The first phase of the project focused on engagement, with a wide range of system stakeholders, including a 24-member Regional Patient Advisory Council, working to establish a vision and identify opportunities for improvement. Each phase of the HCT – HS project has been, and will continue to be, conducted with input from stakeholders and the public.

By August 2015, hospital and LHIN Board provided approval to progress on the development of some of the business cases for review in spring 2016, with the remaining to follow in the fall. The business cases have been developed based on contributions from regional executive leaders, functional experts and frontline managers/staff. The belief is that there are opportunities to save money, while still improving service and quality care for the region.

A shared service governance model with services councils is currently in development, with capability to provide oversight for both business services clinical support services such as lab, diagnostic imaging and pharmacy.

Hospital Integration

Hotel Dieu Hospital and Kingston General Hospital have now joined together to create Kingston Health Sciences Centre. The new hospital corporation became an official legal entity on Saturday, April 1.

Health System Funding Reform

The 2016-17 fiscal year was the fourth year of Health System Funding Reform.

Hospitals in the South East LHIN have performed fairly well, realizing $4.6 million in additional Health Based Allocation Model (HBAM) and Quality-Based Procedures funding. This, coupled with the positive HBAM reset and several other adjustments, equated to an overall increase in 2016-17 hospital funding of $17.2 million.

Overall, our hospitals are reducing expenditures and delivering on expected volumes which will help hospital maintain or improve HBAM share going forward. The South East LHIN continues to work closely with our hospitals to ensure there is a thorough understanding of the HBAM methodology.

Health-Based Allocation Model (HBAM)
HBAM is an evidence-based population-health-based funding formula that uses population and clinical information to inform funding allocations.

Regular performance meetings are held with each hospital. During which HBAM results are reviewed against actual costs and clinical activity to ensure South East LHIN hospitals are making progress towards closing the gap in services where actual cost exceeds expected in order minimize negative HBAM share and funding impacts.

Wait Times for Surgical and Diagnostic Imaging Procedures

Our LHIN continues to focus on reducing wait times for surgical and diagnostic imaging procedures whenever and wherever possible. We engage with our 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 involves quarterly meetings with hospitals, and the ongoing efforts of a local partnership working group created for this purpose.

All of these interactions allow for continual monitoring of processes, identifying and addressing data quality issues, reallocating volumes as deemed appropriate across hospitals, and identifying potential options for performance improvement. Our current focus is on process improvements for MRIs, designed to address longer wait times, and wait list management for Hip and Knee replacement surgeries. It is expected that these initiatives will result in performance improvements in the 2017-18 fiscal year.

Provincial Initiatives and Programs

Hospice Palliative Care

This past year, our LHIN continued working to advance provincial priorities for hospice palliative care. March 2017 marked the first year anniversary for the Ontario Palliative Care Network (OPCN) and provincial level planning continues with a clear governance structure now in place. Funding announcements to support additional residential hospice beds across the province were made, and the south east residential hospice bed plan submitted to the Ministry in July 2016 was approved. Our LHIN contributed to further capacity work via a survey that was launched province-wide, to determine capacity in all settings outside of the residential hospice setting, such as long-term care homes, hospitals, and community organizations.

One of the first OPCN requirements was that each LHIN have a Regional Palliative Care Network in place by March 2017. The South East Regional Palliative Care Network (RPCN) was officially launched on December 13, 2016. Co-Led by the Regional Vice-President of Cancer Care, Vice-President, Performance and Quality, and a CEO delegate from the South East LHIN, the South East RPCN Steering Committee consists of members who were chosen using a skills-based approach. This approach ensured that we have Steering Committee representation from members who provide care and service within each of the sectors, that comprise the hospice palliative care continuum, are caregivers of patients and who possess other specified attributes or skills known to support good governance.

Collectively, they are responsible for providing leadership, oversight, and support for the development and implementation of an effective and coordinated system of delivery for palliative care in this region.

Over the past year, the new South East RPCN held engagement sessions with stakeholders from across the region, including HSPs, patient experience advisors, Francophone citizens, and members of Le Réseau, as well as representation from First Nation, Inuit, and Métis. The focus was on designing the South East RPCN work plan priorities for the next three years and identifying next steps for implementing the work plan using a quality improvement approach.

Community Engagement Efforts

Community engagement is something that all LHINs are required, by legislation, to do. However, it is also something we know we need to do if we are to effectively execute our mandate.

LHINs exists to manage health care in a manner which reflects local needs and priorities. We could not reflect something we do not understand, which is why we work as hard as we do reaching out to stakeholders, patients and other health leaders.

Health Service Providers

The Health Professional Advisory Committee (HPAC) is a multi-disciplinary committee that provides our LHIN with advice on how to better achieve

patient-centered health care. We regularly seek HPAC support and feedback to enlighten current initiatives. This past year, our LHIN actively engaged and gathered feedback and advice from the HPAC on projects such as:

- Health Links
- AMH Redesign
- Health Care Tomorrow
- Patient Flow
- Respite and Convalescent Care
- Patients

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. These are the people with first-hand experience receiving care in our hospitals, and their input is extremely valuable in shaping better patient-centered hospital services in the south east.

The RPAC is currently serving in an advisory capacity to the Health Care Tomorrow - Hospitals Services project, providing valuable input on matters affecting the experience of patients and their families across the south east region.

This past year, our LHIN also sought feedback and engagement with RPAC on the *Patients First* proposal and other MOHLTC initiatives related to the future of healthcare. As part of the *Patients First* implementation, the RPAC will formally sunset in 2017-18, and a new regional Patient and Family Advisory Council will be created.

Governance

The South East LHIN Board of Directors continues to maintain regular contact with the general public, as well as with HSPs and organizational leaders, through monthly open board meetings and by attending HSP events. We understand that this type of public accessibility is critical if we are to successfully build, improve, and sustain health services for the region and our local communities.

As well, to encourage and facilitate the local exploration of issues of interest and the development of strong and collaborative health system partnerships, the Board has restructured and reset the agenda for its former Collaborative Governance and Community Engagement Committee. It is now called the Strengthening Collaborative Governance Committee, and its goal is to promote, foster and support three geographically-based HSP Governance Forums.

These forums support and complement the intent of the *Patients First* legislation to achieve 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 and as close to home as possible. The committee continues to place an emphasis on integrating patient pathways, strengthening communications, and building collaborative health system leadership within local communities.

Enhancing Engagement with our Indigenous and Francophone Communities

As was made clear earlier in this report, our LHIN is deeply committed to ensuring proper access to care for both the French and the Indigenous communities of Southeastern Ontario. We also want to ensure that these communities feel involved in the management of that care.

Performance Indicator Report

The Ministry-LHIN Performance Agreement sets out the obligations of the Ministry of Health and Long-Term Care 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 strengthen our local health care.

Performance on home and community care indicators have been at or near target. The percentage of home care clients with complex needs receiving visits for personal support is just above the provincial average of 87 per cent, but below the provincial target of 95 per cent. There are a relatively few number of clients in this patient population. In a number of cases, client availability affects performance on this indicator (i.e. clients may choose to delay service initiation or the client is not available for service at their treatment address). When these factors are accounted for, 98 per cent of clients received service within five days. Similarly, the percentage of home care clients receiving their nursing visit within five days of being authorized for nursing services, achieves the 95 per cent target after accounting for patient choice or personal circumstance, which explains why the first service is delivered beyond target.

The 90th percentile wait time for Community Care Access Centre (CCAC) in-home services measured as application from the community setting to first CCAC service, have been consistently very close to the provincial target. At year's end, the South East LHIN was one of three LHINs to achieve that target.

The Emergency Room Length of Stay (ER LOS) for complex patients increased slightly over the past year, with the LOS for the top 10 per cent of patients being 17 minutes longer than the previous year (8.9 hours to

9.18 hours). This remains 72 minutes lower than the provincial average. The 90th percentile ER LOS for minor/uncomplicated patients (4.48 hours) remains above the provincial average (4.15 hours).

LHIN-wide performance for diagnostic imaging indicates that more than 75 per cent of patients receive service within

access targets (these targets vary depending on the priority level of the patient). For MRI, the percentage of patients who received service within access targets continues to be the highest in the province.

Wait times for hip and knee replacements improved over the year with considerable effort toward standardizing intake and prioritization of targets. This is evident by the improved percentage of patients receiving the service within access targets in the most recent quarter.

The South East LHIN continues to struggle with patient flow and the Alternate Level of Care (ALC) patients who are waiting in hospital beds for a service elsewhere in the system. With an ALC rate of 17.74 per cent, this speaks to a large percentage of beds being occupied by patients who no longer require the given service. Collective efforts continue though increasing patient volumes and are noted across the region.

There has been considerable reduction in the percentage of repeat unscheduled ER visits for mental health and substance abuse conditions. The rate for substance abuse conditions, in particular, has dropped from over 28 per cent last year to 22.44 per cent in the current year. The LHIN was one of three LHINs that achieved the 22.4 per cent target in the last quarter of the fiscal year.

Readmission for selected HBAM Inpatient Grouper conditions remains modestly above the provincial target. A rededicated effort to address the needs of these patients will be addressed in the coming year.

Indicator		Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
1	Percentage of home care clients with complex needs who received their personal support visit within five days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	82.10%	85.58%	86.84%	84.62%	87.41%	86.90%
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%	94.00%	93.83%	94.53%	92.70%	91.90%	93.15%	93.61%
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	29.00	31.00	23.00	21.00	21.00	22.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	11.03	10.38	9.47	8.90	9.70	9.18
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.23	4.15	4.28	4.35	4.38	4.48
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	54.47%	63.06%	69.17%	76.80%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	89.17%	84.63%	71.01%	76.07%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	55.82%	60.17%	75.00%	66.78%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	61.35%	66.27%	81.30%	74.55%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.85%	15.16%	15.40%	15.24%	15.92%	15.97%

11	ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	17.11%	19.19%	17.05%	17.74%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	21.94%	21.79%	19.28%	19.60%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	24.86%	28.14%	21.63%	22.44%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	16.23%	17.01%	18.02%	17.34%

Monitoring Indicators										
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	88.47%	83.64%	83.94%	83.55%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	95.00%	93.00%	93.00%	98.07%	99.00%	99.00%	99.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.32%	85.01%	90.95%	84.43%	65.19%	65.34%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	14.00	13.00	15.00	15.50	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	8.00	7.00	7.00	7.00	7.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	4.58	12.28	41.11	39.92	10.46	26.98
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	460.80	506.16	137.28	387.93
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.46%	47.81%	42.72%	42.50%	44.91%	43.89%

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)
**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

Operational Performance Analysis

The South East LHIN Corporate Operations received and managed a total of $6.4M in funding for the 2016/2017 fiscal year.

Ancillary Project-Based Funding
Included in the total above, was special funding for projects to support various MOHLTC health system priorities. This 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 allocation of the total funding between LHIN operations and ancillary project-based initiatives is shown in the below graph.

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 and Diabetes Strategy
- Emergency Room/Alternative Level of Care Strategy
- Emergency Department Initiative
- Indigenous Community Engagement
- French Language Services
- Critical Care Initiative
- Primary Care Initiative

2015/16 AUDITED FINANCIAL STATEMENTS

An external audit was conducted by Deloitte LLP in April 2017. A copy of the auditor's report with audited financial statements and notes disclosures are provided in the following section of this document. The results of the audit for the 2016/2017 fiscal year were very positive, with no errors or misstatements noted.

Financial statements of

South East Local Health Integration Network

March 31, 2017

South East Local Health Integration Network
March 31, 2017

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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, 2017, 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, 2017, 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 29, 2017

South East Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**1,085,414**	768,724
Accounts receivable (Note 3)	**32,605**	41,503
	1,118,019	810,227
Liabilities		
Accounts payable and accrued liabilities (Note 4)	**874,082**	555,248
Due to Ministry of Health and Long-Term Care (Note 5b)	**137,594**	115,146
Due to the LHIN Shared Services Office (Note 7)	-	23,035
Deferred capital contributions (Note 8)	**152,410**	207,222
Obligations under capital lease (Note 16)	**143,632**	176,022
	1,307,718	1,076,673
Net debt	**(189,699)**	(266,446)
Commitments (Note 15)		
Non-financial assets		
Prepaid expenses	**37,289**	59,224
Tangible capital assets (Note 9)	**152,410**	207,222
	189,699	266,446
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, 2017

	Budget (Note 10)	2017 Actual	2016 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 10, 11)	**1,086,962,194**	**1,139,922,236**	1,108,268,201
Operations of LHIN (Note 5, 10)	**4,543,169**	**4,511,363**	4,490,774
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)	**929,289**	**929,289**	929,289
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Patients First Pan-LHIN Support for Planning and Implementation	**-**	**181,972**	-
Amortization of deferred capital contributions (Note 8)	**-**	**54,812**	62,052
	1,093,165,652	**1,146,735,672**	1,114,706,316
Funding repayable to the MOHLTC (Note 5a)	**-**	**(93,053)**	(44,541)
	1,093,165,652	**1,146,642,619**	1,114,661,775
Expenses			
Transfer payments to HSPs (Note 11)	**1,086,962,194**	**1,139,922,236**	1,108,268,201
General and administrative (Note 12)	**4,543,169**	**4,558,868**	4,552,376
Project Initiatives (Note 6)			
Enabling Technologies	**510,000**	**510,000**	510,000
Emergency Department	**-**	**36,000**	42,499
Aboriginal Initiative	**15,000**	**6,191**	14,859
ER/ALC Initiative	**100,000**	**100,000**	100,000
French Language Services Initiative	**106,000**	**106,000**	106,000
Critical Care Initiative	**-**	**43,059**	72,000
Primary Care Initiative	**-**	**73,801**	75,000
Chronic Disease Management	**929,289**	**924,492**	920,840
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Patients First Pan-LHIN Support for Planning and Implementation	**-**	**181,972**	-
	1,093,165,652	**1,146,642,619**	1,114,661,775
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, 2017

	2017	2016
	$	$
Annual surplus	**-**	-
Acquisition of tangible capital assets	**-**	(32,395)
Amortization of tangible capital assets	**54,812**	62,052
Decrease (increase) in prepaid expenses, net	**21,935**	(12,238)
Decrease in net debt	**76,747**	17,419
Net debt, beginning of year	**(266,446)**	(283,865)
Net debt, end of year	**(189,699)**	(266,446)

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, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	**54,812**	62,052
Amortization of deferred capital contributions (Note 8)	**(54,812)**	(62,052)
Changes in non-cash operating items		
Accounts receivable	**8,898**	13,452
Prepaid expenses	**21,935**	(12,238)
Accounts payable and accrued liabilities	**318,834**	(106,984)
Due to MOHLTC	**22,448**	44,541
Due to the LHIN Shared Services Office	**(23,035)**	11,926
	349,080	(49,303)
Capital transaction		
Acquisition of tangible capital assets	-	(32,395)
Financing transactions		
Increase in deferred capital contributions (Note 8)	-	32,395
Repayment of obligations under capital lease	**(32,390)**	(30,814)
	(32,390)	1,581
Net change in cash	**316,690**	(80,117)
Cash, beginning of year	**768,724**	848,841
Cash, end of year	**1,085,414**	768,724

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 an Accountability 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 Accountability Agreement ("Accountability 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, 2017.

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, 2017 the LHIN has accounts receivable of $32,605 (2016 - $41,503) which represents HST receivable $30,580 for the last quarter of the fiscal year, and CPP overpayment $2,025.

4. Accounts payable and accrued liabilities

At March 31, 2017 the LHIN has accounts payable and accrued liabilities of $874,082 (2016 - $555,248). This amount represents accounts payable trade of $188,722 (2016 - $268,639), and accrued liabilities $685,360 (2016 - $286,609).

5. Funding repayable to the MOHLTC

In accordance with the Accountability 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 $54,812 (2016 - $62,052), and has deferred 2017 funding used for the acquisition of capital assets of $Nil (2016 - $32,395). This has resulted in an increase to the overall LHIN Operations revenue as shown in Note 5(a) below:

	2017	2016
	$	$
LHIN Operations base funding	**4,511,363**	4,523,169
Less: Amounts deferred related to acquisition of capital assets	**-**	(32,395)
LHIN Operations Revenue (Statement of operations)	**4,511,363**	4,490,774
Add: Deferred revenue from capital contributions	**54,812**	62,052
LHIN Operations Funding (Note 5a)	**4,566,175**	4,552,826

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

			2017	2016
	Funding received	**Related expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**1,139,922,236**	**1,139,922,236**	**-**	-
LHIN operations	**4,566,175**	**4,558,868**	**7,307**	450
Emergency department initiative	**75,000**	**36,000**	**39,000**	32,501
Aboriginal initiative	**15,000**	**6,191**	**8,809**	141
ER/ALC Initiative	**100,000**	**100,000**	**-**	-
French Language Services Initiative	**106,000**	**106,000**	**-**	-
Critical Care Initiative	**75,000**	**43,059**	**31,941**	3,000
Primary Care Initiative	**75,000**	**73,801**	**1,199**	-
Chronic Disease Management	**929,289**	**924,492**	**4,797**	8,449
Patients First Transition Planning and Implementation	**180,000**	**180,000**	**-**	-
Patients First Pan-LHIN Support for Planning and Implementation	**181,972**	**181,972**	**-**	-
Repayable directly to MOHLTC	**1,146,225,672**	**1,146,132,619**	**93,053**	44,541
Enabling technologies, repayable to MOHLTC through Champlain LHIN	**510,000**	**510,000**	**-**	-
	1,146,735,672	**1,146,642,619**	**93,053**	44,541

5. Funding repayable to the MOHLTC (continued)

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

	2017	2016
	$	$
Opening balance	**115,146**	70,605
Funding repaid during the year	**(70,605)**	-
One-time funding repayable to MOHLTC	**85,746**	44,091
LHIN Operations funding repayable to MOHLTC	**7,307**	450
Closing balance	**137,594**	115,146

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:

	2017	2016
	$	$
Salaries and benefits	**1,737,239**	1,391,142
Professional services	**150,000**	180,972
Shared services	**84,541**	82,368
Accommodations	**66,016**	63,765
Public relations	**20,840**	36,256
Supplies	**25,727**	17,650
Mail, courier and telecommunications	**11,124**	7,434
Other	**66,028**	61,611
	2,161,515	1,841,198

Chronic Disease Management (CDM)

The CDM operational expenses are included above and are as follows:

	Budget 2017	**Actual 2017**	Actual 2016
	$	**$**	$
Funding	**929,289**	**929,289**	929,289
Salaries and benefits	**775,381**	**790,684**	768,232
Others	**153,908**	**133,808**	152,608
	929,289	**924,492**	920,840

7. Related party transactions

LHIN Shared Service Office, LHINC Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

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

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Service Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

Patients First Pan-LHIN Support for Planning and Implementation

On June 13, 2016 an amendment to the Ministry-LHIN Accountability Agreement between Toronto Central LHIN and the Ministry resulted in an allocation of $1,080,000 of additional funding to be distributed by the Toronto Central LHIN to various LHINs to be applied to salary and benefit costs created to the support of transition and implementation of the expanded LHIN mandate. South East LHIN received $181,972 of this funding which was spent on eligible expenses in the year.

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 (2016 - $510,000).

8. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**207,222**	236,879
Capital contributions received during the year	**-**	32,395
Amortization for the year	**(54,812)**	(62,052)
Balance, end of year	**152,410**	207,222

9. Tangible capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Office equipment	**425,379**	**416,405**	**8,974**	12,448
Computer equipment	**177,243**	**174,423**	**2,820**	12,023
Leasehold improvements	**407,537**	**266,921**	**140,616**	182,751
	1,010,159	**857,749**	**152,410**	207,222

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, 2016. 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 $1,136,922,236 is made up of the following:

	$
Initial HSP funding budget	**1,086,962,194**
Adjustment due to announcements made during the year	**52,960,042**
Total HSP funding budget	**1,139,922,236**

The total operating budget of $4,511,363 is made up of the following:

	$
Initial LHIN Operations Budget	**4,543,169**
Adjustment (Reduction)	**(31,806)**
Total LHIN Operations funding budget	**4,511,363**

11. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,139,922,236 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2017	2016
	$	$
Operation of Hospitals	**673,586,976**	656,045,023
Grants to compensate for Municipal Taxation - Public Hospitals	**190,725**	190,725
Long-Term Care Homes	**189,581,149**	185,883,240
Community Care Access Centres	**127,792,583**	122,643,463
Community Support Services	**39,616,533**	36,976,678
Assisted Living Services in Supportive Housing	**2,262,722**	2,241,305
Community Health Centres	**30,609,214**	29,472,727
Community Mental Health Addictions Program	**76,282,334**	74,815,040
	1,139,922,236	1,108,268,201

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:

	2017	2016
	$	$
Program based		
Salaries	**3,529,787**	3,410,658
Consulting and LHIN-based projects	**43,881**	17,618
	3,573,668	3,428,276
Shared services	**262,907**	309,098
Collaborative	**35,625**	37,698
Other (Note 12b)	**161,571**	193,002
Accommodations	**192,147**	201,101
Office equipment and supplies	**90,482**	106,262
Board per diem	**80,050**	75,600
Public relations	**47,261**	84,599
Mail, courier and telecommunications	**60,345**	54,688
	4,504,056	4,490,324
Amortization	**54,812**	62,052
	4,558,868	4,552,376

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

	2017	2016
	$	$
Training and development	**40,203**	66,970
Travel	**109,068**	118,399
Recruitment	**7,312**	2,234
Insurance	**4,988**	5,399
	161,571	193,002

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

	2017	2016
	$	$
Board chair per diems	**29,375**	23,625
All other per diems	**50,675**	51,975
Total per diems	**80,050**	75,600
Other administrative costs	**36,481**	28,000
Total governance expenditures	**116,531**	103,600
Overhead - salaries, benefits, accommodations and shared services	**110,536**	142,735
Total governance related costs	**227,067**	246,335

(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 2017 was $286,327 (2016 - $303,353) 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, 2016. 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 expiring in 2021 related to building and equipment. Minimum lease payments due under the building lease as follows:

	$
2018	224,064
2019	224,064
2020	224,064
2021	205,392
	877,584

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2017, the LHIN had signed Accountability 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.

The present value of future minimum rentals is as follows:

	$
2018	40,456
2019	40,456
2020	40,456
2021	37,084
Future minimum lease payments	158,452
Less: amount representing interest	(14,820)
Present value of future minimum rentals	143,632

16. Obligations under capital lease (continued)

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

	$
2018	34,048
2019	35,789
2020	37,621
2021	36,174
	143,632

17. Subsequent events

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the South East Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employess of the CCAC.

Effective May 17, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

The actual financial impact of the transition is not currently known, however it is expected that assets assumed will equal liabilities assumed. Additionally there are no significant commitments being assumed as a result of the transition.