South East **LHIN**

Better System, Better Care

2017/18 Annual Report

Ontario
Local Health Integration Network

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COVER PHOTO: South East LHIN Home and Community Care Coordinator Tina Misevicius (right), with home care patient Shirley, and Salmon River Health Link Care Coordinator Sarah McParland.

Shirley, an 81-year-old South East LHIN Home and Community Care patient, is a two-time stroke survivor who has beaten many odds. While living with chronic conditions that need to be properly managed made the recommendation to move to a Long-Term Care Home appear more ideal to some, Shirley was committed to maintaining her life at home. Once very shy, self-conscious and anxious, with the right connections and proper supports in place she began finding the reassurance she needed in knowing that her voice would be heard and she had a say in the care she received.

At a time when the South East LHIN region has the highest percentage of older adults in the province, the value of regional systems of integrated care has never been so vital – as evident in stories such as Shirley's and so many others.

Care Coordinators like Tina and Sarah dedicate their work to putting patients first, ensuring equitable access and availability to high-quality health care and social supports close to home, or in a setting of a patient's choice. The coordination and assistance of these valuable resources help people like Shirley continue living independently and thriving in the comfort of their own homes.

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Message from the Board Chair and Chief Executive Officer

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 2017-18. This report highlights our LHIN's activities, accomplishments and financial information over the past fiscal year.

This past year was notable for two significant developments in our LHIN. In early 2017, the South East Community Care Access Centre transitioned to the South East LHIN, and we took on responsibility for the delivery of home and community care services in our region. Also in 2017, we established five different sub-regions in our LHIN – communities of care that will help us improve our health system planning and our population-based health planning, so we can better meet the diverse needs of our communities.

Both of these developments shine a light, in different ways, on the efforts the LHIN is making to create a better healthcare system in the south east by implementing regional systems of integrated care. We are taking two approaches to accomplish this. With the first, we are creating horizontally integrated care, whereby specific sectors such as primary care, addictions and mental health services, palliative hospice, home and community care, and acute care services are better integrated across the whole region. With the second, we are creating vertically integrated care in each of the sub-regions, so that primary care is better integrated with sectors such as home and community care, addiction and mental health and acute care to help ensure community care is better integrated with sectors such as palliative and hospice services.

This Annual Report chronicles a year in the South East LHIN in which this drive to integration yielded a number of real successes, and a lot of overall progress. We took several steps towards creating an outstanding system of integrated hospital care. Our Addictions and Mental Health (AMH) Redesign is an example of horizontal integration at its best, as is our Older Adult Strategy, which is now in its second year. In terms of vertical integration, the Health Links in the South East LHIN continue to bring providers and resources from various sectors of the health care system together into a team, one that focuses absolutely on the specific needs of the patient. Finally, the merger of Hotel Dieu Hospital and Kingston General Hospital established the new Kingston Health Sciences Centre, which is an example of the kind of governance integration that is so vital to everything we wish to accomplish in health care. We will continue to work with our partners and identify more opportunities to leverage the benefits of governance integration.

We can look back upon 2017-18 with great pride. For the part they played in our LHIN's many successes, we want to thank the many people who work so hard every day to fulfill the mission of the South East LHIN. We also thank all the health care providers in this region. At the end of the day, the health care we are all in the business of protecting and promoting, is delivered by you.

Finally, we would like to acknowledge the contributions and commitment of the South East LHIN's previous Board Chair, Donna Segal. From the time she was appointed to the Board in 2012 to June of last year, Donna was a respected and admired member of the healthcare community, and

was invaluable in moving our LHIN forward. Donna will be greatly missed at the LHIN and we wish her all the best in her future endeavors.

Through our commitment to achieving our new vision of *Better System, Better Care*, we will continue to develop regional systems of integrated care and encourage all of our health service providers to pursue their important role within our ever-evolving health care system, which will greatly assist us in the continuous enhancement to provide better access to care for our patients.

Sincerely,

Hersh Sehdev, Board Chair

Paul Huras, CEO

South East LHIN Board of Directors

All major decisions made by the South East LHIN go through the Board of Directors, which is ultimately accountable to the Minister of Health and Long-Term Care (MOHLTC). Board members are appointed by Order-in-Council on the recommendation of the Minister, and are selected using a merit-based process.

Board members hold office for a term of up to three years, and serve at the pleasure of the Lieutenant Governor in Council. They may be reappointed for one additional term, for a maximum service of six years. Members are accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds and results achieved within the local health system.

The Chief Executive Officer (CEO) operationalizes the strategic directions established by the Board, while providing regular reports on operational activities and key performance indicator results. The CEO also provides progress updates related to priorities identified in the LHIN's fourth Integrated Health Services Plan.

Board of Directors, 2017-18 Fiscal Year

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

Hersh Sehdev (Chair)
Appointed: January 8, 2018
Term Expires: January 7, 2021

Lois Burrows
Appointed: November 21, 2012
Second Term Expires: November 17, 2018

Maribeth Madgett
Appointed: December 10, 2014
Second Term Expires: December 9, 2020

Chris Salt (Vice-Chair)
Appointed: January 5, 2015
Vice-Chair Appointment: November 28, 2016
Term Expired: January 4, 2018

Brian Smith (Vice-Chair)
Appointed: May 6, 2015
Vice-Chair Appointment: March 1, 2017
Second Term Expires: December 31, 2018

Jack Butt
Appointed: June 17, 2015
Second Term Expires: December 31, 2018

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

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

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

Marsha Stephen
Appointed: April 5, 2017
Term expires: April 4, 2020

Steve Gauthier
Appointed: May 10, 2017
Term expires: May 9, 2020

Linda Murray
Appointed: November 29, 2017
Term expires: November 28, 2020

Jo-Anne Brady
Appointed: February 21, 2018
Term Expires: February 20, 2021

South East LHIN Strategic Directions

With a newly stated **Mission**: *Design and deliver quality patient-centred health care* – and a new **Vision**: *Better Care, Better System, t*he South East LHIN Board of Directors has established corporate strategic directions to guide all decisions made by the LHIN, which include:

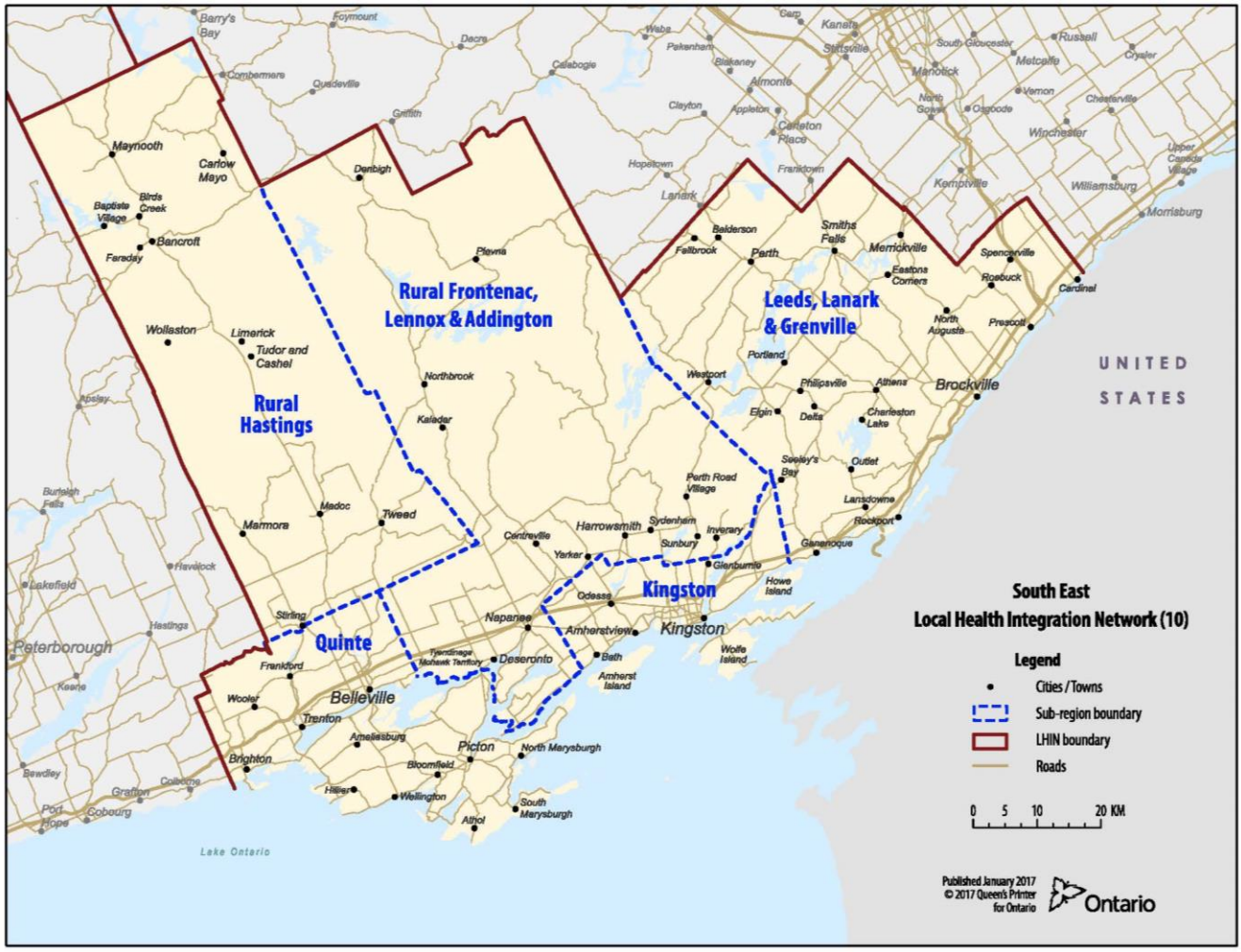
1. Improve quality and the patient experience of care.
2. Promote health equity and recognize the impact of social determinants of health.
3. Create health communities by improving and reducing wait times.
4. Break down silos between sectors and provider to enable seamless transitions.
5. Make effective and efficient use of the resources and capacity within the system.
6. Support innovation for new models of care and digital solutions.

A Profile of the South East LHIN

The South East LHIN is the largest of the Southern Ontario LHINs. West to east, it spans the Highway 401 corridor from Brighton and Quinte West, through Belleville and Kingston, to Brockville and Prescott, and also extends up from Lake Ontario to include areas north of the towns of Bancroft, Perth and Smiths Falls.

The south east encompasses the areas of Hastings, Prince Edward, Lennox and Addington, as well as Frontenac Counties, the bulk of Leeds and Grenville United Counties, and portions of Lanark and Northumberland Counties.

Since the introduction of the Health Links initiative in 2013 and the adoption of sub-regions in 2017, LHIN planning efforts are focused on the geographic areas identified in the map below.



South East LHIN Population

Ours is the third least populous LHIN in Ontario. As of 2017, this LHIN was home to approximately 500,000 people, which accounts for 3.6% of the province's population. Overall, the projected annual growth rate in the region from now until 2021 is estimated to be 0.5%. An important characteristic of the South East LHIN is that compared to the rest of the province, the overall population is old and growing older.

At 22%, the South East LHIN has the highest proportion of adults ages 65 years and older amongst all LHINs. By 2026, the number of people aged 65 years and older is expected to have grown in all sub-regions, and that age group is expected to account for 28% 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 65 years and older, with both at 34%. The highest annual growth rate for those 65-74 in the next five years is projected to be in Rural Hastings, with 2.7% annual growth, and the highest rate for those 75 years and older is in the Rural Frontenac, Lennox and Addington Sub-Region, at 4.5% annual growth.

By contrast, younger age groups are expected to shrink in every Health Link and sub-region, except for Kingston where minimal growth is expected at just over 1% annually in the 0-19 and 20-44 year age groups.

Population Health Profile

Demographics

As noted above, the South East LHIN has an older population and the implications of that are extremely important. Older people tend to suffer from more chronic conditions and require more care. This past year, as in the years before that, the LHIN's priorities have been informed by the knowledge that the number of people in this region living with chronic conditions is increasing, and that as a result we face a growing need for services and care coordination. There is more demand for long-term care and assisted living, as well as palliative and end-of-life services. Overall, because older adults tend to rely on community support services, demand in that area is also increasing.

Health Behaviours and Health Status

Only three in five people in the south east report being in very good or excellent health, according to the 2013 Canadian Community Health Survey, which is in line with the provincial average. In addition, many people in the south east exhibit behaviours that will likely result in health issues. Almost half are physically inactive, and more than half of the people in this region do not consume enough fruits and vegetables. Also, 20% of our residents are daily smokers, and 20% report heavy alcohol use. This threatens to increase already high rates for many chronic conditions, as reflected immediately below.

Chronic Conditions

As of 2013-14, the South East LHIN has notably high rates of certain chronic conditions compared to other areas of the province. Examples include:

- 24.3% of LHIN residents reported having arthritis, compared to the provincial rate of 17.9%
- 22.8% reported having high blood pressure, a rate that has steadily increased in the past ten years, and is significantly higher than the provincial rate of 18.5%
- 12.4% of adults reported having diabetes (types 1 and 2), slightly higher than the provincial rate of 11.9%
- About one in 10 (9.8%) people reported having asthma – a rate that continues to be significantly higher than the provincial rate of 7.6%
- The rate of Chronic Obstructive Pulmonary Disease (COPD) is at 6.4%, much higher than the provincial rate of 4.0%
- 11% of residents in the region reported an anxiety disorder, which was significantly higher than the provincial rate of 7.6%. It is

worth noting that these rates have been increasing over time in both the South East LHIN and Ontario as a whole
- The prevalence of mood disorders such as depression, bipolar disorder, mania or dysthymia has steadily increased in the South East LHIN over the last 10 years, from 6.8% in 2003, to 13.2% in 2013-14. This is well above provincial rates where the prevalence has increased from 5.9% in 2003 to 9.0% in 2013-14

Obesity

In 2013-14, 28.6% of the adult population in the region was classified as obese - significantly higher than 19.2% across the province.

Healthcare Investments

In fiscal year 2017/18, the South East LHIN was assigned a budget of $1,173, 339,180 for the provision of health care services to meet the specific needs of the regional population. This care was delivered by the following Health Services Providers (HSPs):

- 6 Hospital Corporations (operating 12 sites), which provide a range of acute care, complex continuing care, rehabilitation, mental health services and Community Support Service programs
- 31 Long-Term Care providers operating 4,028 beds in 37 facilities
- Provision of Home Care services by 17 contracted service provider organizations
- 5 Community Health Centres, operating eight locations (five main sites and three satellites)
- 3 Addictions and Mental Health agencies*
- 22 Community Support Services agencies*

***Note:** Number of agencies based on agency primary sector. However, a number of South East LHIN agencies do offer additional cross-sectoral programs and services.*

The South East LHIN relies on Service Accountability Agreements (SAAs) and related performance assessments to monitor and appraise the performance of these various agencies. Every year, we report on our use of public funds and our success in meeting provincial health care goals and objectives. By insisting on accountability, and holding ourselves and our HSPs responsible for creating greater effectiveness, increased efficiency and better value, we can develop a regional healthcare system that delivers world class services and will also be sustainable for years to come. The table below shows the proportion of funds allocated to each health care sector in the South East LHIN.

Update on South East LHIN Priorities

At the South East LHIN, we are informed in the work that we do by a number of critical documents, which allow us to fulfill provincial priorities for health care across Ontario while remaining mindful of, and able to respond to, specific needs within our local communities.

Patients First: Action Plan for Health Care

Ontario has made a clear commitment to putting people and patients at the centre of the health care system, and focusing on putting patients' needs first. In 2015, *Patients First: Action Plan for Health Care* was released. It was a significant step forward in the building of a health care system that improves the health care experience for Ontario patients, and also improves their health outcomes.

The plan focuses on four key objectives, which together establish a framework for the health care system transformation in Ontario. Those objectives are:

- **Access** – providing faster access to the right care
- **Support** – providing people and patients with the education, information and transparency they need to make the right decisions about their health
- **Connect** – delivering better coordinated and integrated services in the community, closer to home
- **Protect** – making evidence-based decisions on value and quality, to sustain our universal public health care system for generations to come

Mandate Letter

The mandate letter is sent every year by the Minister of Health and Long-Term Care to each of the LHIN Board Chairs, outlining the Minister's expectations from each LHIN for the fiscal year to come.

The South East LHIN's 2017-18 mandate letter identified 10 priority areas in which the LHIN was expected to show progress. These were:

1. Transparency and Public Accountability
2. Improve the Patient Experience
3. Build Healthy Communities Informed by Population Health Planning
4. Equity, Quality Improvement, Consistency and Outcomes-Based Delivery
5. Primary Care
6. Hospitals and Partners
7. Specialist Care
8. Home and Community Care
9. Mental Health and Addictions
10. Innovation, Health Technologies and Digital Health

Integrated Health Services Plan

Armed with a clear overarching vision from the provincial government, the South East LHIN approached its work in a manner that best reflects the specific needs and priorities of patients, their families and caregivers across our region.

That approach is set out in the fourth edition of the Integrated Health Services Plan (IHSP), which was released in 2015. IHSPs communicate each LHIN's vision and priorities, and describe the directions that the LHIN proposes to take over the following three years to make that vision a reality.

Titled Health Care Tomorrow – Putting Patients First, the IHSP4 covers the years 2016-2019. It is a plan that advances the *Action Plan* objectives noted above, as well as identifying the following LHIN-specific priorities:

- Achieving better patient outcomes through more equitable access to quality care
- Improving the health care experience through an integrated and patient-centred continuum of care
- Working with partners towards the achievement of an accountable, high-performing health care system

Ministry and LHIN Initiatives

Marking the second year covered by IHSP4 and noted throughout this annual report, 2017-18 was a year in which the South East LHIN continued advancing the priorities that have been established for the province's health care system as a whole, while also ensuring that the LHIN remained focused on, and responsive to, the needs of its own local people and communities.

Patients First – Achieving an Integrated System of Care for All

On May 17, 2017, the South East Community Care Access Centre (CCAC) transitioned to the South East LHIN as part of *Bill 41, Patients First Act, 2016.* This transition occurred seamlessly and positioned the LHIN not only as a system manager, but also a health service provider delivering home and community care services. This transition saw the LHIN grow with the addition of 430 staff members from the South East CCAC, and approximately $140M of the South East CCAC funding. However, overall the combined total staffing and administrative budgets decreased by 8%. The transitioned is supporting improvements in the delivery of home and community services. It included the development of a new organization structure for the LHIN and increased the Clinical Leadership capacity in the south east.

Home and Community Care

In the first year of responsibility to deliver home and community care, the South East LHIN embarked on a number of initiatives to monitor and reduce wait times and improve coordination and consistency of LHIN-delivered services. Focus has been given to the following initiatives:

- Monitoring wait times for patients with complex needs who received their Personal Support Services (PSS) within five days of the date of service authorization. In addition to monitoring progress toward the target of 95%, efforts have been made to work closely with service provider partners to improve acceptance of service offers wherever possible
- Monitoring wait times for nursing patients who received their nursing visit within five days of service authorization. Similar to the PSS initiative, efforts have been made with nursing service providers to confirm and ensure that these services are available and being delivered as required 24 hours a day
- Easing the strain on caregivers through careful use of High Needs Caregiver Respite funding. Thanks to a focused effort on the part of the LHIN's Clinical Support and Utilization Team to identify patients and caregivers in need, 609 patients and their caregivers received the much needed support they required
- Enhancing home care coordination within primary care. Several options for delivering more effective care coordination for patients transitioning between points of care have emerged and will continue to be further developed and implemented
- Establishing new Standards of Care/Service Offers to enable the implementation of the Levels of Care Framework. In preparation for the adoption of the Levels of Care Framework, common messaging was developed to assist in communicating what patients and families can expect to receive

The South East LHIN, like other LHINs across the province, has also been asked to continue implementing initiatives that strengthen home and community care. Progress made in the past year includes:

- Ongoing involvement with the Special Needs Strategy (SNS) work required at three separate planning tables
- Preparatory work to enable

implementation of the Family-Managed Home Care program
- Connecting Ontario, formerly known as cNEO, is an initiative that aims to provide clinicians with a secure and timely way to access necessary information. Home and community care direct care providers such as Rapid Response Nurses and Nurse Practitioners are now able to log into the system and access information when and as needed
- Access to the Assisted Living program was expanded to new locations within the LHIN. Prior to the implementation of this program in 2014, no Assisted Living options were available in the south east region making the introduction and eventual expansion of this care option a valued addition in this region
- South East LHIN Home and Community Care have been involved in a number of activities and initiatives aimed at addressing quality of care and service delivery, both locally and in conjunction with peers across the province, such as linking care coordination to primary care
- Client Partnered Scheduling was introduced. This is a new approach to scheduling patient care that ensures patients and their families receive the most appropriate care according to their unique and specific needs
- Planning for an improved intake process for hip and knee replacements

As an active member of the Regional Palliative Care Network (RPCN), the South East LHIN Home and Community Care team work closely with the Ontario Palliative Care Network and others to expand access to, and improve the quality of, palliative and end-of-life care services. The South East RPCN identified five specific priority projects to support this objective with home and community care prominent in each of these efforts. The five initiatives are:

- Coordinated Care – standardize the process of care delivery
- Better Communication – within the circle of care providing centralized, standardized and unified technology and tools
- Circle of Care Involvement – after hours (24/7) coverage
- Competency Building – standardized training required to build competency and standardize service provider and volunteer skills
- Components of the Continuum – residential hospice, hospice volunteer visiting

In addition to Home and Community Care's involvement in these projects, further work has been undertaken to engage service providers and introduce palliative care qualification requirements for Nursing and Personal Support Worker service provision.

Sub-Regions

A significant event this past year was the establishment of sub-regions to help our LHIN focus on smaller geographic planning areas, in order to better understand and address patient needs at the local level. The five sub-regions within our LHIN are:

- Quinte
- Rural Hastings
- Rural Frontenac, Lennox & Addington
- Kingston
- Lanark, Leeds & Grenville

It is important to know that this approach does not determine where patients receive their care, or restrict Ontarians as they make decisions about their own health care. What this approach is intended to do, however, is allow for integrated planning, better coordination, and improved care at the community level. Basically, sub-regions will help us deliver care that better reflects the unique needs of patients, without added bureaucracy.

As part of the South East LHIN's ongoing commitment to engaging stakeholders and communities, the LHIN reached out to all providers and governors across the region, offering an opportunity to attend consultation

sessions on the development of work plans for South East LHIN Sub-Regions.

Primary Care Renewal

Evidence shows that a high-performing health care system requires strong primary care services, and that effective primary care is essential to improving health outcomes. Ontario's determination to put patients first begins with improving access to primary care for all people in the province.

The South East LHIN is committed to providing patients with access to a full range of primary health care services, when and where they need them. This commitment also holds true to improving local connections between primary care providers, hospitals, and other interprofessional health care, in order to best ensure smoother patient experience and transitions in care.

In the south east, primary health care is delivered through a variety of models involving family physicians, nurse practitioners, and other allied health professionals working as part of inter-professional care teams. They are situated in doctors' offices, Family Health Teams, Community Health Centres, Nurse Practitioner-led Clinics, and other Family Health Organizations. Primary care organizations are the lead agencies for the seven Health Links in the south east. These organizations have played the instrumental coordination and champion role for the initiative since the launch of Health Links.

This past year, the South East LHIN continued to focus on expanding and improving primary health care. The 10th Annual Primary Health Care Forum (PHCF) took place in October 2017 with attendance at approximately 300 participants. Because of the ongoing success and positive feedback of this engagement, networking and educational event planning for the 11th PHCF began shortly after the last event and will take place in the fall of 2018.

In addition, two sub-regions in the LHIN were successful in developing business cases and receiving MOHLTC funding for enhanced inter-professional primary care team expansion. This base funding will support providers and patients who currently have little to no access to these inter-professional primary health care services.

Health Links

At the heart of the approach being taken by the South East LHIN is the belief that integration leads to better patient outcomes, more efficient patient care, and a better overall patient experience. This is a belief that is taking hold across Ontario, and it is very much in evident as Health Links continue to establish themselves as a fundamental part of health care delivery in the south east region.

Health Links were established in 2013 as part of the *Patients First: Action Plan for Health Care* to improve the delivery and coordination of care. There are seven Health Links in the South East LHIN, all of which function as networks of diverse providers and organizations, working together to put the patient first.

Over the past five years, Health Links have done an increasingly good job of enhancing the patient experience and improving the quality of care at a lower cost for patients with complex health and social needs. As of Q4 2017/18, a total of 4,984 patients who have complex needs have received the Health Links approach to care coordination.

Emergency Department Wait Times and ALC Pressures

Wait times and Alternate Level of Care (ALC) Days are problems that have bedevilled health care systems, and specifically hospitals, for a very long time. Anyone who has ever sat in an emergency department understands the frustration of overlong wait times. ALC is less widely understood as a concept, but is just as

serious a problem. ALC is a system classification that occurs within acute inpatient, mental health, rehabilitation, and chronic or complex care facilities. When a patient occupying a bed in any of these classifications could actually be served in a community setting, which would free up the bed for another patient, his or her stay is counted as ALC days.

System-wide Patient Flow Strategy

In many ways, wait times and ALC are flip sides of the same coin, and both result from poor patient flow. Patients wait too long for the services they need and spend too much time in hospital once those services have been received. They do not, in other words, flow through the hospital in the fastest and most efficient possible manner.

In response to this problem, the South East LHIN developed a system-wide patient flow strategy. At a high level, it is intended to divert patients from emergency departments if their care needs can be met elsewhere; reduce the length of stays in the Emergency Department (ED) and hospital; decrease the amount of unnecessary time patients remain in hospital beds (ALC) and ensure patients receive appropriate community supports upon discharge from hospital .

This past year, the LHIN moved ahead with the patient flow strategy on several fronts and continues promoting consistency in ALC designation and coding across all regional hospitals, ensuring that hospitals can track the extent of the problem within their organizations.

In addition, because we know that reducing ALC numbers depends on frontline staff participating in senior-friendly activities at the bedside, the South East LHIN started promoting the use of the Accountability Framework document to ensure that unit managers are monitoring and holding staff accountable for performing those activities.

Finally this past year, Providence Care and Kingston Health Science Centre (KHSC) developed ALC avoidance work plans which were shared at our regional meetings to promote consistency in efforts to reduce ALC.

ED Wait times - Performance and Capacity Management

The South East LHIN continued working collaboratively with all EDs across the region, striving to improve performance and capacity management and thereby reduce wait times. South East LHIN ED Clinic Lead Dr. Ken Edwards is finishing his term in May 2018. He will be missed. Over the past year, he served as an invaluable hands-on clinical resource for all ED departments in the region, in addition to helping monitor ED capacity across the LHIN.

A significant success story in 2017-18 was KHSC's impressive jump in the rankings for emergency wait times in Ontario hospitals. KHSC's overall emergency wait times improved from 53rd to 28th-best in the province, in addition to the:

- Number of hours a patient spent waiting in the ED for an inpatient hospital bed was reduced by nearly half
- Time spent waiting to be initially assessed by a physician also improved from 21 to the 15 best time in Ontario
- Best ambulance offload times in the province, steadily between four to six minutes

Efforts across the region are contributing to the decreased wait-times, which include the work of a team of internal medicine care providers who operate the Admission Transfer Unit (ATU). This space, which was repurposed and opened in March of 2017, is designed to improve patient flow by freeing up ED beds that are occupied by patients who have been admitted to the hospital and are waiting for an inpatient bed upstairs.

By moving admitted patients into the ATU while they wait for a bed, spaces are freed up for new patients to come into the ED which decreases wait-times. In addition, the creation

of a new position which oversees patient flow has had a positive impact, helping optimize bed utilization and timely transfer of patients between units.

Short-Term Transition Care Model

In 2017-18, the LHIN was pleased to support an exciting new approach to reducing ALC days. It was the result of a partnership between KHSC, Bayshore HealthCare Ltd. and South East LHIN Home and Community Care. The ALC Transition Unit was created to decrease the number of ALC patients currently in inpatient beds at KHSC, and lessen repeat unscheduled ED visits and avoidable hospital re-admissions by former ALC designated patients.

The Unit consists of 10 co-located beds within a retirement community. These beds support those patients at KHSC whose hospital treatment plan is complete, but are unable to be discharged to the most appropriate post-hospital care setting. ALC patients are transitioned from KHSC to the ALC Transition Unit until their transfer to an appropriate community care setting can be arranged.

The ALC Transition Unit prevented 903 ALC days at KHSC in just less than four months. Overall in 2017-18, there were more than 14,000 ALC days at the hospital. Were the ALC Transition Unit's size and admissions criteria to be expanded, it is estimated that more than 3,400 of those days could be eliminated.

Home First Refresh

Home First is a philosophy to help frail patients get out of hospital and back into their homes as soon as possible. It's meant for patients who no longer require 24-hour attention in hospital, and can heal safely at home with the right support.

In 2017-18, the LHIN continued with efforts across the region to review and refresh the philosophy in hospitals through the Regional Peer to Peer Working Group (P2P). P2P created a regional Home First Dashboard which can be accessed by all south east system partners.

Over the years, Home First has contributed to improved patient outcomes by providing care and support at home where the individual has increased independence and quality of life, while also decreasing hospital wait-times and reducing ALC days.

ED Patient Flow for AMH

The South East LHIN has seen a drop in 30-day repeat ED visits for individuals with mental health and substance abuse conditions over the last couple years. Indeed, as of the end of 2017-18, the South East LHIN ranked second in the province for the lowest rates of repeat visits to the ED in 30 days for individuals struggling with substance abuse challenges.

This success can be directly correlated to our LHIN's AMH Redesign and to the significant investments made for increased clinical counselling, ED Diversion Case Management, increased collaboration between community and hospital partners, and increase supportive housing.

In 2017-18, Ontario began to see increased use of methamphetamines and other substances including opioids, which contributed to a rise in both mental health and substance abuse 30-day repeat ED visits (due to acute psychosis). Our LHIN was no exception. There has also been a significant increase in the number of youth accessing the ED in the evenings for both mental health and substance abuse challenges. In addition, the total number of individuals accessing services has increased across the LHIN, with agencies seeing unprecedented rates of referrals and requests for service.

To address these increased numbers and support individuals in the community, several different investments and planning initiatives have been introduced:

- Opioid Strategy – investments made in Hastings Prince Edward, Kingston Frontenac, Lennox & Addington, and

Lanark, Leeds & Grenville. The strategy is intended to identify areas of highest need and guide investments
- Youth AMH Strategy in Kingston – Initiated by KHSC and United Way
- Acute Addictions Support and Management Planning – initiated in Kingston with community agencies and hospital partners

Older Adult Strategy

2017-18 was the second year of the South East LHIN's Older Adult Strategy (OAS). As previously noted, the population of the South East LHIN is the oldest in Ontario. That fact creates an imperative for care, as it is well-known that an older population requires more and improved health services going forward. The OAS was created to respond to that imperative for care.

The South East LHIN's OAS is inspired by a clear vision, and driven by two overriding objectives. 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 the LHIN to achieve this vision by supporting two objectives:

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

Assisted/Supported Living for Older Adults

A significant component of the OAS is Assisted Living. Research shows that assisted living can help reduce unnecessary ED visits by seniors, shorten their length of stay in hospitals, and reduce unnecessary long-term care (LTC) admissions. This past year, the South East LHIN committed three million dollars in base funding for Assisted Living for High Risk Seniors, and expanded the number of spaces for this service in rural and urban settings across the region.

Additionally, the LHIN shifted not having any Assisted Living capacity three years ago to serving more than 200 older adults with high needs that without this service would be in hospital or long-term care.

Common Basket of Services

The LHIN spent time this past year engaging with patients, care partners and health service providers (HSPs) to develop a common basket of services (CBOS) that will be available to all older citizens in this region who require support.

The CBOS includes meals, transportation, adult day programming, in-home respite, home help, home maintenance and other initiatives to reduce social isolation and foot care. Implementation of the CBOS is expected in April 2019.

Improved Care Coordination

Another important OAS development in 2017-18 was the announced expansion of Regional Care Coordinators in Naturally Occurring Retirement Communities (NORCS) in rural areas.

This provides support for older adults at all levels of care and complexity from low to very high needs. Coordinators will be able to focus on early identification and helping keep older adults at low levels of care for as long as possible, and will also help support them as they transition back and forth along the continuum of care. In this way, coordinators will help push back the "tipping point" at which older adults move to higher levels of care including, LTC.

The number of older adults requesting services in these rural NORCS has exceeded expectation, with more than 200 contacts in first month of service. A second expansion is scheduled in another rural setting in May 2018

covering four NORCS comprised of 200 older adults.

Dementia Framework

The South East LHIN Dementia framework is one of the pillars of our OAS. This framework was developed in concert with the province's Dementia Capacity Planning for all LHINs and is regionally- focused with an importance placed on supporting people with dementia and their care partners in the community for as long as possible. The framework encompasses four areas of focus:

- *Primary Care:* Access to specialists, e-consults, Ontario Telemedicine Network (OTN), and training for primary care providers in the diagnosis and management of care for persons with dementia and their care partners
- *Community Dementia Supports:* Common Basket of Services, Care Partners supports through respite services, education and support, care coordination, and assisted and supported living services
- *Specialty Care:* Memory clinics, day hospitals, interdisciplinary teams, central intake and referral to Behavioral Support Team Units
- *Behavioral Supports:* Support to long-term care homes (LTCH), hospitals and community to address responsive behaviors and support care partners

Regional Integrated Fall Prevention and Management

Two years ago, the South East LHIN unveiled a regional fall prevention strategy, in response to the widely recognized problem posed by falls among older adults. Across the south east there were more than 7,300 ED visits by seniors in 2016/17 that were a result of a fall. The rate of 68.5 falls per thousand of those aged 65 and over is the fourth-highest rate among all LHINs.

The fall prevention strategy was the result of our collaboration with Hastings Prince Edward Public Health (HPEPH), Kingston, Frontenac and Lennox and Addington (KFL&A) Public Health, and the Leeds, Grenville and Lanark District Health Unit. That collaboration continued this past year to strengthen the five pillars of the strategy:

- Public Awareness and Education
- Assessment and Management
- Service Navigation and System Integration
- Engagement and Advocacy
- Provider Skill Development and Education

Enhanced Long-Term Care Home Renewal Strategy

Like most other institutions, LTCHs occasionally need to be redeveloped to continue meeting the needs of their residents. In the south east, 25 of our 37 homes require redevelopment of 1,965 beds by 2025, which represents 49% of the total number of beds in the South East LHIN.

The past fiscal year, work continued with planning and discussions with LTCH providers, with a goal focused on meeting the new design standards by 2025. Over the past year, one home in particular – Crown Ridge in Quinte West – completed a 59 unit redevelopment project and also increase capacity by six new beds in their home. In addition, four LTC beds were opened at Pine Meadow in Northbrook.

French Language Accessibility and Culturally Appropriate Care

The South East LHIN is mandated to ensure that the Francophone community of Southeastern Ontario has access to health care in French.

In order to fulfill this important mandate, the LHIN continues to work closely with the French Language Health Planning Entity, *Le Réseau des Services de Santé en Français du Sud-Est de l'Ontario* (The Réseau) to develop and implement a three-year French Language Services (FLS) strategy, which started in 2015-2016. Below are the highlights of the strategy's accomplishments in 2017-2018.

Active Offer

The LHIN and the Réseau continue to support identified organizations in Kingston with the implementation of their Designation Plan. The LHIN uses the designation process as a planning method to develop the active offer and the access to services in French.

To ease some of the constraints of the designation process on the identified HSPs, the LHIN has been funding some FLS projects. This initiative was highlighted as a best practice in the Study on Designation: Revitalizing the Provision of French Language Services of the Office of the French Language Services Commissioner (March 2018).

In addition, the LHIN has funded for the second time, a French-language course of First Aid in Mental Health.

Information about Health Services

As per the Joint Annual Action Plan and the South East LHIN's Minister's mandate letter, the region's FLS demand and capacity was assessed. The LHIN partnered with the Réseau to collect the information from HSPs. The Réseau will compile and analyze the results, and information about capacity will then be available by sub-region.

Last year, our LHIN secured funding for a Health Care Navigator position for the Francophone population. The implementation of this pilot project will take place next fiscal year, and will aim to connect the services available in French to the Francophone community, to reduce the gaps in the continuum of care in French, and increase access.

Community Engagement

The South East LHIN relies on community engagement to determine the needs and priorities of the people in our region. This past year was no exception when it came to FLS. The LHIN participated in an advisory committee for the French-Language Health Services Capacity Building Day, which gathered more than 100 health care professionals in the south east and included information about the progress and challenges in the region.

The LHIN is also a member of the Francophone Citizens' Committee, which met four times to discuss subjects such as palliative care, the Designation under the *French Language Services Act, 1986*, communication methods of the Francophone community, and patient satisfaction.

The Réseau developed a survey among the Francophone community to study the best ways of reaching this community. With the analysis of the results, the LHIN is now better equipped to contact and connect with the Francophone community, and ensure they are able to access health care services in French.

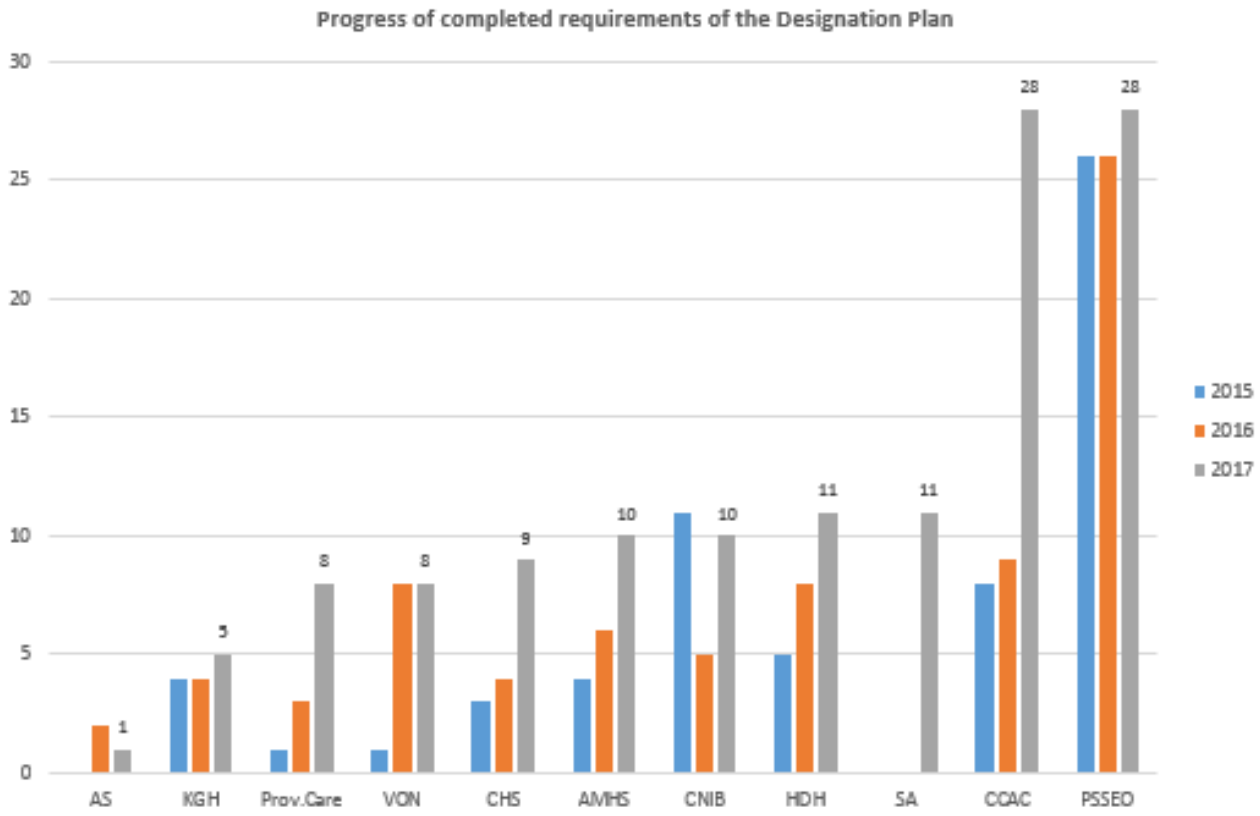
Performance of FLS

Again this year, FLS performance measures were included in the accountability agreements of identified HSPs, including a deadline to submit their plans for FLS Designation to the LHIN. One HSP submitted its Designation plan as of March 31, 2018, which will be reviewed for compliance in the coming months.

The LHIN has been monitoring the submission by HSPs of their FLS annual reports, and will work with the Réseau to analyse the results. Meanwhile, the progress made by identified organizations on the implementation of the 34 requirements for Designation have been compiled in the slide on the following page.:

Supporting the Development of Health Services in French

With Health Service Providers (HSP)



Provision of Home and Community Care Services in French

The South East LHIN adjusted its policies to reflect its commitment to serve the Francophone population in French, and continue building on the work that former Community Care Access Centre (CCAC) had already accomplished.

In addition to the three year strategy, the South East LHIN's FLS Coordinator has been chairing the Pan-LHIN FLS Coordinators network, and also participating in the Ontario Hospital Association's (OHA) FLS Advisory Council meetings, and also in the MOHLTC-LHINs-Entities working group meetings.

Indigenous Care

Ontario's First Nations Health Action Plan (OFNHAP) was created to address health inequities and improve access to culturally appropriate health services over the long term in First Nations, Inuit and Métis communities. The South East LHIN wholeheartedly supports these goals, and is committed to supporting the province's Action Plan.

OFNHAP investments in primary care initiatives for the Mohawks Bay of Quinte (MBQ), in collaboration with Indigenous Health Council of the South East and Kingston Community Health Centre (CHC), are leading to the development of a community-driven, Indigenous-governed Indigenous Interprofessional Primary Care Team (IIPCT). Primary care programs and services include mental health and addiction, chronic disease management, diabetes education as well as service coordination and referral.

Funding has been provided for an additional Indigenous Nurse Practitioner for the Napanee and Area Community Health Centres, to operate in conjunction with the Mohawks of the Bay of Quinte (MBQ). This position will primarily operate out of the MBQ Community Wellbeing Centre, will be staffed in conjunction with them, and will serve the Indigenous community through increased access to care and culturally safe services, while reducing transportation barriers that many patients face.

Finally, our LHIN allocated more than 150 seats to regional HSPs for Indigenous Cultural Safety training. These eight hour sessions were designed to raise cultural literacy, and encourage participants to reflect on their own beliefs and values.

Addictions and Mental Health Services

As part of the overall Health Care Tomorrow – Hospital Services planning, the South East LHIN launched the Addictions and Mental Health (AMH) Redesign in 2013. It was intended to address many of the issues that clients have told us they face when accessing care. Those issues included:

- 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
- Stigma often faced in accessing these and other health services
- Repeat visits to emergency department

In order to tackle these issues, the LHIN has worked with clients, caregivers, providers and stakeholders to achieve what we call the 'Ideal Individual Experience' for clients and their caregivers. Over the last two fiscal years, the AMH sector has accomplished the following components of the overall redesign:

- A single Regional System of Integrated Addictions and Mental Health Care delivered by three coordinated and integrated agencies
- Contracts were signed by the three main AMH agencies, Acute Schedule 1 hospitals and tertiary hospital which will enable the full continuum of AMH care to be the responsibility of the three AMH Agencies
- Standardization of the first phase of the Common Basket of Service implementation – specifically Case Management, Clinical Counselling and Addictions Counselling
- One electronic platform for client software between the three agencies and tertiary hospital – EMHware
- Launch of the first Centralized Intake and Waitlist phase in Hastings Prince Edward
- An operational Regional Back Office for the three AMH agencies
- ER data has begun flowing to the three AMH Agencies, enabling the identification of clients in crisis when they present at EDs

- System psychiatry plan formed with contracts to be implemented by the end of 2018
- Assertive Community Treatment Team (ACTT) fidelity assessment – conducted at AMH Services – Kingston, Frontenac, Lennox & Addington, and to be applied across the South East LHIN region in 2018-2019
- A regional Strategic Alliance which includes the three agencies and the Faculty of Health Sciences and ensures standards are applied across the system

During the early experience with the Redesign, the South East LHIN has seen a decrease in revisits to emergency rooms by those suffering substance abuse and mental illness.

Over the next two fiscal years, the South East LHIN will focus on working with the Strategic Alliance and the AMH Agencies to move ahead with the following components of the redesign:

- Three Centralized Intake and Waitlist structures across the entire south east region
- Fully operational System Psychiatry Model
- Enhanced data flow between hospitals and AMH agencies
- Continuation of standardization and completion of the Common Basket of Service across the region
- Core competency and training plan identified and initiated including stigma reduction, trauma-informed practice etc.
- Continued implementation and monitoring of the Opioid Strategy with a focus on supporting recovery for those struggling with acute concurrent and addictions challenges
- Standardization of ACTT across the south east region and adherence to the provincial standards
- Enhanced partnerships with municipalities, police/justice, Children's Mental Health, supportive living etc.
- Targeted youth strategy for addictions and mental health services

Enabling Care through Technology

Enabling Technologies (ET) are those technologies that advance digital health. The South East LHIN continues to use ET in the region in order to create a future health care system that will be, in effect, an innovative, knowledge-based community. ET priorities and initiatives will enable:

- An improved patient care experience, in which the patient is at the centre of all that we do
- Improved population health, thanks to technology that enables people to access the care they need, when and how they need it
- Value for money, by supporting effective use of resources, lower costs, higher quality, improved safety, and, increased, equitable access to care

Regional Privacy Capacity Project

The South East LHIN initiated the Regional Privacy Capacity Project in 2015. The plan was to develop a regional privacy standard by increasing privacy knowledge and privacy program capacity across the region, and enable more effective sharing of personal health information. The past year saw us continue this project, as we worked to create a health community of privacy leaders.

Regional Hospital Information System

A Hospital Information System (HIS) is an integrated IT tool that allows hospitals to work together, to manage and share medical, administrative, and financial information. This results in greater efficiency, reduced costs, and continuity of care for patients moving between hospitals.

In 2012, hospitals across 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. Work on that project continued this past year. The development of a HIS business case to guide procurement decision has been completed and formally endorsed by all

hospital boards, hospital executive leadership as well as the South East LHIN CEO.

eNotification

eNotification allows for the sharing of information between hospitals and the LHIN Home and Community Care Client Health & Related Information System (CHRIS), which is a web-based application that holds the patient health record for each of the 14 LHINs. This allows home and community care, and hospital patient information and admission systems to:

- Inform home and community care case managers, or other staff, when a home care patient is admitted to, or discharged from, the hospital ED or inpatient unit
- Inform hospital ED clinicians and staff that a patient is receiving, or has recently received, services through home and community care, as well as if the patient has been identified as a Health Link patient in CHRIS
- Through connectivity established between Health Shared Services Ontario (HSSO) and Hospital Report Manager (HRM), the admission/discharge notifications can now be routed to community physician Electronic Medical Records (EMRs) that have already been registered on HRM

eConsult

This past year, the South East LHIN continued to actively participate in the provincial eConsult pilot initiative, in preparation for the program being more widely rolled out across the province. eConsult, which is funded by the province, is a collaboration between Ontario MD, the Southeastern Ontario Academic Medical Organization (SEAMO) and the OTN.

eConsult allows family physicians and nurse practitioners to ask specialist clinical questions about patient care and receive advice quickly and securely. Through eConsult, providers can also attach documents such as a PDF of a patient's EMR chart, lab results and digital images.

eReferral

In 2017-18, electronic referrals continued to support patient transitions across the contimuum of care. They allow appropriate information to be shared between providers, which speeds up the rate of decision making for intake, acceptance and admission of the patient to specific services. Electronic Referrals involve two separate components that work together to improve care delivery of referral management:

- Standardization of processes, workflow, resources, clincial practices and procedures. The objective is to make patient access more equitable and improve wait times
- Automation of the referral by using technology to enhance communication between providers, automatically match patients to appropriate resources, and improve health system reporting and planning

Connecting Ontario Northern and Eastern Region (NER)

The ConnectingOntario project is intended to plan and implement a provincial electronic health record which will provide HSPs with timely access to personal health information from acute and home and community care. ConnectingOntario continues to mature and expand, and our LHIN is poised to become a service delivery partner for the program. Over the past year, we have focused on:

- Facilitating engagement of organizations across all key sectors in the region
- Actively promoting NER to stakeholders
- Identifying key resources and champions, and actively engaging and recruiting their participation
- Actively participating in a wide-range of meetings to ensure information flow and stakeholder engagement is consistently well managed
- Facilitating and supporting communication with regional HSPs, leveraging well established LHIN channels

- Supporting all activities related to determination and roll-out of the Electronic Health Record (EHR) components
- Supporting ministry direction on regional connecting projects
- Supporting any issue escalation and resolution with health service providers as needed

Ontario Lab Information System

The Ontario Laboratories Information System (OLIS) is a province-wide, integrated repository of tests and results that has been built up over the past several years. It provides authorized clinicians with access to lab test orders and results from hospitals, community labs and public health labs. As patients move between hospitals, family physicians, home care and long-term care settings, OLIS makes it easier for health care providers to view their patients' current and past test results and make treatment decisions at the point-of-care. As of this past year, our LHN is contributing all required data to OLIS.

Regional Collaboration Space

The LHIN is committed to helping organizations in the region share information easily, and work continues toward making regional collaborative spaces such as SharePoint available to cross-organizational teams in the south east. This past year, adoption of SharePoint has grown across the LHIN, as HSPs including the RPCN and regional cancer centres, have embraced the value of common programs and services. SharePoint continues to be seen as a platform that will enable regional collaboration.

Health Links Care Coordination/South East Health Integrated Information Portal

The Health Links program provides both an opportunity and a need to leverage IT/IM investments in order to better support and facilitate care coordination activities, which are commonly referred to as care coordination tools (CCT). In particular, these solutions can:

- Identify high-needs patients with complex health needs and have four or more chronic conditions
- Enable the consistent maintenance and sharing of the Health Link patient's Coordinated Care Plan (CCP)
- Assist in effective, timely communication and collaboration for patient management and goal tracking centred around the CCP
- Remove physical barriers to care delivery through the virtualization of care processes

One such solution is the South East Health Integrated Information Portal (SHIIP), which allows for complex patient identification, Health Links performance management, risk stratification for patients with compex care needs, as well as the leveraging of real-time data from the acute and community sectors.

The South East LHIN was an active participant in the provincial comparative evaluation of Care Coordination Tools, with SHIIP being identified as the regional care coordination solution in the outh ast and Erie St-Clair LHINs to support standardized Health Links practices and performance management.

Integration Activities

This annual report provides a welcome opportunity to highlight some successful recent integration activities in our LHIN. It is evident to the LHIN that a truly successful health care system depends on providers and organizations integrating and working together to wrap care around the needs of patients. Kingston Health Sciences Centre (KHSC) is a prime example as it represents a major integration of two academic hospitals in the region, with several initiatives aimed at increasing integration and improved patient care. These include:

- Issuing a first Annual Corporate Plan, which aligns with regional and provincial strategies to support clear pathways across the entire continuum of care for

patients with Chronic Obstructive Pulmonary Disease , hip fractures and those who require palliative care
- Achieving access-to-care targets in both the ED (length of stay) and Urgent Care Centre (wait times)
- Pioneering a new Competency-Based Medical Education model in partnership with Queen's University, which is the first school in North America to implement it across all of its specialty programs at once
- Launching key IT projects that will help unify practices across both sites, including the consolidation of core IT infrastructure to enable a single email and login for KHSC employees

Health Care Tomorrow

The Health Care Tomorrow – Hospital Services (HCT- HS) project was launched in 2014. The goal is to increase access and improve patient care in Southeastern Ontario by exploring opportunities for shared hospital services and new or expanding partnerships.

One of the primary areas of focus of HCT - HS this past year included the Chronic Obstructive Pulmonary Disease (COPD), Complex Frail Elderly - Hip Fracture and Hospital Information System (HIS). The Ontario Centre of Excellence's (OCE) REACH (Resources for Evaluating, Adopting and Capitalizing on Innovative Healthcare Technology) Initiative provided KHSC with funding to implement services where patients received monitoring devices at home to reduce exacerbations, and also to initiate procurement. A standardized COPD action plan and standardized COPD order set are some of the initiatives underway.

CFV-Hip Fracture recognizes that research shows that patients who are treated quickly after a hip fracture have better outcomes. The Hip Fracture Access to Care working group within HCT – HS is proposing a process to ensure timely access to care for hip fracture patients through Lennox and Addington Hospital.

Health System Funding Reform

The 2017-18 fiscal year was the fifth year of Health System Funding Reform, which includes two components:

- The Health-Based Allocation Model (HBAM) is an evidence-based population-health-based funding formula that uses population and clinical information to inform funding allocations
- Quality-Based Procedures (QBPs) use an evidence informed approach to reimburse hospitals for specific procedures based on a 'price x volume' basis, which is then adjusted for patient complexity

Collectively, HBAM and QBP funding (based on 15-16 Actual performance) was reduced slightly by $443k in 2017/18.

Every hospital's HBAM contribution is calculated annually. An increase to the HBAM contribution means that the hospital needs to contribute more money to the provincial HBAM pot. On the other side, a decrease with HBAM contribution means the hospital contributes less to the HBAM pot. The difference is then credited back to the hospital. Last year, South East LHIN hospitals received $8.9 M collectively, due to a decrease in amount contributed to the HBAM provincial pot.

2017-18 Hospital Funding Changes	
HBAM Net Impact	$471,188
QBP Net Impact	-$914,301
New Investments 2017/18	$13,848, 847
*Impact of Lifting 2017/18 HBAM Phase-In and Mitigation	$8,934,200
Overall Funding Impact 2017/18	$22,339,934
Note: This is not new hospital funding. Cashflow impact of lifting phase in mitigation.	

Overall, thanks to a positive HBAM reset and several other adjustments, the LHIN's hospital sector funding increased approximately 3.10%. This equated to an overall increase in 2017-18 hospital funding of $22.3 million.

Wait Times for Surgical and Diagnostic Imaging Procedures

Reducing wait times for surgical and diagnostic imaging procedures continues to be of a major priority in the South East LHIN. This past year, the LHIN continued to coordinate and participate in South East Hospital Executive Forum by engaging with hospitals Vice Presidents, Chiefs of Staff and Chief Nursing Officers to review existing processes, identify and address data quality issues, reallocate volumes as deemed appropriate across hospitals, and identify potential options for performance improvement. Wait times for surgical and diagnostic imaging procedures is one of the most frequently explored topics during these discussions.

Introduction of the Performance Indicator tool has allowed for quarterly responses and successful interactions resulting in continual and consistent monitoring of processes, identifying and addressing data quality issues and identifying potential options for performance improvement. The current focus continues to be on process improvements for diagnostics, including Intervention Radiography, CT, Ultrasound and MRI, concentrating on reducing wait times and wait list management.

In 2017-18, the South East LHIN implemented a Central Intake and Assessment Centre (CIAC) for elective Hip and Knee surgery as part of the musculoskeletal (MSK) strategy, with a staged rollout across the region. KHSC went “live” in May 2017, with Quinte Health Care (QHC) following October 1, 2017, followed by Perth and Smiths Falls District Hospital (PSFDH) and Brockville General Hospital (BGH) in February and March 2018, respectively. As of April 1, 2018, use of CIAC for elective hip and knee surgery is mandatory for all South East LHIN referrals.

Beginning in September 2017, the South East LHIN began planning for the implementation of the Inter-professional Spine Assessment and Education Clinics (ISAEC) model as part of a Musculoskeletal (MSK) Strategy. Regional working groups have formed, a project manager is in place, and an initial plan developed, with the hiring process underway with expectation that ISAEC implementation will occur over the next fiscal year.

Clinical Leadership

Patients First initiated the transition and transformation of the South East LHIN and regional health care system, including clinical leadership capacity. With the appointment of Dr. David Zelt as Vice President Clinical, as well as the appointments of Clinical Leads for our Sub-Regions, Quality, Emergency Services, Primary and Critical Care, the South East LHIN is in a much better position to engage with critical input from our physician population, allowing the LHIN to better understand how to best help their patients.

System Leadership

For the fourth straight year, the South East LHIN has partnered with the Rotman School of Management to offer a 10-day certificate course on Advance System Leadership. This course is offered to 45 current and future leaders from all sectors of the south east health care system. The intent of this course is to develop leaders who can drive system integration. We are working to create a culture of system leadership throughout the south east.

Draft Quality Framework

The South East LHIN initiated work in the fall of 2017 to develop a Quality Framework that would reflect the dual role of the LHIN as a direct health service provider and as an

organization responsible for system planning, integration, and oversight.

The framework will serve as a basis for quality planning, measurement and improvement. A draft definition for quality was developed and reviewed with the Quality Committee in November 2017. The definition was influenced by the quality classifications promoted by Health Quality Ontario (HQO), but reflect the LHIN's dual role with greater specificity. High level roles and responsibilities for the Board, Leadership and HSPs have also been included

Between November 2017 and February 2018, consultations were held with LHIN staff, the Patient and Family Advisory Council (PFAC), Health Quality Ontario and other LHINs in order to gather input on definitions, as well as refine and clarify them accordingly. In addition, this consultation provided an opportunity to discussion quality with LHIN staff, to surface different perceptions, and to inform how the framework can be operationalized.

Community Engagement

LHINs were created to manage health care in a manner that reflects local needs and priorities. To that end, we are required by legislation to engage with our communities. It should be noted, however, that even if there were no such mandate, the LHIN would continue to engage with the patients, families, caregivers, HSPs and other leaders in our communities. Coupled with our sophisticated data analysis, there is absolutely no other way to inform the work the LHIN does and identify areas of importance without engagements. The most obvious example this past year of the importance of engagement would be the development of sub-regions, which was made possible through extensive engagements with providers, community leaders and other stakeholders. There were, however, many other examples.

Engaging HSPs

Engaging with HSPs is quite simply part of everyday work. Over the past year, HSPs offered their insights and support in the creation of sub-regions, the growth of Health Links, and ongoing primary care reform. In 2017-18, the LHIN consulted with providers about the provision of FLS, and also about the Common Basket of Services, which forms such an important part of our OAS.

Primary Health Care Forum

The South East LHIN's Primary Health Care Forum (PHCF) is a one-day annual networking event that brings together primary health care professionals working in the South East LHIN region. PHCF fosters information, knowledge, and best practices sharing within the primary health care sector and across health sectors. Approximately 300 registrants attended the tenth annual PHCF in October 2017. The theme for 2017 was *Celebrating our Gains.* *Mapping our Future*, and the program included plenary speakers and workshops. The agenda for future Forums is based on the feedback we receive on the evaluation of the event.

Patient and Family Advisory Council

The Patient and Family Advisory Council is one of the best examples of the way in which the South East LHIN can listen to, and hear, the voices of the people throughout the various communities. The ultimate goal, as previously stated, is to put patients first. How better to do this than to consult directly with patients and their families about the issues that affect them?

The LHIN held an open application process over the summer of 2017, with the identification of the initial 15 PFAC members in July 2017. The initial kickoff meeting was held on October 2, 2017 and an additional meeting occurred in January, and regular meetings throughout the year. There have also been opportunities between these meetings for members to provide feedback on various LHIN projects via email.

As well, PFAC members were invited to a regional meeting in November of 2017, which was intended to be the first step in development of sub-region integration tables, and the identification of local themes/priorities for each sub-region. PFAC membership was intentionally created with three members per sub-region, facilitating the attendance of PFAC as part of Sub-Region Integration Tables to provide local input.

In addition to these meetings, PFAC members were provided with several other opportunities to engage on other LHIN activities.

Governance

The South East LHIN Board reached full complement with 12 members as a result of the new legislation and dedicated recruitment activities. During 2017/18, leadership shifted from former Board Chair Donna Segal to Hersh Sehdev.

For nearly five years, Donna championed for the South East LHIN and its patients, families and caregivers, and always preserved a deep understanding of the LHIN as a truly local voice in the health care sector, which helped foster many relationships with other Boards and providers both across the region and provincially.

Following Donna's departure, Hersh, former Executive Direction of Kingston Community Health Centres, was appointed as the LHIN's current Chair, bringing many years of experience making a profound impact throughout the community, working tirelessly to help disadvantaged and marginalized citizens, while working to reduce systemic barriers.

Collaborative Governance

Since the beginning of LHINs in 2005, the South East LHIN has recognized the importance of Boards working together. Collaborative governance is an essential enabler to achieving Regional Systems of Integrated Care.

Three governance forums meet regularly to determine how they can better work with other Boards to integrate care within the five Sub-Regions, and continue supporting governance of the local health care systems in addition to their own organizations.

Performance Indicators

For LHINs to successfully do the job they were created to do, it is necessary that we measure the successes, and failures, of the various health care initiatives being carried out in our regions. That is at the heart of the relationship between the Ministry and the LHINs. The Ministry-LHIN Performance Agreement sets out the expectations that the MOHLTC has for LHINs. Developing and updating this accountability agreement is the way in which we at the South East LHIN are able to confirm that we are fulfilling our mandate, and strengthening health care in our region.

Indicator	Provincial target	Provincial				LHIN			
		Fiscal Year Results			17/18 Result	Fiscal Year Results			2017/18 Result
		14/15	15/16	16/17		14/15	15/16	16/17	
1. Performance Indicators									
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services	95.00%	85.39 %	85.36 %	89.86 %	88.50%	86.84 %	84.62 %	90.72%	89.96%
	LHIN performance remained relatively consistent with a small decrease from 90.7% in the previous year to 90% in FY2017/18. This is in line with the provincial performance but below the provincial target of 95%. Patient or caregiver preference is the most common reason the five-day wait time is not met.								
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 %	96.07 %	96.21%	92.70 %	91.90 %	96.14%	96.28%
	The LHIN remains above the provincial target for this indicator and has implemented significant efforts to address performance, with a continued focus on the LHIN Quality Improvement Plan (QIP) and additional/enhanced local reporting; a monitoring/audit plan; and staff education is also in place to ensure staff are requesting service appropriately for patients within five days, or documenting appropriately if service is to be provided outside five days. Wait time within five days of service authorization continues to be monitored on a monthly basis.								
90th percentile wait time from community for home care services - application from community setting to first home care service (excluding case management)	21 days	29	29	30	29	23	21	22	21
	The LHIN remains at the provincial target and ranks second across the 14 LHINs. This performance has been consistent over time. The LHIN works with contracted providers to monitor and address refusal rates to ensure efficient service delivery.								
Note: A 90th percentile wait time indicates the time at which 90% of the patient population completed the process (so 10% - or 1 in 10 patients – wait beyond this time)									

Indicator	Provincial target	Provincial				LHIN			
		Fiscal Year Results			17/18 Result	Fiscal Year Results			2017/18 Result
		14/15	15/16	16/17		14/15	15/16	16/17	
90th percentile wait time from hospital discharge to service initiation for home and community care	TBD	7.00	7.00	7.00	7.00	6.00	7.00	7.00	7.00
	Performance in the south east has remained constant at seven days for the past three fiscal years. This remains consistent with provincial performance								
90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	9.47	8.90	9.18	8.87
	The ED length of stay declined to below nine hours for 90% of complex patients. This is well below the provincial performance and ranks fourth best across LHINs. This improved performance is particularly evident in a considerable drop at KHSC early in the year. The challenge of meeting the needs of this patient population remain a stiff one at larger sites such as Kingston General Hospital, Belleville General Hospital and Brockville General Hospital. All other sites across the LHIN are below the provincial target. Increased admissions over the year, with the influenza season as a major contributor, stressed patient flow across hospitals – locally and provincially. Dedicated efforts remain focused on improving patient flow across our higher-volume sites.								
90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.28	4.35	4.48	4.43
	The ED length of stay for minor/uncomplicated patients declined slightly over the previous year but remains modestly higher than provincial levels. Expansions of existing and promising Pay-for-Results programs are anticipated to improve wait times at the highest-volume sites.								
Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51 %	79.97%	78.47 %	77.99%	55.82 %	60.17 %	66.78 %	80.63%
	Performance across the South East LHIN improved dramatically in the past year. The percentage of surgeries completed within access target has, for the first time, exceeded provincial performance. Performance remains below targeted levels though the ongoing implementation of a CIAC and funding targeted to allow providers to perform additional procedures have contributed to continuous improvement in performance on this metric.								
Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76 %	79.14 %	75.02 %	73.72%	61.35 %	66.27 %	74.55 %	78.17%
	Performance across the South East LHIN improved in the past year. Similar to LHIN performance on hip replacements, the ongoing implementation of a CIAC and funding targeted to allow providers to perform additional procedures have contributed to continuous improvement in performance on this metric.								

Indicator	Provincial target	Provincial				LHIN			
		Fiscal Year Results			17/18 Result	Fiscal Year Results			2017/18 Result
		14/15	15/16	16/17		14/15	15/16	16/17	
Percentage of Alternate Level of Care (ALC) Days	9.46%	14.35 %	14.50 %	15.69 %	15.18%	15.40 %	15.24%	17.21%	17.23%
	Please see comments regarding the ALC rate.								
ALC rate	12.70%	13.70 %	13.98 %	15.19 %	15.49%	17.11 %	19.19 %	17.74 %	19.09%
	The ALC patient population remains a difficult challenge in the south east. Hospitals across the province experienced unprecedented pressures with increasing patient volumes over the past year. In the South East LHIN, all hospitals operated at over 100% capacity in the second-half of the year. With the highest percentage of seniors across all LHINs, the impact of population aging contributes to severe ALC pressure in this LHIN. South east Hospitals have committed to a refresh of the Home First philosophy and innovative programs have been implemented to address the needs of patients outside the hospital.								
Repeat unscheduled emergency visits within 30 days for mental health conditions	16.30%	19.62 %	20.19 %	20.67 %	20.97%	21.94 %	21.79 %	20.12 %	21.42%
	The percentage of repeat visits for mental health conditions increased slightly over the past year. There are several factors that contribute to this increase, including broader determinants of health such as housing issues. The LHIN will continue to drive the AMH Redesign components forward, which includes a Centralized Intake and Waitlist Strategy, unified system psychiatry, and the standardization of core services. It is also anticipated that the committed psychotherapy funding that is part of the MOHLTC MHA strategy will also support a reduction in the ED readmission rates by supporting the clinical counselling needs of the clients struggling with more complex AMH issues.								
Repeat unscheduled emergency visits within 30 Days for substance abuse conditions	16.30%	31.34 %	33.01 %	32.50 %	32.25%	24.86 %	28.14 %	22.84 %	24.53%
	The percentage of repeat unscheduled visits increased over the past year, though performance remains relatively high – the second best performance across the 14 LHINs. All hospital sites have continued to trend below the provincial average, with the exception of KHSC. KHSC has experienced a significant increase in the number of substance abuse repeat visits in the ED. Multiple factors have contributed to this increase. The number of youth, aged 16-24, visiting the ED over the last two years for mental health and substance abuse conditions has increased significantly (almost 30%). The repeat ED visits are also related to a small number of clients who have struggled with drug addiction - which are likely methamphetamines. There are also increasing numbers of 'new' clients who are struggling with methamphetamine and fentanyl addiction that are beginning to surface in the ED.								

Indicator	Provincial target	Provincial				LHIN			
		Fiscal Year Results			17/18 Result	Fiscal Year Results			2017/18 Result
		14/15	15/16	16/17		14/15	15/1	16/17	
Readmission within 30 days for selected HIG conditions	15.50%	16.60 %	16.65 %	16.74 %	16.41%	16.23 %	17.01 %	17.64%	16.30%
	The readmission rate decreased substantially in the South East LHIN over the past year. Performance is now below the provincial average. A dedicated effort to address readmissions has been implemented by hospitals across the LHIN. In-hospital focus has contributed to past improvement. Additionally, COPD has been targeted as a focus for each of the five sub-regions across the LHIN.								
2. Monitoring Indicators									
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93 %	88.09 %	85.01 %	83.95%	90.95 %	84.43 %	65.34 %	67.53%
	The percentage of cases completed within target has declined from over 90% in FY2014/15 to 67.5% in the past fiscal year. The volume of completed cases has remained relatively consistent over this time period. With a rapidly aging population this has resulted in an increasing number of open cases, increasing wait times and a decreasing volume of patients receiving procedures within targeted time periods.								
Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47 %	62.58 %	67.57 %	69.77%	60.94%	67.79 %	67.55%	64.70%
	The percentage of Priority 2 and 3 cases completed within target remained low across the past four years with the percentage below provincial average in the last fiscal year, and also remains low at a provincial level. There is an ever-increasing volume of MRI cases – 26% higher than four years prior. The LHIN continues to work with system partners to address capacity issues and meet patient need.								
Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25 %	78.18 %	82.11 %	84.73%	84.87 %	78.20 %	78.63 %	83.82%
	LHIN performance improved over the past fiscal year but remains below target at 84%. The volume of cases continues to increase every year – now 20% higher than four years prior. The LHIN continues to work with Health Service Providers to increase efficiencies and expand capacity to meet increasing demand.								

Indicator	Provincial target	Provincial				LHIN			
		Fiscal Year Results			17/18 Result	Fiscal Year Results			2017/18 Result
		14/15	15/16	16/17		14/15	15/16	16/17	
Wait times from application to eligibility determination for LTCH placements from community setting	N/A	14.00	14.00	13.00	14.00	13.00	15.00	14.00	13.00
	The LHIN remains consistent with provincial performance levels. Staff visits are prioritized based on the urgency of client need and the LTC application process is routinely monitored to ensure consistency and equity.								
Wait times from application to eligibility determination for LTCH placements from acute-care setting	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00	6.00
	The LHIN remains consistent with provincial performance levels. Staff visits are prioritized based on the urgency of client need and the LTC application process is routinely monitored. Applications are expedited to reduce Alternate Level of Care days for patients within the hospital.								
Rate of emergency visits for conditions best managed elsewhere per 1,000 population	NA	19.56	18.47	17.12	12.06	41.11	39.92	37.54	26.87
	The rate for the South East LHIN has decreased substantially over the past four years – but remains over double the provincial rate. The rate is highest in the most rural LHINs though the work of Health Links and the establishment of LHIN sub-regions have impacted this metric substantially in the south east. It is expected that this positive impact will continue through the work of the sub-regions.								
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population	NA	320.78	320.13	321.18	243.31	460.80	506.16	498.43	389.00
	The rate for the South East LHIN has decreased substantially over the past four years, but remains over double the provincial rate. While rates are highest in rural LHINs, the committed work of Health Links and the continued development of LHIN sub-regions is expected to contribute to continuous improvement in this metric.								
Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge	N/A	46.09%	46.61%	47.43%	47.31%	42.72%	42.50%	43.04%	42.13%
	The percentage of patients with a follow-up visit within 7 days has remained relatively constant across the South East LHIN. With the establishment of LHIN sub-regions, enhanced uptake and utilization of the Southeast Health Integration Information Portal (SHIIP) and resulting communication and collaboration activities it is expected that this percentage will increase.								

Audited Financial Statements

What follows are the South East LHIN audited financial statements for the fiscal year ending March 31, 2018. These statements reflect an extremely significant event that occurred on May 17, 2017. On that day, responsibility for delivery of home and community care was transitioned to the LHIN, along with the related revenues, expenses, assets and liabilities of the South East CCAC.

The effect of this transition is clearly evident in the order of magnitude of results presented for the period ending March 31, 2018, which are much larger than those for the period ending March 31, 2017. The reported revenues of the LHIN this past year also reflect a reduction of 8% of administration costs ($596,800) that occurred on day one of the transition. Transfer payment revenues in the prior fiscal year included revenue provided by the LHIN to the CCAC, whereas in fiscal 2017/18, those revenues were transferred into direct LHIN operations on the transition date. Finally, membership on the board increased from nine to 12 during this fiscal year, with a corresponding impact on board expenses.

Financial statements begin on page 36.

Financial statements of
South East Local Health Integration Network

March 31, 2018

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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, 2018, and the statements of operations and changes in net assets, 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 the LHIN as at March 31, 2018, and the results of its operations, changes in its net assets 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
June 25, 2018

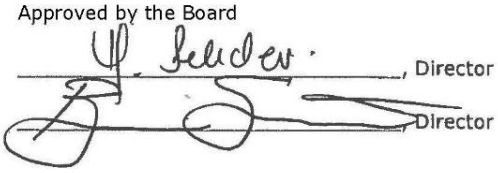
South East Local Health Integration Network

Statement of financial position
As at March 31, 2018

	Notes	2018	2017
	3	$	$
Assets			
Current assets			
Cash		**16,442,157**	1,085,414
Due from Ministry of Health and Long-Term Care ("MOHLTC")		**1,605,381**	—
Accounts receivable		**1,879,271**	32,605
Prepaid expenses		**393,828**	37,289
		20,320,637	1,155,308
Capital assets	7	**164,409**	152,410
		20,485,046	1,307,718
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**14,729,345**	874,082
Due to Health Service Providers ("HSPs")	15	**1,374,710**	—
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**3,639,109**	137,594
Due to Champlain LHIN	5	**65,674**	—
Deferred revenue		**402,215**	—
Current portion of obligations under capital leases	8	**35,789**	34,048
		20,246,842	1,045,724
Obligations under capital leases	8	**73,795**	109,584
Deferred capital contributions	9	**164,409**	152,410
		20,485,046	1,307,718
Commitments	10		
		—	—
Net assets		**20,485,046**	1,307,718

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

Approved by the Board



South East Local Health Integration Network

Statement of operations and changes in net assets

Year ended March 31, 2018

	Notes	2018 Actual	2017 Actual
	3	$	$
Revenue			
MOHLTC funding – transfer payments	15	**1,064,235,812**	1,139,922,236
MOHLTC funding – Operations and Initiatives		**118,397,062**	6,665,571
Interest income		**207,117**	—
Amortization of deferred capital contributions		**180,555**	54,812
Amortization of deferred restricted contributions		**35,264**	—
Other revenue		**1,241,660**	—
		120,061,658	6,720,383
		1,184,297,470	1,146,642,619
Expenses			
HSP transfer payments	15	**1,064,235,812**	1,139,922,236
Operations and Initiatives			
Contracted out			
In-home/clinic services		**70,798,260**	—
School services		**3,894,726**	—
Hospice services		**378,026**	—
Salaries and benefits		**33,464,048**	5,310,907
Medical supplies		**5,723,923**	—
Medical equipment rental		**1,250,195**	—
Supplies and sundry		**2,644,143**	1,096,501
Buildings and grounds		**1,290,488**	258,163
Amortization		**180,555**	54,812
		119,624,364	6,720,383
		1,183,860,176	1,146,642,619
Excess of revenue over expenses before the undernoted		**437,294**	—
Net liabilities assumed on transition	13	**(437,294)**	—
		—	—
Net assets, beginning of year		**—**	—
Net assets, end of year		**—**	—

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

South East Local Health Integration Network

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		**—**	—
Cash received on transition	13	**14,489,718**	—
Net liabilities assumed on transition	13	**437,294**	—
Less amounts not affecting cash			
Amortization of capital assets		**180,555**	54,812
Amortization of deferred capital contributions	9	**(180,555)**	(54,812)
		14,927,012	—
Changes in non-cash working capital items	12	**463,779**	349,080
		15,390,791	349,080
Investing activity			
Purchase of capital assets		**(23,119)**	—
Financing activities			
Increase in deferred capital contributions	9	**23,119**	—
Repayment of capital lease obligations	8	**(34,048)**	(32,390)
		(10,929)	(32,390)
Net change in cash		**15,356,743**	316,690
Cash, beginning of year		**1,085,414**	768,724
Cash, end of year		**16,442,157**	1,085,414

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

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the 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 mandate of the LHIN is as follows:

(a) Plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of 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 health service providers.

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.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

(b) 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.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOHLTC represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOHLTC are set up as repayable to the MOHLTC at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collected is reasonably assured.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOHLTC.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer equipment	3 years
Leasehold improvement	Over the lease term

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and amortized to income at the same rate as the corresponding capital asset.

Adoption of PSAS 3430 – Restructuring Transactions

The LHIN has implemented Public sector Accounting Board ("PSAB") section 3430 Restructuring Transactions. Section 3430 requires that the assets and liabilities assumed in a restructuring agreement be recorded at the carrying value and that the increase in net assets or net liabilities received from the transferor be recognized as revenue or expense. Restructuring is an event that changes the economics of the recipient from the restructuring date onward. It does not change their history or accountability in the past, and therefore retroactive application with restatement of prior periods permitted only in certain circumstances. The impact of this policy on the current year is detailed in note 13.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

2. Significant accounting policies (continued)

Financial instruments (continued)

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the statement of operations and changes in net assets.

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 amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in accounting policy

As a result of the transition of responsibility for the delivery of certain services related to home care as described above, there has been a significant change in the operations of the LHIN over prior year. As a result of these changes, the LHIN has determined that the adoption of Canadian public sector accounting standards for Government not-for-profit organizations is appropriate. Previously the LHIN followed Canadian public sector accounting standards. The adoption of this policy has no impact on numbers previously reported. The impact of the change is limited to presentation only, and as a result the prior year figures presented for comparative purposes have been reclassified to conform with the current year's presentation.

4. Funding repayable to the MOHLTC

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

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

	2018	2017
	$	$
Due to MOHLTC, beginning of year	**137,594**	115,146
Funding repaid to MOHLTC	**(243,159)**	(70,605)
Funding repayable to the MOHLTC related to current year activities	**3,860,984**	93,053
Funding repayable to MOHLTC related to CCAC prior year activities	**(116,310)**	—
Due to MOHLTC, end of year	**3,639,109**	137,594

5. Enabling Technologies for Integration Project Management Office

Effective Fiscal 2014 the LHIN entered into an agreement with Champlain, North East and North West LHIN's (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.

5. Enabling Technologies for Integration Project Management Office (continued)

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from Champlain LHIN of $510,000 (2017 - $510,000) and incurred eligible expenditures of 444,326 2017 = $510,000). The unspent portion of $65,674 (2017 - nil) has been set as up as repayable to the Champlain LHIN.

6. Related party transactions

Health Shared Services Ontario (HSSO)

HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objectives 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.

7. Capital assets

			2018	2017
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer equipment	**1,066,604**	**1,023,694**	**42,910**	2,820
Leasehold improvements	**1,702,067**	**1,592,279**	**109,788**	140,616
Furniture and equipment	**2,409,519**	**2,397,808**	**11,711**	8,974
	5,178,190	**5,013,781**	**164,409**	152,410

8. 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 capital assets and the related liabilities are included in liabilities 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	2017
	$	$
2018	**—**	34,048
2019	**35,789**	35,789
2020	**37,621**	37,621
2021	**36,174**	36,174
	109,584	143,632
Less: current portion	**35,789**	34,048
Long-term portion of capital lease obligation	**73,795**	109,584

Pledged as security for the above borrowings are the leasehold improvements under capital lease.

8. Obligations under capital lease (continued)

The minimum payments over the remaining terms of the leases are as follows:

	2018	2017
	$	$
2018	**—**	40,456
2019	**40,456**	40,456
2020	**40,456**	40,456
2021	**37,084**	37,084
Total minimum payment	**117,996**	158,452
Less: amount representing interest	**8,412**	14,820
	109,584	143,632

9. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**152,410**	207,222
Capital contributions received during the year	**23,119**	—
Capital contributions transferred from SE CCAC	**169,435**	—
Amortization for the year	**(180,555)**	(54,812)
Balance, end of year	**164,409**	152,410

10. Commitments

The LHIN has commitments under various operating leases expiring in 2022 as follows:

	$
2019	1,606,758
2020	434,652
2021	237,487
2022	4,945
	2,283,842

11. Contingencies

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

The LHIN has been named as defendants in various claims. Based on the opinion of legal counsel as to the realistic estimates of the merits of these actions and the LHINs potential liability, management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

12. Change in non-cash working capital balance

	2018	2017
	$	$
Due from MOHLTC	**(1,605,381)**	—
Accounts receivable	**(691,240)**	8,898
Prepaid expenses	**14,050**	21,935
Accounts payable and accrued liabilities	**(784,930)**	295,799
Due to HSP	**1,374,710**	—
Due to MOHLTC	**1,996,339**	22,448
Due to Champlain LHIN	**65,674**	
Deferred revenue	**94,557**	—
	463,779	349,080

13. Transition of South East Community Care Access Centre

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 South East LHIN, including the transfer of all employees of the South East CCAC. This transition took place on May 17, 2017. Prior to the transition, the LHIN funded a significant portion of the CCACs operations via HSP transfer payments. Subsequent to transition date, the costs incurred for the delivery of services previously provided by the CCAC were incurred directly by the LHIN and are reported in the appropriate lines in the statement of operations and changes in net assets.

The LHIN assumed the following assets and liabilities, which were recorded at the carrying value of the CCAC.

	$
Cash	**14,489,718**
Accounts receivable	**1,155,426**
Prepaids	**370,589**
Tangible capital assets	**169,435**
Total assets	**16,185,168**
Accounts payable and accrued liabilities	**14,640,193**
Deferred revenue	**307,658**
Due to Ministry	**1,505,176**
Deferred capital contributions	**169,435**
Total liabilities	**16,622,462**
Net liabilities assumed	**(437,294)**

The net liability resulting from this transaction is recorded as an expense in the statement of operations and changes in net assets.

14. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 430 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2018 was $2,527,953 ($286,327 in 2017) for current service costs and is included as an expense in the 2018 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2017. At that time, the plan was fully funded.

15. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $1,064,235,812 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**699,707,780**	673,586,976
Grants to Compensate for Municipal Taxation – Public Hospitals	**190,725**	190,725
Long-Term Care Homes	**194,576,238**	189,581,149
Community Care Access Centers	**15,978,856**	127,792,583
Community Support Services	**40,367,491**	39,616,533
Assisted Living Services in Supportive Housing	**2,236,697**	2,262,722
Community Health Centers	**32,058,457**	30,609,214
Community Mental Health	**79,119,568**	76,282,334
	1,064,235,812	1,139,922,236

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $1,374,710 (nil in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and changes in net assets and are included in the table above.

Pursuant to note 13, effective May 17, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the South East CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC up to the date of transfer.

16. Board expenses

The following provides the details of Board expenses reported in the statement of operations and changes in net assets:

	2018	2017
	$	$
Board Chair per diem expenses	**27,025**	29,375
Other Board members' per diem expenses	**70,450**	50,675
Other governance and travel	**162,986**	147,017
	260,461	227,067

17. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

18. Guarantees

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

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

Appendix A – Acronyms

ALC – Alternate Level of Care

AMH – Addictions and Mental Health

ATU – Admission Transfer Unit

BGH – Brockville General Hospital

CBOS – Common Basket of Services

CCAC – Community Care Access Centre

CCP – Coordinated Care Plan

CCT – Care Coordination Tools

CEO – Chief Executive Officer

CHC – Community Health Centre

CHRIS – Client Health & Related Information System

CIAC – Central Intake and Assessment Centre

COPD – Chronic Obstructive Pulmonary Disease

ED – Emergency Department

EMR – Electronic Medical Record

ER – Emergency Room

ET – Enabling Technologies

FLS – French Language Services

HBAM – Health-Based Allocation Model

HCT- HS – Health Care Tomorrow – Hospital Services

HIS – Hospital Information System

HPEPH – Hastings Prince Edward Public Health

HQO – Health Quality Ontario

HRM – Hospital Report Manager

HSP – Health Services Provider

HSSO – Health Shared Services Ontario

IHSP – Integrated Health Services Plan

IIPCT – Indigenous Interprofessional Primary Care Team

ISAEC – Spine Assessment and Education Clinic

KFL&A – Kingston, Frontenac and Lennox and Addington

KHSC – Kingston Health Science Centre

LHIN – Local Health Integration Network

LTC – Long-Term Care

LTCH – Long-Term Care Home

MBQ – Mohawks Bay of Quinte

MOHLTC – Ministry of Health and Long-Term Care

MSK – Musculoskeletal

NER – Connecting Ontario Northern and Eastern Region

NORCS – Naturally Occurring Retirement Communities

OAS – Older Adult Strategy

OCE – Ontario Centre of Excellence

OFNHAP – Ontario's First Nations Health Action Plan

OLIS – Ontario Laboratories Information System

OTN – Ontario Telemedicine Network

P2P – Regional Peer to Peer Working Group

PFAC – Patient and Family Advisory

PHCF – Primary Health Care Forum

PSFDH – Perth and Smiths Falls District Hospital

PSS – Personal Support Services

QBP – Quality-Based Procedure

REACH – Resources for Evaluating, Adopting and Capitalizing on Innovative Healthcare Technology

RPCN – Regional Palliative Care Network

SAA – Service Accountability Agreement

SEAMO – Southeastern Ontario Academic Medical Organization

SNS – Special Needs Strategy

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