North East **LHIN** | **RLISS** du Nord-Est

North East Local Health Integration Network

2016/17 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Table of Contents

Cover photo:
Louise Paquette, CEO of the NE LHIN (left) with Marie Brydge, the first client of the Physically Handicapped Adults' Rehabilitation Association's (PHARA) expanded transitional unit in North Bay. The NE LHIN provided $230,000 in new funding to PHARA to staff two additional beds in its Enhanced Congregate Care Unit. This doubled PHARA's ability to offer 24-hour transitional support for people needing extra care as they transition out of hospital to their home care setting. Every year, the NE LHIN provides PHARA with more than $3 million to provide services to more than 200 people such as supportive housing for people with physical disabilities, personal support services, as well as assisted living services.

NE LHIN

555 Oak Street East
3rd Floor
North Bay
P1B 8E3

264 McNabb St.
2nd Floor
Sault Ste. Marie
P6B 1Y6

Rainbow Centre
40 Elm Street, Suite 247
Sudbury
P3C 1S8

681 Algonquin Blvd. East
Suite 3
Timmins
P4N 7E5

Telephone: (705) 840-2872 Toll free: 1-866-906-5446 Fax: (705) 840-0142
E-mail: engagingwithyou@lhins.on.ca www.nelhin.on.ca

ISSN 1911-2955 (Print/Imprimé) Annual Report 2016/17, North East Local Health Integration Network.

Message from the Board Chair and CEO

July 31, 2017

The first year of our 2016-2019 Integrated Health Service Plan (IHSP) was spent advancing our three health care priorities: **improving access and wait times to quality care; enhancing coordination of care;** and **strengthening the sustainability of Northeastern Ontario's health care system.**

Our work was informed by the passing of the ***Patient's First Act***, further focussing our efforts to: improve the patient experience; address the root cause of health inequity; break down silos to ensure seamless transitions for patients; and support innovation by delivering new models of care and digital solutions. As part of our expanded role under the act, leadership of the NE LHIN and North East Community Care Access Centre (NE CCAC) worked together to integrate NE CCAC staff and services with the NE LHIN on May 31st, 2017. With this milestone integration, opportunities abound to better align home and community care and primary care and improve coordination of care for Northerners. Engagement and initial planning began in each of our LHIN's five sub-regions to better integrate the planning and delivery of the continuum health care services and improve the patient experience.

This annual report speaks to the progress made collectively with our many partners including:

- Improving **palliative hospice care** for Northerners by opening a four-bed hospice at the Timmins and District Hospital and one-bed hospices in 17 of our smaller hospitals.
- Launching the ***North East LHIN Aboriginal Health Care Reconciliation Action Plan*** in the fall of 2016 and beginning to implement its 25 calls to action, including cultural safety training for more than 400 Northerners working in health care.
- Fostering the **One Initiative (One Person. One Record. One System),** which will connect 24 acute care hospitals on one information system. Patients will benefit from standardized quality care and will no longer have to repeat their story or tests.
- Establishing a **Francophone Primary Care Collaborative Committee** in Timmins.
- Striking a **Regional Mental Health and Addictions Advisory Council** to implement the recommendations of Dr. Brian Rush's ***Review of Addiction Services in Northeastern Ontario***, commissioned by the NE LHIN.
- Supporting **14 Health Links,** which are now in various stages of development.
- Working with health service providers, municipalities, social service partners, patients, and families to develop two of the province's five **Rural Health Hubs** along the North Shore and in Espanola.
- Releasing the ***Innovative Housing with Health Supports in Northeastern Ontario Strategic Plan: 2016-2019***, which recognizes housing as a social determinant of health, and working with the eight District Social Service Administration Boards and municipalities across the region to move ahead with the strategy's recommendations.
- Working with 24 of our hospitals to support the creation of a **Northern Supply Chain**, to ensure hospitals continue to evolve to meet current and future health needs.

As the NE LHIN moves forward, we will continue to invite Northerners to be part of the important conversation of building a more integrated system of care in Northeastern Ontario and improving the patient experience. We remain committed to ensuring continued quality services to patients, families and caregivers as close to where they live as possible.

R.N. (Ron) Farrell
Chair, NE LHIN Board of Directors

Kate Fyfe
Acting CEO, NE LHIN

Welcome to the NE LHIN

Mission

To advance the integration of health care services across Northeastern Ontario by engaging our local communities.

« Favoriser l'intégration des services de santé dans le Nord-Est de l'Ontario en engageant nos communautés locales. »

Enkiichigaadeg waazhi maajiishkaang maamwizwin eni zhischigaadeg wii minoyaang naadmaadwin. Giiwednowaabnong nikeya dinokiiwning ni zhischigaadeg wii minwaabminaagog endnokiishnang

ᐧᐊᑐᒋᑲᑌᐠ
ᑭᒋ ᒥᐧᓇᔑᑕᓂᐧᐊᐠ ᐁ ᒪᒪᐧᐃᓂᑲᑌᑭ ᒥᓄ ᐱᒪᑎᓯᐧᐃ ᐸᒥᐃᐧᐁᐧᐃᓇ
ᓴᐧᐸᐢᑲᒥᐠ ᑭᐧᐁᑎᓄᐠ ᐧᐊᐸᓄᐠ ᐅᐣᑌᓀᐅ ᐁ ᓇᑕᒪᐧᐊᑯᐠ ᑭᐟ ᐃᑕᐧᐃᓂᓇᐧᐊ᙮

Vision

Quality health care, when you need it.

Des services de santé de qualité au moment voulu.

Ezhi gshkitoong go waani zhi mino yang naadgo wendming pii ndo wendaagog.

ᐧᐊ ᐅᑎᓴᐸᒋᑲᑌᐠ
ᐁ ᒥᐧᓇᔑᐠ ᒥᓄ ᐱᒪᑎᓯᐧᐃ ᐸᒥᐃᐧᐁᐧᐃᐣ ᐃᐢᐱ ᑲ ᐣᑕᐧᐁᓂᑕᒪᐣ

Gloria Daybutch, Chair of the NE LHIN's Local Aboriginal Health Committee speaks at the launch of the *North East LHIN Aboriginal Health Care Reconciliation Action Plan* in September 2016. The plan is an important first step in the journey to build a stronger system of care that addresses the profound health care inequities for Indigenous Northerners. The plan was created in the spirit of reconciliation, mutual understanding and respect.

The NE LHIN Region

Delivering health care across a vast geography like Northeastern Ontario has its challenges. The NE LHIN covers 44% of Ontario's land mass, and is home to 4% of the province's population. Our population is both declining and aging. Northerners live in some of the province's most remote and rural communities and can be many kilometres away from the closest health service provider. In communities along the James and Hudson Bay coast, access is only possible via ice roads or air.

Our large geography is divided into five sub-region planning areas (shown below) which helps to ensure localized planning, quality health care delivery ,and priority setting.

NE LHIN Facts, Stats and Figures

Understanding Northerners -- where they live and their health care needs -- together with available health services and how they are being used, helps to ensure resources are allocated appropriately and investments are made wisely.

Demographics

- Second largest LHIN – about 400,000 square kilometres – 44% of Ontario's land mass.
- A population of about 565,000 people – about 4% of Ontario's population.
- 60% of people live within the boundaries of four cities: Greater Sudbury, Sault Ste. Marie, North Bay and Timmins.
- An aging population – by 2026, one in four residents will be 65 or older.
- 23% of Northerners are Francophone.
- 11% of Northerners are Indigenous and identify as Aboriginal, First Nation, or Métis.

Health Service Providers

The NE LHIN funds 144 health service providers within six sectors. (Note that some organizations provide services in more than one sector and may be counted twice below.)

- Hospitals (25 – including one complex continuing care centre)
- Community Health Centres (6)
- Community Mental Health & Addictions (44)
- Community Support Services (70)
- Long-Term Care Homes (41)
- North East Community Care Access Centre *(Note: NE CCAC integrated with the NE LHIN on May 31, 2017)*

Primary Care in Northeastern Ontario

- 460 primary care physicians
- 27 Family Health Teams
- 6 nurse practitioner-led clinics
- 6 community health centres
- 16 nursing stations
- 3 Aboriginal Health Centres
- 14 Health Links in various stages of development
- 2 Rural Health Hubs
- Health Care Connect helps better connect Northerners with primary care providers.
    - From March 2016 to March 2017, 86% of patients were successfully connected to a primary care provider, compared to 84% the previous year.

Population Health

Overall, compared to the province, the North East LHIN has a higher:

	North East LHIN	Ontario*
Proportion of people with Aboriginal Identity	11%	2%
Proportion of Francophones	23%	4%
Proportion of people living in rural areas	30%	14%
Proportion of people over the age of 65*	20%	16%
Unemployment rate for ages 15+	10%	8%
Proportion of people aged 25-64 who do not have post-secondary education	14%	11%
Percentage of smokers	21%	18%
Percentage of drinkers who report heavy drinking	22%	17%
Percentage of adults (age 18+) who are overweight or obese	62%	54%
Prevalence of high blood pressure	22%	18%
Percentage of residents with multiple chronic conditions	21%	15%

The North East LHIN region is also associated with a lower:

	North East LHIN	Ontario*
Proportion of the population who have a regular medical doctor	85%	91%
Proportion of the population who rate their health as very good or excellent	57%	60%
Proportion of the population reporting physical inactivity	43%	46%

**Ontario percentages also include Northeastern Ontario percentages.*

Sylvie Cloutier, left, Activity Coordinator at South Centennial Manor in Iroquois Falls, is shown with resident Stan Goodfellow, and Stephanie Bolduc, Psychogeriatric Resource Consultant/ Behavioural Supports Ontario (BSO) Lead for the Cochrane Hub area. Stan is benefiting from the specialized care provided through BSO, funded by the NE LHIN. The NE LHIN has invested in adding more than 70 BSO workers across the region in a variety of care settings, including long-term care homes, hospitals, and community agencies.

NE LHIN Board of Directors

Our Board of Directors is an active board with engaged and committed members who bring a wide variety of expertise to the governance table including home and community care, accounting, health system planning, economic development, education, pharmacy, management, and geriatric care. Directors bring the face of the communities we serve to our decision-making.

Board Chair
Ron Farrell
Sundridge

Term: March 2017 to March 2020

Dawn Madahbee Leach
Manitoulin Island

Term: September 2014 to September 2017

Santina Marasco
Sudbury

Term: August 2012 to August 2015, renewed to August 2018

Mark Palumbo
Sudbury

Term: March 2017 to March 2020

Toni Nanne-Little
Sault Ste. Marie

Term: February 2015 to February 2018

John Febbraro
Sault. Ste. Marie

Term: December 2015 to December 2018

Elizabeth Stone
Haileybury

Term: March 2017 to March 2020

Denis Bérubé
Moonbeam

Term: November 2014 to November 2017

Rick Cooper
Interim Chair
Manitoulin Island

Term: October 2013 to October 2016, renewed to October 2019

Board Advisory Committees

Our Board of Directors has two advisory committees: Health Professionals Advisory Committee (HPAC) and Local Aboriginal Health Committee (LAHC). Both committees meet face-to-face twice per year and provide system-level advice to the Board.

Health Professionals Advisory Committee (HPAC)

HPAC serves as a collective voice for health professionals and provides advice to the NE LHIN Board on how to achieve patient-centred health care and further develop the leadership role of health professionals in promoting integrated health care delivery, effective ways and means to move forward with strategic priorities (IHSP), and considerations in the development of integrated models of care across Northeastern Ontario.

HPAC Members

Roger Pilon, Chair of HPAC

- Roger Pilon (Chair), Laurentian University Faculty and Nurse Practitioner, Centre de santé communautaire du grand Sudbury
- Diane Stringer (Vice-Chair), Director of Care, MICs Group of Health Services, Cochrane
- Rick Cooper, Member of the NE LHIN Board of Directors
- Pam Williamson, Executive Director, Noojmowin-Teg Health Centre, Little Current
- Allyson Campsall, Registered Practical Nurse, Temiskaming Hospital
- Deb Hill, Vice President of Patient Care & Chief Nursing Executive, Weeneebayko Area Health Authority, Moose Factory
- Renée-Ann Wilson, Advanced Practice Physiotherapist, North East Joint Assessment Centre
- Jennifer Fournier, Primary Healthcare Nurse Practitioner, Adjunct Professor, School of Nursing, Laurentian University
- Maggie Gareau, Pharmacy Manager, Drug Basics Pharmacy
- Dr. David McPhee, Chief Psychologist, Outpatient Mental Health Program, Sault Area Hospital
- Linda Rankin, Director of the Northern Ontario Postpartum Mood Disorder (PPMD) Project
- Mary Schofield-Salmon, Manager, Patient Flow Mental Health, North Bay Regional Health Centre
- Robert Silvestri, Lead Researcher, Northern Ontario Assessment and Resource Centre, Cambrian College
- Louise Paquette, Chief Executive Officer, NE LHIN (ex officio)
- Cynthia Stables, NE LHIN Director of Communications and Patient Experience (ex officio)

Local Aboriginal Health Committee (LAHC)

The LAHC advises the NE LHIN Board on health service priorities within Aboriginal (First Nations, Métis, urban, rural) communities, as well as on opportunities for the integration and coordination of health care services. The LAHC and the NE LHIN work collaboratively to identify initiatives that lead to outcomes to support enhanced access to care for Northeastern Ontario Aboriginal people.

LAHC Members

- Gloria Daybutch (Chair), Health Director, Mamaweswen North Shore Tribal Council, Cutler
- Tyler Twarowski (Vice Chair), Program Manager, CMHA Cochrane Timiskaming Branch, Timiskaming
- Rachel Cull, Executive Director, Misiway Milopemahtesewin Community Health Centre, Timmins
- Dale Copegog, Director of Health and Social Service, Wasauksing First Nation, Parry Sound
- Sally Dokis, Health Director, Dokis Health Centre, Monetville
- Peggy McGregor, Executive Director, Mnaamodzawin Health Centre, Little Current

Vice-Chair Tyler Twarowski (left) and Chair Gloria Daybutch.

- Giselle Kataquapit, Health Director, Peetabeck Health Centre, Fort Albany
- Veronica Nicholson, Executive Director, Timmins Native Friendship Centre, Timmins
- Angela Recollet, Executive Director, Shkagamik-Kwe Health Centre, Sudbury
- Janice Soltys, Chief Information Officer, WAHA, James and Hudson Bay
- Mary Jo Wabano, Health Services Director, Wikwemikong Health Centre, Manitoulin Island
- Pam Williamson, Executive Director, Noojmowin-Teg Health Centre, Little Current
- Dawn Madahbee, Member of the NE LHIN Board of Directors
- Louise Paquette, Chief Executive Officer, NE LHIN (ex officio)
- Carol Philbin-Jolette, NE LHIN Director, Coast Sub-Region and Population Equity (ex officio)
- Darlene Orton, NE LHIN Aboriginal Lead (ex officio)

Ministry-LHIN Performance Agreement (MLAA)

One of the ways the success of our LHIN performance is measured is through our accountability agreement with the Ministry of Health and Long-Term Care, known as the Ministry-LHIN Accountability Agreement, or MLAA. Embedded in our MLAA are 14 performance indicators, eight monitoring indicators, and two indicators which are under development. The chart below indicates a provincial column which includes targets that all 14 LHINs are aiming to meet. The LHIN column shows NE LHIN performance in meeting this target to-date. The indicators are updated every quarter; for an up-to-date status report on indicators, please contact the NE LHIN or visit www.nelhin.on.ca.

No.	Indicator	Provincial target	Province	LHIN
			2016/17 Result (year-to-date)	2016/17 Result (year-to-date)
1. Performance Indicators				
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.58%	84.03%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.53%	94.48%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	31.00	41.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.38	8.60
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.15	4.05
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	40.17%	45.78%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	75.89%	75.48%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	78.47%	82.28%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	75.02%	81.84%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	15.16%	26.86%
11	ALC rate	12.70%	15.19%	22.47%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.81%	18.03%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.40%	26.26%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.51%	17.07%
2. Monitoring Indicators				
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.23%	94.43%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	93.00%	100.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	85.01%	93.72%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	7.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	10.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	12.28	37.14
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	241.40	456.50
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	47.81%	39.24%

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

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

Report on MLAA Performance Indicators

It is important to note that all provincial targets have been established with a three-year timeframe for LHINs to meet them (starting in 2015/16 and ending in 2018/19). The following four pages outline performance on each indicator and provide context for what each indicator measures.

Home and Community – monitored by three performance indicators associated with services provided by the North East Community Care Access Centre (NE CCAC) as per below.

Personal Support Services (PSS): Percentage of home care clients with complex needs who received their PSS visit within 5 days of the date in which they were authorized for services. At 84%, performance is below target (95%). This indicator captures about 230 patients each quarter out of more than 16,000 served by the CCAC each day. About 20 patients per quarter are not receiving services within target and of these, half did not because the patient/family indicated they were unavailable to receive this service within 5 days. Once these patient choices are taken into consideration, over 95% of clients are receiving services within 5 days. In some cases, system challenges such as a shortage of PSS workers in communities has led to delays in receiving care.

Nursing: Percentage of home care clients who received their nursing visit within 5 days of the date they were due for nursing services. At 94%, performance is close to the target (95%). Over 3,000 patients receive nursing visits each quarter. Of the group of patients who did not receive services within 5 days, a number of patients/families indicated their unavailability within 5 days. Taking this cohort of patients into account each quarter means that over 95% of patients received care within the target. The NE CCAC improved processes and communication with its contracted service providers as a means to reach additional improvements.

Wait for Service: 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management). At 41 days, performance is not meeting target (21 days), however performance has improved by 25% - down from a previous high of 55 days. A wait time improvement strategy was enacted in 2015/16 to reduce wait times for therapy services such as occupational therapy, physiotherapy and others. A number of strategies were used including, referral process improvements, focused recruitment to fill vacant therapy positions, maximizing use of therapy assistants and using technology to enable mobile workforce. Focus remains on decreasing wait times and in the fourth quarter of 2016/17, wait times had further decreased to 32 days.

System Integration and Access – monitored by performance in hospital emergency departments (ED), surgery and diagnostic imaging, and managing patients who have been designated as requiring an alternate level of care (ALC).

ED Performance: 90th percentile ED length of stay for complex patients. At 8.6 hours, performance exceeds target (8 hours), by just over 30 minutes. Two patient cohorts are key to this indicator, including complex patients admitted to hospital and those discharged from the ED. Of these two cohorts, patients requiring admission to hospital are driving performance above target. In two of four of the NE LHIN's large Hub) hospitals, the ED length of stay exceeds 25 hours for patients requiring admission to hospital after the ED physician has determined their disposition. This patient back-log is the result of high inpatient occupancy exceeding 100% and a high number of patients designated as ALC. Improving patient flow from the ED to inpatient units is key to performance improvement. A number of initiatives are underway to improve patient flow including the deployment of an ALC Avoidance Strategy which will be adopted across all four Hub hospitals.

Alternate Level of Care (ALC) including Percent ALC Days and ALC rate: At 26% ALC days and 22% for ALC rate, performance is above targets (9.46% and 12.7% respectively). Patients designated as ALC are people who remain in hospital after the acute portion of their care is completed, but their next destination is unavailable. Their hospital stay is thus prolonged waiting for an "alternate level of care." While 95% of hospital patients do not accumulate ALC days, 5% are delayed getting to their next level of care due to system challenges. The NE LHIN, in collaboration with the multi-sectoral North East Health System Advisory Committee, is implementing a three-year patient flow/ALC avoidance strategy to drive improvement. Adoption of the strategy is key to improving patient flow in the four Hub hospitals and will be fully deployed in 2017/18. Capacity in the community support service sector is also key to the successful transitioning of patients from hospital -- the NE LHIN continues to invest in strategies such as assisted living for high risk seniors, behavioural supports for long-term care residents, assess and restore beds, and a commitment to the "home first" philosophy. Building capacity in rehabilitation and working to the standards of the Rehabilitative Care Alliance of Ontario will also contribute to improved access to post-acute care and a reduced reliance on ALC designation in hospitals.

Elaine Burr, NE LHIN Patient Flow Lead, works with partners to improve patients' access to care, and their flow through the Northeastern care system. This is especially important for improving what's known as "ALC" – Alternate Level of Care – patients who have finished their hospital treatment, but become designated ALC, meaning they are occupying a bed in a hospital but don't require the intensity of resources provided there.

ED Performance: 90th percentile ED length of stay (LOS) for minor/uncomplicated patients. At 4.05 hours, performance is 3 minutes above the provincial target of 4 hours. The NE LHIN supports several strategies to improve ED LOS, including a Pay for Results Action Plan, which is a focused-performance improvement in the four Hub hospitals. Another initiative is Geriatric Emergency Management nurses who support discharge from the ED for frail seniors who need additional supports after physician assessments are completed. As well, the ED Outreach Service in Sudbury provides on-call support to residents of local long-term care homes by sending ED nurses to the home, which in many cases prevents a trip to the hospital. Performance in 2016/17 was challenged by high volumes of patients in the ED who required admission to hospital but could not be moved to inpatient floors in a timely way. This ED backlog had an impact on the flow of non-admitted patients as, in some hospitals, over 50% of ED stretchers were occupied by patients requiring admission. Improving patient flow from the ED to inpatient units will improve ED backlog for non-admitted patients and thus improve performance in 2017/18.

Diagnostic Imaging – MRI Scans: At 45.78%, performance is below target (90%) but improved from two previous years. Overall, the NE LHIN performance was ranked third amongst the 14 LHINs, which is indicative of the performance gap across the province. Across Ontario there are 70,000 MRI scans per month and a wait list of 140,000. In the NE LHIN, there is a gap of approximately 2,500 (difference between volume of scans completed and patients waiting). In the NE LHIN, the least urgent MRI scans (priority 4 scans), represent over 85% of all scans and there remains a gap between the funded-volume of scans and the demand for scans. The NE LHIN continues to support a second MRI scanner for the regional teaching hospital in Sudbury as a strategy to improve wait time performance across the region. The NE LHIN will address the five key recommendations of the LHIN CEO Council to improve overall MRI performance in 2017/18.

Diagnostic Imaging – Computed Tomography (CT) Imaging: At 75.48%, performance is below target (90%) and stable as compared to last year. High demand for CT scans is a key factor in driving wait time performance.

Surgery, Hip Replacement: At 82%, performance is below target (90%). The NE LHIN's focus on improving wait times for hip replacements has resulted in improvements from 60% in 2012 to over 80% in 2016. This means that patients waited 168 days for hip replacement surgery, down from 270 days in 2012/13. The NE LHIN achieved this remarkable improvement through a focus on surgeons' wait lists, monthly monitoring of surgical volumes and getting the most appropriate patients to surgery by utilizing the NE LHIN's centralized intake and assessment program – five North East Joint Assessment Centres.

Surgery, Knee Replacement: Percent of priority 2, 3 and 4 cases completed within access target for knee replacement. At 82%, performance was below target (90%). The NE LHIN's focus on improving wait times for knee replacements has resulted in performance improvement from 55% in 2012 to over 80% in 2016. This means that patients waited 177 days for knee replacement surgery, down from nearly 400 days in 2012/13.

Health and Wellness of Ontarians – Mental Health

Repeat unscheduled visits to the ED within 30 days for Mental Health: At 18%, performance is above target (16.3%) and stable. Key NE LHIN strategies to support people with mental health conditions and reduce revisits include: supportive housing initiatives and rental subsidies; maximizing technology to support virtual psychiatric consultations using Ontario Telemedicine Network (OTN); coordinating/facilitating virtual referrals for Family Health Teams; supporting investments in counselling treatment and case management; focusing resources on smaller communities not previously well served; more coordinated care planning for people with mental health conditions (Health Links); and training of emergency medical services (EMS) to support safe diversion from the ED to community services.

Repeat unscheduled visits to the ED within 30 days for Substance Abuse: At 26%, performance is above target (22.4%) but improved from the previous year. NE LHIN strategies to support people with substance abuse conditions include: supportive housing initiatives and rental subsidies; supporting investments in counselling treatment and case management; training EMS to support people's safe diversion from the ED to community services; initiatives to address a small high-user cohort of alcohol addicted residents with an ambulatory program of harm reduction; and improving assessment tools that are anticipated to improve the timeliness for screening and assessment. Harm reduction is a proven approach and is being used to mitigate re-visits to the ED for people with chronic alcoholism. The managed alcohol program introduced in Sudbury in December 2015, has contributed to a reduced rate of ED revisits from as high as 50% to less than 35% in 2016/17.

Sustainability and Quality

Hospital Readmissions within 30 days for selected Health Based Allocation Model Inpatient Grouper (HIG) conditions: At 17%, performance is above target (15.5%). NE LHIN initiatives include: a congestive heart failure clinic and care transitions unit at Health Sciences North, focusing on the patient's journey in hospital and supporting care after discharge; the placement of CCAC case managers in selected Family Health Teams who contribute to earlier identification and treatment for the frail elderly; deployment of rapid response nurses to focus on the frail elderly with complex conditions and high risk of readmission to hospital; Telehomecare support for patients with congestive heart failure and chronic obstructive pulmonary disease; and Health Links.

Monitoring Indicators

Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery: At 94% performance exceeds target (90%).

Percent of priority 2, 3 and 4 cases completed within access target for cardiac bypass surgery: At 100% performance exceeds target (90%).

Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery: At 94% performance exceeds target (90%).

The following monitoring indicators do not have assigned targets as yet:

CCAC wait times from application to eligibility determination for long-term care home placements: from community setting: Performance at 7 days is better than provincial experience at 10 days.

CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting: Performance at 10 days is worse than provincial experience at 8 days. Key to performance is timely provision of documentation for family decision making. Getting a family of decision-makers together can be a challenge in the NE LHIN as families are spread-out across the province, contributing to delays in eligibility determination.

Rate of emergency visits for conditions best managed elsewhere per 1,000 population: There are about 7,000 of 114,000 visits to the ED each quarter (6% of total visits) related to conditions that could be managed outside of the ED such as in primary care settings. The NE LHIN's rate at 37 visits per 1,000 residents compares to 12 per 1,000 residents across Ontario. The higher rate is related to the rural and remoteness of much of the NE LHIN and the 20 small rural hospital ED's and few walk-in clinics. In parts of Ontario, lower rates of ED visits for these conditions is directly related to the availability of walk-in clinics which exist in the NE LHIN in the Sudbury area only.

Pearl Balfe, 95, and her daughter Anne Kraushaar. The NE LHIN has worked to ensure Northerners like Pearl are waiting shorter periods of time to be placed into a long-term care home in their community.

Hospitalization rate for ambulatory care sensitive conditions per 100,000 population: The NE LHIN rate of 456 hospitalizations per 100,000 residents compares to 221 per 100,000 across Ontario. There are higher rates of conditions such as congestive heart failure and chronic obstructive lung disease in the NE LHIN and in the absence of specialized clinics, patients are admitted to hospital for care. The NE LHIN has about 2/3 the number of specialists such as respirologists and cardiologists per population compared to Ontario which is another factor contributing to higher rates of hospitalization for ambulatory care sensitive conditions.

Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge: The NE LHIN rate of follow-up after discharge from hospital is 39% compared to 48% across Ontario. Improving the use of electronic medical records (EMR) has been a key initiative to ensure that physicians receive timely hospital discharge summaries. Over 90% of family physicians in the NE LHIN use EMR and these physicians receive electronic hospital discharge summaries. Improving attachment to physician care after hospital discharge is an evidence-based best practice to assist in reducing hospital readmissions.

Community Engagement

Engagement is integral to every aspect of the NE LHIN organization and outcomes inform LHIN decision-making. Engagements incorporate the cultural diversity of our region and include: one-on-one discussions with health service providers and Northerners; teleconferences; online surveys; presentations; regular meetings with stakeholder-based committees; and two-way discussions at community events.

More than 80 engagements were held in 2016/17, including more than 65 working groups, advisory, and steering committees who met regularly to discuss solutions to system challenges and ways to improve the patient experience. Some example engagements in the past year include:

- **Rural Health Hubs.** 178 patient surveys, 10 patient interviews, 4 patient focus groups, and 50 health service provider interviews were completed to identify the current state of health care in the North Shore catchment area. Similar engagement was undertaken in Espanola.

- **Nipissing/Temiskaming Planning Days held May 26 and December 16, 2016**. Strategic sessions facilitated by the NE LHIN, in partnership with the North Bay Regional Health Centre, brought 150 stakeholders together to discuss key components for a sub-region strategy.

Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer of the Sudbury & District Health Unit and Acting Medical Officer of Health for Algoma Public Health, spoke to members of the NE LHIN's LAHC at its October 2016 meeting. The discussion focused on opportunities to work collaboratively with public health units to improve the health of Indigenous Northerners.

- **Northern Telemedicine Forum, June 2016.** A collaborative and interactive engagement where over 100 participants from NE, NW and NSM LHIN's shared and learned about telemedicine initiatives.

- **Nurse Practitioner-Led Clinics.** In July 2016, the NE LHIN engaged with the region's six Nurse-Practitioner-Led Clinics to talk about primary care planning and ways to work together better.

- **Elliot Lake Sub-Region Planning Engagement.** More than 20 providers in the area met to discuss the proposed boundary change of Elliot Lake to the Sudbury/Manitoulin/Parry Sound sub-region and offer input to the NE LHIN on ensuring better integrated and coordinated patient care.

- **Falls Prevention Conference held in October 2016.** This regional conference brought close to 200 people together to learn and share best practices on preventing falls by seniors.

- **Online complaints system and engagement with Ontario's Patient Ombudsman.** The NE LHIN's complaints, compliments, concerns process was revised to ensure complaints are received and acted upon promptly, fairly, and with confidentiality protected. A total of 63 complaints were received and resolved. In addition, the NE LHIN hosted Christine Elliott, Ontario's Patient Ombudsman who held sessions in North Bay, Sault Ste. Marie, Espanola and Sudbury. More than 125 people participated.

The NE LHIN held engagements with Francophone communities and stakeholders and consistently heard from Northerners that the Active Offer of French language services makes a big difference in a person's life. Pierrette Sylvestre, a long-term care home resident in Chapleau, is pleased to understand what her activities for the day are in French. Active Offer happens when Francophones are informed of available services in French, have access to the services, and are satisfied with the service quality. Improving access, coordination and sustainability of health services in French for Francophones in the North East, helps the LHIN to reach its goals of ensuring quality care and improving the patient experience.

- **Uptake and adoption of Ontario Common Assessment of Needs (OCAN).** The LHIN facilitated a process which brought together a steering committee to review the adoption of this common assessment tool along with the Integrated Assessment Record (IAR). This led to a survey of approximately 20 community mental health providers, coupled with key informant interviews and a resulting report with nine recommendations.

- **Long-Term Care Homes.** The NE LHIN engaged face-to-face with its 41 homes in June 2016 to share ideas on how to enhance quality care for residents living in long-term care homes across the region.

Community Engagement with Aboriginal/First Nations/Métis People

The NE LHIN is committed to an engagement process with Indigenous people that is respectful of language, nationhood, culture and spiritual beliefs. The LHIN continues to focus on building meaningful relationships in an effort to improve services and health status of Indigenous Northerners whose health care needs are significant in scope and magnitude. Efforts continue to enhance health outcomes by better aligning existing Indigenous regional, provincial and federal health delivery structures. Engagements held in 2016/17 include:

- **Local Aboriginal Health Committee (LAHC):** Members travelled from their communities to attend two full-day meetings in April and October and provided their input on moving forward with strategies to enhance the care of Indigenous Northerners.
- **LAHC** was fully engaged in the development of the ***North East LHIN Aboriginal Health Care Reconciliation Action Plan***, published in the fall of 2016.
- **Coastal communities:** To encourage awareness and dialogue, the NE LHIN developed a newsletter, in partnership with the Canadian Red Cross and the North East Specialized Geriatric Centre. The NE LHIN's Senior Coastal Advisor and team made several trips to the coast to engage with providers on how to strengthen the delivery of care in this most Northerly part of the NE LHIN region. In addition, several engagements were held with provincial and federal partners to discuss ways to improve communication, planning and service delivery to Indigenous Northerners who are served by more than one level of government.

The NE LHIN CEO, physicians, and senior LHIN management spent 2 days in Attawapiskat, Fort Albany, Moosonee and Moose Factory to meet and listen about how the NE LHIN can strengthen primary care and home and community care in coastal communities. From left to right: David McNeil, Vice President of Patient Services, Clinical Transformation & Chief Nursing Executive at Health Sciences North, Louise Paquette, NE LHIN CEO, Dr. Paul Preston, NE LHIN VP Clinical and Dr. Jason Sutherland, NE LHIN Primary Care Lead for Sudbury/ Manitoulin/Parry Sound Sub-Region.

Community Engagement with Francophones

The NE LHIN works in partnership with the Réseau du mieux-être francophone du Nord-Est de l'Ontario to engage with Francophone Northerners on access to care in their language of choice. Engagements held in 2016/17 include:

- Increasing the awareness of the importance of "Active Offer" across the LHIN through presentations to various health service providers, including the Home and Community Care Sector Table, the local Palliative Care Tables and Personal Support Worker Managers.
- Active participation of the Réseau in various health service provider tables across the region, including Home and Community Care, Mental Health and Addictions and Health Links.
- The Réseau and the LHIN developed a Joint Action Plan (2016-19) in alignment with the NE LHIN's Integrated Health Service Plan and support the plan through: a LHIN-Réseau Liaison Committee; a LHIN-Réseau Working Group; and LHIN-Réseau Executive Director-Governance meetings.
- A Steering Committee for the Review of Francophone Primary Care Services in Timmins continued to meet until July 2016 to guide the work of the review of Primary Care needs of Francophones.
- Three community consultations were held with the Francophone community in Timmins as part of the review of Primary Care needs of Francophones. Results of the consultations were included in the final report received in August 2016.

Ministry and LHIN Initiatives

Selected Highlights of Progress on the Three NE LHIN Priorities

Priority #1: Improve Access and Wait Times

Accessible health care means getting the quality care you and your family need, when and where you need it, and in a timely manner. This could include help from a family doctor or nurse practitioner, an Indigenous or Francophone community health centre, a Family Health Team, an integrated health care team, a specialist, mental health and addiction counsellor, long-term care home, or a home and community care provider. Sometimes we need the services of several of these providers, particularly as we age. The following are a few of the key highlights undertaken to move this priority forward:

Goal: Support primary and specialty providers to ensure more timely access

Meet Anna…

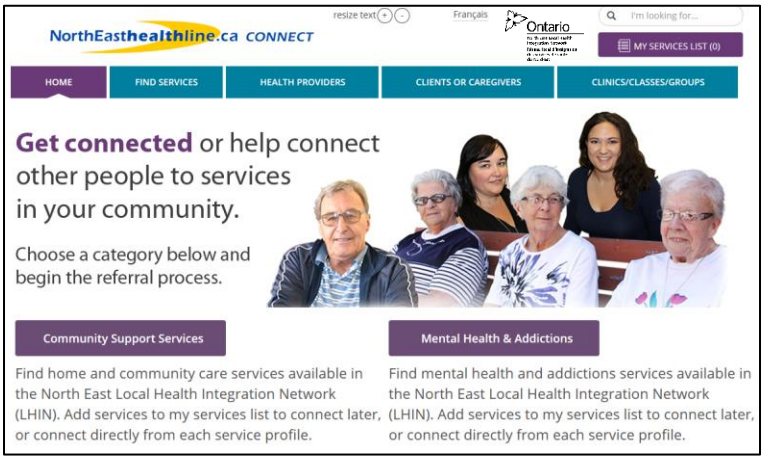
Seniors with complex medical issues in the Timmins area, now have access to the resources of an interdisciplinary clinical team from the North East Specialized Geriatric Centre of Health Sciences North. Additional NE LHIN annual investment supported the integration of the team as well as salaries of some of the members, including a primary care geriatric nurse clinician, primary care geriatric social worker, geriatric occupational therapist, and geriatric social worker supported by two care of the elderly physicians. The clinic, which opened in January 2017, benefits geriatric patients in the area by providing specialized geriatric assessments, and short-term treatment and rehabilitation services for frail older adults.

As a caregiver, Anna Loreto, 77, has seen first-hand how specialized geriatric care has made a difference in her husband Mario's journey with Alzheimer's disease, calling it her "lifeline."

"I knew, if I was having a problem, someone would help me. The geriatric program introduced me to what was available in the community," she said. "For me, it stalled the admission into a long-term care facility and kept him home longer, by about two years."

Anna Loreto (right), is pictured with family members of Dr. Edson Smith, a long-time champion of geriatric care for the Timmins are at the opening of the clinic with Dr. Smith's sister-in-law Marilyn Dufresne (left), his son Bradley Smith, wife Helen Smith, and Dr. Julie Auger, Clinical Lead at the new clinic.

Goal: Enhance the availability of coordinated home and community care services and programs



Help is only a click away thanks to a newly enhanced website -- www.connect.northeasthealthline.ca -- that connects Northerners to the home and community care or mental health and addiction services they need to stay healthy and independent at home.

The website was developed with the support of the NE LHIN by *Healthline*, a not-for-profit organization that provides reliable and up-to-date online information about health services to people across the province. The site is available for use by Northerners looking for services for themselves or a loved one, as well as health care providers such as physicians, nurse practitioners, and nurses looking for support services for their patients. People can self-refer or refer others using the standardized referral form on the site.

Goal: Enhance dementia/behavioural support services for seniors and their caregivers

North East Behavioural Supports Ontario (BSO) provides a comprehensive system of support to enhance care for older adults with responsive behaviours that may be associated with dementia, mental health, substance use and/or other neurological conditions, as well as their caregivers.

New NE LHIN BSO investments this year included:

- The creation of a new Enhanced Care Seniors Support Program at the Hoivakoti Long-Term Care Home in Sudbury to provide enhanced staffing levels and specialized programs modelling different approaches and techniques for communicating and caring for older residents struggling with, and demonstrating, responsive behaviours as a result of dementia.
- The addition of a BSO clinician at the Espanola Regional Hospital and Health Centre, Anson General Hospital, and the Canadian Mental Health Association (CMHA) Cochrane -Temiskaming.
- Support to develop North East BSO Aboriginal Strategy project and enhance the BSO Regional Central Intake.
- Support to enhance the work of the Alzheimer Societies across the North East.
- Funding for eight long term-care homes for professional development to foster in-house BSO champions within existing staff.
- Funding distributed among 14 long-term care homes to cover professional development replacement wages – to backfill positions as employees receive specialized training.

Goal: Improve older adults' access to falls prevention strategies

Meet Louis …

Louis Demers is doing his very best to avoid becoming one of the approximately 1,200 older adults hospitalized every year in Northeastern Ontario as a result of a fall. He's participating in one of the close to 300 free exercise programs funded by the NE LHIN.

"I feel good when I finish the exercise class," says Louis, 65. "People with limited mobility, like me, likely think they can't be doing exercise, but they can do a lot sitting down!"

Following a series of small strokes in recent years, he's found the classes helped improve his hand-eye coordination, balance, and his ability to put thoughts together to communicate. He also likes the opportunity to meet people.

Stay on Your Feet (SOYF) is delivered in a partnership between the NE LHIN and the region's five Public Health Units, along with other health service providers and older adults. Across the North East LHIN region, more than 2,000 seniors took part in classes in the past year.

Goal: Work with partners to increase housing opportunities and associated supports for vulnerable populations

Meet Rachelle …

The NE LHIN met with the senior leadership of the region's eight District Social Administration Services Boards (DSSABs), as well as Service Managers of municipalities in March 2017 to move ahead with the recommendations of its *Innovative Housing with Health Supports in Northeastern Ontario Strategic Plan: 2016-2019* (published fall of 2016). The partners identified leaders who will be responsible for the strategy's 43 recommendations -- aimed at strengthening collaboration and ensuring there are health supports for vulnerable populations such as seniors and people with mental health and addiction challenges.

Rachelle Poirier knows how hard it is to communicate with and care for a loved one with dementia. "Having a parent diagnosed with dementia quickly puts you on a journey of change. In my case, I was met with many challenges along the way when trying to access services in the community. BSO quickly became my lifeline for understanding behaviours, navigating the system and accessing support in the community."

Priority #2: Increase Care Coordination

People living in Northeastern Ontario have been quite clear in NE LHIN engagements – they want to be cared for at home, with supports, for as long as possible and be cared for in an institution only when necessary. Supporting more patient-centred care across the health care continuum, from birth to death, is helping to ensure that Northerners are better able to navigate the system with services that are more coordinated, delivered in partnership, and integrated to ensure less duplication and fewer gaps in service. The following are a few of the key highlights undertaken to move this priority forward:

Goal: Work with providers to develop a more coordinated system of primary care and more seamless service delivery for Northerners

The NE LHIN's two Rural Health Hubs -- Espanola and North Shore -- are working together to better coordinate care for local residents.

In August of 2016, the North Shore Health Network and Espanola Regional Hospital and Health Centre's Rural Health Hubs were announced by Premier Wynne as two of the early adopters of the Rural Health Hub sites in Ontario. Supported by the NE LHIN, these hospitals received funding to collaborate with stakeholders, identify health care needs, and develop a locally driven plan to address the local health care needs.

Premier Wynne is shown (second from left) at the August 7 announcement with three NE LHIN staff (from left to right) – Sherry Frizzell, Director, Home and Community Care; Nancy Lacasse, Hub Officer, Sudbury, Manitoulin, Parry Sound; and Cynthia Stables Director, Communications and Patience Experience – along with the Honourable Marie-France Lalonde, Minister of Government and Consumer Services and Minister Responsible for Francophone Affairs.

The Espanola hospital and the North Shore Health Network, which have a history of collaborating, partnered to create a project team which has been meeting with health care providers in the area to talk about the Rural Health Hub model and identify local opportunities to strengthen service delivery. Each Rural Health Hub plan will be developed through the efforts of both LHIN-funded and non-LHIN funded providers from acute care, primary care, long-term care, mental health and addictions, palliative care, home and community care, public health, and social services. The hubs are seeking guidance from patients and families, as well as municipalities.

Goal: Establish a Regional Mental Health and Addictions Advisory Council to support NE LHIN efforts

The NE LHIN's new regional Mental Health and Addictions Advisory Council met for the first time in November of 2016.

Co-chairs Carol Philbin-Jolette (left) and Pam Williamson with North East LHIN CEO Louise Paquette (middle).

This new council was struck to implement the recommendations of Dr. Brian Rush's *Review of Addiction Services in Northeastern Ontario*, commissioned by the NE LHIN, as well as a mental health *Blueprint* undertaken by Health Sciences North and North Bay Regional Health Centre.

The Council meets four to six times a year and has developed a work plan with seven goals which include: 1) developing a system approach that brings providers together to achieve better health outcomes for clients; 2) improving access to care and services for the NE LHIN region; 3) supporting a culture of care that reflects recovery-oriented practice and implementing a recovery orientation at a policy, program and practice level; 4) increasing health outcomes of Indigenous populations; 5) recognizing that all people with lived experience should have access to safe, affordable, and appropriate housing; 6) improving outcomes for people through increasing care connections between primary care providers and the ED, hospital, front-line community and ensure cultural and/or linguistic appropriate services; and 7) ensuring that people can access a primary care provider.

Goal: Develop coordinated care for patients at the end of their life's journey

The NE LHIN worked to increase access to hospice palliative care by opening four hospice beds at the Timmins and District hospital and one-bed hospices in 17 of its small and medium size hospitals.

Kirkland Lake and District Hospital, one of the first to pilot a one-bed hospice model, received an honourable mention in the category of innovation award at the 2016 Quality and Innovation Awards.

Goal: Strengthen home and community care for Northerners

Priority Assistance to Transition Home (PATH), which helps older adults get home safely with the services, food, and medication in place needed to recuperate, was rolled-out across the region and is now available in nearly all of the NE LHIN's hospitals. The program has helped more than 6,000 seniors get home safely from hospital.

After two weeks in hospital, North Bay's Wes Nord was happy to be heading home -- accompanied every step of the way by a care worker Brittany Roy who helped to make sure things went smoothly. "I'll be fine," said Wes. "I didn't even know they (PATH workers) existed before."

Priority #3: Strengthen System Systainability

A sustainable Northeastern Ontario health care system is one that reflects a multi-level commitment to improving the lives of Northerners today and for generations to come. It is a system that is driven by what is right for patients and improving quality and efficient care while being financially responsible. It is a system that focuses on health, not just health care, and one that invests in keeping people healthy, out of hospital, and living with quality of life in community. The following are a few of the key highlights undertaken to move this priority forward:

Goal: Work with communities to ensure their hospitals continue to evolve to meet current and future health needs

Northerners are benefitting from the creation of a newly expanded shared service organization for NE LHIN hospitals. The newly formed /expanded Northern Supply Chain (NSC) will pass on savings made from purchasing medical products and equipment, putting it towards frontline hospital patient care.

From left to right: Paul Chatelaine, Vice Chair of the Northern Supply Chain Steering Committee and CEO of the MICs Group of Health Services, Tamara Shewciw, Chief Information Officer and Enabling Technologies Lead for the North East LHIN, and Derek Gascoigne, General Manager of the Northern Supply at the launch of the Supply Chain in November of 2016.

The NE LHIN worked closely with its 24 hospitals and the NSC to help create this shared service organization launched in the fall of 2016. NSC (formerly known as North West Supply Chain) has operated a shared service organization for 12 North West hospitals for the past five years. With the addition of the 24 from the North East, it will become the largest in the province by the number of members and customers, representing a collective spend of approximately of $430 million annually.

The Ministry of Government and Consumer Services' (MGCS) OntarioBuys Program is investing $4.4 million over the next four years in the NSC to drive collaborative procurement, innovation and efficiencies. Benefits include enhanced supply chain management, as well as significant savings in the purchase price of medical products and equipment and sharing of best practices across the North.

Goal: Work with partners to improve the patient experience through a relentless focus on quality

Quality is an integral part of the NE LHIN's Integrated Health Service Plan. Equity in health care means that everyone has access to the same high standard of care no matter where they live, what they earn, or what language they speak. The ultimate goal of aligning the NE LHIN quality agenda with the needs of Northerners is to create a culture of quality that enables improved patient outcomes.

The NE LHIN is working to improve the overall health status of Northerners through quality initiatives with representatives from all LHIN-funded sectors, Ministry of Health and Long-term Care, Health Quality Ontario (HQO), Ontario Hospital Association, front-line providers, and patients and caregivers.

In May, 2016, Dr. Reena Dhatt, a family physician based in Sudbury, was appointed to lead efforts to align the quality agenda with improved patient outcomes. Dr. Dhatt chairs a NE LHIN Regional Quality Table. The table focuses on quality challenges and initiatives. The NE LHIN is working with HQO, our five public health units, the North West LHIN, the Réseau du mieux-être francophone du Nord de l'Ontario and other partners to develop a ***Northern Ontario Health Equity Strategy***.

Goal: Work with partners to improve patients' timely follow-up from a primary care practitioner after discharge from hospital

After serving for three years as the NE LHIN's Primary Care Lead, North Bay's Dr. Paul Preston (left) began work as the Vice-President Clinical in March 2017.

Dr. Preston engages with providers across the region to help connect primary care to other parts of the health care system. His focus in the coming year is to better align home and community care with primary care and place Care Coordinators within primary care settings.

Dr. Preston works with a team of health leads who are engaged with the LHIN on a part-time basis including clinical specialists Dr. Derek Manchuk, Dr. Gary Bota, and Dr. Reena Dhatt. In addition, the LHIN's sub-region primary care leads are also part of Dr. Preston's team, including: Dr. Jodie Stewart, Dr. David Fera, Dr. Jason Sutherland, and Dr. Yves Raymond.

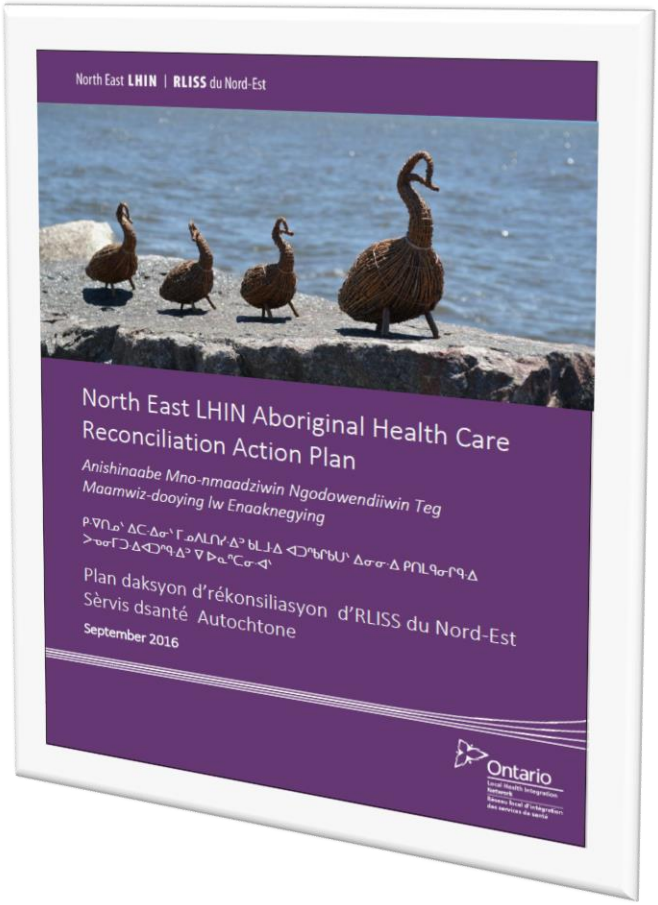
Goal: Support redevelopment of long-term care homes to meet the highest safety and design standards

Algonquin Nursing Home is one of 20 homes in the NE LHIN that will be redeveloped over the next eight years. Algonquin's total redevelopment cost is approximately $17.5 million.

The redeveloped home will provide 73 residents with increased access to health care services as they'll be on a single site, more privacy, larger bedrooms, enhanced infection control processes, better access to bathrooms, and an improved dining space.

Aboriginal Health Care

In Northeastern Ontario about 11% (62,000) of the population is Indigenous. The need for an Aboriginal Health Care Strategy and Reconciliation Plan was identified as a result of LHIN-led engagements with Indigenous Northerners and the guidance of the LHIN's Local Aboriginal Health Committee (LAHC).



- The NE LHIN works in partnership with the LAHC, an advisory committee to the Board, to guide LHIN work in meeting the health needs of Indigenous Northerners. LAHC is comprised of senior representatives of Aboriginal health care organizations across the region. It advises the LHIN on health service priorities, opportunities for engagement, and ways to better the coordination of services within Indigenous urban and rural communities.

- In 2016, LHIN staff worked with the LAHC to develop Northeastern Ontario's first *North East LHIN Aboriginal Health Care Reconciliation Action Plan*. This plan is an important step in our journey to build a stronger system of care that addresses the profound inequities in the health of Indigenous Northerners.

- The *Reconciliation Action Plan* outlines goals in four strategic directions that are aligned with the Medicine Wheel's quadrants. Goals for the four areas – opportunities, relationships, knowledge and understanding, and sustainability and evaluation. The plan includes 25 calls to action, and measurable targets that the NE LHIN is committed to deliver on over the next three years.

- Reconciliation Plan progress is reviewed biannually at LAHC meetings and annually at a meeting of the NE LHIN Board of Directors.

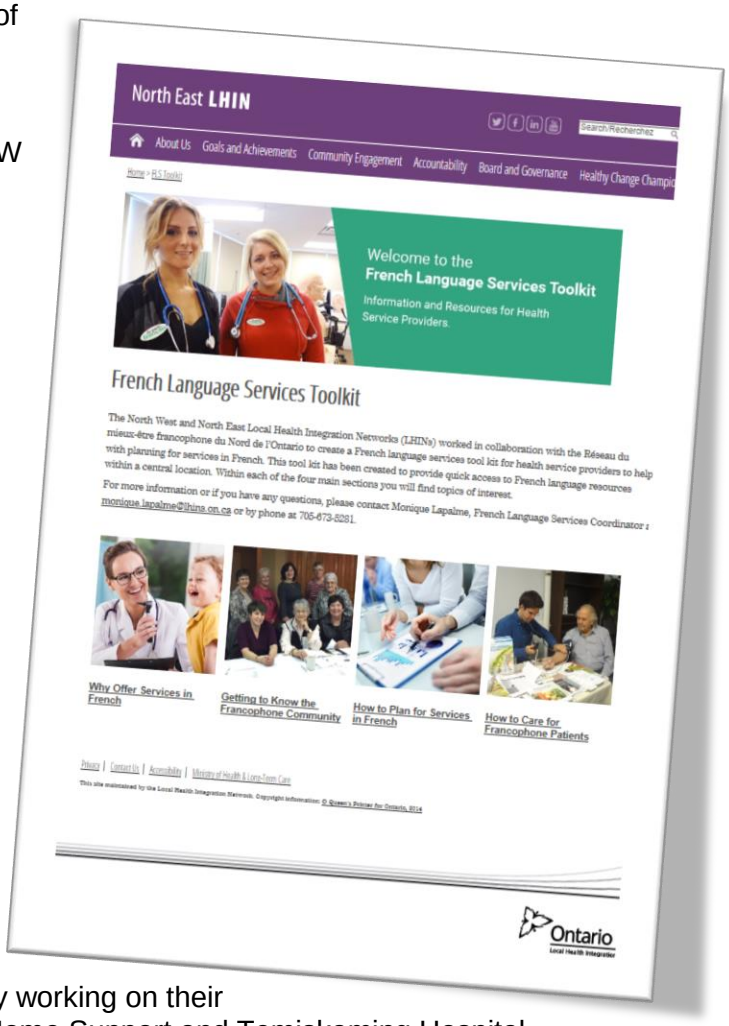
- Within the first nine months of the plan's launch, the NE LHIN provided cultural safety training for more than 400 Northerners through an eight-week online training course designed to broaden understanding of the history of Aboriginal Canadians, and strengthen the skills of practitioners working with Aboriginal people.

- This past year, the NE LHIN appointed an Indigenous Co-Chair to its Mental Health and Addictions Advisory Council and re-aligned its internal resources to ensure a designated group of LHIN staff work in partnership with federal and provincial partners, as well as health service providers, to strengthen the relationships and services needed to better support the needs of Aboriginal Northerners.

French Language Health Services

In Northeastern Ontario, 23% (130,000) of the population is Francophone. Currently 43 health services providers are officially designated under the French Language Services (FLS) Act, and the NE LHIN is working with 56 others who are planning for a designation.

The NE LHIN works in partnership with the Réseau du mieux-être francophone du Nord de l'Ontario (Réseau) to help meet the needs and priorities of French speaking Northerners.



- An online FLS toolkit (shown at right), collaboratively undertaken by the NE and NW LHINs and the Réseau, was launched in March of 2017 to help providers with their FLS planning and provision of quality services in French.

- A key objective of the LHIN's Integrated Health Service Plan (IHSP) and the Joint Action Plan is to increase the number of providers that complete a submission for designation under the FLS Act. The LHIN and Réseau work together to identify health service providers whose FLS planning make them good candidates for designation. They also work to support a provider in completing a designation plan, and evaluate designated providers to ensure they continue to meet designation criteria:
  - Over the past year, 1 health service provider received a designation -- Maison McCulloch Hospice and 1 provider submitted a request for partial designation, CMHA Nipissing District.
  - Two health service providers are actively working on their designation submission, Temiskaming Home Support and Temiskaming Hospital.
  - An FLS report is required by all providers identified to plan for the provision of FLS.
  - Ten designated health service providers were evaluated by the NE LHIN and the Réseau, using the Office of Francophone Affairs Designation and Evaluation Form.
  - Earlier in the year, an official launch took place of the collaborative project between Tel AIde Outaouais and NISA to enhance Warm Line services in French throughout the North East.

- The LHIN and the Réseau jointly promote the Active Offer approach for FLS.

- The NE LHIN, in collaboration with the Réseau, is engaged in primary care planning in Timmins through a Timmins Primary Care Collaborative Committee. Chaired by a member of the NE LHIN Board of Directors, the Collaborative is charged with developing a business case for a Francophone Community Health Centre to serve the area's Francophone population.

Key Provincial Priorities

Enabling Technologies (eHealth)

The NE LHIN is one of the highest users of Telemedicine with more than 260 sites across the region. One of our programs delivered through the Manitoulin Central Family Health Team -- a Mobile Tele-ophthalmology Screening Program -- recently won a provincial 2016 Bright Lights Award from the Association of Family Health Teams of Ontario. This innovative and collaborative program brings eye screening services to 11 Manitoulin Island communities and one on nearby Birch Island as well as helps address population health inequities and transportation challenges.

The **"ONE"** initiative (One Person. One Record. One System) will improve quality of care and the ease of delivering that care across the region. All 24 acute-care hospital Boards have committed to work together to achieve this goal. The ONE Initiative will see the installation of a regional electronic medical record for all 24 acute hospitals, the creation a new business entity to deliver I.T. services in the North East, and the establishment a regional Enabling Technologies Governance Group. The benefits for patients are numerous including: improvements in patient care and safety, ensuring equitable care for all, and creating one record per person so that patients don't have to tell their story over and over again or repeat invasive tests.

Home and Community Care

The NE LHIN continues to make targeted investments to provide more programs and services to allow people to be cared for at home or in community and only in an institution when needed. With approximately 70 community-based service providers in the North East, patients being discharged from hospital (or who are otherwise seeking services in the community) are challenged to navigate a broad range of services, catchment areas, and eligibility requirements. The NE LHIN is leading several initiatives to help enhance coordination and transitions to community or home-based care to improve the patient experience, including:

- The NE LHIN secured additional funding of $10.4M to support home and community care enhancements, including:
    - Expanding services provision for high needs clients;
    - Supporting hospital-based hospice suites in 17 communities across the region;
    - Bringing respite services delivered by multiple home and community providers to an additional 815 patients and caregivers.
    - Investments in personal support services, care connectors and other system enhancements.

- Wait times for Northerners receiving home and community care through the NE CCAC was reduced wait times from 48 to 32 days (since 2015/16) and an improved patient experience by over 65% (since 2013/14). These performance outcomes were achieved through process improvements that reduced the time of assessments and the implementation of a focus on truly home-bound patients.

- Over the course of the year, leadership of the NE LHIN and the NE CCAC worked together on a transition plan to integrate NE CCAC staff and services in the LHIN May 31st, 2017. One of the goals of the integration was to ensure no disruption of services to patients. By bringing the delivery of home and community care services under the LHINs, care coordination and a better alignment of primary care and home and community care will be realized.

- The NE LHIN conducted a ***North East Assisted Living Review***, with the help of its providers, including an examination of work that has occurred since the introduction of the revised policy in 2011, and a gap analysis to help inform future decision making.

- In 2016/2017, the NE LHIN provided an additional $425,000 to enhance assisted living services, as well as an additional $480,000 invested into various programs dedicated to supportive housing and rent supplements. In addition, $456,000 was invested into organizations across the North East to support Peer Support Worker Wage and Benefit Enhancements.

- Additional funding was allocated to various programs across the home and community sector such as Hospice Visitor Programs, the Geriatric Model of Care program, and other investments in Acute Brain Injury services.

- Recognizing that housing is a social determinant of health, the NE LHIN developed the ***Innovative Housing with Health Supports in Northeastern Ontario Strategic Plan: 2016-2019,*** with the help of Northern Ontario Service Deliverers Association and the CMHA – Sudbury/Manitoulin and other partners, publishing it in September of 2016.Currently the NE LHIN is working with the eight District Social Service Administration Boards and municipalities across the region to move ahead with the strategy's recommendations.

- An abundance of work took place to strengthen processes between Community Support Service (CSS) providers and the NE CCAC to transition low acuity clients to CSS providers. The achieved goal was to increase capacity in the system, improve coordination, and bring the home and community sector more closely together. So far 345 clients have been transitioned.

Health Links

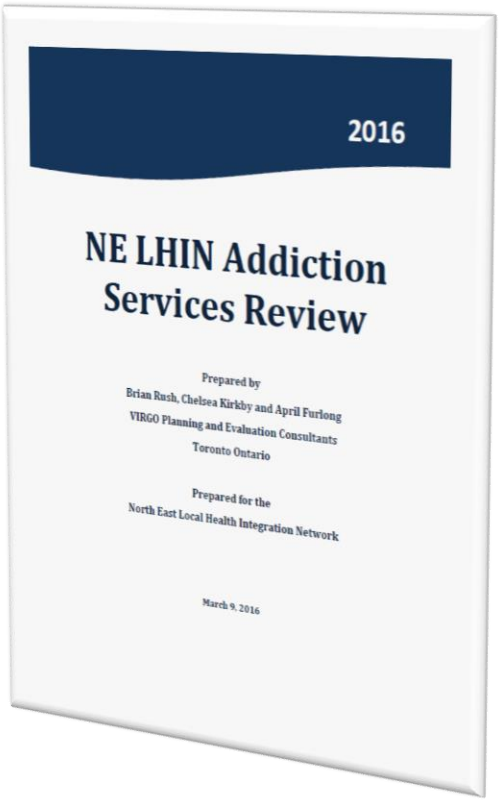
In the North East, there are now 14 Health Links in various stages of development and more than 600 Northerners with coordinated care plans.

Health Links are designed to help the five per cent of patients who account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. When the hospital, the family doctor, long-term care homes, community organizations and others work as a team, the patient receives better, more coordinated care. Working together, providers design individualized care plans with patients and their families to ensure they are supported to reach their goals and receive the support and care they need. For the patient it means:

- Care focused on their needs.
- Providers having a consistent understanding of their patients' conditions.
- Easier navigation of health care services.
- Feeling more supported in their health care journey and having fewer visits to hospital

The Health Links approach to coordinated care planning is about bringing health care, social service providers and other supports together to better understand a patient's goals and support the patient. It promotes a shared understanding of what is most important to a patient.

Mental Health and Addiction Services



Last year, the NE LHIN commissioned and published a report looking at Addictions Services across the region. Conducted by Dr. Brian Rush it found:

- Use of health services related to substance use in the North East is 1.5 to 2.5 times higher than the provincial average.
- There is an imbalance in residential versus day/evening community treatment programs with the vast majority of withdrawal management clients ending up in residential programs. However, based on a national needs-based planning model, more community day/evening treatment programs are needed.

Following the release of Dr. Rush's report the NE LHIN put a call out to form a regional mental health and addiction council to address the recommendations of his report, as well as a Blueprint created by HSN and NBRHC. The Council has begun drafting a work plan.

In addition the NE LHIN is working on:

- Collaborative partnerships to increase housing opportunities and associated supports for older adults, people with mental health and addiction challenges, and other vulnerable populations.
- Provision of rent supplements and supports in the four sub-region communities, to support those with various housing needs, including addictions supportive housing.
- Improving access to mental health and addictions services through the implementation of a standardized regional referral form, an on-line information mini-site.
- Supporting the development of situation tables in sub-regions to provide people with serious mental health and addictions challenges with wrap-around care.
- Implementing and monitoring a Managed Alcohol Program in Sudbury.
- Engaging in a process with partners to ensure equitable access to mental health and addictions care for James and Hudson Bay Coast communities.
- Working with the Centre for Addictions and Mental Health (CAMH) to implement new screening and assessment tools.
- Working with partners to implement the Ontario Perception of Care tool, to allow service users and their families to provide feedback on the care they've received.
- Ensuring mental health and addictions partners are provided cultural awareness and sensitivity training.

- Working with CAMH to focus on the needs of transitional-aged youth.
    - Providing supports to CAMH to offer Telepsychiatry to Family Health Teams, and working in partnership with Ontario Psychiatric Outreach Program to support individuals in remote and rural locations to access services.
    - Engaging in provincial work that will help connect those with mental health and addictions challenges to primary care

Alternate Level of Care (ALC) Strategies and Solutions

Hospital patients designated as ALC have needs that are better met in alternate settings such as long-term care, rehabilitation, assisted living or home. Having more home care and community services enables ALC patients to leave the hospital sooner, live independently in their setting of choice, and make more beds available to patients who are waiting to be admitted to hospital for acute care.

After spending time at NISA, using many of its peer-run programs, Annette Larabie was to become a Warm Line worker. The 65-year-old now works one night a week, taking calls from "lonely people, some having a hard time with depression, and others just wanting to talk." Not all have a mental illness, she explained "some just want to touch base with us."

"I love my job," she said. "Because of my background and what I've been through, I know where many of them coming from and I can relate to them."

The Regional Warm Line (1-866-856-9276) is a bilingual peer support line, open from 6 pm to midnight, staffed by individuals who have personal experience with mental health challenges.

In the spring of 2016, the NE LHIN launched a three-year regional Patient Flow Strategy. This strategy builds on previous and current work as well as experience within and outside the NE LHIN to address patient flow across the continuum of health care needs and services. Several factors drive the need for a renewed focus on ALC, including continued ALC challenges coupled with the new aggressive province-wide target of 9.46% ALC in acute care, and 12.7% ALC in combined acute and post-acute settings.

The patient flow strategy is an opportunity to apply the Triple Aim framework in our LHIN -- improving the patient experience of care; health of populations; and reducing the per capita cost of health care. Most of all, it will better meet patient needs and address system pressures.

Patient flow refers to the movement and transition of patients between care settings, providers and organizations. Transitions might occur, for example:

- within organizations (e.g. from the ED to an inpatient bed, from a medical inpatient bed to a rehabilitation inpatient bed or outpatient service);

- between organizations of the same type (e.g. from one hospital to another hospital, from one LTCH to another LTCH, from one CSS provider to another CSS provider); or

- between sectors (e.g. from/to a hospital to/from primary care, CCAC, long-term care home or assisted living program).

The new strategy involves a combination of regional and local work plans, as well as the application of project management techniques.

Emergency Department (ED) Wait Times

The region's four Hub hospitals continue to participate in the provincial ED Pay for Results program which supports a range of ED performance projects. For those ED visits not resulting in admission to hospital (90% of ED visits) the NE LHIN performs well against the provincial experience with overall ED length of stay close to five hours as compared to six hours for the province. NE LHIN ED length of stay performance for admitted patients continued to be an area for improvement in 2016/17 related to issues of alternate level of care challenges, community capacity, ED volume increases and high inpatient volumes. Overall performance for admitted patients was above target but consistent with provincial performance.

Pay for Results initiatives, which have demonstrated success in the North East hospitals include: ED triage nurses, a clinical decision unit, patient flow navigators, "see and treat" clinicians, and dedicated lab and pharmacy technicians in the ED.

All four Pay for Results hospitals in the NE LHIN participated fully in the ED Return Visit Quality Program introduced in 2016 and will continue their auditing of return visits to the ED in 2017.

Wait times for Surgical and Diagnostic Imaging

The NE LHIN's Wait Time and Volumes Sub-Committee reviews performance on surgical and diagnostic imaging wait time quarterly with hospital partners. Hospitals are responsible for updating performance chart books as well as documenting challenges and improvement plans to the LHIN. The Committee also provides critical input into surgical volumes to inform the NE LHIN's Local Partnership on opportunities for reallocating surgical cases across NE hospitals in a timely way. The NE LHIN's Joint Assessment Centres (JACs) provide centralized intake and assessment for hip, knee and shoulder replacement surgery ensuring the right patients are referred on to surgeons and patients not yet ready for surgery are provided with ongoing care plans to ensure continued functionality and pain tolerance. The NE LHIN has initiated a MRI Working Group charged with review and implementation of the LHIN CEO Council's five recommendations for improving MRI performance in the province. Overall performance on surgical and diagnostic imaging is reported above (see p. 13-14).

Health System Funding Reform

The NE LHIN Local Partnership Group analyzes the implications of Health System Funding Reform (HSFR) across the NE LHIN. Part of the group's role is to work with a subcommittee that examines performance indicators associated with QBPs such as wait times and volume to increase access for patients. The group meets quarterly and reviews data as part of its efforts to ensure best quality care practices are used throughout the region.

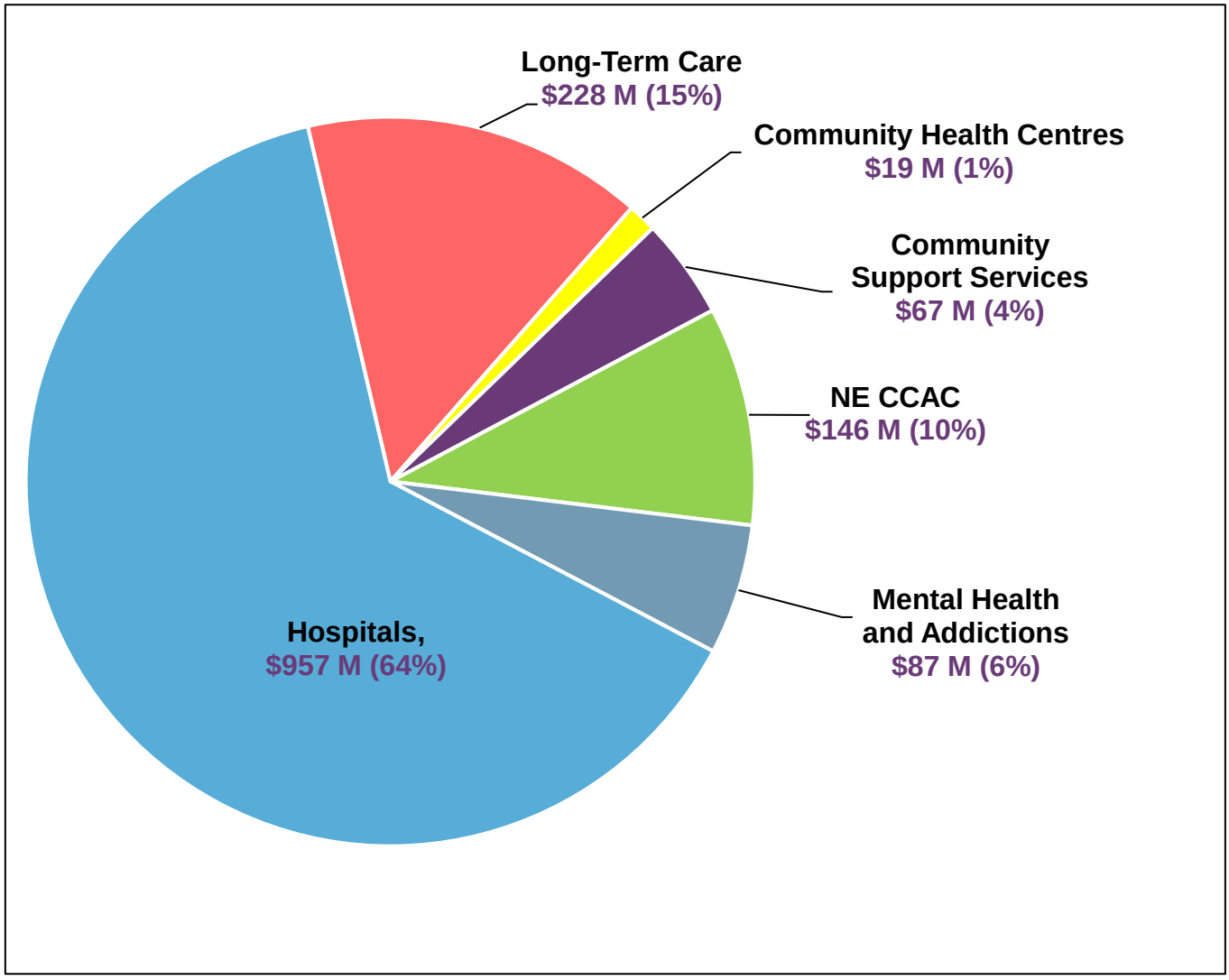
The group also briefs the Ministry of Health and Long-Term Care on issues that affect the implementation of HSFR in our LHIN. Membership is representative of hospitals across the North East, and the NE CCAC (North East Community Care Access Centre). Within the NE LHIN in 2016/17, there were eight HSFR-participating hospitals.

Analysis of LHIN Operational Performance

The NE LHIN ended the 2016/17 year in a balanced position. In 2016/17, the NE LHIN provided $1.4 billion dollars to 144 HSPs who deliver more than 200 programs and services across Northeastern Ontario.

Local offices in North Bay, Sault Ste. Marie, Sudbury and Timmins enable the NE LHIN team to meet regularly with people in their home community. Through the negotiation and monitoring of accountability agreements with health care partners, the NE LHIN is able to direct funding to initiatives to improve patient care and advance a more integrated and efficient delivery of services at the community level.

Funding by Sector, 2016/17



Financial statements of

North East Local Health Integration Network

March 31, 2017

North East Local Health Integration Network

March 31, 2017

Table of contents

Deloitte LLP
400 Applewood Crescent
Suite 500
Vaughan ON L4K 0C3
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

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

We have audited the accompanying financial statements of the North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2017, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Chartered Professional Accountants
Licensed Public Accountants
May 30, 2017

North East Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**565,035**	418,629
Accounts receivable	**27,533**	24,166
HST receivable	**67,536**	26,496
Due from MOHLTC-Health Service Providers ("HSP") (Note 7)	**15,757,699**	24,187,382
	16,417,803	24,656,673
Liabilities		
Accounts payable and accrued liabilities	**700,017**	483,268
Due to the LHIN Shared Services Office (Note 3)	**-**	37
Due to Health Service Providers ("HSP") (Note 7)	**15,757,699**	24,187,382
Deferred capital contributions (Note 4)	**155,347**	209,231
	16,613,063	24,879,918
Net debt	**(195,260)**	(223,245)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	**39,913**	14,014
Tangible capital assets (Note 5)	**155,347**	209,231
	195,260	223,245
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

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

North East Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 6)	2017 Actual	2016 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,440,484,300**	**1,503,092,882**	1,475,183,814
Operations of LHIN	**4,737,866**	**4,743,741**	5,070,965
Project Initiatives			
Enabling technologies	**510,000**	**510,000**	510,000
French Language Health Service	**296,800**	**296,800**	296,800
Réseau du mieux-être francophone du Nord de l'Ontario	**796,159**	**796,159**	796,159
Emergency Department Lead	**75,000**	**75,000**	75,000
Critical Care Lead	**75,000**	**75,000**	75,000
Aboriginal Engagement	**100,000**	**100,000**	100,000
Emergency Room/Alternate Level of Care	**100,000**	**100,000**	100,000
Primary Care Lead	**75,000**	**75,000**	75,000
Diabetes Regional Coordinating Centre	**1,065,809**	**1,065,809**	1,065,809
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Patients First Pan-LHIN Support for Planning and Implementation	**-**	**111,720**	-
Amortization of deferred capital contributions (Note 4)	**67,708**	**74,619**	102,869
	1,448,383,642	**1,511,296,730**	1,483,451,416
Expenses			
Transfer payments to HSPs (Note 7)	**1,440,484,300**	**1,503,092,882**	1,475,183,814
General and administrative (Note 8)	**4,737,866**	**4,743,741**	5,070,965
Project Initiatives Note 9)			
Enabling technologies	**510,000**	**510,000**	510,000
French Language Health Service	**296,800**	**296,800**	296,800
Réseau du mieux-être francophone du Nord de l'Ontario	**796,159**	**796,159**	796,159
Emergency Department Lead	**75,000**	**75,000**	75,000
Critical Care Lead	**75,000**	**75,000**	75,000
Aboriginal Engagement	**100,000**	**100,000**	100,000
Emergency Room/Alternate Level of Care	**100,000**	**100,000**	100,000
Primary Care Lead	**75,000**	**75,000**	75,000
Diabetes Regional Coordinating Centre	**1,065,809**	**1,065,809**	1,065,809
Patients First Transition Planning and Implementation	**-**	**180,000**	-
Patients First Pan-LHIN Support for Planning and Implementation	**-**	**111,720**	-
Amortization of tangible capital assets	**67,708**	**74,619**	102,869
	1,448,383,642	**1,511,296,730**	1,483,451,416
Annual surplus and accumulated surplus, end of year	**-**	**-**	**-**

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

North East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	Budget	2017	2016
	$	$	$
Annual surplus	**-**	**-**	-
Acquisition of tangible capital assets	**-**	**(20,735)**	(125,693)
Amortization of tangible capital assets	**67,708**	**74,619**	102,869
(Increase) decrease in prepaid expenses, net	**-**	**(25,899)**	24,561
Decrease in net debt	**67,708**	**27,985**	1,737
Net debt, beginning of year	**(223,245)**	**(223,245)**	(224,982)
Net debt, end of year	**(155,537)**	**(195,260)**	(223,245)

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

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Items not affecting cash		
Amortization of tangible capital assets	**74,619**	102,869
Amortization of deferred capital contributions (Note 4)	**(74,619)**	(102,869)
Changes in non-cash working capital		
Accounts receivable	**(3,367)**	(7,008)
HST Receivable	**(41,040)**	8,641
Due from MOHLTC-Health Service Providers	**8,429,683**	(20,702,143)
Accounts payable and accrued liabilities	**259,816**	37,745
Due to the LHIN Shared Service Office	**(37)**	(7,401)
Due to Health Service Providers	**(8,429,683)**	20,702,143
Prepaid expenses	**(25,899)**	24,561
	189,473	56,538
Capital transaction		
Acquisition of tangible capital assets net of change in accounts payable related to capital asset acquisitions	**(63,802)**	(82,626)
Financing transaction		
Increase in deferred capital contributions (Note 4)	**20,735**	125,693
Net increase in cash	**146,406**	99,605
Cash, beginning of year	**418,629**	319,024
Cash, end of year	**565,035**	418,629

(See additional information presented in Note 5.)

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

1. Description of business

The North 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 North 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 mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

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

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2017.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

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

Basis of accounting

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

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

2. Significant accounting policies (continued)

Government transfer payments

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

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

Deferred capital contributions

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

Tangible capital assets

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

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

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

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

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

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Related party transactions

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

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

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

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

Patients First Pan-LHIN Support for Planning and Implementation

On June 13, 2016 an amendment to the Ministry-LHIN Accountability Agreement between Toronto Central LHIN and the Ministry resulted in an allocation of $1,080,000 of additional funding to be distributed by the Toronto Central LHIN to various LHINs to be applied to salary and benefit costs created to the support of transition and implementation of the expanded LHIN mandate. North East LHIN received $111,720 of this funding which was spent on eligible expenses in the year.

Enabling Technologies for Integrated Project management Office

In fiscal 2014, the LHIN entered into an agreement with the Champlain, South East and North West LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Funding was provided to enable the cluster LHINs Project Management Offices to advance eHealth, information management and information technology initiatives as outlined in the ETI PMO Toolkit Business Case approved by the MOHLTC.

The LHIN's financial statements reflects its share of the MOHLTC funding for ETI PMO for its Cluster and related expenses. During the year the LHIN received of $510,000 (2016 - $510,000).

4. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**209,231**	186,407
Capital contributions received	**20,735**	125,693
Amortization	**(74,619)**	(102,869)
Balance, end of year	**155,347**	209,231

5. Tangible capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Furniture and fixtures	**215,060**	**202,710**	**12,350**	51,734
Computer equipment	**287,963**	**249,154**	**38,809**	28,413
Leasehold improvements	**1,235,980**	**1,131,792**	**104,188**	129,084
	1,739,003	**1,583,656**	**155,347**	209,231

Non-cash transactions

During the year, tangible capital assets were acquired at an aggregate cost of $20,735 (2016 - $125,693) of which $ Nil (2016 - $43,067) were paid after year-end and $20,735 (2016 - $82,626) were paid during the year.

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of operations reflect the initial budget at April 1, 2016. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,503,092,882 is made up of the following:

	$
Initial HSP Funding budget	**1,440,484,300**
Adjustment due to announcements made during the year	**62,608,582**
	1,503,092,882

The total operating budget of $8,129,229 is made up of the following:

Initial budget	**7,831,634**
Additional funding received during the year	**318,330**
Amount treated as Capital Contribution	**(20,735)**
Total budget	**8,129,229**

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,503,092,882 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2017	2016
	$	$
Operation of Hospitals	**957,015,404**	950,979,622
Grants to compensate for Municipal Taxation - Public Hospitals	**211,725**	211,725
Long-term Care Homes	**227,563,522**	223,277,091
Community Care Access Centres	**145,532,336**	135,563,964
Community Support Services	**39,525,889**	37,623,196
Acquired Brain Injury	**3,770,183**	3,028,649
Assisted Living Services in Supportive Housing	**23,439,912**	22,892,242
Community Health Centres	**19,144,535**	18,384,080
Community Mental Health	**63,725,937**	60,754,003
Substance Abuse and Gambling Problem	**23,163,439**	22,469,242
	1,503,092,882	1,475,183,814

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2017, an amount of $15,757,699 (2016 - $24,187,382) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

8. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies these same expenses by object:

	2017	2016
	$	$
Salaries and wages	**3,011,276**	3,256,005
HOOPP	**263,635**	295,501
Other benefits	**302,378**	403,421
Staff travel	**151,262**	135,273
Governance Travel	**25,191**	24,693
Communications	**118,127**	135,160
Accommodation	**208,160**	216,846
Advertising	**5,053**	6,051
Consulting fees	**52,959**	45,795
Equipment rentals	**9,475**	9,792
Board Chair per diems	**12,810**	17,500
Other Governance per diems	**36,745**	20,637
Insurance	**6,719**	6,287
LHIN Shares Services Office	**251,579**	260,956
LHIN Collaborative	**47,500**	47,500
Other meeting expenses	**33,117**	35,643
Other governance expenses	**6,890**	7,095
Printing and translation	**80,857**	80,739
Staff development	**53,212**	18,123
IT equipment	**43,943**	15,267
Office supplies and equipment	**15,904**	30,055
Other	**6,949**	2,626
	4,743,741	5,070,965

9. Program initiatives

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

	2017	2016
	$	$
Salaries and benefits	**2,105,628**	1,814,477
Professional services	**224,014**	223,871
Shared services	**115,800**	120,708
Occupancy	**74,040**	77,568
Public relations and community engagement	**20,111**	29,367
Supplies	**11,394**	9,541
Mail, courier and telecommunications	**8,415**	10,937
Réseau du mieux-être francophone du Nord de l'Ontario	**796,159**	796,159
Other operating expenses	**29,927**	11,140
	3,385,488	3,093,768

9. Program initiatives (continued)

Diabetes strategy operational expenses included in the project initiative expenses above are as follows:

	Budget 2017	**Actual 2017**	Actual 2016
	$	**$**	$
Salaries and benefits	**877,620**	**877,613**	877,620
Other operating expenses	**188,189**	**188,196**	188,189
	1,065,809	**1,065,809**	1,065,809

10. Funding repayable to the MOHLTC

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

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

			2017	2016
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**1,503,092,882**	**1,503,092,882**	**-**	-
LHIN operations	**4,743,741**	**4,743,741**	**-**	-
Amortization of capital assets	**74,619**	**74,619**	**-**	-
Enabling technologies	**510,000**	**510,000**	**-**	-
French Language Health Services	**296,800**	**296,800**	**-**	-
Reseau du mieux-etre franophone du Nord l'Ontario	**796,159**	**796,159**	**-**	-
Emergency Department Lead	**75,000**	**75,000**	**-**	-
Critical Care Lead	**75,000**	**75,000**	**-**	-
Aboriginal Engagement	**100,000**	**100,000**	**-**	-
Emergency Room/Alternate Level of Care	**100,000**	**100,000**	**-**	-
Primary Care Lead	**75,000**	**75,000**	**-**	-
Diabetes Regional Coordination Centre	**1,065,809**	**1,065,809**	**-**	-
Patients First Transition Planning and Implementation	**180,000**	**180,000**	**-**	-
Patients First Pan-LHIN Support for Planning and Implementation	**111,720**	**111,720**	**-**	-
	1,511,296,730	**1,511,296,730**	**-**	-

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan (“HOOPP”), which is a multi-employer plan, on behalf of approximately 56 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 2017 was $417,246 (2016 - $432,307) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2016. At that time the plan was fully funded.

12. Guarantees

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

13. Commitments

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

	$
2018	242,201
2019	179,792
2020	179,792
2021	95,948
2022	68,000
Thereafter	68,000
	833,733

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2017 the LHIN had signed Accountability Agreements with all Hospitals, Long-Term Care Home and Community Agencies. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

14. Subsequent events

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

Effective May 31, 2017 the LHIN will assume 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.

Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé