North East Local Health Integration Network

2017/18 Annual Report

North East Local Health Integration Network

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

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North East LHIN

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ISSN 1911-2955 (Print/Imprimé) Annual Report 2017/18, North East Local Health Integration Network.

Message from the Board Chair and CEO

July 30, 2018

The second 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 ***Patient's First Act*** and the Minister of Health and Long-Term Care's Mandate Letter, further focussing our efforts to: improve the patient experience; address the root cause of health inequity; improve access to primary care and reduce wait times for specialist care, mental health and addictions, home and community care, and acute care; break down silos to ensure seamless transitions for patients; support innovation by delivering new models of care and digital solutions; and reduce the burden of disease and chronic illness.

As part of our expanded role under the Act, the North East Community Care Access Centre (NE CCAC) merged with the North East Local Health Integration Network (NE LHIN) on May 31st, 2017. With this milestone integration, the NE LHIN became responsible for the delivery of home and community care services to 17,000 Northerners, in addition to planning, funding and integrating the Northeastern Ontario health care system. Some of the year's key highlights include:

- **Collaborative governance initiatives** undertaken by our NE LHIN Board of Directors --now at 10 members-- to help improve patient flow in urban hospitals such as Health Sciences North, as well as offer governance support to community hospitals such as Temiskaming. In addition, the Board supported and provided leadership to the Timmins Primary Care Collaborative in undertaking a business case to develop a **Community Health Centre** for Francophones in Timmins.
- Our newly formed **Patient and Family Advisory Committee** which includes 18 Northerners from each of our five sub-regions who advise the NE LHIN on ways and means to include the patient voice in our work to strengthen the local health care system.
- Engagement and planning with our **five sub-regions and 35+ care communities through** Collaborative Tables which identify gaps and opportunities to enhance patients' continuum of care at the local level.
- Implementing the **ONE** Initiative **(One Person. One Record. One System),** to connect 24 acute care hospitals on one information system and support seamless patient navigation.
- Developing and implementing a **North East Regional Opioid Strategy** in partnership with our Regional Mental Health and Addictions Advisory Council.
- Working with Health Quality Ontario, the North West LHIN, public health units and other partners to publish a **Northern Health Equity Strategy.**
- Bringing all home and community care partners together with our **One Client One Plan** project so that people can easily access the services they need and tell their story only once.
- Linking **home and community care coordinators within primary care settings.**

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 their patient experience.

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

Jérémy Stevenson
CEO, NE LHIN

Welcome to the NE LHIN

Mission

To strengthen the coordination of health care services and improve access.

Renforcer la coordination des services de santé et améliorer l'accès.

Nokii twindwaa bemaadsijig weweni nyaagdowendaagog.
Enkiichigaadeg waazhi maajiishkaang maamwizwin eni zhischigaadeg wii minoyaang naadmaadwin.
Giiwednowaabnong nikeya dinokiiwning ni zhischigaadeg wii minwaabminaagog endnokiishnang

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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.

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Values

People: People are what really matter. Our health care system is people caring for people. We include patients, families, caregivers, health service providers, community partners and employees in our decision-making. We value and respect their input.

Trust: We recognize that trust built on relationships of integrity and respect are foundational in caring for people and connecting the health care system for everyone.

Caring: We believe that health care is about caring for people with a human touch. We support and empower patients and their families in collaborating with providers and taking ownership of their personal care plan. We believe a care plan must respect an individual's cultural and linguistic needs and honour their heritage.

Collaborative: We unite under a common vision and purpose that enables us to maximize each other's contributions to a system of care that is focused on improving the health of our population, including Francophone and Indigenous people.

Responsible: We hold ourselves accountable to make transparent decisions based on health equity, best practices, and patient safety that contribute to a high quality, integrated, safe and fiscally responsible health care system.

Innovative: We believe in building a safe environment to embrace opportunities to improve patient care and connect all parts of the local health care system in creative and meaningful ways.

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 coasts, access is possible only via ice roads or air, depending on the time of year.

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. In addition, more than 35+ care communities have been identifed. A care community is a network of health and social service providers working together to integrate care for individuals, close to home. We have identified care communities around patients to improve access to health and social services as close to where Northerners live as possible.

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 based on the populations' needs.

Demographics

- Second largest LHIN by geography – about 400,000 square kilometres – 44% of Ontario's land mass.
- 552,000 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.
- 13% of Northerners are Indigenous and identify as Aboriginal, First Nation, Inuit, or Métis.

Health Service Providers

The NE LHIN holds accountability agreements with, and provides funds, for 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)
- Home and Community Care Services (70)
- Long-term Care Homes (40)

Primary Care in Northeastern Ontario

- 27 Family Health Teams
- 6 nurse practitioner-led clinics
- 6 community health centres
- 10 nursing stations
- 3 Aboriginal Health Access Centres
- 14 Health Links in various stages of development
- 2 Rural Health Hubs
- Health Care Connect – a website and system that helps better connect Northerners with primary care providers. From March 2017 to March 2018, 89% of patients were successfully connected to a primary care provider, compared to 86% the previous year.

Home and Community Care

The NE LHIN is the largest direct service provider of home and community care in Northeastern Ontario. In addition, we manage eligibility and admissions to long-term care homes, short stay respite, assisted living, and adult day programs. Care is planned, delivered and coordinated by a multi-disciplinary team of care coordinators, physicians, nursing professionals, physiotherapists, occupational therapists, speech language pathologists, rehabilitation assistants, social workers, dietitians and others.

- The NE LHIN provides services to over 17,000 people across Northeastern Ontario on any given day:
  - 97,138 therapy visits/year
  - 22,719 school therapy visits/year
  - 399,483 nursing visits/year
  - 1,256,945 personal support visits/year

- Within the delivery of home and community care, the NE LHIN holds contracts with about 40 service provider organizations who help to deliver home and community care to Northerners.

Population Health

Overall, compared to the province, the NE LHIN has a higher:

	NE LHIN	Ontario*
Proportion of people with Indigenous Identity	13%	2%
Proportion of Francophones	23%	4%
Proportion of people living in rural areas	30%	14%
Proportion of people over the age of 65*	21%	16%
Unemployment rate for ages 15+	9%	7%
Proportion of people aged 25-64 who do not have post-secondary education	14%	10%
Percentage of smokers	19%	12%
Percentage of drinkers who report heavy drinking	22%	18%
Prevalence of high blood pressure	25%	18%
Percentage of residents with multiple chronic conditions	21%	15%

The NE LHIN region is also associated with a lower or similar:

	NE LHIN	Ontario*
Proportion of the population who have a regular medical doctor	86%	90%
Proportion of the population who rate their health as very good or excellent	54%	60%
Proportion of the population reporting physical inactivity	43%	43%

**Ontario percentages also include Northeastern Ontario percentages.*

NE LHIN Board of Directors

Our Board of Directors operates under a collaborative governance model and regularly engages with fellow Boards across the North East in its work to improve the patient experience and system performance. Five committees of the Board meet on a regular basis: Audit, Community Nominations, Executive, Governance and Quality. Directors bring a wide range 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.

Ron Farrell
Board Chair
Sundridge

Term: March 2017 to March 2020
Member of Executive Committee, *ex-officio* on all other committees

Kim T. Morris
Vice-Chair
Sudbury

Term: July 2017 to July 2020
Chair of Governance and Community Nominations Committees and Member of Executive Committee

Denis Bérubé
Board Treasurer
Moonbeam

Second Term: November 2017 to November 2020
Chair of Audit Committee, Member of Community Nominations, Executive and Governance Committees

Lorraine Dupuis
Sudbury

Term: April 2018 to September 2020
Member of Governance, Quality and Community Nominations Committees

John Febbraro
Sault. Ste. Marie

Term: December 2015 to December 2018
Vice-Chair of Audit Committee, Member of Community Nominations, Quality, and Governance Committees

Mark Palumbo
Sudbury

Term: March 2017 to March 2020
Member of Community Nominations, Governance, and Quality Committees

Cheryl St-Amour
Timmins

Term: April 2018 to February 2021
Member of Audit Committee

Anne Stewart
Pointe Au Baril

Term: September 2017 to September 2020
Member of Audit and Quality Committees

Elizabeth Stone
Haileybury

Term: March 2017 to March 2020
Chair of Quality Committee, Vice-Chair of Governance and Community Nominations Committees and Member of Audit Committee

Petra Wall
Spring Bay, Manitoulin Island

Term: September 2017 to September 2020
Member of Quality, Governance, Community Nominations, and Local Aboriginal Health Committees (Advisory Committee to the Board)

Board Advisory Committees

Our Board of Directors had two advisory committees: Health Professionals Advisory Committee – HPAC (sunset in January, 2018) and the Local Aboriginal Health Committee (LAHC).

Health Professionals Advisory Committee (HPAC)

HPAC served as a collective voice for health professionals and provided 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 service delivery.

Given the multidisciplinary approach with the establishment of collaborative tables whose membership includes health and social services system leaders across sub-regions, the NE LHIN Board of Directors passed a resolution in January 2018 to sunset HPAC. The NE LHIN has continued to engage with former HPAC members as part of its sub-region and care communities work.

HPAC Members

- 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
- Dr. Paul Preston, Physician, North Bay Regional Health Centre
- Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit
- Cynthia Stables, NE LHIN Director of Communications and Patient Experience (ex officio)

Roger Pilon, Former HPAC Chair

Local Aboriginal Health Committee (LAHC)

LAHC advises the NE LHIN Board on health service priorities within Indigenous (First Nations, Métis, Inuit, urban, rural) communities, as well as on opportunities for the integration and coordination of health care services to better meet the needs of Indigenous Northerners. LAHC and the NE LHIN work collaboratively to identify initiatives that lead to outcomes to support enhanced access to care for Northeastern Ontario Indigenous people and advance the 25 calls for action found in our ***Northeastern Ontario Health Care Strategy and Reconciliation Action Plan***.

LAHC Members

- Tyler Twarowski (Chair), Program Manager, Canadian Mental Health Association, Cochrane Timiskaming Branch, Timiskaming
- Rachel Cull (Co-Chair), Executive Director, Misiway Milopemahtesewin Community Health Centre, Timmins
- Judy Black, Nurse Manager of Children Services Program, Wikwemikong Health Centre, Manitoulin Island
- Dale Copegog, Director of Health and Social Service, Wasauksing First Nation, Parry Sound
- Sally Dokis, Health Director, Dokis Health Centre, Monetvill
- Kim Lalonde, Director of Health Services, Lawrence Commanda Health Centre, Nipissing First Nation
- 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
- Mariette Sutherland, Manager of Indigenous Engagement, Sudbury Health Unit
- Petra Wall, NE LHIN Board of Directors
- Pam Williamson, Executive Director, Noojmowin-Teg Health Centre, Little Current
- Carol Philbin-Jolette, NE LHIN Director, Coast Sub-Region and Population Equity (ex officio)
- Darlene Orton, NE LHIN Aboriginal Lead (ex officio)

LAHC Chair Tyler Twarowski and past Chair Gloria Daybutch (photo above). LAHC helped to lead the development of our *Northeastern Ontario Aboriginal Health Strategy and Reconciliation Action Plan*. The Plan's 25 calls to action include supporting increased access to traditional healing programs, educating health service providers on the value of Indigenous healing practices, and implementing cultural competency and safety training for people working in health care. The plan can be found at www.nelhin.on.ca.

Ministry-LHIN Accountability 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 13 performance indicators and eight monitoring indicators. The chart below shows 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, visit www.nelhin.on.ca.

No.	Indicator	Provincial target	Province	NE LHIN
			2017/18 Year Result (Year to	2017/18 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%	87.60%	87.70%
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%	96.40%	98.50%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	28.00	31.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.75	8.43
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.38	4.10
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	77.99%	76.67%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	73.72%	74.45%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	15.18%	24.76%
10	ALC rate	12.70%	15.49%	24.92%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	20.97%	17.64%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	32.25%	28.05%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.41%	16.68%
2. Monitoring Indicators				
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	83.95%	93.61%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	69.77%	71.99%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	84.73%	83.25%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	7.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	12.06	38.94
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	243.31	452.38
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	47.31%	38.19%

*FY 2017/18 is based on the available data from the fiscal year (Q1-Q3, 2017/18)
**FY 2017/18 is based on the available data from the fiscal year (Q1-Q2, 2017/18)

Report on MLAA Performance Indicators

The following pages outline the 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 LHIN Home and Community Care as per below.

Indicator #1: 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 87.7%, performance is close to the target (95%). This indicator captures about 200 patients each quarter out of more than 15,500 served each day. About 20 patients per quarter are not receiving services within the target due to system challenges such as a shortage of PSS workers in communities. The NE LHIN is working with partners to implement solutions to meet this challenge.

Indicator #2: Nursing: Percentage of home care clients who received their nursing visit within 5 days of the date they were due for nursing services. At 98.5%, performance is better than the target (95%). Over 3,600 patients receive nursing visits each quarter. NE LHIN Home and Community Care is working to improve processes and communication with its contracted service providers to improve wait times.

Indicator #3: Wait for Service: 90th Percentile Wait Time for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management). At 31 days, performance is not meeting target (21 days), however performance has improved by 25% - compared to 41 days in 2016/17 and down from a previous high of 55 days. A wait time improvement strategy began 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.

The following performance indicator does not have an assigned target as yet:

Indicator #4: Hospital Discharge Service Initiation: 90th Percentile Wait Time from hospital discharge to service initiation for home and community care. At 7 days, performance is the same as the provincial experience of 7 days.

Rosalee Côté, left, with NE LHIN Care Coordinator Katherine Courvoisier, who assesses Rosalee's needs on an ongoing basis and coordinates her care. The NE LHIN is the largest direct service provider of home and community care services in Northeastern Ontario, delivering care to more than 17,000 Northerners of all ages.

Indicator #5: ED Performance: 90th percentile ED length of stay for complex patients. At 8.43 hours, performance is above the target time (8 hours). Two patient groups are key to this indicator, including complex patients admitted to hospital and those discharged from the ED. Of these two groups, patients requiring admission to hospital are driving performance above target. In all 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 Alternate Level of Care (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.

Indicator #6: ED Performance: 90th percentile ED length of stay (LOS) for minor/uncomplicated patients. At 4.10 hours, performance is 6 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 2017/18 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.

Indicator #7 and #8: Surgery, Hip Replacement: Percent of priority 2, 3 and 4 cases completed within access target for knee replacement. At 76.67%, performance has not met 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 in 2016/17, down from 270 days in 2012/13. Unfortunately, the hospitals were unable to keep up with the increasing demand for this service, thereby leading to an increase in wait list times to 236 days in 2017/18. The NE LHIN is refocussing its improvement efforts on surgeons' wait lists, monthly monitoring of surgical volumes and getting the most appropriate patients to surgery by using the NE LHIN's centralized intake and assessment program – five North East Joint Assessment Centres.

Tonia Cockburn (left), Advanced Practice Physiotherapist with the NE LHIN-funded North East Joint Assessment Centre (NE JAC) at the North Bay Regional Health Centre, discusses hip ailment options with Nicole Perron. The five NE JACs, located in North Bay, Parry Sound, Sault Ste. Marie, Sudbury and Timmins, have assessed more than 34,000 hip, knee, and shoulder joints.

Elaine Burr, NE LHIN Patient Flow System Planning Lead, and David McNeil, VP with Health Sciences North in Sudbury, discuss the NE LHIN's Alternate Level of Care Avoidance Framework. The Framework includes over 60 strategies to help hospitals get patients to the right place of care as quickly as possible.

Indicator #9 and #10: Alternate Level of Care (ALC) including Percent ALC Days and ALC rate: The ALC "rate" focuses on patients who have completed their acute hospital treatment and await the availability of their next care level or "alternate level of care." The number of ALC days is a proportion of the total length of stay in acute care. At 24.76% ALC days and 24.92% for ALC rate, performance has not met 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 94% of hospital patients do not accumulate ALC days, 6% 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 framework to drive improvement. Adoption of the framework is key to improving patient flow in the four Hub hospitals and will be fully deployed in 2018/19. Capacity in the home and community care 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.

Health and Wellness of Ontarians – Mental Health

Indicator #11: Repeat unscheduled visits to the ED within 30 days for Mental Health: At 17.64%, performance is above target (16.3%). 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); 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.

Indicator #12: Repeat unscheduled visits to the ED within 30 days for Substance Abuse: At 28.05%, performance is above target (22.4%). 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; helping a small group of people who are high users of alcohol with a harm reduction ambulatory program; implementation of Rapid Access Addiction Medicine clinics in each sub-region; 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 35% in 2017/18.

Sustainability and Quality

Indicator #13: Hospital Readmissions within 30 days for selected Health Based Allocation Model Inpatient Grouper (HIG) conditions: At 16.68%, 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 North East LHIN Care Coordinators 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

Indicator #14: Percent of priority 2 (42 days), Priority 3 (84 days) and Priority 4 cases (182 days) completed within access target for cataract surgery: At 93.61% performance is better than the target (90%).

Indicator #15: Diagnostic Imaging – MRI Scans: At 71.99%, performance is below target (90%) but improved from previous years. Overall, the NE LHIN performance was ranked seventh amongst the 14 LHINs, which is indicative of the performance gap across the province. Across Ontario there is an average of 70,000 MRI scans per month and a wait list of over 170,000. In the NE LHIN, there is a gap of approximately 26,000 (difference between volume of scans completed and patients waiting). In the NE LHIN, the least urgent MRI scans (priority 4 scans), represent over 86% 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.

Indicator #16: Diagnostic Imaging – Computed Tomography (CT) Imaging: At 83.25%, performance has not met target (90%). High demand for CT scans is a key factor in driving wait time performance. In the past year, the NE LHIN funded additional CT hours in order to provide more scans for Northerners and has worked with several hospitals to increase the number of CT scanners in the region.

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

Indicator #17a: Wait times from application to eligibility determination for long-term care home placements: from community setting: Performance at 7 days is better than the provincial experience at 14 days.

Indicator #17b: Wait times from application to eligibility determination for long-term care home placements: from acute-care setting: Performance at 9 days is lower than provincial experience at 7 days, but represents a 1-day improvement relative to the previous year. 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 region, contributing to delays in eligibility determination.

Indicator #18: Rate of emergency visits for conditions best managed elsewhere per 1,000 population: There are about 6,500 of 112,000 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 38.94 visits per 1,000 residents compares to 12.06 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 do not exist across the NE LHIN region.

Indicator #19: Hospitalization rate for ambulatory care sensitive conditions per 100,000 population: The NE LHIN rate of 452 hospitalizations per 100,000 residents compares to 243 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.

Indicator #20: 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 38.19% compared to 47.31% 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.

During his first week as CEO of the NE LHIN, Jérémy Stevenson met with our Patient and Family Advisory Committee in North Bay (January, 2018). The committee brings valuable experience and insight to the LHIN table and is key to ensuring Northeastern Ontario's health care system is patient-centered. To date, Patient Advisors are involved in 12 northern initiatives.

Community Engagement

Community engagement is integral to all aspects of our work. Outcomes inform and guide work that helps to improve the patient experience, system performance, and population health.

Engagements incorporate the cultural diversity of our region and include: one-on-one discussions with health service providers and Northerners; focus groups, online surveys; community presentations; regular meetings with stakeholder-based committees; and active participation in community-led events.

The NE LHIN listens to patients, families and caregivers to ensure that changes in the health care system reflect the needs of the people we serve. In October 2017, we established a Patient and Family Advisory Committee (PFAC) made up of 18 individuals from across Northeastern Ontario who advise our CEO on how we can continue to build a more patient-focussed system of care in partnership with fellow Northerners.

Some highlights of our engagements in 2017/18 include:

- Seventeen engagement sessions with health system partners to refresh the **NE LHIN's strategic directions**. The resulting ***Priority Alignment Framework*** (see page 20) is guiding our health system transformation work and informing the development of our next strategic plan (Integrated Health Service Plan).

- A **Steering Committee** was established, made up of representatives from the NE LHIN's health system tables to help guide the development of our 2019-2022 Integrated Health Service Plan.

- Two all-day face-to-face meetings were held with our **Patient and Family Advisory Committee**.

- Fifteen **Community Health Recruitment and Education Events** to help educate Northerners on the services we offer and engage them in conversation about what they need to live healthy and well in their communities.

- **One Client One Plan (OCOP):** 96 engagements were held with stakeholders to gather feedback on the current state of home and community care and work towards creating a seamless experience for clients. In addition, more than 115 home and community care leaders from across our region spent two days looking at ways to improve the way clients and their families access and receive services. The "**Betty's Journey Workshop**," supported by the NE LHIN, led participants through the

experience of a composite client named Betty, as they identified challenges and ways to build a more seamless process to improve a client's experience when receiving home and community care services in the NE LHIN.

- Together with Health Quality Ontario we hosted the first **Inspiration to Action Forum** to celebrate ideas that have helped to change the delivery of care across Northeastern Ontario.

- **Collaborative Tables** were established around 14 Health Link communities. These are communities where health care, social service providers and other supports are supporting the patient in a more coordinated way.

- We partnered with the North West LHIN, Northern Ontario School of Medicine, and Health Force Ontario to develop a ***Summit North: Building a Flourishing Physician Workforce*** **conference,** held in Thunder Bay. The event brought together over 130 health system partners to focus on short and long-term solutions to build a sustainable physician workforce for Northern Ontario.

- A webinar was offered on the NE LHIN's focus for year one of ***Patients First*** -- delivering on home and community care and primary care to better support patients and their caregivers at a local level. The LHIN later released a one-year update on how we are progressing with the implementation of *Patients First.*

- **The North East Community and Specialty Hospital Working Group** met regularly. The group is comprised of CEOs from small hospitals across the region. It is a forum for communication and action among partners in relation to common issues, needs, and opportunities.

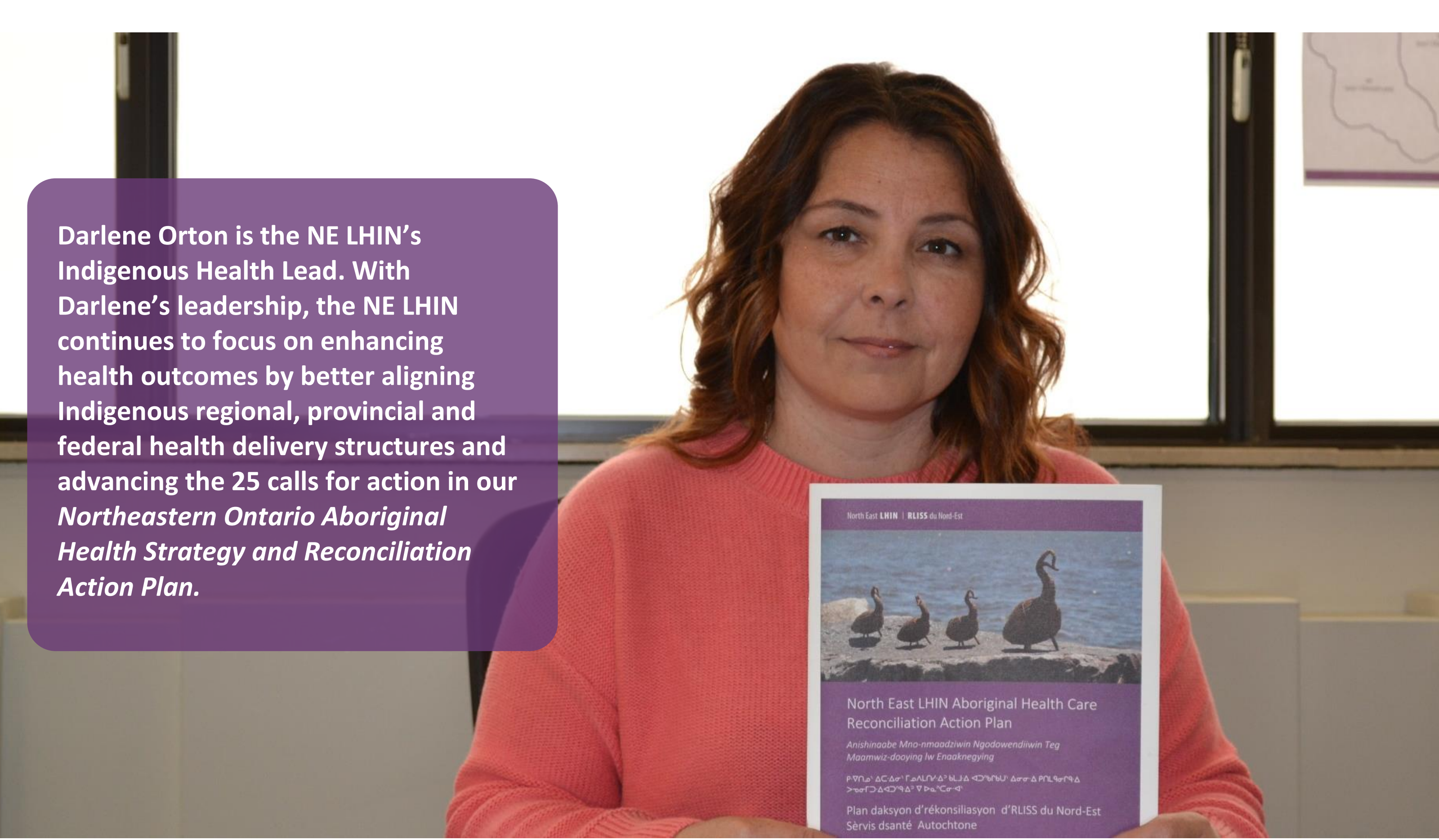
- **The North East Health System Advisory Committee** comprised of representatives from community hospitals, long-term care, community support services, and mental health and addictions networks, provides system-level strategic advice to the NE LHIN.

- Engagements were held to seek input from health service providers on the **Rapid Access Addiction Medicine (RAAM)** clinic model. Each sub-region established a task force to collaborate with partners to develop the model which was implemented to refer services to Northerners living with addiction issues.

NE LHIN CEO Jeremy Stevenson with Marie Leon (right), the chair of the Regional Home and Community Care Network, and Sherry Frizzell (left), NE LHIN Director, at the Betty's Journey Workshop in March. More than 115 home and community care leaders from across our region spent two days looking at ways to improve the way clients and their families access and receive services.

The NE LHIN is committed to an engagement process with Indigenous peoples that is respectful of language, nationhood, culture and spiritual beliefs. We continue 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. Highlights of engagements held in 2017/18 include:

- The **Local Aboriginal Health Committee (LAHC)** continued to advise the NE LHIN on health service priorities within Indigenous communities and held two face-to-face meetings.
- LAHC established an Indigenous Engagement sub-committee to develop a strategy to engage the Indigenous population across the NE LHIN region and focus on ensuring the proper protocols and alignments with First Nation priorities are respected.
- We collaborated with First Nations and Urban Indigenous members to establish an Indigenous-Led Health Committee to create formal linkages with the NE LHIN's sub-region Collaborative Tables.
- Members of the Provincial Aboriginal Lead Network (Indigenous Health Leads from Ontario's 14 LHINs) met with the Ministry of Health and Long-Term Care to discuss LHIN Indigenous Engagement & Inclusion Survey Results.
- We partnered with Maamwesying North Shore - Heath and Addition Services – to review the further spread of the Naandwe Noojimowin program across the region. The Naandwe Noojimowin program addresses intergenerational trauma.
- We implemented a cultural mindfulness program that supports cultural competency training for front-line health care providers and administrators who work across the region.
- The NE LHIN and Ministry of Children and Youth Services participated with the Ministry of Health and Long-Term Care on an Indigenous journey mapping exercise to identify health gaps and/or unidentified services for Indigenous children and youth.
- A tripartite committee was established to support Weeneebayko Area Health Authority's (WAHA) financial viability and clinical improvements. A strategy was developed to engage all coastal communities in strengthening the relationship between WAHA and the people it serves.
- LAHC advanced the 25 calls for action in the ***Northeastern Ontario Aboriginal Health Strategy and Reconciliation Action Plan*** and developed a scorecard to monitor and measure implementation.



Darlene Orton is the NE LHIN's Indigenous Health Lead. With Darlene's leadership, the NE LHIN continues to focus on enhancing health outcomes by better aligning Indigenous regional, provincial and federal health delivery structures and advancing the 25 calls for action in our *Northeastern Ontario Aboriginal Health Strategy and Reconciliation Action Plan.*

Community Engagement with Francophone Northerners

We work in partnership with the Réseau du mieux-être francophone du Nord-Est de l'Ontario and engage with French speaking Northerners on ways to improve access to care in their language of choice. More than 125,000 people living in Northeastern Ontario identify as a Francophone. Key highlights of engagements held in 2017/18 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.

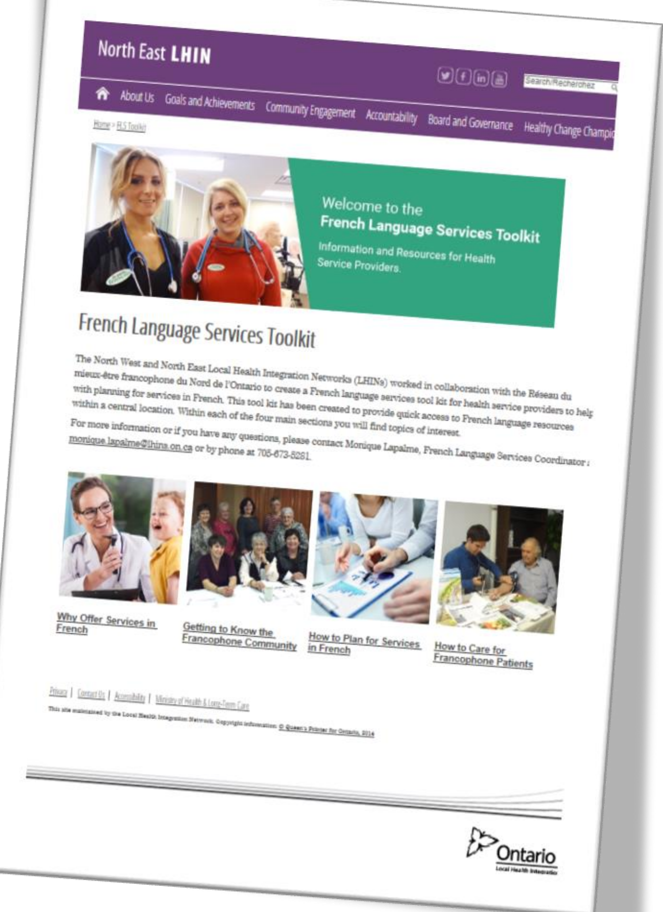
- Active participation of the Réseau in various health service provider tables across the region, including Home and Community Care, Mental Health and Addictions, sub-region tables, Regional Quality Table and Health Links.

- The LHIN-Réseau Liaison Committee and Working Group work collaboratively to improve the health outcomes of Francophones.

- The NE LHIN and the Réseau worked with the Timmins Primary Care Planning Collaborative Committee to develop a business case for the proposed, and later approved, Francophone Community Health Centre in Timmins.

- A review was conducted by the Réseau in collaboration with the NE LHIN and Long-Term Care administrators. The LTC study covered the challenges faced by Francophones who live in long-term care homes, the importance of culturally appropriate care, and provided examples of best practices gathered from long-term care homes across the province.

- The NW and NE LHINs, in collaboration with the Réseau, developed an online French Language Services (FLS) Toolkit to provide Northern health care providers with resources to help them better deliver quality health care services to Francophones.



- The Réseau and NE LHIN attended a French Language Health Services Forum, hosted by the Ministry of Health and Long-Term Care, which included opportunities to engage in discussions related to improving French Language Health Services across the province.

- The NE LHIN and the Réseau took part in a panel discussion, to present on our collaborative efforts in supporting French Language Health Services.

- The NE LHIN and the Réseau worked in partnership to plan and hold extensive community engagement sessions with Northerners as part of the NE LHIN's strategic plan development – Integrated Health Service Plan (IHSP), 2019-2022.

Ministry and LHIN Initiatives

Over the past year, through a series of internal and partner engagements, we developed a **Priority Alignment Framework** to strengthen our path to improve the patient experience across Northeastern Ontario.

Guided by the Ministry of Health and Long-Term Care's **four strategic directions** identified in the Patients First Act (2016) – **improve the patient experience, access, integration, and health equity** – the Framework ensures all of our efforts remain focused on the needs of Northerners and ensuring: **improved patient experience, system performance, and population health.**

Our current strategic plan – the Integrated Health Service Plan (IHSP) – has three priorities that we have been working on since 2016. They are each aimed at building a stronger system of care across the full continuum of what people need to live healthy and well – from birth to death. More details on our work to advance these priorities can be found on pages 24 to 38. Our current IHSP priorities include:

- **Improve access and wait times,**
- **Increase care coordination, and**
- **Strengthen system sustainability.**

Over the course of 2017/18, we engaged with system partners, internal stakeholders, and our Patient and Family Advisory Committee on how to re-focus our energies given the changing health care landscape and the fact that the NE LHIN became the largest home and community care service provider in Northeastern Ontario in 2017. Our **Renewed Strategic Direction** was then developed:

To improve the health of our population by building capacity to increase access to quality integrated care for Northerners, including Francophone and Indigenous people.

This renewed strategic direction reflects the deliverables in the Minister of Health and Long-Term Care's **Mandate Letter** which was delivered to the NE LHIN in the spring, 2017 (see pages 22 to 23).

The NE LHIN believes in working as closely to patients as possible with **concrete local priorities** in place to advance patient-centered care. These priorities are developed alongside system leaders in many Northeastern Ontario communities who sit together at a **Collaborative Table** and meet regularly. Collaborative tables have membership from the NE LHIN, health care partners, social service agencies, the police, public health, District Social Service Administration Boards and often patients or people with lived experience. Developed in partnership, these concrete local priorities address system gaps in the continuum of care at a community level. The NE LHIN's current **Concreate Local Priorities** include improving:

- **(System) Capacity**
- **Mental Health and Addictions**
- **Home and community Care**
- **Primary Care**
- **Digital Health**
- **French Language Services**
- **Indigenous Health.**

The outcomes of all of this work is found in our **Annual Business Plan, Community Level Plans and Measurable Indicators**. Our collective goal is to improve the Northeastern Ontario **patient experience, system performance and population health.**

North East LHIN Priority Alignment Framework

Patients First: 4 Provincial Strategic Directions

Patient Experience | Access | Integration | Health Equity

Integrated Health Service Plan Priorities (2016-2019)

- Improve Access and Wait Times
- Increase Care Coordination
- Strengthen System Sustainability

Renewed Strategic Direction (2018)

To improve the health of our population by building capacity to increase access to quality integrated care for Northerners, including Francophone and Indigenous people

Minister's Mandate Letter Priorities

Concrete Local PRIORITIES

1. Capacity
   - *Sub-Regions/Care Communities*
   - *Alternate Level of Care (ALC)*
   - *Integration (Internal/External)*
   - *Transportation*
   - *Long-Term Care*
   - *Population Health Strategies*
   - *Standardized Rehab Care*
   - *Dementia/BSO*
   - *Continuous Quality Improvement*
2. Mental Health and Addictions
3. Home and Community Care
4. Primary Care
5. Digital Health
6. French Language Services
7. Indigenous Health

Annual Business Plan

Community Level Plans (Develop a plan for each priority *(quarterly reporting placemat)*

Measurable Indicators: NE LHIN Performance and Quality Scorecard

Desired Outcomes: Improved Patient Experience, System Performance, Population Health

Minister's Mandate Letter Priorities

The Minister of Health and Long-Term Care provided the NE LHIN with a Mandate Letter in 2017 to guide our efforts in managing and strengthening the Northeastern Ontario health care system. The following are key highlights of the NE LHIN's work over the past year to meet the 10 priority areas identified in the mandate letter. More detailed descriptions of many of these projects can be found on pages 24 to 38.

Transparency and Public Accountability

- Quarterly **Ministry-LHIN Accountability Agreement (MLAA)** performance indicators are posted on the NE LHIN website.
- Patients and families can review **wait times for each long-term care home** – updated monthly on the NE LHIN website.

Improve the Patient Experience

- Established **a Patient and Family Advisory Committee** (PFAC), made up of 18 Northerners with 2-3 members per sub-region, including a youth advisor.
- PFAC **Advisors** are involved in more than 12 NE LHIN initiatives to improve the patient experience.
- PFAC developed year 1 **priorities and a work plan**.
- Developed a **patient story process** which includes stories told to our Board and Senior Leadership Team each quarter and an annual report back on resulting outcomes.

Build Healthy Communities Informed by Population Health Planning

- Participate in regular meetings with the **region's five Public Health Units**
- Established **five sub-regions** and aligned staff to ensure more localized and tailored health system transformation.
- Identified 35+ **care communities** around patients to improve access to health and social services close to home. A care community is "a network of health and social service providers working together to integrate care for each person."
- Applying **population health and health equity** principals to recognize the unique needs of each care community and the mix of services required to best serve the people of each care community.

Equity, Quality Improvement, Consistency and Outcomes-Based Delivery

- Held first **Inspiration to Action Forum** to celebrate ideas that have helped to change the delivery of quality care across Northeastern Ontario.
- Worked with Health Quality Ontario, the North West LHIN, public health units and other partners to create a **Northern Health Equity Strategy.**

Primary Care

- Working to improve transitions of care by more closely **linking care coordinators with primary care providers**. Early adoption is focused in the Nipissing-Temiskaming sub-region and communities in other sub-regions with a limited number of primary care providers.
- Worked closely with community partners and the Ministry of Health and Long-Term Care to develop submissions for **interprofessional primary care** teams and Indigenous interprofessional primary care teams across the region, resulting in the approval of new family health teams for Mattawa and Kapuskasing, a new nurse practitioner-led clinic (NPLC) to serve White River/Pic Mobert First Nation, an NPLC to bring together the existing six nursing station in the Parry Sound area and new models of care to serve Temiskaming Indigenous communities, the Mushkegowuk Tribal Council members living in the James and Hudson Bay Coastal communities, and the Taykwa Tagamou First Nation in the Cochrane area.
- Dr. Paul Preston is the NE LHIN's VP of Clinical who works with the LHIN's regional clinical leads – Emergency Department, Critical Care and Palliative Care Leads –as well as with the LHIN's Primary Care Clinical Leads based in four of the sub-regions. Clinical Health Leads are primarily physicians and specialists who work part time at the NE LHIN, in addition to their regular practice, to improve clinical health care for Northerners.

Hospitals and Partners

- The **ONE** Health Information System renewal project is a joint initiative of the North East LHIN and the 24 acute-care hospitals in the region. This renewal project is helping to create a platform for a high-performing, patient-centred health care system in the Northeast.
- The boards of Englehart and District Hospital and Kirkland and District Hospital **amalgamated**, creating a new health service provider with a single governance and management model.
- Implemented an ALC Avoidance Framework to improve ALC rates and patient flow at the hospital.
- Supported **20 energy efficiency projects** at 15 NE LHIN hospitals through the Hospital Energy Efficiency Program.
- Worked with **collaborative tables and 14 Health Links regions** to strengthen the coordination of care for Northerners and build health care capacity.

Specialist Care

- **Musculoskeletal (MSK)** eReferral: A two-day workshop was held in February to begin planning for implementation of electronic referrals to orthopedic specialists and neurosurgeons. The MSK initiative will improve outcomes for patients with persistent or unmanageable recurrent low back pain and better connect patients and primary care to specialists.
- Between January 2015 and December 2017, the North East LHIN recorded the second-highest number of eConsults sent of the 12 LHINs participating in the project. eConsults allow physicians and nurse practitioners to engage in a secure, electronic dialogue with specialists to manage patient care, without the need for a patient visit with the specialist.

Home and Community Care

- **Reduced wait times** for occupational and physiotherapy by 36%.
- Laid ground work to implement **Family Managed Care**. Family Managed Care means that patients or their families receive funding directly to pay for home care services, which provides flexibility and choice.
- Brought home and community care partners together to launch the **One Client One Plan** to improve client experience. The project includes developing a single point of access for clients, a standard process to identify services, removing duplication in home and community care assessments, and creating a standard approach to coordinate services.
- Developed **PSW capacity** through initiatives including Client-Partnered Scheduling" (also known as windows of time). This involves scheduling visits for a block of time (e.g., "morning" or "early morning" / "late morning") for visits where it is not clinically necessary for a visit to occur at a specific time.
- For additional information please see pages 33 to 34.

Mental Health and Addictions

- Launched Regional Opioid Strategy, bringing **RAAM clinics** to four communities with outreach capacity to many more.
- **Increased access to mental health counselling** in Hearst, Kapuskasing, and Smooth Rock through a partnership with Hornepayne Community Hospital.
- Supported the creation of Indigenous mental health and addiction programs along the North Shore.
- Worked with partners to increase access to psychiatric beds for people living in James Bay Coastal communities.

Innovation, Health Technologies and Digital Health

- Supported the **expansion of virtual care** through the Ontario Telemedicine Network (OTN). The NE LHIN has the highest number of sites (264) and highest number of active systems (498) in the province.
- The NE LHIN, Hospital Pharmacy Peer Group (HPPG) and the Ontario College of Pharmacists (OCP) collaborated on a joint **Pharmacy Strategy** to support NE LHIN hospitals in collectively providing medication management services according to standards set by the OCP. The vision of the HPPG is, "By 2025, the NE LHIN hospital pharmacies will be fully automated with integrated technology and staffed with registered professionals (either on site or virtual)."

Selected Highlights of Progress on Three NE LHIN Priorities

The following pages (24 to 38) provides select highlights of our work to advance our current Integrated Health Service Plan (IHSP) priorities over the past year. **Our efforts to improve the patient experience, system performance and population health for people living in Northeastern Ontario is found under three priorities: *improve access and wait times*, *increase care coordination*, and *strengthen system sustainability*.** These priorities were developed in partnership with fellow Northerners, more than 4,000 of whom contributed to the development of our 2016-2019 strategic plan (IHSP). For a more fulsome account on our work to advance each priority, visit www.nelhin.on.ca.

Improve Access and Wait Times

Home and Community Care services provided to over 17,000 people across Northeastern Ontario on any given day

Wait times for occupational therapy and physical therapy reduced by 36%

27,200

Hours of service received by 3,120 palliative patients and their caregivers through 9 volunteer hospice visiting programs across Northeastern Ontario

89% of people registered with Health Care Connect now have a primary care provider, up from 86% in 2017

34,800 hips, knees, and shoulders have been assessed by the NE LHIN Joint Assessment Centres

Increase Care Coordination

Assisted living spaces added throughout the region

Seniors supported in their safe transition from hospital to home (PATH Program)

More coordination of primary care for Northerners through 14 Health Links and Local Collaborative Tables

70 home and community care agencies working together so that Northerners will more easily be able to access coordinated home care

Strengthen System Sustainability

Northerners have benefited from Telehomecare to better self-manage their COPD or heart failure

800 Health professionals received cultural safety/cultural mindfulness training

3,000 Northerners have benefited from Telehomecare

Older adults participating in 300 free exercise and falls prevention classes

43

Health Service Providers designated under the French Language Services Act, and 55 identified HSPs in different designation planning stages

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. This could include care 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 select highlights speak to our work to move this priority forward over the past year.

Increasing Access to Assisted Living – Meet Renée

Renée Loyer at Independence Centre and Network (ICAN) where she receives assisted living services that is supported by the NE LHIN.

The Independence Centre and Network (ICAN), is a NE LHIN funded community-based health service provider. These providers, found in many Northeastern Ontario communities, deliver front-line care that help Northerners to live healthy, productive, and independent lives for as long as possible.

ICAN offers several housing options that provide support services 24 hours a day, for people with disabilities as well as seniors. Renée Loyer has been an ICAN client for more than a decade. Through the program, she manages her own lifestyle, and trained support staff are available to help with personal care needs and homemaking.

Investing in access to assisted living has been a NE LHIN focus over the last several years. Since April 2016, 107 new spaces have been added across the region and more than 1000 Northerners are now benefiting from this much needed community-based service.

Increasing Access to Mental Health and Addictions Services – Meet Alicia

Alicia Reid was prescribed morphine to help her cope with severe abdominal pain. What was supposed to be a temporary prescription turned into a physical dependency that lasted for more than three years.

In January 2018, Alicia shared her story as the NE LHIN launched its Opioid Strategy, with a total of $1.65 million in base funding being invested across Northeastern Ontario to increase access to treatment and care coordination closer to where Northerners live.

The new funding created **Rapid Access Addiction Medicine (RAAM) Clinics** and provided an addictions treatment pathway between the clinics and places where clients are likely to seek care such as emergency departments, primary care providers, mental health and addiction agencies, and withdrawal management programs.

At the launch of the NE LHIN Regional Opioid Strategy in January, Alicia Reid shared her story of how the Sudbury Rapid Access Addiction Medicine (RAAM) Clinic in Sudbury helped her. New RAAM clinics have now also been established in North Bay, Timmins, Sault Ste. Marie, with access to outlying communities.

For people like Alicia, the strategy and investments are making it easier to get help and treatment for opioid addictions. After being referred by her physician to a RAAM clinic, Alicia was able to transfer to suboxone and successfully withdraw from morphine.

Four of the NE LHIN's sub-regions received $200,000 to establish a RAAM clinic and $130,000 to enhance withdrawal management and addiction counselling. In addition, support was provided to Health Sciences North (HSN), as the lead agency for research, data collection/analysis, and evaluation.

Supporting Culturally Appropriate Care for Indigenous Northerners

Our work to advance the strategic directions identified in ***Northeastern Ontario's Aboriginal Health Care Strategy and Reconciliation Action Plan*** continues. First-launched in 2016, the Reconciliation Action Plan has 25 calls to action.

To date, more than 800 health professionals in Northeastern Ontario have received cultural safety training through an eight-week online training course, and cultural mindfulness sessions. This training helps health care workers learn about the history of Indigenous peoples in Canada, the legacy of residential schools, and approaches that will help them deliver health services in a culturally safe manner.

Increasing access to culturally-appropriate care is another call to action of the Reconciliation Action Plan. Last year, we supported the Naandwe Noojimowin (formerly Beauty for Ashes) program, a five-day residential treatment program that helps participants address the effects of domestic violence, childhood trauma, and inter-generational trauma. Administered by Maamwesying North Shore Community Health Services, the program provides services to seven First Nations communities and the urban Indigenous population of Sault Ste. Marie, representing about 15,500 First Nation and Métis people.

Kelly Jeffords is a resident of Serpent River First Nation and a facilitator with the Naandwe Noojimowin residential treatment program—formerly known as Beauty for Ashes. "There comes a time when we should all revisit some of our past history and look at how it has impacted us as an adult. Beauty for Ashes is an intense residential program, but it takes place in a safe environment," said Kelly.

Johanne Labonté, NE LHIN French Language Lead (left) and Sylvie Sylvestre, Cochrane Region Officer with the Réseau du mieux-être francophone du Nord de l'Ontario. The NE LHIN works closely with the Réseau to help meet the health care needs of the 125,000 Northerners who identify as Francophone.

Increasing Access to French-Language Services in Health Care

About 125,000 French-speaking people live in Northeastern Ontario - 23% of the region's total population. The NE LHIN works in partnership with the *Réseau du mieux-être francophone du Nord de l'Ontario* to help increase access to health care services in French. This past year, we worked together to actively promote the 'Active Offer' of French Language Services and are working with over 50 health service providers who are planning to offer services in French.

Currently, 43 health service providers in the Northeast are designated to provide French language services under the French Language Services Act. Having a designation means that a health service provider is capable of providing French language services that meet criteria set by Ontario's Office of Francophone Affairs. Francophone patients can feel confident that designated providers are able to offer services in French and best meet their health care needs.

Working collaboratively with the Réseau, and the North West LHIN, we developed a joint work plan to improve access to quality health services in French. We undertook a data-gathering exercise using a French Language Services Reporting Tool. The tool was used by hospitals, home and community care, mental health and addictions services, community health centres, and long-term care homes to determine how many French-speaking people were using their services and each organization's capacity to provide French language services.

The NE LHIN also supported the Timmins Primary Care Planning Collaborative, which was chaired by a member of the NE LHIN Board of Directors. The Collaborative worked to develop a business case for a Francophone Community Health Centre in Timmins which was then approved in the Spring of 2018. A new Timmins Francophone Community Health Centre will connect Francophones in Timmins and the surrounding area with a range of health care professionals and French-language services. Work is now underway to support this new model of care for Francophone Northerners.

Increasing Access to Primary Care

This past year, extensive work took place to increase primary care options for Northerners. The NE LHIN worked closely with community partners and the Ministry of Health and Long-Term Care to develop submissions for interprofessional primary care (IPC) teams across the region. Team-based health care clinics empower patients and their families and encourage them to be active participants in living healthy lives. The teams serve patients living in areas that have historically had less access to primary health care services. These efforts resulted in:

- New family health teams for Mattawa and Kapuskasing.
- A new nurse practitioner-led clinic to serve White River/Pic Mobert First Nation.
- A nurse practitioner led clinic to bring together the existing six nursing stations in the Parry Sound area.
- Interprofessional primary care investments through existing nurse practitioner led clinics to serve marginalized patients in North Bay and Sudbury
- A Francophone community health centre in Timmins.
- Enhancements to the Wasauksing First Nation nursing station and Noojmowin-Teg Aboriginal Health Access Centre.
- New models of care to serve Temiskaming Indigenous communities, the Mushkegowuk Tribal Council members living in the James and Hudson Bay Coastal communities, and the Taykwa Tagamou First Nation in the Cochrane area.

Increasing Access to End of Life Care

Hospice beds in 17 Northeastern hospitals have been opened. The one-bedroom hospice suites provide patients and families with compassionate palliative care in a home-like setting.

The beds are located in communities where there has been limited availability of access to hospices or palliative beds. These beds give rural patients more access to expert care, including nursing, social work, and personal support services, as well as help to support families and friends during a difficult time.

The hospice suites are located in the following communities: Blind River; Chapleau; Cochrane; Elliot Lake; Espanola; Hearst; Hornepayne; Iroquois Falls; Kapuskasing; Little Current; Matheson; Mattawa; Mindemoya; Smooth Rock Falls; Sturgeon Falls; Timiskaming Shores; and Wawa.

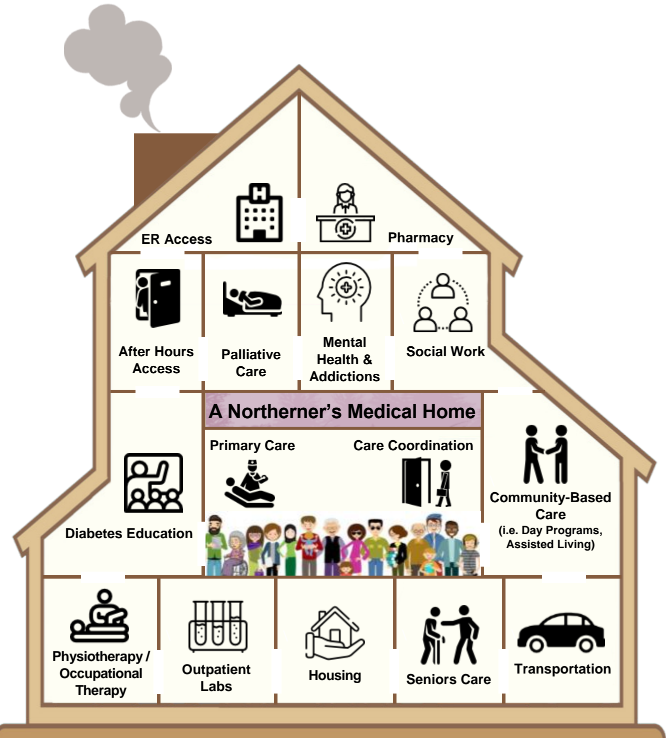
The one bedroom hospice suite at Lady Dunn Health Centre in Wawa. The 17 new hospice suites across Northeastern Ontario are providing a compassionate palliative care environment to 250 patients and families each year.

Priority #2: Increase Care Coordination

Throughout NE LHIN engagements, Northerners have said they want to be cared for at home, with supports, for as long as possible and in a hospital or long-term care home only when necessary. Supporting patient-centred care across the health care continuum - from birth to death - is helping Northerners navigate the system and coordinate the services they need. The following are select highlights of initiatives underway to help move this priority forward.

Coordinating Localized Primary Care for Northern Patients Close to Home

The NE LHIN is working with local and provincial partners to realize a vision of creating an integrated health care system that delivers world-class patient care and ensures equitable access to health services. This vision sees each Northerner having their own **"Medical Home"** that is tailored and appropriate for their health needs. As noted in the diagram to the right, this home relies on strong linkages between primary care (a person's family physician or nurse practitioner) and home and community care coordination.



Care communities: All Northerners should have access to primary care and related health and social services close to home regardless of where they live. Therefore we need to plan health care at the community level.

The NE LHIN has identified 35+ care communities, based on a half hour travel time for residents in a given area to access primary and other care. Ultimately, Care Communities will become "a network of health and social service providers working together to integrate care for each person." This definition includes primary care, allied health services (social workers, pharmacists etc.), and related programs such as diabetes education, housing and transportation.

The NE LHIN is applying population health and health equity principals to recognize the unique needs of each care community and the mix of services required to best serve the people who live there. Engagement with community members is occurring throughout 2018 to successfully plan for care communities.

Ten Pillars of the Patient's Medical Home*

1. Patient-centred care
2. Personal family physician
3. Team-based care
4. Timely access
5. Comprehensive care
6. Continuity of care
7. Electronic medical record
8. Education, training, and research
9. Evaluation and quality improvement
10. Internal and external supports

** College of Family Physicians of Canada*

Optimizing Care Coordinators with Primary Care: To build Medical Homes for Northerners, we are working on forging stronger links between home and community care and primary care providers. Our goal is to ensure smooth transitions of care between home and community care and other health and social services as required. This past year, we focused on the Nipissing-Temiskaming sub-region and communities in other sub-regions with a limited number of primary care providers.

Ensuring Care Coordination for Complex Patients with Health Links: In the North East, there are now 14 Health Links in various stages of development and more than 1,700 Northerners have benefitted from coordinated care plans. Health Links are designed to help the 7% to 9% of patients in the North East who have multiple, complex conditions and are high users of the health care system. The model also focuses on vulnerable populations such as the frail elderly, palliative patients, and people with mental illnesses. Health Links allow for more coordinated care for patients as providers (including health and social services) work as a team to meet a patient's needs.

The geographic areas covered by the 14 Health Links regions also align with our Sub-Region Collaborative Tables, and roll-up to our 5 Sub-Regions. Leaders of health and social services organizations in the 14 regions have demonstrated dedication and commitment to work together with a "broad systems lens" to build capacity for Northerners. Common quality improvement initiatives are being identified by the Sub-Region Collaborative Tables, with a focus on strengthening mental health and addictions services, home and community care services, and access to primary care at a local level.

Medical Assistance in Dying (MAID): Following the Supreme Court of Canada's recognition of Medical Assistance in Dying (MAID) as a constitutional right, people who find themselves suffering with a serious illness, disease or disability, and are in an advance state of decline that cannot be reversed, have additional options to manage their suffering. MAID allows physicians and nurse practitioners to help patients, who have given informed consent, to end their lives after a thorough assessment of their health.

As part of the NE LHIN's work to ensure an equitable distribution of primary care services across the region, the NE LHIN facilitated training for primary care providers – physicians and nurse practitioners – to deliver MAID. Patients requesting MAID must be assessed by two independent physicians or nurse practitioners to determine their eligibility for the service. Physicians and nurse practitioners are the only medical professionals who can assess for eligibility, or prescribe or administer MAID.

Coordinating Home and Community Care

The NE LHIN continues to work with its health service providers and other partners to provide more programs and services to allow people to be cared for at home or in community for as long as possible. The NE LHIN is both a planner and funder of home and community care, as well as the largest direct service provider in Northeastern Ontario, delivering care to more than 17,000 Northerners of all ages. With about 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:

- **One Client One Plan (OCOP)** is a partnership project bringing together the region's 70 home and community care providers, with core team members that include the Independence Centre and Network, March of Dimes Canada, and the NE LHIN. The vision is to deliver a consistent approach to care planning for clients with all providers within a client's circle of care. With OCOP, the client experience will be improved when accessing care, as they will be informed of, and connected to, services based on their identified care needs. Clients will tell their story once and add to their story as their needs change. Ultimately the goal is to transform home and community care services into one cohesive system. Elements of the project include developing a single point of access for clients, a standard process to identify services, removing duplication in home and community care assessments, and creating a standard approach to coordinate services.
- **Providing greater flexibility and choice for clients and caregivers with Family Managed Care (FMC):** The LHIN began training care coordinators to deliver FMC in March of 2018 as well as identifying 20 potential clients who might be a good fit for the program. Providing greater flexibility and choice, eligible patients or their families can receive funding directly to pay for home care services. They become responsible for the related administrative tasks, such as finding, hiring and paying service providers.
- **Investing in more Assisted Living throughout the region:** The NE LHIN worked to support high risk seniors by increasing capacity in the system with 107 more assisted living spaces (since April 2016). Assisted living offers both scheduled and unscheduled visits to seniors living in their own home or at a residence operated by health service providers.

- Expanding **Priority Assistance to Transition Home (PATH)** program across the region. PATH has provided the services and supports needed to help over 6,000 seniors get home safely from hospital. In the past year, PATH has been rolled out to most communities across the region with a hospital.
- **Building Personal Support Workers (PSW) capacity to meet the needs of Northerners now and in the future:** The NE LHIN and other areas of the province are experiencing a shortage in available Personal Support Workers (PSWs). We are working with our partners to develop more capacity within this vital workforce so that we can meet the needs of Northerners. The NE LHIN is undertaking several initiatives to develop PSW labour capacity including: holding 15 recruitment and information events for providers and the public in March, moving to a “Client-Partnered Scheduling” framework with contracted service provider organizations scheduling visits in two-hour windows of time rather than at specific times which has increased capacity, and developing a pilot project with a long-term care home.
- **Connecting people to care online:** 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 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. NorthEastHealthline.ca also provided updated information and is used as a resource by Northerners, NE LHIN staff, and health service providers. It receives a lot of traffic with 76,000 page views per month.

Transforming Hospital Care for Patients with ONE

ONE is a project that involves the NE LHIN and 24 hospitals. The project vision is a “one person, one record, one system” that will use common technology, an integrated electronic medical record system, and clinical standards based on hospital best practices. ONE is about improving and saving lives and increasing positive health outcomes for patients.

When ONE is fully implemented, patients and care providers will benefit from a world-class system, as 24 Northeastern Ontario hospitals become one of only a few regional health care networks to use a single Health Information System. For Northerners, this means the delivery of coordinated hospital care. Each patient’s health record will be privately and securely shared when they move to another hospital or to a different department within the same hospital.

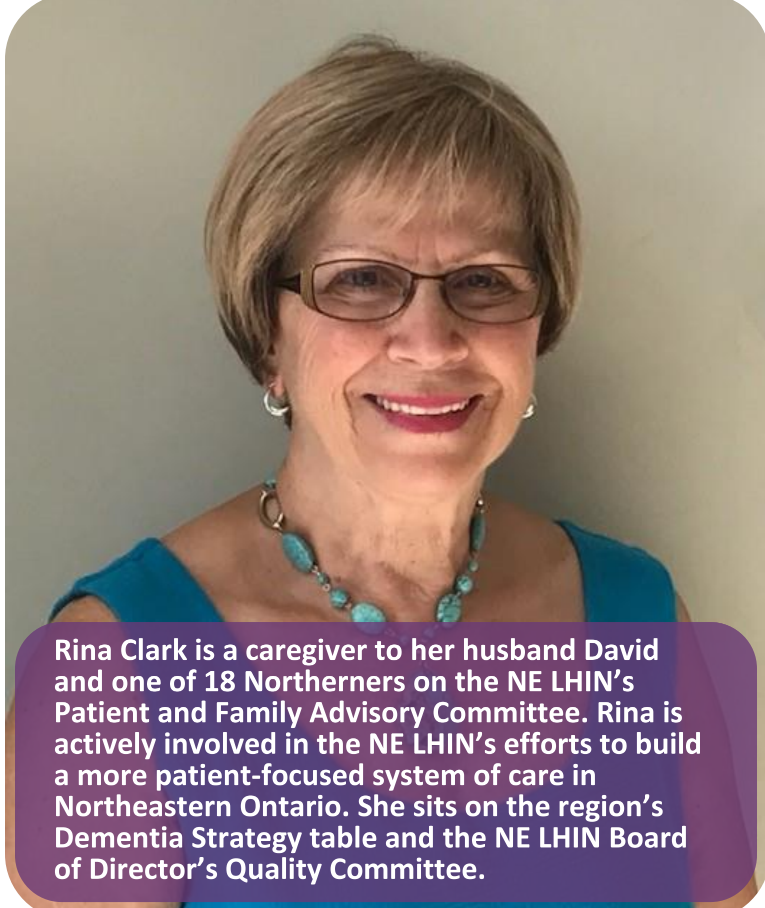
Jeremy Stevenson, North East LHIN CEO (left) and Gary Sims, Executive Sponsor to the ONE Initiative (also President and CEO of Blanche River Partnership). ONE brings together 24 hospitals in Northeastern Ontario with an integrated electronic medical record system.

ONE will help medical professionals in our Northeastern hospitals deliver high-quality and safe care, by keeping them up-to-date with important patient information. With one record per person, patients won’t be asked to tell their story over and over again or repeat unnecessary tests. A complete and accurate record will follow them throughout their care journey.

This past year, ONE started its first wave of transforming patient care, beginning with the creation of a new Health Information System at North Bay Regional Health Centre, Sault Area Hospital, and West Parry Sound Health Centre.

Increasing Support for People Living with Dementia and Their Caregivers – Meet Rina

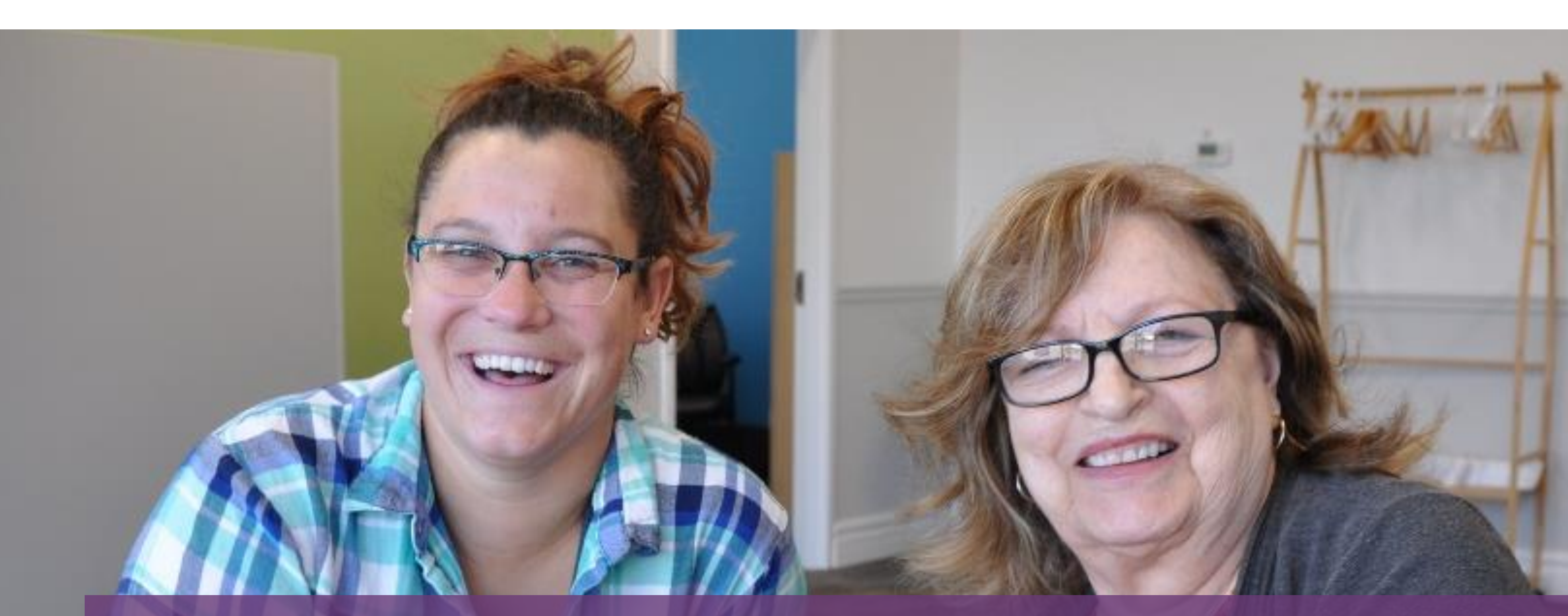
Rina Clark knows how life-altering a dementia diagnosis can be. The Sault Ste. Marie woman has been a caregiver and advocate for her husband, David, since he was diagnosed with Alzheimer's 13 years ago. Rina speaks publicly about her experiences and is a member of our inaugural Patient and Family Advisory Committee.


Rina Clark is a caregiver to her husband David and one of 18 Northerners on the NE LHIN's Patient and Family Advisory Committee. Rina is actively involved in the NE LHIN's efforts to build a more patient-focused system of care in Northeastern Ontario. She sits on the region's Dementia Strategy table and the NE LHIN Board of Director's Quality Committee.

Having access to high-quality care is an essential part of the dementia journey. To help facilitate the delivery of that care across the region, the NE LHIN provided support to the North East Specialized Geriatric Centre (NESGC) as they led the development of a North East Dementia Strategy. With Rina's help, the strategy is improving the system of care and supports for people living with Alzheimer's or related dementias.

Work on the strategy is a collaborative effort guided by the North East Dementia Strategy Steering Committee which includes many partners, including Rina.

In the fall of 2017, as part of Year 1 of the Ontario Dementia Strategy, the NE LHIN supported the expansion of Behavioural Supports Ontario programming in long-term care across the region. North East Behavioural Supports Ontario (North East BSO) is part of province-wide work to help improve the quality of life for people living with dementia and their care partners by helping to manage responsive behaviours. The expansion supported positions at an additional 13 long-term care homes and now there are 87 front-line BSO staff working across the region in long-term care, hospitals, and community agencies.


Recreational Therapist Lisa Ritchie (left) and client Jackie Johns (right) playing Jenga as part of a recreational therapy session at the Alzheimer's Society of Sault Ste. Marie office. The One Client One Plan project will help home and community care clients like Jackie receive more seamless care and be able to more easily navigate the system to get the care she needs.

Priority #3: Strengthen System Sustainability

A sustainable Northeastern Ontario health care system works to improve the lives of Northerners today and for generations to come. It is a system driven by what is right for patients and improving quality and efficient care while being financially responsible. It focuses on the health and wellness of people along the full continuum of care. The following pages include select highlights of work underway to advance this priority.

Northern Health Equity Strategy

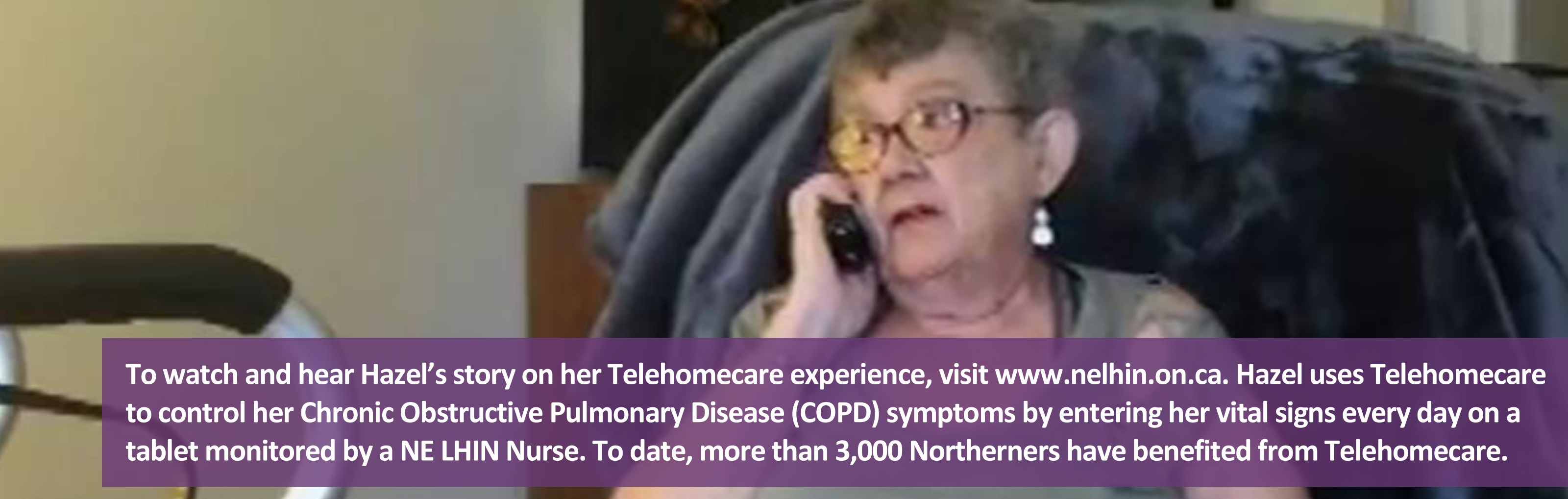
Northern Ontario has unique health challenges, largely due to our geography, dispersed population and overall health status. We also know that Northerners are more likely to have worse health outcomes and die earlier, compared to residents living elsewhere in the province.

To address these inequities, we collaborated with the North West LHIN, Health Quality Ontario, public health units and Northerners to develop the region's first ***Northern Ontario Health Equity Strategy.***

Developed by the people of the North, for the North, the strategy identifies four foundations for action to improve health equity in Northern Ontario:

- address social determinants of health
- equitable access to high-quality and appropriate health care services
- Indigenous healing, health and well-being
- and evidence availability for equity decision-making.

The central recommendation of the strategy is to create a **Northern Ontario Health Equity Network** to ensure consistent collaboration to effect real change in the persistent health inequities of the North. In order to effect the change needed, the Network is required to bring together the combined strength of key partners – public health, municipalities, LHIN, Indigenous organizations and authorities, educational and research institutes, Francophone organizations, provincial and federal ministries, agencies, the business community and community organizations and members – and seize the potential to improve the health of people living in Northern Ontario. Key clinical health priorities include **mental health and addictions**, **diabetes prevention and management**, and **parental and child health.** The Northern Network for Health Equity is aligned with our mandate to convene cross-sectoral tables, and would also support the current movement towards greater collaboration between public health units and our LHIN.



To watch and hear Hazel's story on her Telehomecare experience, visit www.nelhin.on.ca. Hazel uses Telehomecare to control her Chronic Obstructive Pulmonary Disease (COPD) symptoms by entering her vital signs every day on a tablet monitored by a NE LHIN Nurse. To date, more than 3,000 Northerners have benefited from Telehomecare.

Telehomecare – Meet Hazel

Senior Hazel Mcgee doesn't have a computer or a cellphone, however entering her vital signs every day on a tablet, as a way to control her Chronic Obstructive Pulmonary Disease (COPD) symptoms has been a breeze. She's also breathing a bit easier now too thanks to the NE LHIN's Telehomecare program. "It helps me take charge of my health," said Mcgee. "I was scared at first but it is very simple to do and if there is something wrong, Lisa (her Telehomecare nurse) checks it right away and gets back to me."

Telehomecare supports patients with COPD or Chronic Heart Failure (CHF), using remote monitoring equipment to connect with a NE LHIN nurse who monitors a patient's health and provides regular health coaching sessions. Patients gain confidence and learn to take control of their health while staying at home. If their primary care provider chooses, Telehomecare will also send their physician or nurse practitioner regular updates.

The NE LHIN has the highest amount of patients served – 528 this past year and more than 3,000 since 2012. Statistics show about an 80% decrease in emergency department visits by patients using the program and a reduction of hospital admissions of about 78%.

Improving Access to Long-term Care Beds

One in ten residents of Northeastern Ontario who are older than 75 live in a long-term care home. To help ensure that long-term care patients are receiving quality care and better access to services, 19 long-term care homes in the NE LHIN will be redeveloped by 2025. These redevelopments will bring facilities up to the latest standards and allow for the opportunity to enhance access to short stay and respite beds, part of on-going efforts to decrease waitlists and divert patients from alternate level of care (ALC) beds.

In February 2018, we worked with numerous long-term care homes in Northeastern Ontario to help them submit applications for new or redeveloped beds. The call for applications was made under the Government of Ontario's *Aging with Confidence: Ontario's Action Plan for Seniors*, with the goal of adding 5,000 new long-term care beds across the province by 2022. The result of these applications was that 232 new beds were approved for long-term care homes in our Northeastern Ontario region.

This additional long-term capacity will help more Northerners receive quality care close to home, notably in places like Moosonee which will now have a long-term care home for the first time.

Long-Term Care Home	Community	# of New Beds
Mauno Kaihla Koti	Sault Ste. Marie	68
Extendicare (Canada) Inc.	Sault Ste. Marie	20
Waters Edge	North Bay	12
Extendicare York	Sudbury	54
Temiskaming Lodge	Haileybury	46
Weeneebayko Area Health Authority	Moosonee	32

eConsult

Northeastern Ontario patients and medical practitioners have been benefitting from a new program that makes it easier to get advice from medical specialists anywhere in Ontario. eConsult enables physicians and nurse practitioners to engage in a secure, electronic dialogue with specialists to manage patient care, without the need for a patient visit with the specialist. This helps patients save the expense and stress associated with travel, while physicians and nurse practitioners get answers sooner and reduce the number of unnecessary referrals.

According to statistics from OntarioMD, the NE LHIN has had the second-highest number of eConsults sent of 12 participating LHINs (1,600 between January 2015 and December 2017).

More than 100 specialties are accessible through eConsult. The average time for an eConsult request to be answered is just over two days, and the turnaround time can be as little as four hours, resulting in timely, quality care for Northerners.

Right Place of Care for Northerners

In March 2017, the NE LHIN hired a Patient Flow Lead to support NE LHIN hospitals in implementing our Alternate Level of Care (ALC) Avoidance Framework. The Framework provides a road map of ALC avoidance strategies and practices that have been shown to be effective for hospital teams who are working to get their patients to the right place of care. For Northerners, this means that fewer hospital beds will be occupied by patients who could be better treated in another setting, leading to less over-crowding in hospitals.

A patient becomes ALC when they have completed their treatment in a hospital but are unable to be moved to their next place of care, such as a long-term care home. ALC patients remain in hospital even though they no longer need that level of care and could be successfully treated elsewhere.

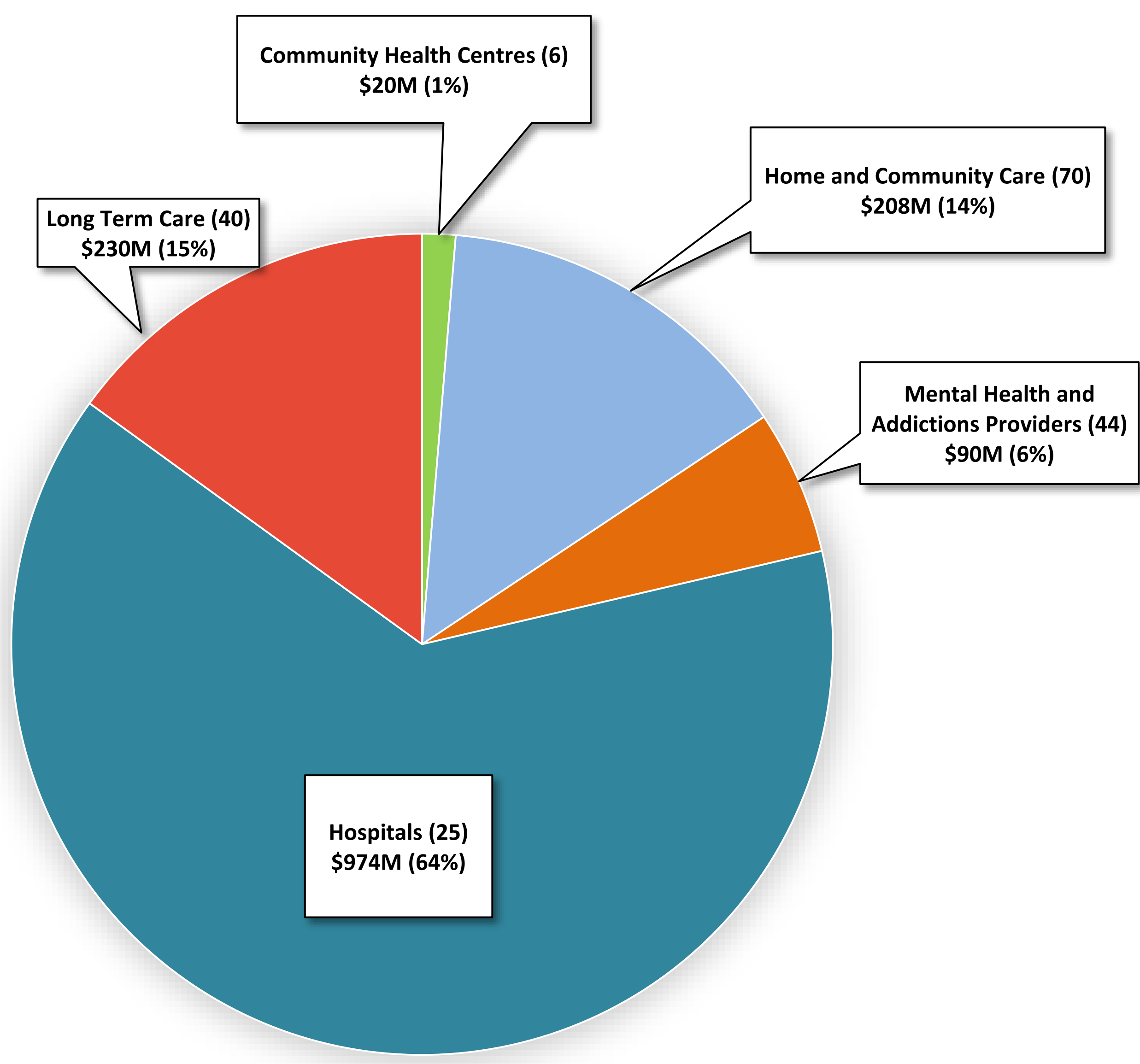
The NE LHIN is working with the region's larger hospitals to improve patients' access to care, and their flow through the health care system, with a first-year emphasis on improving ALC rates at Health Sciences North (HSN) in Sudbury. These efforts have led to notable improvements at HSN. In November and December 2017, there were on average 30 fewer ALC patients at the hospital compared to the same time in 2016.

Analysis of LHIN Operational Performance

The NE LHIN ended the 2017/18 year in a balanced position. In 2017/18, we provided $1.4 billion dollars to 144 Health Service Providers who deliver more than 200 programs and services across Northeastern Ontario.

Staff work out of 20 local offices across Northeastern Ontario, enabling 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 directs patient-focussed investments to improve patient care and advance more coordinated services at the community level.

Funding by Sector, 2017/18



Financial statements of North East Local Health Integration Network

March 31, 2018

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Statement of financial position 2
Statement of operations 3
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Statement of cash flows 5
Notes to the financial statements 6–14

Deloitte.

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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, 2018, and the statements of operations, changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2018, and the results of its operations, changes in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 6, 2018

North East Local Health Integration Network
Statement of financial position
As at March 31, 2018

	Notes	2018	2017
	3	$	$
Assets			
Current assets			
Cash		**18,364,763**	565,035
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Transfer payments)		**5,907,319**	15,757,699
Accounts receivable		**684,387**	95,069
Prepaid expenses		**222,123**	39,913
		25,178,592	16,457,716
Capital assets	7	**1,103,200**	155,347
		26,281,792	16,613,063
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**16,865,328**	700,017
Due to Health Service Providers ("HSPs")	15	**5,907,319**	15,757,699
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**2,370,614**	—
Deferred contributions		**19,153**	—
		25,162,414	16,457,716
Employee Future Benefits	8	**4,502,210**	—
Deferred capital contributions	9	**1,103,200**	155,347
		30,767,824	16,613,063
Commitments	10		
Net liabilities		**(4,486,032)**	—
		26,281,792	16,613,063

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

Approved by the Board

_______________, Director

_______________, Director

North East Local Health Integration Network
Statement of operations
Year ended March 31, 2018

	Notes	2018	2017
	3	**$**	$
Revenue			
MOHLTC funding - transfer payments	15	**1,406,271,882**	1,503,092,882
MOHLTC funding - operations and initiatives		**132,700,585**	8,129,229
Interest income		**183,676**	—
Amortization of deferred capital contributions		**400,743**	74,619
Other revenue		**1,384,648**	—
		134,669,652	8,203,848
Total revenue		**1,540,941,534**	1,511,296,730
Expenses			
HSP transfer payments	15	**1,406,271,882**	1,503,092,882
Operations and Initiatives			
Contracted out			
In-home/clinic services		**57,886,886**	—
School services		**2,387,248**	—
Hospice services		**4,282,850**	—
Salaries and benefits		**53,288,127**	5,734,701
Medical supplies		**4,950,939**	—
Medical equipment rental		**1,765,467**	—
Supplies and sundry		**6,494,446**	2,186,368
Building and ground		**2,184,701**	208,160
Amortization		**400,743**	74,619
Repairs and maintenance		**94,914**	—
Employee Future Benefits		**211,871**	—
		133,948,192	8,203,848
Total expenses		**1,540,220,074**	1,511,296,730
Excess of revenue over expenses before the undernoted		**721,460**	—
Net liabilities assumed on transition	13	**(5,207,492)**	—
Excess of expenses over revenue		**(4,486,032)**	—

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

North East Local Health Integration Network
Statement of changes in net financial assets
Year ended March 31, 2018

	Unrestricted	Employee benefits	Internally restricted	2018 Total	2017 Actual
	$	$	$	$	$
Net assets, beginning of year	—	—	—	—	—
Excess of revenue over expenses before the undernoted	933,331	(211,871)	—	721,460	—
Net liabilities assumed on transition	(933,331)	(4,290,339)	16,178	(5,207,492)	—
Net assets, end of year	—	(4,502,210)	16,178	(4,486,032)	—

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

North East Local Health Integration Network
Statement of cash flows
Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of expenses over revenue		**(4,486,032)**	—
Cash Received on transition		**11,230,772**	—
Net liabilities assumed on transition		**5,207,492**	—
Less amounts not affecting cash			
Amortization of capital assets		**400,743**	74,619
Amortization of deferred capital contributions		**(400,743)**	(74,619)
		11,952,232	—
Change in non-cash working capital items	12	**5,847,496**	189,473
		17,799,728	189,473
Investing activities			
Purchase of capital assets		**(54,065)**	(63,802)
Financing activity			
Increase in deferred contributions		**54,065**	20,735
Net change in cash		**17,799,728**	146,406
Cash, beginning of year		**565,035**	418,629
Cash, end of year		**18,364,763**	565,035

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

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 mandate of the LHIN is as follows:

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

The LHIN has also entered into an accountability agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

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

(b) Effective May 31, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

2. Significant accounting policies

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

Revenue recognition

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

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

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

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

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

Capital assets

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

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

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

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

Deferred capital contributions

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

Adoption of PSAS 3430 – Restructuring Transactions

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

2. Significant accounting policies (continued)

Financial instruments

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

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

Employee future benefits

The LHIN accrues its obligations for sick leave and post-employment benefit plans as the employees render the services necessary to earn the benefits. The actuarial determination of the accrued benefit obligations uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors). Under this method, the benefit costs are recognized over the expected average service life of the employee group.

Actuarial gains and losses on the accrued benefit obligation arise from differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation. The excess of the future actuarial gains and losses will be amortized over the estimated average remaining service life of the employees (8.7 to 11.8 years). The most recent actuarial valuation of the sick leave plan and the benefit plan was as of March 31, 2015.

Substantially all of the employees of the LHIN are eligible to be members of the Health Care of Ontario Pension Plan ("HOOPP"), which is a multi-employer, defined benefit, final average earnings and contributory pension plan. Defined contribution plan accounting is applied to HOOPP as the LHIN has insufficient information to apply defined benefit accounting at the predecessor NE CCAC.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in accounting policy

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

4. Funding repayable to the MOHLTC

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

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

	2018	2017
	$	$
Due from MOHLTC, transferred from NE CCAC	**(439,490)**	—
Funding received from MOHLTC	**439,490**	—
Funding repayable to the MOHLTC related to current year activities	**2,370,614**	—
Due to MOHLTC, end of year	**2,370,614**	—

5. Enabling Technologies for Integration Project Management Office

Effective Fiscal 2016 the LHIN entered into an agreement with South East, North West, and Champlain LHIN's (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from Champlain LHIN of $510,000 ($510,000 in 2017).

6. Related party transactions

Health Shared Services Ontario (HSSO)

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

7. Capital assets

			2018	2017
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Furniture and equipment	**1,021,113**	**926,449**	**94,664**	12,350
Computer equipment	**1,367,039**	**1,313,509**	**53,530**	38,809
Leasehold improvements	**4,429,598**	**3,474,592**	**955,006**	104,188
	6,817,750	**5,714,550**	**1,103,200**	155,347

8. Employee future benefits

The North East Local Health Integration Network provides for the reimbursement of medical and some life insurance expenses to certain retired employees provided that specified conditions are met. The LHIN provides 50% of accumulated sick leave entitlement not taken by certain employees, on their departure, provided certain conditions are met. The LHIN provided for a non-vesting benefit where it accrues to employees. An actuarial calculation of the future liabilities thereof has been made and forms the basis for the liability reported in these financial statements.

The significant assumptions used are as follows (weighted-average):

	Vested and non-vested sick leave	**Post-employment benefit obligation**
Discount rate	**3.37%**	**3.37%**
Rate of compensation increases	**4%**	**4%**
Health care costs trend rate	**—**	**6.5% trending to 4% over a 10 year period**

Information about the LHIN's benefit plans in aggregate is as follows:

	Vested and non-vested sick leave	Other employee future benefits	Total
	$	$	$
Balance – May 31, 2017, transferred from North East Community Care Access Centre	2,455,424	1,834,915	4,290,339
Benefit cost	147,912	84,192	232,104
Interest cost	75,417	46,130	121,547
Benefits paid	(82,978)	(29,829)	(112,807)
Amortization of actuarial gains	(2,050)	(26,923)	(28,973)
Employee future benefit liability, March 31, 2018	**2,593,725**	**1,908,485**	**4,502,210**
Obligation	2,395,916	1,187,358	3,583,274
Unamortized net actuarial gains	197,809	721,127	918,936
Employee future benefit liability, March 31, 2018	**2,593,725**	**1,908,485**	**4,502,210**

8. Employee future benefits (continued)

Employee future benefits expense

	Vested and non-vested sick leave	Other employee future benefits	Total
	$	$	$
Benefit cost	**147,912**	**84,192**	**232,104**
Interest on accrued benefit obligation	**75,417**	**46,130**	**121,547**
Amortization charges	**(2,050)**	**(26,923)**	**(28,973)**
Employee future benefits expense	**221,279**	**103,399**	**324,678**

The total expense of $211,871 is included in salaries in wages in the statement of operations. The Ministry does not fund the full actuarial expense, but rather the actual payments made during the year. The funded portion of the overall expense is reported through the unrestricted fund, the unfunded portion is reported in the employment benefit fund as follows:

	Vested and non-vested sick leave	Other future benefits	Total
	$	$	$
Benefit expense	**221,279**	**103,399**	**324,678**
Funded portion of expense	**(82,978)**	**(29,829)**	**(112,807)**
Unfunded portion of expense	**138,301**	**73,570**	**211,871**

9. Deferred capital contributions

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

	2018	2017
	$	$
Balance, beginning of year	**155,347**	209,231
Capital contributions received during the year	**54,065**	20,735
Capital contributions transferred from NE CCAC	**1,294,531**	—
Amortization for the year	**(400,743)**	(74,619)
Balance, end of year	**1,103,200**	155,347

10. Commitments

The LHIN has commitments under various operating leases as follows:

	$
2018	2,151,875
2019	1,905,297
2020	1,436,587
2021	1,314,072
2022	1,064,777
Thereafter	281,704

11. Contingencies

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

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

12. Change in non-cash working capital balance

	2018	2017
	$	$
Due from MOHLTC	**9,850,380**	8,429,683
Accounts Receivable	**791,420**	(44,407)
Prepaid expenses	**808,733**	(25,899)
Accounts payable and accrued liabilities	**2,095,411**	259,779
Due to Health Service Providers	**(9,850,380)**	(8,429,683)
Due to MOHLTC	**2,370,614**	—
Deferred revenue	**(430,553)**	—
Employee Future benefits	**211,871**	—
	5,847,496	189,473

13. Transition of North East Community Care Access Centre

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the North East Community Care Access Centre the (CCAC), to the North East LHIN, including the transfer of all employess of the North East CCAC. This transition took place on May 31, 2017. Prior to the transition, the LHIN funded a significant portion of the CCACs operations via HSP transfer payements. Subsequent to transition date, the costs incurred for the delivery of services previously provided by the CCAC were incurred directly by the LHIN and are reported in the appropriate lines in the statement of operations.

13. Transition of North East Community Care Access Centre (continued)

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

	$
Cash	**11,230,772**
Accounts receivable	**1,380,738**
Prepaids	**990,943**
Tangible capital assets	**1,294,531**
Total assets	**14,896,984**
Accounts payable and accrued liabilities	**14,519,606**
Employee future benefits	**4,290,339**
Deferred capital contributions	**1,294,531**
Total liabilities	**20,104,476**
Net liabilities assumed	**(5,207,492)**

The net liability resulting from this transaction is recorded as revenue in the statement of operations.

14. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 752 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2018 was $3,976,864 ($417,246 in 2017) for current service costs and is included as an expense in the 2018 Statement of Financial Operations. The last actuarial valuation was completed for the plan as of 2017. At that time, the plan was fully funded.

15. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $1,406,271,882 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2017 as follows:

	2018	2017
	$	$
Operations of hospitals	**972,977,062**	957,015,404
Grants to Compensate for Municipal Taxation – Public Hospitals	**211,725**	211,725
Long-Term Care Homes	**230,103,100**	227,563,522
Community Care Access Centers	**23,787,521**	145,532,336
Community Support Services	**40,708,612**	39,525,889
Acquired Brain Injury	**3,779,279**	3,770,183
Assisted Living Services in Supportive Housing	**24,297,247**	23,439,912
Community Health Centers	**20,081,307**	19,144,535
Community Mental Health	**65,033,349**	63,725,937
Substance Abuse and Gambling Problem	**25,292,679**	23,163,439
	1,406,271,882	1,503,092,882

15. Transfer payment to HSPs (continued)

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $5,907,319 ($15,757,699 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

Pursuant to note 13, effective May 31, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the North East CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC up to the date of transfer.

16. Board expenses

The following provides the details of Board expenses reported in the Statement of operations:

	2018	2017
	$	$
Board Chair per diem expenses	**63,600**	12,810
Other Board members' per diem expenses	**65,165**	36,745
Other governance and travel	**58,784**	31,115
	187,549	80,670

17. Financial risk

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

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

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

18. Accumulated non-vesting sick pay

The accumulated non-vesting sick pay comprises the sick pay benefits that accumulated but do not vest. These adjustments are not funded by the Ontario Ministry of Health and Long-Term Care.

19. Guarantees

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

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

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