ANNUAL REPORT 2021-22

NORTHERN HEALTH REGION

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Letter of Transmittal

September 30, 2022

The Honourable Audrey Gordon
Minister of Health and Seniors Care
Room 302, Legislative Building
Winnipeg, Manitoba
R3C 0V8

Dear Minister:

We have the honour to present the annual report for the Northern Regional Health Authority, for the fiscal year ended March 31, 2022.

This Annual Report was prepared under the Board's direction, in accordance with *The Regional Health Authorities Act* and directions provided by the Minister. All material including economic and fiscal implications known as of March 31, 2022 have been considered in preparing the annual report. The Board has approved this report.

Respectfully submitted on Behalf of the Northern Regional Health Authority,

Cal Huntley
Board Chair

Board of Directors Chair's Message

Like the previous two years of reporting, the COVID-19 pandemic and vaccination campaigns continued to dominate healthcare efforts provincially and nationally. All of our monthly board meetings this past year were held virtually using Microsoft Teams with our first in-person meeting planned for the fall of 2022. Of note, our Board is getting much better with this form of technology so our meetings run smoothly and effortlessly.

Once again, we could not have experienced the success we had with our Region's COVID-19 efforts were it not for our staff, supported by their loved ones, in ensuring our patients, our Elders and our community members remained safe and cared for throughout the past two plus years of this global pandemic. We join with all Manitobans in expressing our gratitude to our health care professionals for their dedication, sacrifice and bravery during these unprecedented times. Please know that you have my gratitude and that of the entire Board of Directors.

On behalf of all Manitobans, the Board would like to extend its thanks to departing Board members for all of their work in advancing the Vision, Mission and Values of the Northern Health Region.

From myself and the Board of the Directors, I would like to send out a sincere thank you to the Executive and Senior leadership, our staff, our patients, our residents and our community leaders for the time and effort you have invested in helping us deliver another year of care in the Northern Health Region.

Respectfully,
Cal Huntley, Board Chair

Chief Executive Officer's Message

Like the last fiscal year reporting, this year once again focused on the COVID-19 pandemic management and vaccination efforts throughout Manitoba. We teamed with our community partners, both elected and unelected as well as partner health care organizations. The provincial Health System Transformation efforts continued despite the challenges of this turbulent environment.

These were the demands being placed on our health system locally, regionally, provincially, nationally and globally. We knew these extraordinary times would require the best of all of us for a sustained, yet unknown, period of time. We also knew that Resiliency was a critically important skill and attribute we needed to embrace as a Region, throughout the fiscal year.

Our Public Health teams main focus was planning vaccine clinics throughout the region which included travelling to communities to not only administer vaccines but provide contact/case management to those residents. The community outreach this past year has strengthened those partner relationships and brought the entire Region together as we continued to fight the constant pressures of this pandemic.

I continue to be so proud of the work of my Executive Leadership Team and every member of our staff throughout the Northern Health Region for the exemplary work and service they provided and the sacrifices they made for their fellow Manitobans. While the vaccine provided the "light at the end of the tunnel", a new problem arose whereby the pressures of workload stress and staff screening out due to illness or family illness meant that many of our departments were short of staff. Wave 4 demands were excessive as regular services such as surgery were trying to be maintained given the growing wait lists and the need to re-establish normal health care services as there are grave concerns about the mounting number of patients that have waited long periods of time for elective and urgent services.

Our staff worked tirelessly all the while keeping in mind our vision of Healthy People, Healthy North.

Finally, I want thank our Board of Directors for all of the support my team and I received throughout the year. Our virtual board meetings continued monthly where they were provided with operational highlights which are based on our four strategic directions. All citizens served by the Northern Health Region are served well by the Board and its steadfast commitment to our Mission and Vision throughout the pandemic.

Ekosi, Ekosani, Meegwetch, Masicho!

Respectfully,
Helga Bryant, Chief Executive Officer

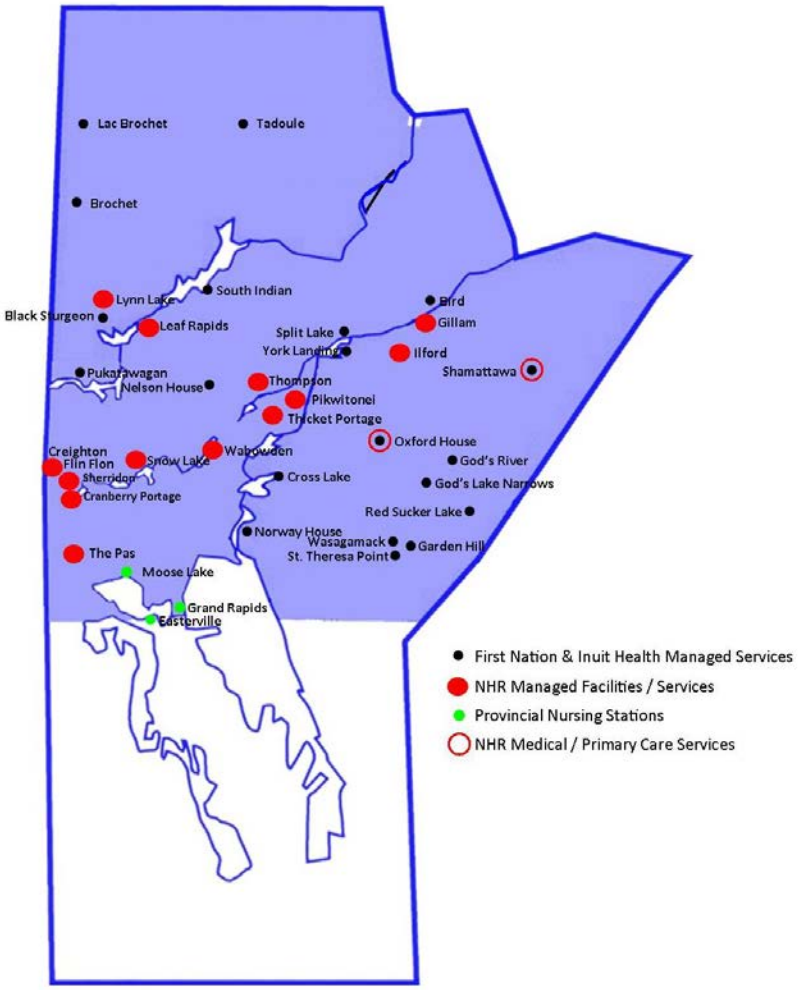
Northern Health Region

Our Region

With a total of 396,000 square kilometres and a population of 76,847, the Northern Health Region (NHR) has the unique challenge of planning and providing health care services and programs to a small population over 60% of Manitoba's total land mass.

The Northern Health Region consists of:

- 2 cities (Thompson and Flin Flon)
- 6 towns (The Pas, Gillam, Grand Rapids, Leaf Rapids, Lynn Lake, Snow Lake)
- 1 rural municipality (Kelsey)
- 1 local government district (Mystery Lake)
- Multiple hamlets and cottage settlements making up "unorganized territories"
- 26 First Nations communities
- 16 Northern Affairs Communities



Overview of the Northern Health Region

The Northern Health Region has a young population, which is projected to continue to expand 12.7% from 2017 to 2030. It is predicted the 0 to 24 age group will remain the greatest percentage of the population, but the most growth will happen in the 35 to 44 age group and the 65 to 74 age group. The change in population will have an impact on the demand for health services in the NHR.

According to the 2016 Census, a total of 51,260 NHR residents self-identified as Indigenous, which represented 72.6% of all NHR residents. 3.2% of the residents within the NHR self-identify as a visible minority other than an Indigenous person. In the NHR, 78% of the time the English language is spoken in the home and 19% of the time a language other than English or French is spoken in the home.

Almost a quarter (24.4%) of Northern residents speaks a non-official language at home. The most predominant language is Cree (59.1%) and Oji-Cree (32.2%). Approximately 37% of the Northern population reports a mother tongue other than English or French. These proportions are much higher than in the rest of Manitoba (21.5%).

Demographic Issues

Data on key demographic issues supports the comments and concerns of community members:

- **Isolation and Remoteness** - The Region's rural and remoteness and the number of widely scattered communities and jurisdictional issues impacts residents' access to services. Some communities are accessible only by air or winter roads, and many homes may not have a telephone or running water. Factors such as weather can impact accessibility to health services when health teams are required to fly into communities and flights are delayed or cancelled due to weather conditions. Affordability is also an issue when residents must leave the community at their own expense to access health services that are not available in the community.

- **Jurisdictional Issues** - At least 40% of the Regions' residents live on reserve. However, residents frequently travel on and off-reserve and access health services in both locations. Having more than one provider of health services (First Nation Inuit Health (FNIH) for on-reserve services and the Region for off-reserve services) can cause confusion for our residents in terms of accessing care. It can also create issues with gaps in follow up with patients and on-going continuity of care. It is imperative that the Region continue to strive towards seamless services with all stakeholders involved.

- **Education** – A total of 44.6% (22,035) NHR residents age 15 and over do not have a certificate, diploma or degree. Of the 22,035 residents, males make up the larger percentage, 47.4% (11,780) compared with 41.8% (10,255) of females.

- **Unemployment** – Rates of unemployment in the NHR were the highest in the province at 14.2% with 3,975 unemployed. NHR unemployment rates were higher for males (16.3%) than for females (11.8%).

- **Income inequality** – In the NHR overall, the median after-tax income of one-person households ($37,374) was above the provincial average ($31,538) whereas the NHR median after-tax income of two-person households ($68,394) was below the provincial average ($72,688) in 2015. Within the NHR, the largest percentage of low-income households includes those with children zero to five years of age.

- **Government Transfers** - There is a high dependence on government transfer payments with higher rates observed in the outlying communities.

- **Families** – In the NHR, there was a total of 5,800 lone parent families, which totals 31.8% of all private households. In Manitoba, there was a total of 58,865 lone parent families, which totals 17% of all private households.

- **Housing** - Issues of affordability, quality and shortage of housing are concerns, particularly in outlying communities.

- **Healthy Foods** - Access to affordable nutritious food is a concern in particular in the outlying communities.

- **Transportation and communication infrastructure** are not as extensive as in other parts of the province and can limit the access to specialty health services.

Key Health Issues and Challenges

Health and health care issues that are identified as key priority areas for the Northern Health Region include:

- **Communicable disease prevention** - The Region continues to struggle with very high rates for communicable diseases, particularly for syphilis, chlamydia, gonorrhea and tuberculosis. The Region continues to work on providing greater awareness and information campaigns along with improved monitoring and surveillance. The significant increases in incidence and prevention of sexually transmitted blood borne infections (STBBI) have resulted in the public health portfolio enhancing testing and contact follow-up. Harm reduction strategies in the Northern Health Region are well developed and highly utilized by public. Demands for harm reduction supplies are also escalating exponentially.

- **Chronic Disease Treatment and Prevention** - While some progress was noted on the incidence levels of some chronic diseases, the number of those living with diabetes, arthritis and high blood pressure remains very high. Increased efforts to promote healthier living strategies to reduce the incidence of chronic disease remains a regional priority.

- **Disparity in Health Status** - In many cases, there have been significant gains in our direct service communities such as improved immunization rates and reductions in rates of some sexually transmitted infections. However, when combined with data for residents living on-reserve, these improvements are masked. Indigenous residents, and residents living on-reserve more specifically, are more likely to have higher rates of acute care stays as well as longer days spent in hospital. Lower rates of immunization and higher rates of diabetes, teen births, high birth weight babies, sexually transmitted infections and

tuberculosis are noted for residents living on-reserve. This underscores the need for the Region to work to cross any jurisdictional barriers and work closely with First Nations and Inuit Health Branch (FNIHB) and First Nations stakeholder groups toward the goal of improving the health status of all residents of our Region.

- **Maternal, Infant and Child Health** - The Region continues to see high birth rates and poorer outcomes related to low birth weights and preterm births as well as access to prenatal care given geography and remoteness of communities. Given the concerns expressed about the level of maternal health support, more attention needs to be paid in this area to ensure improved outcomes for mothers and their infants.

- **Mental Health and Addictions** – The NHR saw 5,593 diagnosed with a substance abuse disorder from 2010/11 to 2014/15 which represents 10.8% of the NHR population aged 18 and older. Between that same time period, 58,178 Manitoban's were diagnosed with a substance abuse disorder. Both Prairie Mountain Health and the NHR were found to have prevalence significantly higher than the Manitoba average.

- **Injury, Premature Death and Life Expectancy** - Premature mortality and injury rates continue to be very high in the Region. It underlines the point that to make measurable progress in improving life expectancy and reducing the number of premature deaths, injury prevention strategies need to be effective and communities need access to safe and healthy activities particularly for youth. Engaging youth in organized and productive activities was an important theme for community consultation participants. Although injury is a very important contributor to premature death, it is also important to note that cancer is the leading cause of death in the Region.

- **Accessibility and Effectiveness** - Access to primary care providers, which is necessary in providing ongoing primary and chronic care management outside of a hospital setting, continues to be an area of concern for the Region. The Region continues to struggle with high levels of unattached residents who have no regular primary care provider. Recruitment efforts are extensive, however physicians are reluctant to be living and working in the north. In 2016/17, 72.4% of the time NHR residents saw primary care physicians and nurse practitioners within the district that they lived, 13.6% of the time they saw physicians and nurse practitioners elsewhere in the NHR, 3.3% of the time in other health regions and 10.6% of the time in Winnipeg. These numbers were consistent over time.

- **Health System Utilization** – The past year has involved work on supporting a provincial dashboard. These indicators, coupled with local regional indicators, provide a snapshot as to access and quality dimensions of care provided in the Region. Indicator results showed that the Region had improved its performance with lower hospital use and physician use due to injury and poisoning. Increasingly though, the Region has seen long term care resources under strain which is impacting accessibility to Personal Care Homes (PCH). More efforts will need to be directed to independent living strategies for seniors and home care to reduce the reliance of PCHs. This is particularly important as the senior population continues to increase.

- **Social Determinants of Health** – The disparity of the Northern Health Region in terms of the social determinants of health increases the need for partnerships outside the scope of the NHR's influence. In order to improve the health status of the Region, partnerships with education, industry, housing and others will be key in effecting change.

- **The Provincial Clinical and Preventative Services Plan** forms the basis for clinical care delivery across the province.

Our Strengths

Areas of Strength include:

- **Quality Health Services** - The Region provides quality health care and services. Client and staff feedback continue to be monitored for suggestions to improvement in quality. The Region received its current accreditation in June 2018 through Accreditation Canada. The next Accreditation survey is scheduled to take place in May, 2023.

- **Responsiveness** - The Region is responsive to client's needs. Through indigenous liaison staff, patient experience, and committed managers and physicians, suggestions, concerns and complaints from patients are quickly explored with follow-up with patients and families through the patient experience portfolio and/or individual managers, executive directors, VPs or the CEO.

- **Programs and services** - Based on fiscal realities, the Region is currently providing an appropriate number of programs and services to residents. The provincial clinical plan as noted above will further inform the clinically and population health appropriate mix of programs, services and providers. This allows us as a Region to better meet the health needs of our population.

- **Our Staff** - The Regions' staff are caring, committed, experienced and knowledgeable. Although recruitment and retention challenges exist, our staff demonstrates commitment to the patients/clients/residents they care for. In times of staff shortages, staff support care by working additional hours all in an effort to sustain care and service; over the past year an increase in use of agency staff has occurred. While this is not optimal, given our vacancies it is often the only means by which to continue care provision.

- **Teamwork** - Teamwork is valued and modeled in the Region. It is evident that teams are change ready, excited about the provincial clinical plan and will be highly engaged in the clinical changes that may be contemplated.

- **Innovative Partnerships** - The Region values our team approach and innovative partnerships. Numerous organizational relationships have been developed with outcomes beginning to be realized. Through community engagement, community support in welcoming newly recruited health care professionals, and joint planning we aim to have a great impact on the overall health status of the people and families that we serve.

- **Chronic Disease Prevention** - Work being done in chronic disease prevention is excellent and will continue. Community level initiatives were praised by many focus group participants; these initiatives can have a lasting impact in relation to cost and involve community members at the grass roots level.

- **Primary Health Care Centres** - The Regions' primary health care centres are very important resources and positive for the Region. Expanded services and same day appointments have an ongoing positive impact in improving access to care.

- **Telehealth** - Telehealth is viewed as a means by which access to healthcare providers can be significantly increased. This was validated by the planning that occurred for the provincial clinical plan in that Telehealth was seen as a strategic vehicle for all clinical services and specialties.

- **Representative workforce** - The Region continued to be intentional in increasing the numbers of representative employees in order to better reflect the ethnic makeup of our population.

- **Good administrative systems** - The Region has mechanisms in place to deal with issues/complaints.

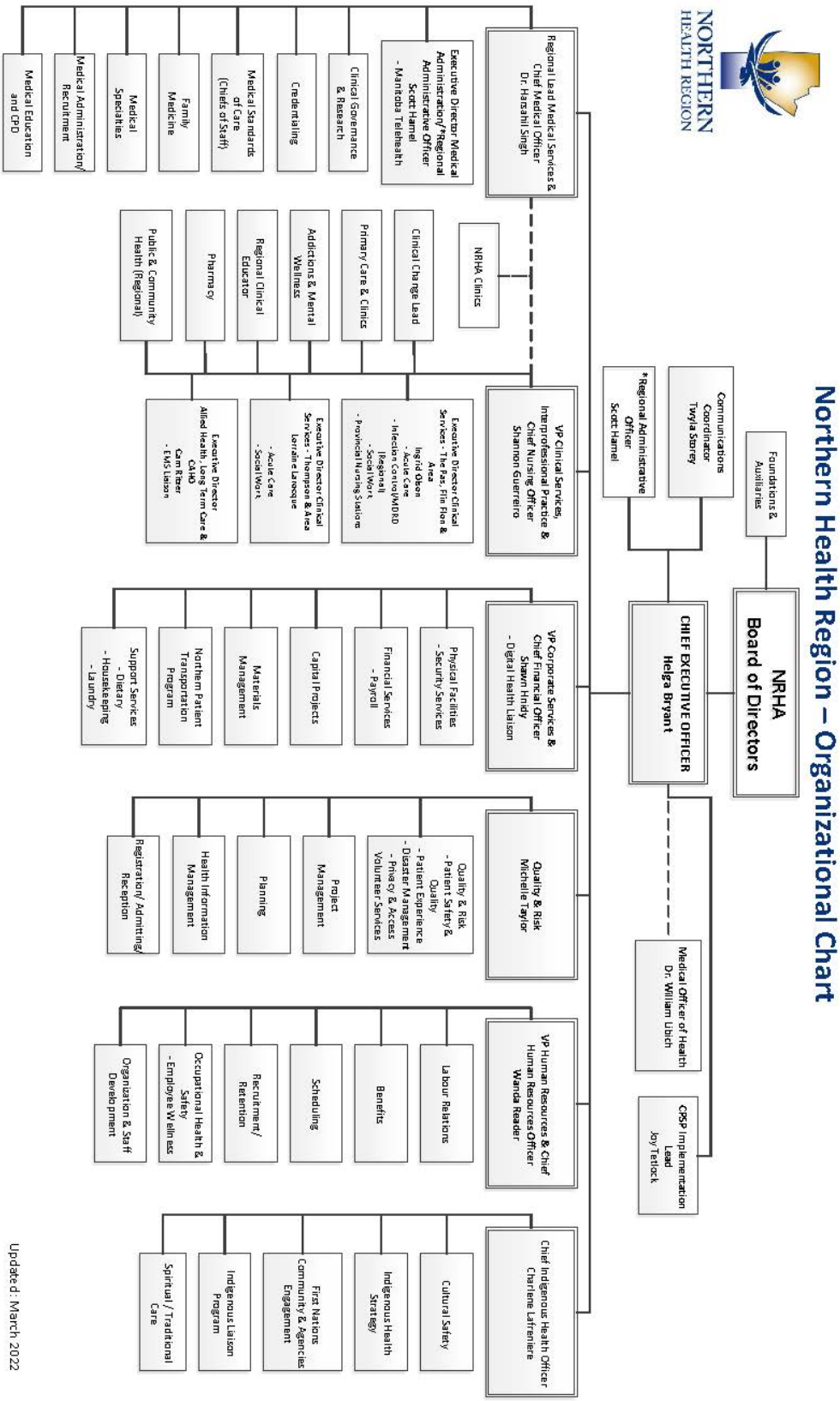
- **Flexibility** - The Region is flexible and adaptable to the changing environment.

- **Our Reputation** - The Region is well respected locally and provincially.

- **Leadership** - The Region has strong leadership doing innovative work. While there are times wherein we experience challenges in filling leadership positions, we have recruited some key individuals that are creating energy in their respective work sites/programs.

- **Governance** - The Region has a supportive board that is committed to the organization and its leadership. The Board continues to receive governance education, maximize technology, and develop governance principles and policies.

Organizational Structure



Updated: March 2022

Executive Leadership Council

- **Helga Bryant**, Chief Executive Officer
- **Dr. Harsahil Singh**, Regional Lead Medical Services and Chief Medical Officer
- **Wanda Reader**, Vice-President, Human Resources and Chief Human Resources Officer
- **Joy Tetlock**, Vice-President, Planning and Population Health
- **Shawn Hnidy,** Vice-President, Corporate Services and Chief Financial Officer
- **Scott Hamel,** Regional Administrative Officer & Executive Director of Medical Administration
- **Shannon Guerreiro,** VP Clinical Services & Inter-Professional Practice & Chief Nursing Officer
- **Lorraine Larocque,** Executive Director of Clinical Services, Thompson and Area
- **Ingrid Olson,** Executive Director of Clinical Services, Flin Flon and The Pas and Area
- **Charlene Lafreniere**, Chief Indigenous Health Officer
- **Cam Ritzer,** Executive Director, Allied Health and Chief Allied Health Officer

For full biographies on our Executive Leadership Council, please visit our website at www.northernhealthregion.com/about-us/our-leadership-team.

Board of Directors

The Minister of Health, Seniors and Active Living, in accordance with provisions of The Regional Health Authority Act, appoints directors to each Regional Health Authority (RHA) Board. The appointments represent a broad cross-section of skills, interests, experience and expertise. Nominees should all share a strong sense of commitment to achieving the provincial vision of healthy Manitobans through an appropriate balance of prevention and care.

Health authority boards are accountable to the Minister of Health, Seniors and Active Living and are responsible for the mandate, resources and performance of the health authority. As such, members must represent the region as a whole, not any particular community or interests. A board must ensure that the organization complies with applicable legislation, regulations, provincial policies and Ministerial directives. Boards have a strategic role in setting direction for the health authority and a fiduciary role in policy formulation, decision-making, and oversight.

Any resident of a health region may, for the Board of the Regional Health Authority for that region, nominate a person or persons, including himself or herself. Nomination forms may be submitted directly your RHA office or to the Minister of Health, Seniors and Active Living.

The 2021-22 Northern Health Region Board of Directors includes:

Cal Huntley, Chair – Flin Flon

Linda Markus – The Pas

June Chu - Wabowden

Anne Kenny Thompson - Lynn Lake

Ashling Sweeny – Thompson

Carrie Atkinson, Vice-Chair – The Pas

Jim Berscheid – The Pas

Dianne Russell – Flin Flon

Angela Enright – Snow Lake

Chris Matechuk – Thompson

Board Committees include the Executive, Governance, Audit, Finance, Indigenous Health & Human Resources and the Quality and Patient Safety Committees. Committee meetings were held at the discretion of the Chair of each committee. Meetings were generally held in conjunction with scheduled Board meetings to reduce travel and other costs. Following each meeting, the recommendations of the committee were presented to the Board for approval. Committee activities appeared in the Board Highlights posted on the Region's website.

Our Vision, Mission and Values

The Vision, Mission and Values of our organization were created and approved by our Board of Directors. More than simple words on a paper, these are the foundations that our organization is built upon.

Our Vision is the future state we want to create for the people we are here to serve.

The Mission is the way we will achieve this on a day to day basis.

Our Values are those attributes we want our staff and communities to know are important to our organization so that they can guide our behaviors and daily decision making in a way which reflects well on the work we do in service to our Northern citizens.

Our Vision:

Healthy People, Healthy North

Our Mission:

The Northern Health Region is dedicated to providing quality, accessible and compassionate health services.

Our Values:

Trust

We are honest and reliable in fulfilling our commitments.

Respect

We treat people and organizations with dignity and consideration.

Integrity

Our beliefs, behaviours, words and actions are honestly, ethically and morally aligned.

Compassion

Our interactions are rooted in empathy and sensitivity.

Collaboration

We work with others to enhance service delivery and maximize resources.

Strategic Directions, Priorities & Performance Measures

In order to achieve the Vision of the Northern Health Region, the Board of Directors set out four strategic directions along with their supporting strategic priorities to guide the organization over the next three years. These directions and priorities build on our commitment to the Vision and Mission of the organization. To have Healthy People in a Healthy North, we must make improving population health and accessible health services our key focus. Being an employer of choice ensures we are recruiting and retaining qualified, professional staff who provide the best quality healthcare to our residents. Being a sustainable, innovative organization ensures that we have the resources in place to support access to quality health services. We are committed to encouraging improved ways of providing health services to ensure our patients are receiving the best possible care we can deliver. The Directions and Priorities are outlined below.

Strategic Direction One: Improve Population Health **Supporting Strategic Priorities:** ▸ Focus on prevention and promotion activities ▸ Improve health equity throughout the region	**Strategic Direction Two: Deliver Quality Accessible Health Services** **Supporting Strategic Priorities:** ▸ Improve access to health services ▸ Promote a culture of Patient Safety
Strategic Direction Three: Be a Sustainable and Innovative Organization **Supporting Strategic Priorities:** ▸ Increase services closer to home as appropriate ▸ Ensure fiscal responsibility	**Strategic Direction Four: Be an Employer of Choice** **Supporting Strategic Priorities:** ▸ Enhance recruitments ▸ Enhance employee engagement

Declaration of Patient Values

The Local Health Involvement Groups conducted a public consultation in regards to what the residents of the Northern Region most value in our health system. The survey results were compiled and as a result, patient values were created. These values were approved by our Board of Directors in January 2019 and are now displayed throughout our Region.

Trust and Confidentiality

Accessibility and Responsiveness

Quality and Safety

Continuity of Care and Information Sharing

Operations Report Highlights

As reported last year, the health care system in Manitoba began a journey of system transformation in the 17/18 fiscal year and changes have been wide sweeping, focusing on improved access, improved equity and improved service delivery across the province. Shared Health, Manitoba Health, Seniors and Active Living and the Regional Health Authorities have been collaborating on the planning and implementation of Manitoba's first ever Clinical and Preventive Services Plan which was released in the fall of 2019.

The Northern Health Region was well represented on the clinical teams which were organized around specialty areas such as primary health and community services, mental health and addictions, chronic and complex medicine and women and child health. Those teams are transitioning into provincial clinical teams which will be inter-regional and co-led by the provincial medical specialty lead and a rural/northern lead. The focus will be on standards, safe patient care and consistent practices across the province.

An update on Health System Transformation is provided further on in this report.

Strategic Direction One: Improve Population Health

The two strategic priorities that were focused on under this Strategic Direction are:

- Focus on prevention and promotion activities
- Improve health equity throughout the region

The highlights from 2021/22 fiscal year include the following:

- Improve population health through the delivery of a regional public health program that focuses on equity, harm reduction and health promotion/prevention strategies.
    - COVID-19 and Vaccinations
        - The 21/22 Fiscal Year was totally focused on pandemic management and vaccinations. This included: travel to communities to provide case and contact management/vaccinations; vaccination strategy that included pop up sites in Flin Flon and The Pas, a supersite in Thompson, community outreach, in-patient/long-term care vaccinations and a focus on youth as they became eligible.
        - Flu shots were offered in conjunction with COVID-19 Vaccine Clinics.
        - Provincially, Wave 4 demands were excessive as regular services such as surgery were trying to be maintained given the growing wait lists and the need to re-establish normal health care services as there are grave concerns about the mounting number of patients that have waited long periods of time for elective and urgent services.
        - Requests were made for support for COVID-19 outbreaks in First Nation communities and Northern Health Region nurses were seconded there to assist.
        - The vaccination mandatory testing for all direct health care workers took an incredible amount of planning. The NHR had 56 staff that were not vaccinated and underwent mandatory testing every 48 hours. There was a combination of 3 LOAs and resignations.
        - COVID-19 operational issues:

- Regional Incident Command wound down end of March in tandem with provincial command team. A weekly "leadership huddle" began in April to allow for problem solving on any operational issues.

- Emergency visits continued to be high with the number of visits at Thompson General Hospital emergency department equal to the number of visits at Brandon General Hospital emergency department (80-100/day).
- Child Health Clinics (CHC) are running at full capacity in Thompson, however, due to staff redeployment, we continued to work at a reduced capacity in The Pas and Flin Flon. Wait times for Thompson, Flin Flon and The Pas CHC clinics were 4 weeks. Public Health Nurses made attempts whenever possible, to book CHC clients who are behind on their immunizations, into their personal templates. Bayline/Outlying Community CHC appointments continued to be offered with available appointments weekly.
- "Level-loading" occurred wherein patients in Winnipeg and the Interlake Eastern Regional Health Authority (IERHA) primarily were being moved to the NHR and Prairie Mountain Health, without patient consent in efforts to support a bed base in Winnipeg and Southern for acute patients.
    - Flin Flon General Hospital had capacity and accepted eight (8) patients.
- A provincial group was been struck, supported by consultants, in developing a "backlog" project to manage the very lengthy wait lists. There is a possibility that surgeons may be interested in locum work in the North.
- Anti-Virals and Microbial Anti-bodies: Several logistical challenges existed in delivering these medications timely within 5-7 days of onset of symptoms. Processes were developed with pharmacy and Emergency Department.

- Continue to monitor and increase regional capacity within community-based prevention services where fiscally responsible
    - Leaf Rapids Health Centre was temporarily closed December 27th, 2021 for a few days due to no staff. There is agreement with Manitoba Keewatinowi Okimakanak (MKO) / Keewatinohk Inniniw Minoayawin (KIM) to construct a working group to develop a primary care model for Leaf Rapids that would better serve the community.
    - Engagement began with First Nation leaders and community on the future of health services in Leaf Rapids. MKO, KIM conducted some engagement with the community.

- Focus on activities that aim to improve overall mental wellness of our population
    - There are ongoing discussions with Shared Health regarding a Mental Health and Addictions model. The Provincial Clinical Team (PCT) met for provincial planning and coordination. Activities identified: environmental scan, distribution of services across the Region to be reviewed as there is an imbalance between sites related to number of clients and number of staff and their roles.
    - Spiritual Care: A plan for elders is in development by the NHR's Chief Indigenous Health Officer.
    - Psychiatry: Ongoing efforts continued to recruit an onsite psychiatrist in The Pas in conjunction with the Regional Medical Director of Psychiatry.
    - Plans ongoing regarding Addiction Services provincially and regionally and moving Addictions Foundation of Manitoba to the Northern Health Region as of April 1, 2022.
    - Primary Care

- The NHR is more and more being asked to fill primary care physician gaps in places where we do not have the mandate; First Nations communities.
- We continued to work with our partners to ensure the appropriate funding is in place given increased demands.
- Although a shortage in nursing is driving potential site closures, the physician supply is also becoming precarious.
- More clarity on appropriate funding is needed if we are asked to provide physician services outside of provincial sites long term, or it will affect our primary care deliverables (e.g., third next available)

- Strengthen partnerships and connections with our Indigenous communities
  - While COVID-19 raised many challenges, there were numerous unique and productive opportunities to collaborate and partner with Indigenous and Northern Affairs communities. Primary partnerships have been with MKO, KIM, local community leaders (Mayors, Chiefs and their Councils), Emergency Measures Organization (EMO) (have supported in 3 specific situations).
  - Northern and Indigenous Partners and Community calls continued weekly. Multiple partners and communities participated with good dialogue. MKO, KIM, First Nations Inuit Health Branch (FNIHB) provided updates and to be present to respond to questions.
  - Cree Nation Tribal Health put forward a proposal to Manitoba Health for a Healing Lodge.

- Provide a culturally safe environment
  - COVID-19 allowed for the development of extensive partnerships and relationships with First Nations Communities, agencies and Northern Affairs Communities. The trust gained through this will continue into a post COVID-19 environment.
  - Systemic racism: Development of a strategy to address racism in the Region. A survey for Senior Management Team was conducted to get a baseline of our understanding and experience with racism in the workplace and healthcare system.
  - The Indigenous Cultural Safety in-session training sessions restarted in October, 2021. An online Manitoba Indigenous Cultural Safety Training program was made available to staff in 50 seat increments.
  - A Declaration to Eliminate Anti-Indigenous Racism will be released jointly by MKO and Northern Health Region when ready.

- Improve the health status of the Region's Indigenous population by identifying areas of improvement that aim to reduce health inequity amongst our population
  - Specialty services: Internal Medicine virtual clinics began a pilot with Dr. Ken Van Amyede (HSC) and held via Beatrice Wilson Health Centre. Virtual care will be a foundational aspect of specialist services in conjunction with Shared Health; this pilot offered an early opportunity to assess, learn, adapt and improve.
  - NHR Anti-Indigenous Racism Strategy: Addressing Racism and Colonialism. Timelines on the strategy were impacted by Transformation and COVID-19, although still moved forward. A high-level blueprint was developed as an initial guide to the work. When complete, this work will be brought to Indigenous Health and Human Resources Committee and the Board of Directors for endorsement.

- Northern Health Services co-design work began with creating definitions, principles and the development of a framework. This will be extensive work moving forward into the 22/23 fiscal year involving the Transformation Management Office, Shared Health, NHR and various Indigenous leaders, communities and agencies.

Strategic Direction Two: Deliver Accessible, Quality Health Services

The two strategic priorities focused on under this Strategic Direction are:

- Improve access to health services
- Promote a culture of patient safety

The highlights from 2021/22 fiscal year include the following:

- Improve access to primary care services through identification of gaps, mitigation planning and management of continuity of patient care. Maximize use of technology where appropriate in order to access service currently unavailable in communities.
  - Virtual Care was a success in Thompson, in particular during the 1st wave of COVID-19. This will continue post COVID-19 as a foundational aspect of the Clinical Preventive and Services Plan.
  - Work proceeded on the planning for a site assessment of The Pas Health Complex.
  - Physicians in The Pas requested a more efficient work flow which may include the creation of micro-teams similar to what exists in Thompson. This will ensure retention stays high in The Pas as space continues to be a challenge.
  - Home Care Program:
    - New policies such as self-managed care, client not home and medication reconciliation came under development to better meet the needs of clients and support patient flow processes.
    - Provided increased role clarity to standardize program operations and to ensure all staff are working to their full scope of practice, streamline the organizational structure within the Home Care Program.
    - Increased front line nursing services where possible; reviewed nursing rotations to provide better coverage and moving to 8-hour shifts.
    - "Foot Care" continued to be a topic of discussion in the Thompson area. Numerous complaints to the NHR, Ask Health and even to the floor of the provincial Legislature. A briefing note was submitted to Health to provide them the background primarily that "foot care" is not an insured or funded service. In the event there are foot "wounds" requiring medical care and attention, that is provided through Home Care and via a referral from a regulated provider (GP, specialist, NP).
  - The Pas Clinic
    - Much work has progressed on the Clinic plans and working in tandem with Manitoba Health, Shared Health and the Northern Health Region. Proposal has been submitted; approval in principle has been gained.
  - Disaster Management:
    - Frequent town water issues in Lynn Lake resulted in occasions of no town water at hospital; this was and continues to be an ongoing issue.

        - Gillam: oxygen concentrator issues highlighting the fragility of systems in our sites and accentuated by the remoteness issues re supply costs and securing contractors/vendors to engage in the work.
        - Thompson sterilizer was down for a few days while awaiting repairs (takes days to get vendors to North); an effective contingency was getting supplies back and forth between Thompson and The Pas.
    - The Manitoba Accessibility Office asked and received feedback on the Accessible Information and Communications standard. It is estimated this new standard will come into force January, 2022.

- Improve client flow throughout the organization by working proactively with internal teams and teams across other sectors
    - Emergency Department CTAS: visit volumes returned to pre-COVID-19 stats and increasing to record high numbers, particularly in Thompson and The Pas. On a 4-month analysis, Thompson had slightly less emergency department visits per month than Brandon; more EMS arrivals than Brandon, as well as slightly less than the provincial average for percentage of high acuity visits. This data did not include the 500 calls per month to the Thompson emergency department to support the nursing stations nor does it fully reflect the complexity of our clientele, nor the time spent arranging transfers and medevacs.
    - Thompson Dialysis: An emerging issue in that there are numerous patients on the wait list to return to Thompson post stabilization period in Winnipeg with housing often being the limiting factor in returning patients to Thompson. Increasing the physical footprint is not an option for the Thompson unit; when capacity is increased in Thompson it will occur by adding an evening shift. Even if funding were made available a limiting factor is staffing the increased capacity. Work is ongoing with the Manitoba Renal Program (MRP) however ultimately this has to be approved, funded and then staffed before any expansion can be operationalized.
        - The Renal Education program didactic portion is now on-line with flexible start dates so any new hire can go into the program immediately.
    - Acute Care Planning: Provincially there was great concern regarding acute care/critical care capacity. A provincial approach was taken and the NHR did its part where it could which was minimal as it relates to critical care. The goal was to keep Northern patients in our own Region unless tertiary care was required.
        - Alternate level of care (ALC) patients were moved from the 3 regional hospitals to the personal care homes (PCHs) and smaller sites to free up acute care beds.
        - The acute care system in the Province of Manitoba was overwhelmed during the pandemic. The North continued to focus on timely repatriations, continued offering surgical services including endoscopy and keeping more acute patients in Northern facilities.
    - The Pas Obstetrical unit continued to experience staffing fluctuations throughout the year with periods of time where only minimum trained staffing were available.
    - Flin Flon General Hospital Feasibility study: this remained a need and will be resumed post pandemic. This study is critical to further the visioning work for services at the hospital. This needs to align with the Clinical Preventive Services Plan (CPSP) and learnings from COVID-19.
    - Nurse Initiated Protocols: There are certain lab, imaging tests that can be ordered by Emergency Department nurses at triage with the goal of moving care along and being prepared for the physician

to see patients; this is a safe, accepted practice with medical staff supportive. These protocols were formally accepted by the Clinical Advisory Council.

- ABI/Spruce House was utilized for Alternate Isolation Patients during the pandemic. Post COVID-19, a plan for "Spruce House" has been developed that supports care needs and patient flow concerns in Thompson. Various data sets including emergency department CTAS data, primary care data informed this planning.
- Pharmacy: NAPRA Standards have become a requirement. This is a provincial project with the Northern Health Region at the planning tables.

- Build understanding of and strengthen compliance with the Northern Patient Transportation Program (NPTP) policy and processes
  - Increased opportunities for virtual care and services closer to home were continually sought.
  - COVID-19: there was increased workload related to the AIA (alternate isolation accommodations) processes as well as issues related to reduced transportation options for patients accessing care in Winnipeg primarily. Reduced commercial, scheduled flight services impacted significantly on timely travel to Winnipeg as well as increased costs for patients.

- Develop and support an organizational culture centered on patient safety
  - Critical Incident, Occurrence reporting processes continued. Of note is that critical incident reviews and the resultant recommendations were increasingly implemented in a timely consistent process.
  - EPICC: Regional educators were asked by the Society of Professionals in Emergency Care to write an article and submit to journals as the north is unique in Manitoba for offering the Emergency Practice, Interventions and Care Canada (EPICC) in Manitoba; the Northern Health Region is the only region in Canada that mandates this course for medicine nurses.
  - The Patient & Public Involvement Coordinator position was revised to take on a larger role in assisting with management of complaints while continuing to support accessibility and engagement activities; the position was renamed Public Engagement & Indigenous Experience Coordinator.
  - Cree translation continued in both written and audio translation.
  - Home for Summer: students hired to enhance programming and to maintain a connection with Region with plan for employment post-graduation.
  - Accreditation**:** the next Accreditation survey was planned for June 2022; given the ongoing pandemic, and extension was requested and approved for May of 2023. New standards applicable to our survey were available in May 2021.
    - System Level: performance appraisals, education and training to promote client and family centered care, physical environment (The Pas and Thompson General Hospital pharmacies and Medical Device Reprocessing Department (MDRD).
    - Program Level: client and family engagement, operational planning & indicator monitoring, quality improvement initiatives that are formalized, documented and monitored for effectiveness.
    - Significant Revisions to Falls Routine Operating Practices in long term care.

- Annual Acute Care Patient Experience Survey Results report 2020-2021 became available on the NHR Intranet. As part of the Accreditation process patient experience surveys will need to be administered in additional program areas; Primary Care, Home Care, long term care, Community Mental Health and In-patient Mental Health.
- Patient Safety Culture Survey opened October 25th, 2021 to coincide with Canadian Patient Safety Week (CPSW); survey closed December 21, 2021. Report now available on the Intranet. Action plan under development to address the results.
- Clinical Education:
  - Two years of education planning for the NHR completed. Part of plan was to begin to work on accreditation education to prepare staff for surveys and understanding accreditation language.
- RCMP Liaison: developed a process by which there are regular connections with a focus on inquiry/escalation processes, and collaboration on items such as violent occurrences in health settings, investigations, information sharing, privacy related issues/incidents and overall concerns from either party.

- Ensure health information management adheres to regional policy and provincial legislation
  - The NHR's Privacy Officer is highly competent in all aspects of the Personal Health Information Act (PHIA) and the Freedom of Information and Protection of Privacy Act (FIPPA). A provincial approach is taken on requests that come to numerous SDOs to ensure a consistent strategy is applied to the response.
    - Review of PHIA and FIPPA Amendments came into effect January 1, 2022
    - Met Manitoba Legislative Unit in regards to PHIA amendments
    - Review and revision of STBBI/CDC Facebook Messenger Guideline
    - PHIA breaches are taken seriously, thorough investigations conducted and appropriate action taken.
    - Saskatchewan eHR Viewer Access Request form and Guideline completed, with the rollout access to Flin Flon providers mid-February 2022; this was a long awaited access for patients in Flin Flon area accessing care in Saskatchewan.
    - Audits were conducted of the EPR, eChart, PHIMS
  - HIROC attention given to ensure data recorded consistently to ensure diligent annual liability insurance renewal.
  - DMOne transcription software rolled out with transcription backlogs significantly reduced.
  - Completed Privacy Assessment Tool (PAT) for The Fischer Clinic Video Surveillance
  - Collaborated with Digital Health/Shared Health and SDO's in regards to CPSM requesting access to EMRs for physician chart review through their Quality Improvement program;
  - Research Agreement Mutual Material and Data Transfer Agreement between NHR and U of M reviewed and will be adopted when finalized.
  - Manitoba Ombudsman attended Grand Rounds on November 30, 2021 to speak on the topic "Overcoming Privacy Paralysis: How to make good decisions about disclosing personal health information".

- Review and develop ICT security policies and guidelines that protect patient information and assist in the disaster planning and recovery of information
    - Ongoing and escalating service issues were experienced throughout the year. Digital Health continued to be an active liaison and participated in 2-way communication between the NHR and Shared Health.

- Develop a professional practice model which provides a quantitative basis for excellence in care delivery and produces outcomes defined by best practice benchmarks
    - Inter-Professional Rounds were imbedded in daily unit practices.
    - Provincial Privileging (physicians) processes not yet rolled out provincially; we await them.
    - Models of Care: COVID-19 was a catalyst for altering and advancing inter-professional models of care.
    - Medical Leadership Model (Shared Health/Clinical Plan): MHSC/Shared Health developed a template of FTE required for various medical leadership positions, with a goal of standardization across the province. No remuneration model or implementation plan has as yet been developed. Next steps will be for the NHR to develop a model that will meet our needs and available resources.
        - Met with Dr. Perry Gray and made important suggestions for provincial Medical Leadership structure which he is bringing to the Government; awaiting the outcome. Goal is to have Regional Specialty Leads with dual reporting to the Chief Medical Officer and Provincial Specialty Lead.
        - Addictions leads positions finalized; interviews held. One for The Pas and one for Thompson.
        - Discussions held with Anesthesia provincial lead regarding rotational model for specialists rather than locum, to be built into work expectation and funded by MHSAL.
    - Family Medicine: As we are now “full” our focus shifts to space considerations as well as requesting additional primary care physicians with the best practices outlined in the Peachy Report. Given space and support staff needs, any new recruits must include an assessment of support staff / allied health care staff and space.
        - Discussions held with MB Health, Shared Health, DocsMB and the provider that wants to start a fee for service clinic in Flin Flon. The fee for service provider plans on a scheduled opening of 2023.
        - AmDocs ceased providing on-call services to several First Nation communities. The Northern Health Region agreed to cover Shamattawa and Oxford House. It was made clear to MHSC that, while we do not have funding, refusing to help is not an option.
    - Third Next Appointment (TNA): TNA target met in Snow Lake, Leaf Rapids and Lynn Lake only. These targets are worse in Thompson and The Pas although slowly improving. Virtual care increases access and is an intentional strategy. Recommendation to overfill with contracted physicians so that there is leave coverage and gap coverage. Also, important to ensure continuity of care and comprehensive care which are also MHSAL priorities.
    - Virtual Care: College of Physicians and Surgeons of Manitoba (CPSM) virtual care standards came into effect on November 1st. Will continue to monitor how we can enable our physicians to follow these standards.

- Allied Health: recruitment successes include:
  - 2 Speech Language Pathology (SLP) students in region for placement. One accepted FT position in The Pas, and 2 external candidates have accepted SLP positions in Thompson General which will allow us to expand to both Adult and Peds SLP and eliminate 2 contracts for service.
  - Return of Service (ROS) for Occupational Therapy and Respiratory Therapy completed summer of 2022. Both have taken 1.0 FTE positions in the NHR to honor their agreements.
- Significant vacancies exist in Diagnostics (imaging/lab) Shared Health. This resulted in service gaps in Gillam, Lynn Lake and Leaf Rapids.

- Build a culture of quality and learning across clinical care that encourages, supports and spreads teamwork across all disciplines
  - All aspects of the NHR's COVID-19 planning and response were tracked to allow for a comprehensive debrief post-COVID-19.
  - Wisdom Council Foundational documents for Wisdom Council consultation were presented to and support by the IHHR Committee of the Board.

Strategic Direction Three: Be a Sustainable and Innovative Organization

The two strategic priorities focused on under this Strategic Direction are:

- Increase services closer to home as appropriate
- Ensure fiscal responsibility

The highlights from 2021/22 include the following:

- Ensure clinical program areas are delivering appropriate services based on resources available including the needs of the community, staff and equipment
  - Clinical Services COVID-19 related: Surgical services, rehab services and other services were restarted.
  - Tele-Rehab: Using TEAMS, Telehealth and other opportunities used to increase virtual access to care.
  - Opaskwayak Health Authority (OHA) requested support to increase work for internal medicine specialist at Beatrice Wilson Health Centre.
  - Hospice Care: Converted 1 room in St Paul's (reduce to 59 LTC beds) to accommodate a hospice bed for community under guidance of palliative care program, reducing need for acute care usage and increased community access.
  - The Pas:
    - Obstetrics experienced staffing and unit culture issues over the course of the past year. Discussions held on a rotational model for obstetricians to retain skills and competencies with rotations from Winnipeg to The Pas. Unit under Article 10 of the Manitoba Nurses Union for a period of time. Discussions also on neonatal capabilities in The Pas as well as a need for on-site pediatric support (provincial rotational model). Health Care Aide 24/7 rotation approved for a 1-year period to

experience impact on workload and support for nurses/patients on the unit. Implemented role assignment and bedside reporting with goal to more equitably distribute the workload and enhance patient safety.

- Thompson:
  - Urology services commenced as services restart during/post COVID-19 and some equipment issues get worked through.
  - Obstetrics also had periods of being in a very fragile state from a staffing and clinical work environment perspective. Discussions held, plans developed and implemented; more stable at end of fiscal year.
  - Orthopedics: The Cast Clinic at the Thompson General Hospital must be moved out of the Emergency Department as space needed for ED patients. This will require creative planning.
  - Pediatrics: Two recent resignations now require locums to fill the gaps. Ongoing discussions held on recruitment of pediatricians.
  - Sexual Assault cases: Provincial program introduced for training and ongoing competency of registered nurses.
  - Endoscopy program: Endoscopy procedures increased at Thompson General Hospital to address the large waitlist with endoscopists from Winnipeg; this happened with funding support from MHSC.
  - Gyne waitlist continues to grow with actions taken to decrease. The NHR's Medical Services portfolio will review all OBS/GYN practice ready applications and interview in October. This would aid with wait lists.
  - Surgical gaps continue; less interest from Winnipeg surgeons than hoped.
  - Ongoing partnership with Drs. Buchel and Lipschitz. Dr. Hyun approved by Executive Leadership Council to lead endoscopy work in Thompson to alleviate the large waitlist via improved efficiencies, utilize QI and research. Medical Student request approved for Home for the Summer program to aid in endoscopy research and QI work. Need partnership with Indigenous communities to improve uptake and overcome barriers to endoscopy. Ongoing surgical gaps and partnership with provincial leads, as well as hiring more into locum pool from across the country
  - Thompson General Hospital (TGH) in process of reintroducing dental surgery slates that were put on hold due to the pandemic. There is a very significant backlog of cases on the current waitlist. The planned dental surgery slate (one per day) would be in addition to current slate activity i.e. two Anesthesiologist providers working daily at the TGH.
- Cardiology: in process of being explored as there are several exciting initiatives happening currently due to strong collaboration with provincial leads. All these initiatives improve patient satisfaction, sustainability of services and serves the mandate of "care closer to home".
  - Carelink express is a device to record pacemaker and other implanted cardiac devices to send data to Winnipeg; this eliminates need for patients to travel to Winnipeg 1-2 times a year for this check-up- improved patient satisfaction and sustainability of services.
  - Echocardiogram Thompson is under discussion with a cardiology lead to bring this service to Thompson a few times a year.

- Cardiac CT is under discussion with cardiology and requiring approval from Medical Director of diagnostic imaging; continue to wait. Goal would be to reduce travel to Winnipeg for low risk patient for MIBI scan.

- Lynn Lake/Leaf Rapids/Gillam: Leaf Rapids closed twice related to no staff. Gillam closed once due to no staff. All remote sites struggle with staffing and always only 1 sick call away or agency nurses cancelling from needing to close.
- Flin Flon:
  - Endoscopy continued, successful programming.
  - A provincial committee looked at identifying and standardizing Endoscopy work across the province; fully supported. The FIT test will soon replace the FOB as it is best practice, has more sensitivity at detection of cancers.
- Long Term Care: Movement of Alternate Level of Care continued throughout the Region as well as movement out of region. The NHR continued to meet and exceed provincial target. This is an important strategy as patients are cared for in most appropriate setting and to ensure adequate acute care capacity.
  - Stevenson Report (Maples PCH Review post COVID-19 outbreak): Accountability letter received by the NHR's Board Chair from the Deputy Minister. Funding for first set of recommendations received and in process of being implemented.
  - Standards Review Updates complete and submitted for St Paul's Personal Care Home.
  - Unannounced Reviews 2022 occurred in early spring for the Northern Spirit Manor in Thompson and the two First Nations' service purchase agreement PCHs.
  - Accreditation work is ongoing with the updating of all LTC policies and uploading to intranet.
- IV Pumps to be delivered in October of 2022. A significant portion of the funding is being provided by the Northern Health Foundation.
- ePrescribe-Mb eHealth rolled out in Thompson, Flin Flon, The Pas.
- Palliative Care needs to be revamped in the communities. A work plan developed to use Homecare Palliative care coordinators to their full scope of practice which will allow for expanded services.
- All of the services in the Northern Health Region are reliant on health human resources. Numerous positions are vacant from nursing staff, to support staff, to leadership positions. Creative recruiting occurred throughout the year with positions filled as able given the global labour shortage.
- Security: Increased security measures being taken at the hospital in The Pas with recent hostility in visitors. TSI Security brought in to support hospital staff. The homeless shelter in The Pas closed for repairs which created pressure on the emergency department in The Pas. Responsibility of the management of Oscar's Place moved to CMHA, out of the Swan River office.
- Clinical Services:
  - A "Christmas 21" Response Team was established to ensure leadership support and response over the Christmas 2021 period of time. This group of extremely dedicated managers, directors, executive met frequently to problem solve staffing challenges, close sites when needed based on very tough decisions and to support each other. Commitment and dedication of management teams around the region assisted in maintaining services over the holidays were above and beyond and enough can not be said about their commitment.

        - Medical Leadership Model: Continued lack of physician leadership model has enabled the provincial leads to put forth ideas with little if any coordination or accountability. For example, pediatrics, surgery, and anesthesia each have initiatives that cost significant dollars that are not negotiated and are resulting in reduced services in the north.
            - Medical Remuneration: Meeting held with NHR Medical Services and Dr. Peachy. It is well understood by Dr. Peachy that the NHR's overages are predictable and systemic due to the nature of physician practice and funding models not keeping pace. Increased pediatric remuneration to match Brandon and HSC, was required in order to continue service.

- Assess specialty programs to identify present and future needs and options for accessibility through either technology or in region
    - As supported by Provincial Clinical Plan, specialty services closer to home has been accepted as a principle. Where challenges lie is in willing providers, travel costs and wrap around supports in regional sites.
    - Provincial announcement of new Dictation and Transcription system, including front and back-end speech recognition with the DMOne in ER (EDIS facilities) implementation fall of 2021.
    - Addictions: Virtual programming at Rosaire House continued during the year; once the space is no longer required for Alternate Isolation, programming will begin to return to normal.
    - Clinical Psychology: discussions held and recruitment plans implementation with University of Manitoba Clinical Psychology
    - OAT Therapy (Opioid Antagonist Therapy): there are a couple of potential physicians interested to provide this service in Flin Flon.

- Utilize current NPTP data as well as utilization data to determine areas of service needs within the region
    - NPTP data is regularly used to assess where needs and opportunities lie. Analysis has been done on NPTP and carrier cost comparison for potential savings: follow-up is now needed between MTCC and MHSAL.

- Provide support to planning and decision making through high quality, reliable data sources
    - Risk Management: work continued on Risk Register, mitigation of risk even through COVID-19.
        - Risk, Disaster Management, Workplace, Health & Safety and facilities managers worked on improving property risk mitigation strategies and training as recommended by our insurers for; ERP for Water Leaks, Hot Works procedures and Fire Suppression Impairment procedures.
    - Provincial Dashboard metrics and Operational Planning came under review. Improving data management and reporting continued to be a target for the NHR with new commissioning requirements.
    - St. Anthony's Hospital in The Pas experienced significant and increasing infrastructure issues. Boiler failed (twice) which resulted in need to have the Flin Flon General Hospital do laundry and other contingencies. Due to the extent of the repairs there also needed to be an inspector on site to inspect every single weld that is done in the repair process prior to moving onto the next step of the repair. Contingency plans remained in place until work completed.

- Develop procurement strategies that focus on adhering to contract management both external and internally
    - Personal Protective Equipment (PPE): PPE issues prevailed from time to time during the year with most being resolved. Guidelines changed from time to time based on the case numbers.

- Build financial capacity within the NHR Management Team
    - COVID-19: bi-weekly reporting on COVID-19 related costs began Friday April 25th, 2021. Executive Directors had regular meetings to review PPE orders and manage the supply/demand. Staffing costs related to COVID-19 were diligently tracked.
    - Summary Budget: submitted with some follow up questions from MHSAL.
    - Increased focus and priority on forecasting to government.
    - Ongoing work ensued on cleaning up balance sheet accounts and processes which minimized adjustments at year end.
    - Financial reporting: Increases in reporting to MHSC & Office of the Provincial Controller and Treasury Board as well COVID-19 greatly impacted workload, funding received for all incremental COVID-19 costs.
    - Operational budget for 21/22 completed in April.
    - The MNU CBA implementation intricacies created much work for Finance.

- Build the sustainability of the NHR by maximizing the use of financial software tools in order to provide timely access to and reporting of financial information
    - Great Plains is the financial software system utilized in the Region; all managers have access to their cost centres and are expected to monitor and analyze their spending, compare to budget and note the variances on a monthly basis. VIVID reports provide the platform to allow the Managers to review and analyze their spending/budgets.
    - Nelson House and Norway House PCH residential charges and the NHR's role in levying/collecting those are being reviewed by MHSAL and the NHR.
    - COVID-19 related costs continued to escalate and were all covered by MHSC.
    - Financial:
        - Briefing note for air ambulance and FNIHB bad debt prepared for Manitoba Health (MH); the forecast for bad debt is $2.7M; the air ambulance over budget is forecasted at $4.8M.
        - MH has indicated a potential $2M one-time funding for FNIHB's bad debt.
        - With an operating deficit forecasted at only $3.1M & medical remuneration of $1.5M deficit, it is clear that operations and possibly patient care is being impacted by the cost savings required by the uncontrolled costs.
        - Operational budget for 21/22 completed.
        - Summary budget for 22/23 completed.
        - Analysis done on NPTP & carrier cost comparison for potential savings; government made aware of challenges at every opportunity.
        - Nelson House and Norway House PCH residential charges and the NHR's role are being reviewed by MHSC and the NHR, funding reductions relating to these two PCH's, calculated residential revenues have been added back to funding for Summary Budget 21/22 & for 22/23 for $1.1M.

- Gained feedback and questions on Strategic Operating Plan. Some strategies to balance included in the 2022 commissioning letter and funding is anticipated for strategies to balance that were declined.
- Cashflow has been an issue from time to time over the past fiscal year. Discussions ensued regularly with Manitoba Health to request timely payment of receivables as the Region cannot afford to hold such large receivables.
- The amount owed for the new stat day of September 30th will be calculated once payroll is complete for the pay period. This will be recoverable from MHSC.

- Complete an infrastructure ten-year plan that assesses current resources and forecasts future needs
  - Capital Plan Provincial Prioritization occurred. The process of periodization continues to be complex and the final decision-making process lacks clarity.
  - Thompson General Hospital (TGH) MDRD construction occurred. Shared Health reviewed list with the Region and then forwarded to MB Health. Finalized Health Plan list on Provincial Scoring Matrix and submitted to Shared Health. The Regional list is then to be incorporated into the Provincial Scored List.
  - Flin Flon Emergency Department: Legal Issues ongoing, but brought in a restoration company, Accord Cleaning, to investigate any mold/air quality issues and remove damaged drywall/ducting to get a better idea of what damages have occurred, prepared for future repair Project as well as reassure staff of air quality.
  - Thompson General Hospital (TGH): have gained compliance from Office of the Fire Commissioner on present TGH Power Plan Boiler Requirements; significant issues experienced with power engineer staffing needs.
  - Issue related to an excessive water bill in Thompson continued. Several attempts made to discuss with City. A new water meter is required. Was escalated to the attention of the CEO.
  - COVID-19 Clinic (Thompson): costs related to fit up, renovations and leases fell to the Region after being established by government services. The space was rented; workload excessive for the in-house maintenance, rather a local contractor provided a quote on the work and job. This space may well endure past COVID-19 for general public health space and immunization(s) site in Thompson.

- Optimize the management of Support Services Departments to improve client satisfaction and to reduce costs
  - Support Services remained in pandemic status given their critical role in maintaining a safe clean clinical/site environment. Cafeterias remain closed to the public due to COVID-19.

Strategic Direction Four: Be an Employer of Choice

The two strategic priorities focused on under this Strategic Direction are:

- Enhance recruitments
- Enhance employee engagement

Recruitment, retention, engaging and developing employees are the foundational principles of furthering our goal of employer of choice.

The highlights from 2021/22 include the following:

- Coordinate with Shared Health Services in order to build medical recruitment processes that are deliberate, sustainable and meet the needs of the region
    - Provincial Credentialing process: is cumbersome and creates delays. Still awaiting provincial processes.
    - The Region is in the position of being a "victim of our own success" in medical recruitment. Based on Board discussion regarding increasing the menu of specialist and primary care, we continue to pursue any interested providers. We continue to recruit our annual allotment of International Medical Graduates; 4 for upcoming year.
    - Medical Services Administration:
        - Conducted a detailed analysis of medical remuneration, travel, accommodations as compared to funding prepared and sent to MHSC.
        - A consultant was retained by the province to explore provincially the challenges and potential solutions to the medical remuneration issues.
        - Medical Renumeration models are being discussed provincially hopefully with the goal to have an approved locum compensation.
        - Significant risk to specialist and itinerant services as Manitoba Health looked to cease all non DocMB rates. However, the specialist leads are looking to increase the existing stipends which are already over and above. A clear plan and process needs to be developed with full support of Health

- Continued to work with MHSAL regarding alternate models of funding for medical services that consider the geographical and health needs of our region
    - Virtual care continues to be maximized. It has been noted that in the Northern Consultation Clinic (NCC) in particular, the number of cancellations and no shows have been significantly reduced from prior to virtual care opportunity.
    - Provincial Health Human Resources Plan to be developed provincially to accompany and enable the Provincial Clinical Preventive Services Plan.
    - Community of Practice (CoP) (physicians): Physician Health and Wellness is a hot topic world-wide. Although physicians have higher than average suicidal ideation and completed suicides, the topic is truly “Staff Health and Wellness”.

- Utilize electronic tools to improve access for potential students and employees to the region such as QSS online recruitment
    - On-line COVID-19 staff screening was in place and staff are expected to complete prior to the start of their work day. This ceased spring of 2022. Staff continue to do rapid testing at home with an obligation to contact Occupational Health or Infection Prevention and Control when they test positive for COVID-19.

- Develop an innovative Northern recruitment and retention strategy that fits with the unique needs of our region and the expectations of new employees

- Pediatrics: Ongoing work with Dr. Patricia Birk, Provincial Lead for Pediatrics. Vision of partnership with U of M and Winnipeg pediatricians, in order to maintain sustainable pediatric service in Thompson.
- Surgery: Work commencing with vision of rotating group of surgeons to work in Thompson and Selkirk. Discussions continued slowly. The goal is, within CPSP to develop locum groups for sites outside of Winnipeg. A surgeon in The Pas is commencing laparoscopic hernias starting in the fall which is a huge step forward for surgery in The Pas.
- Nursing: partnership with Shared Health, University of Manitoba for Northern Clinical Placements; over-arching goal is to diminish reliance on agency nurses by more aggressive recruitment of nurses.
    - UNE (Undergraduate Nursing Employee) – new classification within MNU collective agreement that allows for the hiring of a nursing student to a casual position and pay the LPN start rate of pay. The intent is to start the employment relationship early and maintain the employment once the student graduates as a nurse.
    - NNSOP (Northern Nursing Senior Practicum Opportunity) – This partnership is with Manitoba Health Seniors and Active Living and University of Manitoba and Red River College. Funding has been approved and now anticipate having senior year nursing students in the Region for the clinical placements.; students are our greatest source for recruitment.
    - Experiencing extreme difficulty obtaining agency services particularly in remote areas (Gillam, Lynn Lake, Leaf Rapids and Snow Lake). Have drafted and received approval for an appendix to the agency fee guide for an "isolated post" daily allowance.
- Nurse Recruitment: the NHR's Chief Nursing Officer (CNO) spoke to 4th year nursing students about the "Joy of Nursing" in the North.
- The NHR's Educator and now Clinical Change Lead and the CNO along with Human Resources and MB Health presented goals to have senior students complete their practicum in Northern.
- Funding was secured (by University College of the North) to start an LPN program in Thompson beginning September (2022) pending ability to recruit instructors.
- Student intake numbers are all very encouraging and will greatly support patient care, as well as allowing a reduction of agency costs; it is the graduation numbers that are critical.
- Dialysis nursing education: work continued to offer remotely.
- Social Work: creating innovative placement opportunities for social work students.
- Audiology: unable to recruit; virtual contract to be organized in lieu of local permanent position.
- Respiratory Therapy: Converted a long-term vacant audiologist position into Senior RT position which will focus on introducing RT into Operating Room. Student relationship successful and resulted in a couple of hires.
- Health Care Aides: very difficult to recruit and retain in spite of the UCN educational program. Accelerated and Extended Orientation program continued. This began April 12, 2021 in The Pas as a pilot, with extension to all personal care homes.
- Collective Agreement Bargaining: several groups in negotiation. MNU concluded in the 21/22 fiscal year. Both the CNO and Chief Human Resources Officer (CHRO both heavily involved in bargaining which is taking a significant portion of their time over and above regular operations and COVID/vaccine related issues. In the event of labour action, Provincial Essential Service Agreement templates have been established. Current staffing and proposed staffing numbers are finalized for use in the event of a work stoppage.

- Leadership: in general, the demands on leadership were high at the best of time; these demands and the time involved in those demands significantly intensified during COVID. It was imperative our leaders remained committed, engaged and productive at all times, but particularly during a pandemic. Staff are feeling overwhelmed with redeployments, screening, outbreaks, sustained PPE use., etc. The role of a manager is foundational to supporting and encouraging staff.
    - Provincial Resilience Project: a consultant was hired by the province to engage employees within the health system to resiliency in the workplace. An employee survey was distributed and results compiled provincially as well as SDO level results. From there a provincial plan is to be established to ensure health care workers are supported. Critical Incident Stress Response is one component of this.
- Executive Director Flin Flon and Area: This position was amalgamated with the like position for The Pas and Area. A third manager was created for The Pas to allow for this combined Executive Director to be more manageable.
- Manager Lynn Lake/Leaf Rapids/Gillam: very difficult position(s) to fill. A leadership structure change is being contemplated.
- Manager positions in many program areas became or remained vacant over the 21/22 fiscal year. Leadership requires a skill set and level of commitment that is not held by many. The goal is to recruit for skill and fit, not merely to fill a "chair".
- Registration and Information Management vacancies continued to exist. The positions are entry level yet require a skill set greater than can be expected by an entry level. Financial compensation is an aspect of this as well as the challenges of the role.
- Security: The NHR entered into a partnership with the Northern Manitoba Sector Council (NMSC) to host a security training program in February 2022. Duration of the program is 6 to 7 weeks and incorporates upskilling, conflict resolution and mental health first aide.
- Home for the Summer Program, continued to be an important recruitment initiative for the NHR.
    - Established an Interprofessional Program for our Anti-Racism Strategy that will engage 6 students.
    - Summer student opportunities included a Patient Safety Advocate, Allied Health Summer Program Facilitator and Fit Testing Thompson, The Pas/Flin Flon
- Nursing: partnership with Shared Health and University of Manitoba for Northern Clinical Placements. The goal is to diminish reliance on agency nurses by more aggressive recruitment of nurses.
- Discussions continued with educational facilities re increasing seats: there will be increased expectations on the Region for clinical placements.
- Physicians:
    - 5 IMG physicians started late in 2021.
    - 1 University of Manitoba resident interested in relocating to Thompson.
    - 1 University of Manitoba Resident interested in doing shifts in Snow Lake and working in the emergency department in Flin Flon.

  In March the IMG interviews took place with the Northern Health Region seeking the usual 4 – 5 candidates. Goal is to focus towards competency-based training and holding more rotations in rural/northern RHAs where they will be placed. Program should remain 1 year and is needed in the future or else there will be no permanent physicians outside Winnipeg; needs to be adapted to be

more successful. The NHR has already been very successful due to the immense efforts during the interview process to find the right fits.

- Provincial Float Pool / Travel Nurse: There is new language in the MNU Collective Agreement. Work is underway and VP HR is a member of this working group. It is hoped that in health care we in essence create our own agency and can assign nurses across the province. As well there will be additional incentives to travel for assignments in the north.
- Provincial Patient Care Optimization Committee: The NHR's CHRO is a member of this committee. $4 million/year allocation to improve recruitment and retention of nurses and to incentivize training or education in areas of need.
- Nursing Student Mentorship: A provincial program has been developed and approved by PNLC and the expectations is the program will be rolled out in the SDO's. Consideration being given to an LMS module for mentors to guide the mentor in responsibilities associated with the role.
- UCN continued to be the primary producer of health care staff in the areas of HCAs, LPNs and RNs.
  - RN program; there was only 23 grads this year out of a potential 40 seats.
  - There are challenges, complexities and opportunities at this juncture which offers optimism.

- Enhance Employee Wellness Framework with focus on psychological health and safety
  - COVID-19 pandemic: Communication to staff occurs regularly through a number of venues along with emails of the daily situation reports and updates.
  - Staff felt the impact of COVID-19: COVID-19 fatigue is a very present reality; it has been over 2 years. Managers are watchful and provide support. Managers as well require support. Intentional strategy being developed together with Managers to ensure they are supported for this long haul.
  - As with last year, the long service recognition awards luncheons were once again cancelled due to COVID-19. Unit level presentations by Managers were conducted in place of the corporate event.

- Implementing of Performance Management System including training, application and monitoring
  - With most performance management system processes, managers find it challenging to find time to engage in the process. Managers are regularly prompted to engage in performance conversations.

- Enhance Education programs for all staff
  - Absorb as an on-line learning management system is highly utilized by staff and allows for the offering of an array of mandatory and developmental learning modules in an on-line medium versus face to face. That being said there are a number of sessions that must be face to face such as Advanced Cardiac Life Support (ACLS); in a COVID-19 environment; these were finally re-established as staff were due for re-certification. These were offered respecting COVID-19 restrictions.

- Analysis results from patient experience surveys for opportunities for improvement
  - Patient surveys and patient complaints were regularly reviewed and utilized to improve the system.
  - Home Care client experience survey was administered Oct-Nov 2021, report drafted and sent to the program manager and director for review. On May 26, 2022 CIHI will begin to publicly report 5 point reported experience measures (PREMS) at the hospital, regional, provincial & national level for NS, NB, MB, AB. The 5 PREMS will be:
    - Communication with Doctors

        - Communication with Nurses
        - Involvement in Decision-Making and Treatment Options
        - Information and Understanding When Leaving the Hospital
        - Overall Hospital Experience

- Engage and empower healthcare professionals to act as leaders in ensuring high quality patient care
    - Leadership was key during the planning and response to COVID-19 in the Northern Health Region. There were times of anxiety and challenge as certain processes are developed/managed provincially and at times did not take into account the unique dynamics of health care delivery in the North. Advocacy and insistence on the part of the NHR leaders were frequently required. We continued to maintain an environment of calmness and confidence for both staff and public.
    - System Transformation: provincial work continues on transformation.
        - Health System "Realignment" Project: minimal impact for the Northern Health Region but other Regions had significant impact.
        - The transformation team from Northern continued to provide feedback to the Transformation Management office to ensure Northern concerns are addressed. System redesign work continues to occur in fits and starts.
        - The NHR's CIHO has been assigned to support the Transformation Management Office (TMO) on Indigenous Engagement provincial strategy. As a result of the 60% transfer to TMO, an Indigenous Health Coordinator position was created, posted and filled.
        - The Physician leadership redesign work is also in its infancy. Job descriptions, payment models, implementation plans are yet to be worked through.
        - A full-time Clinical plan Implementation Lead was required and the NHR's Joy Tetlock agreed and was re-assigned to this role. Her current role(s) was re-allocated along with some re-organization to build increased analytical strength in the Region.

COMMUNITY ENGAGEMENT

Community engagement is the vehicle by which the region connects with, learns from and shares information with the communities, agencies and groups within the Northern Health Region. Much effort is taken to connect with communities throughout the region and direct care staff to executive play an active role in engaging with communities. We meet with communities when invited as well as upon inviting ourselves when there are specific health care related issues to discuss with a particular community.

SHARE YOUR STORY

The Northern Health Region is committed to providing high patient quality care. We value feedback from patients about their healthcare. That is why it is important to share your compliment, concern or complaint as a way for the Region to understand the first-hand experience of you, the patient. This also allows us to learn and improve patient safety and quality of care.

GET INVOLVED!

The Northern Health Region values the contributions made by the community to the health care system. Volunteers play an important role in supporting the Region's values of meaningful collaboration through community participation to improve the health and wellbeing of individuals, families and communities. Your involvement strengthens and builds a healthier community!

How can you get involved?

We have several engagement opportunities based on your area of interest lived experience and availability. Some examples include:

- Client Family Advisory Groups
- Participating on quality project teams
- Sharing your personal health story
- Document review groups

Patients and public can get more information on our website www.northernhealthregion.com

LOCAL HEALTH INVOLVEMENT GROUPS (LHIG's)
2021 – 2022 UPDATE

Due to the COVID-19 pandemic, in 2021-22 there were no planned LHIG activities.

Administrative Cost Reporting

Administrative Costs

The Canadian Institute of Health Information (CIHI) defines a standard set of guidelines for the classification and coding of financial and statistical information for use by all Canadian health service organizations. The Northern Regional Health Authority adheres to these coding guidelines.

Administrative costs as defined by CIHI, include:

Corporate functions including: Acute, Long Term Care and Community Administration; General Administration and Executive Costs; Board of Trustees; Planning and Development; Community Health Assessment; Risk Management; Internal Audit; Finance and Accounting; Communications; Telecommunications; and Mail Service.

Patient Care-Related costs including: Patient Relations; Quality Assurance; Accreditation; Utilization Management; and Infection Control.

Human Resources & Recruitment costs including: Personnel Records; Recruitment and Retention (general, physicians, nurses and staff); Labour Relations; Employee Compensation and Benefits Management; Employee Health and Assistance Programs; Occupational Health and Safety.

Administrative Cost Percentage Indicator

The administrative cost percentage indicator (administrative costs as a percentage of total operating costs) also adheres to CIHI guidelines.

Figures presented are based on data available at time of publication. Restatements, if required to reflect final data or changes in the CIHI definition, will be made in the subsequent year.

	2021/22	**2020/21** (Restated)
Administrative cost (% of total):	5.53%	5.44%
Corporate operations (% of total):	3.48%	3.42%
Patient-care related functions (% of total):	0.93%	0.93%
Human Resources & Recruitment functions (% of total)	1.12%	1.09%

2021/22 Totals: Corporate = $8,980,465.29; Patient Care Related = $2,389,839.89; HR & Recruitment = $2,882,649.48; **Total Administration = $14,252,954.66.**

Health System Transformation

Manitoba's Health System Transformation includes initiatives that improve patient access and the quality of care experienced by Manitobans while establishing a health system that is both equitable and sustainable. As

transformation projects and initiatives are planned and implemented, opportunities to re-invest administrative efficiencies in patient care are sought out and prioritized.

Under the Regional Health Authorities Act of Manitoba, health authorities must ensure their corporate administrative costs do not exceed a set amount as a percentage of total operation costs (2.99% in WRHA; 3.99% in Rural; 4.99% in Northern).

Across Manitoba, within all Service Delivery Organizations with the exception of Shared Health, which assumed responsibility for planning and coordination to support health services throughout the COVID-19 pandemic, administrative costs decreased as a percentage of total operating costs.

Clinical and Preventive Services Plan

Detailed planning to support the implementation of Manitoba's Clinical and Preventive Services Plan continued over the past year, with several initiatives established to support health system response to COVID-19. This included expanded virtual care options, secure online portals for test results and immunization information, and a provincial approach to increasing surgical and critical care capacity.

Further steps were also taken to progress Manitoba's Provincial Clinical Network in line with guidance from local teams of clinical and operational experts. Detailed work has been underway to build up care locally and to plan how services and resources will be used in smarter, modern ways with well-integrated health care teams and hubs that are staffed and equipped to meet the needs of Manitoba patients.

This means, Manitobans will have access to:

- **Care closer to home:** more access to quality and equitable care at home or in the community, with less need to travel for services;
- **Enhanced virtual care options**, when appropriate and safe to do so;
- **More surgical capacity** at designated sites in the community or closer to home;
- **Clearer pathways for providers and patients** to access specialized care.

As part of these efforts, the Government of Manitoba announced a historic $812 million capital investment in building, expanding and renovating health-care facilities, including:

- $70-million investment to expand and renovate the Brandon Regional Health Centre and Western Manitoba Cancer Centre, establishing Brandon as Manitoba's intermediate hub for western Manitoba;
- construction of a new $283-million hospital in Portage la Prairie that offers more inpatient beds, expanded medical and surgical capacity and a modern emergency department;
- a $32-million expansion of Bethesda Regional Health Centre in Steinbach that will include additional acute care inpatient beds and expanded medical capacity including a new renal dialysis unit;
- a $64.4-million expansion of Boundary Trails Health Centre in the Morden/Winkler area that adds new acute-care inpatient beds and provides larger, more modern spaces for patient-care programs;
- $31.6-million to expand surgical services, renovate the emergency department and add up to 30 new inpatient beds at Selkirk Regional Health Centre;
- renovations totaling $5 million at Dauphin General Hospital that allow for more endoscopies and cancer treatments;

- construction of a $127-million health centre in Neepawa that will include more acute care inpatient beds, an expanded emergency department and enhanced spaces for a number of programs as well as the addition of dialysis services; and
- a $10.8 million renovation and expansion of services at Lakeshore General Hospital in Ashern that will include an expanded emergency department with additional treatment space and a planned increase of up to 12 inpatient beds to meet the area's growing local health needs.

These improvements will lay the foundation for the Provincial Clinical Network, building up local service delivery, enhancing and expanding services available outside Winnipeg, modernizing the delivery of care at home and in the community, and ultimately leading to improved access, quality and patient outcomes experienced by Manitobans. An important component of the planning for these projects is engagement with key partners and stakeholders, as well as communities these new and renovated facilities will serve. Initial opportunities for engagement have focused on early capital planning efforts, including meaningful and collaborative discussions with local Indigenous partners, site health leadership, and key stakeholders.
Further details on the projects and additional opportunities for input will occur over the coming year with specific emphasis on connecting with local health-care workers, patients and their families to inform service delivery planning.

Over the coming months, detailed planning to support successful implementation of the Clinical and Preventive Services Plan will continue with an ongoing commitment to information sharing and clear communication.

The Public Interest Disclosure (Whistleblower Protection) Act

The Public Interest Disclosure (Whistleblower Protection) Act came into effect in 2007. This law gives employees a clear process for disclosing concerns about significant and serious matters (wrongdoing) in the Manitoba public service, and strengthens protection from reprisal. The Act builds on protections already in place under other statutes, as well as collective bargaining rights, policies, practices and processes in the Manitoba public service.

Wrongdoing under the Act may be: contravention of federal or provincial legislation; an act or omission that endangers public safety, public health or the environment; gross mismanagement; or, knowingly directing or counseling a person to commit a wrongdoing. The Act is not intended to deal with routine operational or administrative matters.

A disclosure made by an employee in good faith, in accordance with the Act, and with a reasonable belief that wrongdoing has been or is about to be committed is considered to be a disclosure, whether or not the subject matter constitutes wrongdoing. All disclosures receive careful and thorough review to determine if action is required, and must be reported in a department's annual report in accordance with Section 18 of the Act.

The following is a summary of disclosures received by Northern Regional Health Authority for fiscal year 2021-2022:

Information Required Annually (per Section 18 of The Act)	Fiscal Year 2021-2022
The number of disclosures received, and the number acted on and not acted on. *Subsection 18 (2a)*	0
The number of investigations commenced as a result of a disclosure. *Subsection 18 (2b)*	0
In the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations or corrective actions taken in relation to the wrongdoing, or the reasons why no corrective action was taken. *Subsection 18 (2c)*	0

The Regional Health Authorities Act

Accountability Provisions

The Regional Health Authorities Act include provisions related to improved accountability and transparency and to improved fiscal responsibility and community involvement. In keeping with those provisions, the Region has taken the following actions:

- Employment contracts are consistent with Sections 22 and 51 in that they meet the terms and conditions established by the Minister;
- The Strategic Plan was prepared, implemented, is updated as required and is posted on the Region's website as per Section 23(2c);
- The Region's most recent Accreditation Canada Reports are published on the website as per Section 23.1 and 54; and
- The Region is in compliance with Sections 51.4 and 51.5 regarding employing former designated senior officers.
- Expenses of the CEO and designated officers are published on the Region's website in accordance with Section 38.1(1).

Public Sector Compensation Disclosure Act

In compliance with *The Public Sector Compensation Disclosure Act of Manitoba,* interested parties may inspect a copy of the Northern Health Region's public sector compensation disclosure which has been prepared for this purpose and certified by its auditor to be prepared, in all material respects, in accordance with the provisions of the Public Sector Compensation Disclosure Act of the Province of Manitoba. The report contains the amount of compensation it pays or provides in the corresponding calendar year for each of its officers and employees whose compensation is $75,000.00 or more. The report is available on the Northern Health Region website at www.northernhealthregion.com. For more information, contact Scott Hamel by email shamel2@nrha.ca or by telephone at (204) 687-3012 or toll free (888) 340-6742.

Audited Financial Statements 2021-22

Adoption of Public Sector Accounting Standards

The Province of Manitoba directed organizations, including the Northern Regional Health Authority, to change its basis of accounting to Public Sector Accounting Standards (PSAS) effective April 1, 2019. Amounts related to the fiscal year ending March 31, 2022 have been restated as required to be compliant with policies under the new method of presentation.

The most significant changes as a result of the change to PSAS include:

- Deferred contributions – Capital can no longer be recognized for provincially funded Tangible Capital Assets (TCA).
- Funding received to pay down principal and interest on the debt associated with the funded TCA is recognized as revenue upon receipt.
- Current year budget is presented on the statement of operations along with current and comparative year actual amounts.

Northern Regional Health Authority
Financial Statements
March 31, 2022

Management's Responsibility

To the Board of Directors of Northern Regional Health Authority:

Management is responsible for the preparation and presentation of the accompanying financial statements, including responsibility for significant accounting judgments and estimates in accordance with Canadian public sector accounting standards. This responsibility includes selecting appropriate accounting policies and methods, and making decisions affecting the measurement of transactions in which objective judgment is required.

In discharging its responsibilities for the integrity and fairness of the financial statements, management designs and maintains the necessary accounting systems and related internal controls to provide reasonable assurance that transactions are authorized, assets are safeguarded and financial records are properly maintained to provide reliable information for the preparation of financial statements.

The Board of Directors and Audit Committee are composed entirely of Directors who are neither management nor employees of the Authority. The Board is responsible for overseeing management in the performance of its financial reporting responsibilities, and for approving the financial information included in the annual report. The Board fulfils these responsibilities by reviewing the financial information prepared by management and discussing relevant matters with management and external auditors. The Committee is also responsible for recommending the appointment of the Authority's external auditors.

MNP LLP is appointed by the Board to audit the financial statements and report directly to them; their report follows. The external auditors have full and free access to, and meet periodically and separately with, both the Committee and management to discuss their audit findings.

Chief Executive Officer

Vice President, Corporate Services and Chief Financial Officer

Independent Auditor's Report

To the Board of Directors of Northern Regional Health Authority:

Opinion

We have audited the financial statements of Northern Regional Health Authority (the "Authority"), which comprise the statement of financial position as at March 31, 2022, and the statements of operations and accumulated surplus (deficit), changes in net debt and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Authority as at March 31, 2022, and the results of its operations, change in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the Authority in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Other Information

Management is responsible for the other information. The other information comprises Management's Discussion and Analysis. The other information also comprises the information included in the annual report, but does not include the financial statements and our auditor's report thereon. The annual report is expected to be made available to us after the date of this auditor's report.

Our opinion on the financial statements does not cover the other information and we will not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information identified above when it becomes available and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

When we read the annual report, if we conclude that there is a material misstatement therein, we are required to communicate the matter to those charged with governance.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the Authority's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Authority or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Authority's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 Authority's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Authority's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Authority to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Winnipeg, Manitoba

June 15, 2022

MNP LLP

Chartered Professional Accountants

Northern Regional Health Authority
Statement of Financial Position
As at March 31, 2022

	2022	2021
Financial assets		
Cash *(Note 2)*	**193,133**	150,636
Accounts receivable *(Note 3)*	**4,239,968**	4,803,508
Due from Manitoba Health *(Note 4)*	**13,082,592**	4,495,155
Vacation entitlement receivable - Manitoba Health *(Note 5)*	**5,429,191**	5,429,191
Pre-retirement receivable - Manitoba Health *(Note 5)*	**3,239,559**	3,239,559
Total financial assets	**26,184,443**	18,118,049
Liabilities		
Bank indebtedness *(Note 2)*	**6,761,083**	1,606,025
Accounts payable and accrued liabilities *(Note 6)*	**26,406,001**	22,022,568
Vacation liability	**12,350,484**	11,330,133
Unearned revenue *(Note 7)*	**5,754,375**	4,350,690
Sick leave benefit obligation *(Note 8)*	**1,647,000**	1,646,982
Pre-retirement obligation *(Note 9)*	**9,963,800**	9,800,218
Long-term debt *(Note 10)*	**81,297,831**	84,959,821
Total financial liabilities	**144,180,574**	135,716,437
Net debt	**(117,996,131)**	(117,598,388)
Significant events *(Note 21)*		
Non-financial assets		
Tangible capital assets *(Note 11)*	**111,814,066**	114,970,059
Inventory	**1,164,951**	1,284,241
Prepaid expenses	**1,319,170**	955,088
Total non-financial assets	**114,298,187**	117,209,388
Accumulated surplus (deficit)	**(3,697,944)**	(389,000)

Approved on behalf of the Board

NRHA Board Chair

NRHA Board Vice-Chair

The accompanying notes are an integral part of these financial statements

Northern Regional Health Authority
Statement of Operations and Accumulated Surplus (Deficit)
For the year ended March 31, 2022

	2022 Budget	2022 Capital	2022 Operating	2022	2021
Revenue					
Province of Manitoba					
Health – operating	**146,762,494**	**-**	**178,598,513**	**178,598,513**	158,472,434
Health – medical renumeration	**39,791,800**	**-**	**41,689,782**	**41,689,782**	42,933,435
Health – capital	**9,217,735**	**10,499,656**	**-**	**10,499,656**	10,751,705
MHCW – operating	**13,734,836**	**-**	**13,748,800**	**13,748,800**	15,079,916
MHCW – medical renumeration	**1,345,080**	**-**	**1,345,080**	**1,345,080**	-
Other departments	**972,555**	**-**	**2,245,611**	**2,245,611**	1,386,254
Total Province of Manitoba *(Note 12)*	**211,824,500**	**10,499,656**	**237,627,786**	**248,127,442**	228,623,744
Federal government	**50,681**	**-**	**227,500**	**227,500**	121,513
Interest revenue	**25,000**	**-**	**8,497**	**8,497**	15,780
Patient income	**626,000**	**-**	**574,247**	**574,247**	494,842
Personal care home income	**3,512,500**	**-**	**3,330,726**	**3,330,726**	3,225,511
Northern patient transportation program recoveries	**5,225,000**	**-**	**5,366,313**	**5,366,313**	5,533,317
Miscellaneous income/other revenue	**3,325,603**	**-**	**4,197,604**	**4,197,604**	5,645,307
Other capital revenue	**200,000**	**317,286**	**-**	**317,286**	289,308
Total revenue	**224,789,284**	**10,816,942**	**251,332,673**	**262,149,615**	243,949,322
Expenses					
Acute care	**86,219,678**	**-**	**97,558,179**	**97,558,179**	85,763,529
Medical remuneration	**41,736,881**	**-**	**44,431,797**	**44,431,797**	44,878,596
Public health	**22,818,218**	**-**	**23,233,039**	**23,233,039**	21,322,556
Home care	**7,931,532**	**-**	**8,792,986**	**8,792,986**	8,161,780
Mental health	**6,596,335**	**-**	**6,012,051**	**6,012,051**	6,018,668
Long term care (PCH)	**16,581,641**	**-**	**19,953,073**	**19,953,073**	17,079,260
Northern patient transportation program	**20,675,899**	**-**	**22,031,606**	**22,031,606**	19,669,441
NPTP federal bad debt	**-**	**-**	**2,449,871**	**2,449,871**	2,896,780
Ancillary programs	**2,635,800**	**-**	**2,161,591**	**2,161,591**	1,960,166
Unallocated administration	**13,441,649**	**-**	**12,901,791**	**12,901,791**	11,866,467
COVID expenses	**-**	**-**	**15,393,149**	**15,393,149**	13,765,945
Capital expenses	**11,424,217**	**10,539,426**	**-**	**10,539,426**	12,203,823
Total expenses *(Note 13)*	**230,061,851**	**10,539,426**	**254,919,133**	**265,458,559**	245,587,011
Deficit	**(5,272,567)**	**277,516**	**(3,586,460)**	**(3,308,944)**	(1,637,689)
Accumulated surplus (deficit), beginning of year	**(389,000)**			**(389,000)**	1,248,689
Accumulated surplus (deficit), end of year	**(5,661,567)**			**(3,697,944)**	(389,000)

The accompanying notes are an integral part of these financial statements

Northern Regional Health Authority
Statement of Change in Net Debt
For the year ended March 31, 2022

	Budget	*2022*	*2021*
Annual deficit	**-**	**(3,308,944)**	(1,637,689)
Purchases of tangible capital assets	**-**	**(4,463,284)**	(10,364,868)
Amortization of tangible capital assets	**-**	**7,619,277**	7,727,402
Decrease (increase) in inventory	**-**	**119,290**	(214,572)
Decrease (increase) in prepaid expenses	**-**	**(364,082)**	(470,461)
	-	**2,911,201**	(3,322,499)
Increase in net debt	**-**	**(397,743)**	(4,960,188)
Net debt, beginning of year	**(117,598,388)**	**(117,598,388)**	(112,638,200)
Net debt, end of year	**(117,598,388)**	**(117,996,131)**	(117,598,388)

The accompanying notes are an integral part of these financial statements

Northern Regional Health Authority
Statement of Cash Flows
For the year ended March 31, 2022

	2022	2021
Cash provided by (used for) the following activities		
Operating activities		
Deficit	**(3,308,944)**	(1,637,689)
Amortization of tangible capital assets	**7,619,277**	7,727,402
	4,310,333	6,089,713
Changes in working capital accounts		
Accounts receivable	**563,540**	3,363,159
Due from Manitoba Health	**(8,587,437)**	(4,495,155)
Inventory	**119,290**	(214,572)
Prepaid expenses	**(364,082)**	(470,461)
Accounts payable and accrued liabilities	**4,383,433**	5,766,016
Vacation liability	**1,020,351**	893,372
Unearned revenue	**1,403,685**	516,502
	2,849,113	11,448,574
Financing activities		
Net change in long-term debt	**(3,661,990)**	2,226,535
Change in accrued pre-retirement obligation	**163,582**	201,800
Change in sick leave benefit obligation	**18**	(18,269)
Change in bank indebtedness	**5,155,058**	(3,516,621)
	1,656,668	(1,106,555)
Capital activity		
Purchases of tangible capital assets	**(4,463,284)**	(10,364,868)
Increase (decrease) in cash resources	**42,497**	(22,849)
Cash resources, beginning of year	**150,636**	173,485
Cash resources, end of year	**193,133**	150,636

1. Significant accounting policies

These financial statements are the representations of management, prepared in accordance with Canadian public sector accounting standards and including the following significant accounting policies:

Nature and purpose of the Authority

Effective May 28, 2012, a Regulation was registered in respect to the Regional Health Authorities Act, affecting the amalgamation of Burntwood Regional Health Authority with the Norman Regional Health Authority to form a new authority named the Northern Regional Health Authority (the "Authority"). The amalgamation of the regional health authorities was part of the provincial budget announcement made on April 17, 2012 to reduce the number of regional health authorities in Manitoba.

All operations, properties, liabilities and obligations and agreements with contract facilities of the predecessor organizations were transferred to the Authority on this date.

The Northern Regional Health Authority is a registered charity under the Income Tax Act and accordingly is exempt from income taxes, provided certain requirements of the Income Tax Act are met.

Basis of reporting

These financial statements include the accounts of the following operations of the Authority:

Cormorant Health Care Centre
Cranberry Portage Wellness Centre
Gillam Hospital
Ilford Community Health Centre
Leaf Rapids Health Centre
Lynn Lake Hospital
Pikwitonei Community Health Centre
Thicket Portage Community Health Centre
Thompson General Hospital
Wabowden Community Health Centre
Northern Spirit Manor
Flin Flon General Hospital
Flin Flon Personal Care
Northern Lights Manor
The Pas Health Complex
The Snow Lake Medical Nursing Unit
Thompson Clinic
Northern Consultation Clinic
Sherridon Health Centre
St. Paul's Personal Care Home
Acquired Brain Injury House
Hope North Recovery Centre for Youth

Basis of presentation

Sources of revenue and expenses are recorded on the accrual basis of accounting. The accrual basis of accounting recognizes revenue as it becomes available and measurable; expenses are recognized as they are incurred and measurable as a result of the receipt of goods or services and the creation of a legal obligation to pay.

Cash and cash equivalents

The Authority considers deposits in banks, certificates of deposit and other short-term investments with original maturities of 90 days or less at the date of acquisition as cash and cash equivalents.

1. Significant accounting policies *(Continued from previous page)*

Inventory

Inventory consists of medical supplies, drugs, linen and other supplies that are measured at average cost, except drugs which are valued at the actual cost using the first in, first out method. The cost of inventory includes the purchase price, shipping, unrebated portion of goods and services tax, and provincial sales tax. Inventory is expensed when put into use.

Tangible capital assets

Tangible capital assets are initially recorded at cost. Contributed tangible assets are recorded at their fair value at the date of contribution if fair value can be reasonably determined. Interest on the debt associated with construction in progress projects is capitalized as incurred.

Amortization

Tangible capital assets are amortized annually using the following methods and rates intended to amortize the cost of the assets over their estimated useful lives:

	Method	***Rate***
Land improvements	straight-line	2.5 %
Buildings	straight-line	2.5 %
Computers	straight-line	20 %
Equipment	straight-line	10 %

No amortization is provided for construction in progress.

Long-lived assets

Long-lived assets consist of tangible capital assets. Long-lived assets held for use are measured and amortized as described in the applicable accounting policies.

When the Authority determines that a long-lived asset no longer has any long-term service potential to the Authority, the excess of its net carrying amount over any residual value is recognized as an expense in the statement of operations. Write-downs are not reversed.

Net debt

The Authority's financial statements are presented so as to highlight net debt as the measurement of financial position. The net debt of the Authority is determined by its financial assets less its liabilities. Net debt is comprised of two components, non-financial assets and accumulated surplus (deficit).

Asset classification

Assets are classified as either financial or non-financial. Financial assets are assets that could be used to discharge existing liabilities or finance future operations. Non-financial assets are acquired, constructed or developed assets that do not normally provide resources to discharge existing liabilities but are employed to deliver government services, may be consumed in normal operations and are not for resale in the normal course of operations. Non-financial assets include tangible capital assets, inventory and prepaid expenses.

1. Significant accounting policies *(Continued from previous page)*

Revenue recognition

Manitoba Health operating revenue
Under the Health Services Insurance Act and regulations thereto, the Authority is funded primarily by the Province of Manitoba in accordance with budget arrangements established by Manitoba Health. Operating grants are recorded as revenue in the period to which they relate. Grants approved but not received at the end of an accounting period are accrued. Where a portion of a grant relates to a future period, it is deferred and recognized in that subsequent period. These financial statements reflect agreed arrangements approved by Manitoba Health with respect to the year ended March 31, 2022.

Government transfers
Government transfers are recognized in the financial statements when the transfer is authorized and eligibility criteria are met except, when and to the extent, stipulations by the transferor gives rise to an obligation that meets the definition of a liability. Stipulations by the transferor may require that the funds only be used for providing specific services or the acquisition of tangible capital assets. For transfers with stipulations an equivalent amount of revenue is recognized as the liability is settled.

Unearned revenue represents funding for equipment not yet purchased. These amounts will be recognized as revenue in the fiscal year the equipment is purchased.

In Globe funding
In Globe funding is funding approved by Manitoba Health for Regional Health programs unless otherwise specified as Out of Globe funding. This includes volume changes and price increases for the five service categories of Acute Care, Long Term Care, Community and Mental Health, Home Care and Emergency Response and Transport. All additional costs in these five service categories must be absorbed within the global funding provided.

Any operating surplus greater than 2% of the budgeted amount related to In Globe funding arrangements is recorded on the statement of financial position as a payable to Manitoba Health until such time as Manitoba Health reviews the financial statements. At that time Manitoba Health determines what portion of the approved surplus may be retained by the Authority, or repaid to Manitoba Health. Under Manitoba Health policy the Authority is responsible for In Globe deficits, unless otherwise approved by Manitoba Health.

Out of Globe funding
Out of Globe funding is funding approved by Manitoba Health for specific programs.

Any operating surplus related to Out of Globe funding arrangements is recorded on the statement of financial position as a payable to Manitoba Health until such time as Manitoba Health reviews the financial statements. At that time Manitoba Health determines what portion of the approved surplus may be retained by the Authority, or repaid to Manitoba Health.

Non-insured revenue
Non-insured revenue is revenue received for products and services where the recipient does not have Manitoba Health coverage or where coverage is available from a third party. Revenue is recognized when the product is received and/or the service is rendered.

Other revenue
Other revenue comprises recoveries for a variety of uninsured goods and services sold to patients or external customers. Revenue is recognized when the goods are sold or the service is provided.

Northern patient transportation program recoveries
Northern patient transportation program recoveries includes recoveries of patient transportation costs. Revenue is recognized when the underlying service is provided.

Ancillary funding
Ancillary funding comprises amounts received for specific programs funded outside of global funding from Manitoba Health and other Province of Manitoba departments. Revenue is recorded as unearned until the service is provided.

1. Significant accounting policies *(Continued from previous page)*

Contributed materials and services

Contributions of materials are recognized at fair market value only to the extent that they would normally be purchased and an official receipt for income tax purposes has been issued to the donors.

A substantial number of volunteers contribute a significant amount of their time each year. Because of the difficulty of determining the fair value, contributed services are not recognized in the financial statements.

Capital management

The Authority's objective when managing capital is to maintain sufficient capital to cover its costs of operations. The Authority's capital consists of net debt.

The Authority's capital management policy is to meet capital needs with working capital advances from Manitoba Health.

The Authority met its externally imposed capital requirements.

There were no changes in the Authority's approach to capital management during the year.

Employee future benefits

The Authority's employee future benefit programs consist of a multi-employer defined benefit plan, as well as pre-retirement obligations and sick leave benefits obligation.

Multi-employer defined benefit plan

The majority of the employees of the Authority are members of the Healthcare Employees Pension Plan - HEPP (the “Plan”), which is a multi-employer defined benefit pension plan available to all eligible employees. Plan members will receive benefits based on length of service and on the average annualized earnings calculated on the best five of the eleven consecutive years prior to retirement, termination or death, that provide the highest earnings. The costs of the Plan are not allocated to the individual health entities within the related group and as such, individual entities within the related group are not able to identify their share of the underlying assets and liabilities. Therefore, the Plan is accounted for as a defined contribution plan in accordance with Canadian public sector accounting standards Section 3250.

Pension assets consist of investment grade securities. Market and credit risk on these securities are managed by the Plan by placing Plan assets in trust through the Plan investment policy. Pension expense is based on Plan management’s best estimates, in consultation with its actuaries to provide assurance that benefits will be fully represented by fund assets at retirement, as provided by the Plan. The funding objective is for the employer contributions to HEPP to remain a constant percentage of employee's contributions. Variances between funding estimates and actual experience may be material and any differences are generally to be funded by the participating members.

The Healthcare Employees’ Pension Plan is subject to the provisions of the Pension Benefits Act, Manitoba. This Act requires that the Plan’s actuaries conduct two valuations – a going-concern valuation and a solvency valuation. In 2010, HEB Manitoba completed the solvency exemption application process, and has now been granted exemption for the solvency funding and transfer deficiency provision. As at December 31, 2013 the Plan’s going concern ratio was 96.1%.

As at December 2008, the actuarial valuation shows a deficit of $388 million. In order to ensure the long-term sustainability of the Plan contribution rates increased 2.2% through a gradual implementation over 27 months from January 1, 2011 to April 1, 2013. Contributions to the Plan made during the year on behalf of its employees are included in the statement of operations.

The remaining employees of the Authority are eligible for membership in the provincially operated Civil Service Superannuation Fund. The pension liability for the Authority’s employees is included in the Province of Manitoba's liability for the Civil Service Superannuation Fund. Accordingly, no provision is required in the financial statements relating to the effects of participation in the Plan by the Authority and its employees. The Authority is in receipt of an actuarial report on the Statement of Pension Obligations under the Civil Service Superannuation Act as at December 31, 2012.

During the year, the Authority contributed $7,013,346 (2021 - $6,541,878) to the Plan.

1. Significant accounting policies *(Continued from previous page)*

Pre-retirement obligation

The accrued benefit obligation for pre-retirement benefits are actuarially determined using the projected benefit method pro-rated on service and management's best estimates of expected future rates of return on assets, termination rates, employee demographics, salary rate increases plus age related merit-promotion scale with no provision for disability and employee mortality and withdrawal rates.

Based upon collective agreements and/or non-union policy, employees are entitled to a pre-retirement leave benefit if they are retiring in accordance with the provisions of the applicable group pension plan. The Authority's contractual commitment is to pay based upon one of the following (dependent on the agreement/policy applicable to the employee):

a) The Authority's contractual commitment, based on an actuarial valuation, for the pre-retirement entitlement for members of the Healthcare Employees Pension Plan ("HEPP") is to pay out four days of salary for each year of service upon retirement if the employee complies with one of the following conditions:

i. has ten years service and has reached the age of 55; or
ii. qualifies for the "eighty" rule which is calculated by adding the number of years service to the age of the employee; or
iii. retires at or after age 65; or
iv. terminates employment at any time due to permanent disability.

b) The Authority's contractual commitment, based on an actuarial valuation, for the pre-retirement entitlement for members of the Civil Service Superannuation Plan, is to pay out the following severance pay upon retirement to employees who have reached the age of 55 and have nine or more years of service:

i. one week of severance pay for each year of service up to 15 years of service; and
ii. two weeks of additional severance pay for each increment of five years service past the 15 years of service up to 35 years of service.

c) The Authority's contractual commitment, based on an actuarial valuation, for the pre-retirement entitlement for members of the MGEU Collective Agreement, is to pay out one week's pay for each year of accumulated service, or portion thereof, upon retirement if the employee has accumulated 10 or more years of accumulated service, up to a maximum of 15 week's pay.

Actuarial gains and losses can arise in a given year as a result of the difference between the actual return on plan assets in that year and the expected return on plan assets for that year, the difference between the actual accrued benefit obligations at the end of the year and the expected accrued benefit obligations at the end of the year and changes in actuarial assumptions. In accordance with Canadian public sector accounting standards, gains or losses that arise in a given year, along with past service costs that arise from pre-retirement benefit plan amendments, are to be amortized into income over the expected average remaining service life ("EARSL") of the related employee group.

Sick leave benefits obligation

At April 1, 2016, a valuation of the Authority's obligations for the accumulated sick leave bank was done for accounting purposes using the average usage of sick days used in excess of the annual sick days earned. Factors used in the calculation include average employee daily wage, number of sick days used in the year, number of sick days earned in the year, excess of used days over earned days in the year, dollar value of the excess and number of unused sick days.

Key assumptions used in the valuation were based on information available. The valuation used the same assumptions about future events as was used for the pre-retirement obligation valuation noted above.

1. Significant accounting policies *(Continued from previous page)*

Measurement uncertainty

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.

Areas requiring the use of significant estimates include the useful lives of tangible capital assets, allowance for accounts deemed uncollectible, provisions for slow moving and obsolete inventory, amounts recognized for employee benefit obligations and wage accrual for unsettled union negotiations. Changes to the underlying assumptions and estimates or legislative changes in the near term could have a material impact on the provisions recognized.

These estimates and assumptions are reviewed periodically and, as adjustments become necessary they are reported in the statement of operations in the periods in which they become known.

Financial instruments

The Authority recognizes its financial instruments when the Authority becomes party to the contractual provisions of the financial instrument. All financial instruments are initially recorded at their fair value.

At initial recognition, the Authority may irrevocably elect to subsequently measure any financial instrument at fair value. The Authority has not made such an election during the year.

All financial assets and liabilities are subsequently measured at amortized cost using the effective interest rate method.

Transaction costs directly attributable to the origination, acquisition, issuance or assumption of financial instruments subsequently measured at fair value are immediately recognized in the statement of operations. Conversely, transaction costs are added to the carrying amount for those financial instruments subsequently measured at cost or amortized cost.

All financial assets except derivatives are tested annually for impairment. Any impairment, which is not considered temporary, is recorded in the statement of operations. Write-downs of financial assets measured at cost and/or amortized cost to reflect losses in value are not reversed for subsequent increases in value. Reversals of any net remeasurements of financial assets measured at fair value are reported in the statement of remeasurement gains and losses.

Fair value measurements

The Authority classifies fair value measurements recognized in the statement of financial position using a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- Level 1: Quoted prices (unadjusted) are available in active markets for identical assets or liabilities;
- Level 2: Inputs other than quoted prices in active markets that are observable for the asset or liability, either directly or indirectly; and
- Level 3: Unobservable inputs in which there is little or no market data, which require the Authority to develop its own assumptions.

Fair value measurements are classified in the fair value hierarchy based on the lowest level input that is significant to that fair value measurement. This assessment requires judgment, considering factors specific to an asset or a liability and may affect placement within the fair value hierarchy. There were no transfers between levels for the years ended March 31, 2022 and 2021.

2. Cash

The Authority has an authorized operating line of credit of $10,000,000 (2021 - $9,400,000) bearing interest at the bank's prime rate minus 1.00% per annum (2021 - prime minus 1.00%). Security provided on this line of credit includes an overdraft borrowing agreement and a Letter of Comfort from Manitoba Health. As at March 31, 2022 the bank's prime rate was 2.45% (2021 - 2.45%).

3. Accounts receivable

	2022	*2021*
Northern Patient Transportation Program receivables	**29,132,607**	28,450,563
GST rebates receivable	**266,338**	198,697
Patient and other receivables	**968,339**	890,761
Allowance for doubtful accounts - Northern Patient Transportation Program receivables	**(25,124,455)**	(22,674,584)
Allowance for doubtful accounts - patient and other receivables	**(1,002,861)**	(2,061,929)
	4,239,968	4,803,508

4. Due from Manitoba Health

	2022	*2021*
Manitoba Health receivable	**13,082,592**	4,495,155

5. Pre-retirement and vacation entitlements due from Manitoba Health

The amount recorded as a receivable from the Province of Manitoba for pre-retirement costs and vacation entitlements was initially determined based on the value of the corresponding actuarial liabilities for pre-retirement costs and vacation entitlements as at March 31, 2004. Subsequent to March 31, 2004, the Province of Manitoba has included in its ongoing annual funding to the Authority an amount equivalent to the change in the pre-retirement liability and for vacation entitlements, which includes annual interest accretion related to the receivables. The receivables will be paid by the Province of Manitoba when it is determined that the funding is required to discharge the related liabilities.

6. Accounts payable and accrued liabilities

	2022	*2021*
Accounts payable	**7,385,910**	9,352,634
Pension liability	**955,237**	956,767
Salaries and benefits	**18,064,854**	11,713,167
	26,406,001	22,022,568

7. Unearned revenue

Unearned revenue consists of Province of Manitoba funding received in the fiscal year for various programs. This allocation of funding is recognized as revenue when program expenses are incurred. The change in unearned revenue balance for the year is as follows:

	2022	*2021*
Balance, beginning of year	**4,350,690**	3,834,188
Funding received during the year	**2,541,022**	2,550,617
Amount recognized as revenue during the year	**(1,137,337)**	(2,034,115)
Balance, end of year	**5,754,375**	4,350,690

8. Sick leave benefit obligation

The Authority's sick leave benefit obligation is based on an actuarial report prepared as of March 31, 2022. The following table presents information about the sick leave benefit obligations, the change in value and the balance of the obligation as at March 31, 2022:

	2022	***2021***
Sick leave benefit, beginning of year	**1,646,982**	1,352,550
Current period service cost	**133,200**	129,334
Interest cost	**34,400**	36,006
Benefits paid	**(177,482)**	(194,105)
Actuarial gain and other	**9,900**	(4,851)
Sick leave benefit, end of year	**1,647,000**	1,318,934
Unamortized net actuarial gain	**-**	328,048
Sick leave benefit obligation, end of year	**1,647,000**	1,646,982

9. Accrued pre-retirement obligation

The Authority's pre-retirement obligation is based on an actuarial report prepared as of March 31, 2022. The valuation includes employees who qualify as at March 31, 2022, and an estimate for the remainder of the employees who have not yet met the years of service criteria. The following table presents information about accrued pre-retirement benefit obligations, the change in value and the balance of the obligation as at March 31, 2022:

	2022	*2021*
Pre-retirement benefit obligation, beginning of year	**9,800,218**	8,735,471
Adjustment to opening pre-retirement benefits	**(692,569)**	-
Current period service cost	**756,886**	754,808
Interest cost	**233,326**	232,349
Benefits paid	**(633,617)**	(568,750)
Actuarial gain and other	**312,433**	(21,264)
Amortization	**187,123**	-
Pre-retirement benefit obligation, end of year	**9,963,800**	9,132,614
Unamortized net actuarial gain	**-**	667,604
Pre-retirement accrued benefit liability, end of year	**9,963,800**	9,800,218

9. Accrued pre-retirement obligation *(Continued from previous page)*

The actuarial valuation was based on a number of assumptions about future events including a discount rate of 2.65% (2021 - 2.60%), a rate of salary increases of 4.00% (2021 - 3.50%) and an expected average remaining service life of 8.5 years.

Funding for the pre-retirement obligation is recoverable from Manitoba Health for costs incurred up to March 31, 2004 on an Out-of-Globe basis in the year of payment. As of April 1, 2004, In-Globe funding has been amended to include these costs.

10. Long-term debt

	2022	*2021*
Long-term debt with Manitoba Treasury with maturity dates between January 31, 2022 and February 28, 2042, with repayments ranging from $1,034 to $124,048 per month including interest at rates ranging from 0.00% to 6.25% per annum.	**78,335,600**	77,891,867
Line of credit facility with Manitoba Treasury to fund construction in progress. Due on demand and bearing interest at prime minus 1.00% per annum (2021 - prime minus 1.00%). As at March 31, 2022 the prime rate was 2.45% (2021 - 2.45%).	**2,398,073**	6,326,193
Loan payable to Royal Bank of Canada with monthly payments of $10,016 including interest at 3.72% per annum, due May 2027, secured by certain buildings.	**564,158**	661,390
Manulife Life Insurance Company loan, with monthly payments equal to the energy savings including interest at 6.30% per annum, fully re-paid during the year.	**-**	80,371
	81,297,831	84,959,821

Principal repayments on long-term debt in each of the next five years, assuming long-term debt subject to refinancing is renewed, are estimated as follows:

2023	5,777,874
2024	5,853,261
2025	5,736,869
2026	5,650,150
2027	5,728,719

Interest on long-term debt amounted to $2,335,933 (2021 – $2,495,531) and is included in capital expenses on the statement of operations.

11. Tangible capital assets

	Cost	***Additions***	***Disposals***	***Accumulated amortization***	***2022 Net book value***
Land and land improvements	**761,178**	**-**	**-**	**373,992**	**387,186**
Buildings	**160,942,550**	**9,459**	**-**	**84,954,485**	**75,997,524**
Computer hardware and software	**5,875,343**	**-**	**-**	**5,261,768**	**613,575**
Machinery, equipment and furniture	**67,470,849**	**6,961,579**	**-**	**47,366,278**	**27,066,150**
Construction in progress	**10,257,385**	**(2,507,754)**	**-**	**-**	**7,749,631**
	245,307,305	**4,463,284**	**-**	**137,956,523**	**111,814,066**

	Cost	*Additions*	*Disposals*	*Accumulated amortization*	*2021 Net book value*
Land and land improvements	761,178	-	-	373,992	387,186
Buildings	160,008,345	934,206	-	82,031,390	78,911,161
Computer hardware and software	5,875,343	-	-	4,907,188	968,155
Machinery, equipment and furniture	64,232,755	3,238,094	-	43,024,677	24,446,172
Construction in progress	4,064,817	6,192,568	-	-	10,257,385
	234,942,438	10,364,868	-	130,337,247	114,970,059

Construction in Progress

Other projects with total costs incurred to-date of $7,749,631 are in various stages of completion. Total projected costs for these projects are $25,860,775.

There were no disposals of tangible capital assets for the years ended March 31, 2022 or 2021. Changes in accumulated amortization reflect amortization expensed in capital expenses in the statement of operations for each year.

12. Revenue from Province of Manitoba

	2022	*2021*
Revenue as per Manitoba Health's funding document	**215,397,880**	196,803,336
Adjust for:		
Payments on prior year receivables	**(3,877,248)**	(92,864)
Unearned revenue - visitation shelters	**(1,818,000)**	-
Flow-through funding	**20,170**	-
Basic equipment - unearned revenue	**-**	(338,424)
PCH unearned revenue	**-**	784,663
Ancillary programs	**-**	1,523,678
Anticipated COVID funding	**1,313,782**	4,376,304
Principal and interest funding	**10,499,655**	10,132,847
Other	**11,464,327**	925,215
Provincial nursing stations	**-**	(259,915)
Miscellaneous	**-**	(348,868)
CIHI fees	**32,965**	37,856
	233,033,531	213,892,696
Add: Other Province of Manitoba Funding		
Mental Health & Community Wellness	**15,093,911**	15,079,916
	248,127,442	228,623,744

13. Expenses by object

Expenses in the statement of operations and accumulated surplus are reported by function. Below is the detail of expenses by object:

	2022	*2021*
Salaries and benefits	**192,979,574**	175,798,551
Transportation	**30,394,436**	24,644,867
Communication	**279,701**	370,625
Supplies and services	**23,228,178**	24,155,670
Minor capital	**627,490**	2,011,258
Other operating	**7,993,970**	8,383,107
Amortization	**7,619,277**	7,727,402
Debt servicing	**2,335,933**	2,495,531
	265,458,559	245,587,011

14. Related party transactions

The Pas Health Complex Foundation, Inc. and The Northern Health Foundation Inc. (together the "Foundations") are non-profit voluntary associations whose purpose is the betterment of health care at The Health Complex facilities. The aims and objectives of these Foundations coincide with those of the Authority. The Authority regularly provides the Foundations with a listing of project/equipment requirements for the Foundations to consider in their annual funding processes. During the year the Authority received capital donations of $317,286 (2021 - $289,308) of donated equipment.

15. Commitments and contingencies

(i) The Authority has entered into various operating leases for rental units to assist with accommodation needs of the Authority with estimated payments of $998,781 in 2023.

(ii) In the normal course of operations, there are pending claims by and against the Authority. Litigation is subject to many uncertainties, and the outcome of individual matters is not predictable with assurance. In the opinion of management, based on the advice and information provided by its legal counsel, final determination of these other litigations will not materially affect the Authority's financial position or results of operations.

(iii) On July 1, 1987, a group of health care organizations ("Subscribers") formed Healthcare Insurance Reciprocal of Canada ("HIROC"). HIROC is a pooling of the public liability insurance risks for its members. All members of the pool pay annual premiums which are actuarially determined. All members are subject to reassessment for losses, if any, experienced by the pool for the years in which they were members and these losses could be material. No reassessments have been made to March 31, 2022.

16. Financial instruments

The Authority as part of its operations carries a number of financial instruments. It is management's opinion that the Authority is not exposed to significant interest, currency or credit risks arising from these financial instruments except as otherwise disclosed.

Risk management policy

The Authority is exposed to different types of risk in the normal course of operations, including credit risk and market risk. The Authority's objective in risk management is to optimize the risk return trade-off, within set limits, by applying integrated risk management and control strategies, policies and procedures throughout the Authority's activities.

Credit risk

Credit risk is the risk of financial loss because a counter party to a financial instrument fails to discharge its contractual obligations. Financial instruments which potentially subject the Authority to credit risk consist principally of accounts receivable.

The Authority is not exposed to significant credit risk as accounts receivable are spread among a large client base and geographic region and payment in full is typically collected when it is due. The Authority establishes an allowance for doubtful accounts based on management's estimate and assumptions regarding current market conditions, customer analysis and historical payment trends. These factors are considered when determining whether past due accounts are allowed for or written off.

The Authority is not exposed to significant credit risk from due from Manitoba Health, vacation entitlement receivable and pre-retirement receivable, as these receivables are due from the Province of Manitoba.

Market risk

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk and interest rate risk.

16. Financial instruments *(Continued from previous page)*

Currency risk

Currency risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate relative to the Canadian dollar due to changes in foreign exchange rates.

The functional currency of the Authority is the Canadian dollar. The Authority's transactions in U.S. dollars are infrequent and are limited to non-resident charges, certain purchases and capital asset acquisitions. The Authority does not use foreign exchange forward contracts to manage foreign exchange transaction exposures.

Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the Authority to interest rate risk arises primarily on its bank indebtedness and long-term debt, the majority of which include interest at variable rates based on the bank's prime rate. The Authority's cash includes amounts on deposit with financial institutions that earn interest at market rates. The Authority manages its exposure to the interest rate risk of its assets and liabilities by maximizing the interest income earned on excess funds while maintaining the liquidity necessary to conduct operations on a day-to-day basis. Fluctuations in market rates of interest on assets and liabilities do not have a significant impact on the Authority’s results of operations.

17. Liability for contaminated sites

Effective for fiscal years beginning on or after April 1, 2014, public sector accounting standards requires recognition of a liability for remediation of contaminated sites where contamination exceeds environment site standards and a reasonable estimate of the amount can be made. Reporting requirements are limited to the contamination of soil, water and sediment. As of March 31, 2022, the Authority has no known contaminated sites or no known future potential contaminated sites.

18. Comfort funds under administration

At March 31, 2022, the balance of Resident comfort funds held in trust is $64,314 (2021 - $57,747). These funds are included in the accounts payable and accrued liabilities balance of the Authority's financial statements.

19. Economic dependence

The Authority received approximately 95% (2021 - 94%) of its total revenue from Manitoba Health and is economically dependent on Manitoba Health for continued operations. This volume of funding transactions is normal within the industry, as regional health authorities are primarily funded by their respective provincial Ministries of Health.

20. Budget information

The disclosed budget information has been approved by the Board of Directors of the Northern Regional Health Authority at the meeting held on August 25, 2021.

21. Significant events

In March 2020, the World Health Organization characterized the outbreak of a strain of the novel coronavirus ("COVID-19") as a pandemic which resulted in a series of public health and emergency measures that have been put in place to combat the spread of the virus. Governments and central banks have reacted with significant monetary and fiscal interventions designed to stabilize economic conditions.

Significant expenditures were incurred by the Authority as part of the response to combat COVID-19. Throughout the fiscal year, the Authority was reimbursed by Manitoba Health for those costs identified as incremental expenditures due to the COVID-19 pandemic.

The duration and impact of the COVID -19 pandemic continues to be unknown at this time, as is the efficacy of the government and central bank interventions.

In 2022, a contingent liability was recognized in accounts payable and accrued liabilities related to expired collective agreements. An offsetting receivable from Manitoba Health has also been recognized related to a portion of this liability. The amount recorded is an estimate, which may be subject to change. The extent of the liability accrued is not being disclosed pending the completion of labour negotiations.

22. Comparative figures

Certain comparative figures have been reclassified to conform with current year's presentation.

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