

North East
LOCAL HEALTH INTEGRATION NETWORK



**Building a Better Health Care System
Overcoming Geography and Circumstance**

North East LHIN 2005/06 Annual Report



Introducing Local Health Integration Networks

Local Health Integration Networks (LHINs) are not-for-profit organizations designed to plan, integrate and fund local health services within specific geographic areas. There are 14 LHINs across the province. They were created as recognition that a community's health needs and priorities are best understood by people familiar with the needs of that community and the people who live there, not from offices hundreds of miles away.

LHINs are an important part of the evolution of health care in Ontario from a collection of services that are often uncoordinated to a true health care system.

Why Were They Created?

LHINs were created to fix the piecemeal way Ontario's health care system was organized. The goal is to forge local links between health care services and health care providers, to make it easier for patients and their loved ones to find their way through a very complex health system as they move from one health service provider

to another. LHINs are changing the way our health care system is managed.

What Will LHINs Do?

LHINs will manage health services that are delivered in hospitals, long-term care homes, community health centres, community support services, Community Care Access Centres and community mental health and addictions agencies.

LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities. LHINs will determine the health service priorities required in their local community and will work with health providers and community members to develop an integrated health service plan for their local area. They will eventually be respon-

sible for funding and ensuring accountability of local health service providers.

While LHINs will not directly provide services, the government is giving them the mandate for planning, integrating and funding health care services. LHINs will oversee nearly two thirds of the health care budget in Ontario – nearly \$21 billion. They have been specifically mandated to engage people and providers in their communities about their needs and priorities. As LHIN roles evolve over the next few years, the immediate benefits will be unprecedented opportunities for community input into health care planning. In the years to come, we expect to see better access to patient care.

BENEFITS OF LHINS

Health care choices by the community, for the community

Under LHINs, people close to what is really going on will identify community health care priorities at a local level.

We're all in this together

LHINs will, for the first time, involve Ontarians in the health care conversation, giving them a chance to participate in decisions about the health care system in their communities. This will give the people of Ontario true ownership of the health care system for which they pay for and depend on.

Transparency, accountability and responsibility

LHINs will ensure that health care dollars are spent in the most efficient and effective way possible, yielding tangible results. Accountability agreements between health care providers and LHINs, and between LHINs and government, will ensure the responsible use of

precious health care resources. LHINs will oversee the sustainability of the health care system for all Ontarians.

A system with patients at the centre

LHINs will break down the barriers that patients face navigating a complex health care system. They will ensure that decisions are made in the best interest of patient care.

For more information about LHINs, including frequently asked questions, visit the LHINs' website at www.lhins.on.ca

HIGHLIGHTS OF LOCAL HEALTH SYSTEM INTEGRATION ACT 2006

LOCAL HEALTH SYSTEM INTEGRATION ACT 2006

The Local Health System Integration Act, 2006, was introduced on November 24, 2005 and received royal assent on March 28, 2006. The purpose of the act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the community level by Local Health Integration Networks.

The act establishes 14 Local Health Integration Networks (LHINs) as crown agencies of the Ministry of Health and Long-Term Care. It gives LHINs the power to plan, coordinate and fund health service providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions

agencies) in their specified geographic areas. It sets out the corporate organization of the LHINs, the powers of the LHIN boards of directors and requires the LHINs to have an accountability agreement with the Minister of Health and Long-Term Care.

The act provides the legislative framework for creating a health system in Ontario that is:

- Community-based: engages the local community about needs and priorities
- Based on Partnerships: system partners are the Minister of Health and Long-Term Care, the ministry, LHINs and service providers
- Forward Looking: emphasis on planning and priority setting
- Efficient: effective allocation of funding to achieve priorities
- Accountable: clearly defined expectations and measurement of achievement; monitoring and public reporting provide checks and balances in system
- Integrated: coordinated health care with focus on client needs

The act sets out certain requirements and authorities for the ministry and the LHINs in the areas of planning, community engagement, funding, accountability and integration.

Planning and Community Engagement

The Minister must develop a provincial strategic plan for the health system and make the plan public. Each LHIN is required to engage their community and Aboriginal and French Language local planning entities to develop a local Integrated Health Service Plan. Community is broadly defined in the act and

includes patients, health service providers, employees and others. The act identifies some of the methods LHINs will use to engage their communities, including community meetings, focus groups, and advisory committees.

Funding and Accountability

The Minister determines each LHIN's funding and enters into an accountability agreement that sets out performance goals and standards, reporting requirements, a spending plan and a performance management process.

The act ensures that people can access care outside of the LHIN in which they live. The LHIN boundaries do not restrict people in any way.

Once the LHINs have funding authority, they will enter into service accountability agreements with health-care providers to deliver health services in their local communities, in accordance with the LHIN's accountability agreement with the Minister.

Integration

To ensure a coordinated health system, LHINs may facilitate integration discussions between health-care providers. (i.e., transfer services to another location or provider, start or stop providing a service or change the amount of a service) LHINs will also have the power to require integration where they believe it is in the public interest. The act also includes mechanisms to protect employees when services are integrated.

As of March 31, 2006, not all parts of the act had been proclaimed in force. A full copy of the legislation is available on e-laws at http://www.e-laws.gov.on.ca/home_E.asp?lang=en

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WELCOME TO THE NORTH EAST LHIN

The North East LHIN is home to close to 600,000 individuals. It is the second largest LHIN geographically in Ontario, covering 400,000 square kilometres or nearly 42 per cent of the province's land mass. About 57 per cent of the population lives in the larger centres of Sudbury, Sault Ste Marie, North Bay and Timmins. The remainder of the residents are spread out in rural and isolated communities, mainly along the Highway 11 and 17 corridors and the James Bay Coast.

The North East LHIN is a culturally and linguistically vibrant and distinct region. It has the largest number of French-speaking communities in the province, with francophones comprising 25 per cent of the region's population. Aboriginal and First Nations communities make up 8 percent of the North East region.

The size of the North East LHIN—an area larger than the country of France—and the dispersion of its population, presents great challenges to the delivery and equitable access to health care services.

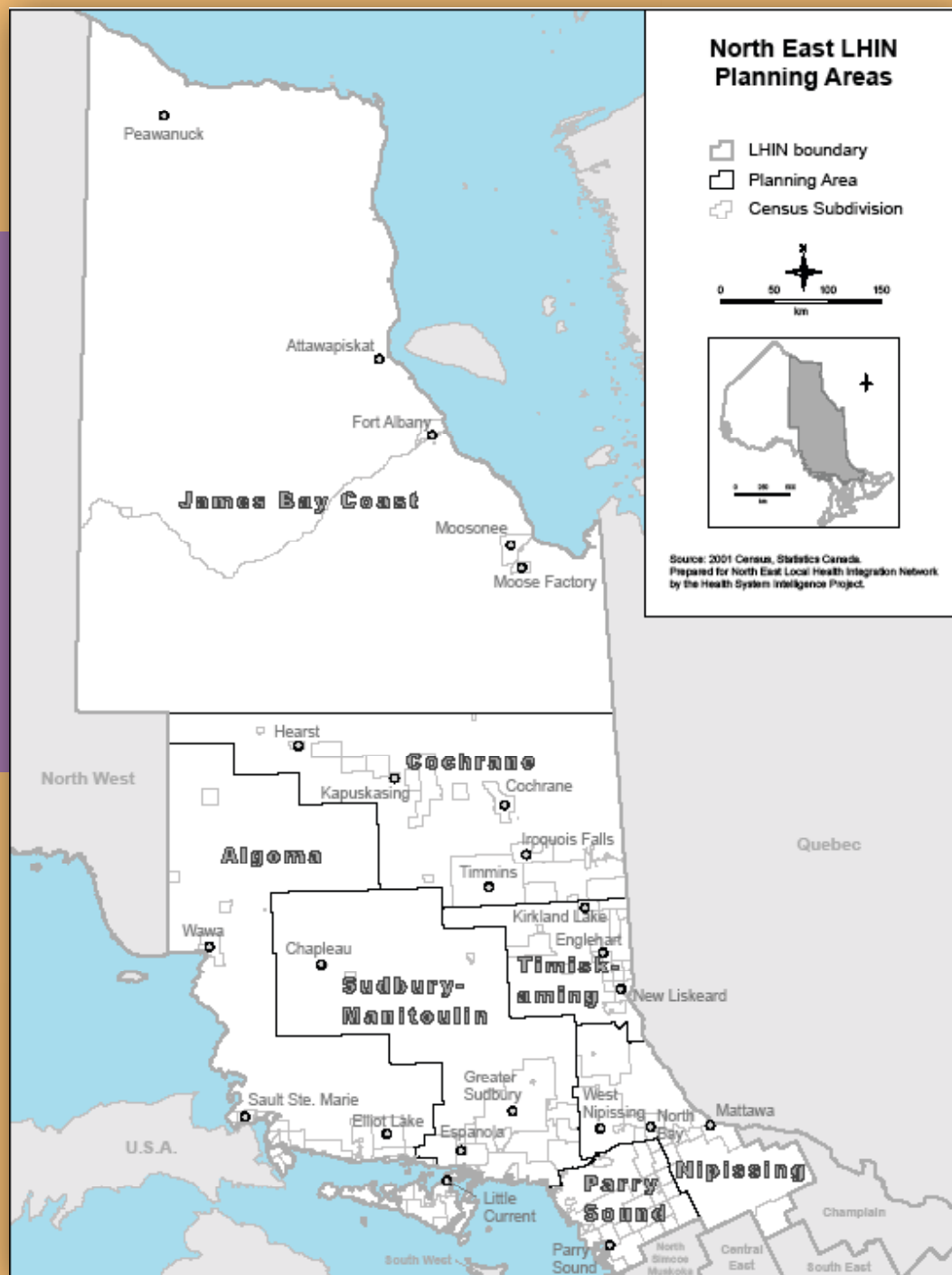
Many of the communities also face extreme economic and social difficulties. The North East region has one of the highest unemployment levels in Ontario, relatively poor health status and the lowest levels of education and income in the province.



Mathilde Gravelle Bazinet, North East LHIN Chair, the Honourable Minister David Ramsay, MPP Monique Smith, Nipissing District and Mayor Vic Fedeli, City of North Bay, Official Ribbon Cutting on June 16, 2006.

The North East LHIN has the mandate to locally lead the transformation of the health system. Yet, many of the challenges faced by the communities are much more fundamental than other areas of the province. There are many communities struggling to survive and maintain sparse services.

North East LHIN Planning Areas





Message from the Chair

This has indeed been an eventful year for the North East LHIN. We have accomplished much in a short period of time. Looking back over our start-up year, I am most gratified by the overwhelming response of our communities in their enthusiasm to get involved and support the mandate and work of the North East LHIN.

Our LHIN held eight information sessions across our region in the following communities: Sudbury, Elliott Lake, Timmins, North Bay, Parry Sound, Sault Ste Marie, Kapuskasing and New Liskeard, to engage the public and invite interested individuals to submit their names as possible board candidates.

The turnout at the public meetings was overwhelming. Over 60 experienced and talented applicants submitted their candidacy—a much higher proportion than in other areas of the province. It made our job of choosing just four nominees a complex, but gratifying exercise. I am delighted to welcome the new members to our board. The board membership now encompasses a wealth of experience and community diversity and will bring tremendous value to this decision-making body.

Our LHIN is still looking to add a board member of Aboriginal background to help bring representation of First Nations' communities onto our board.

This past year has given me numerous opportunities to travel thousands of kilometres across our vast and beautiful region. Our LHIN leadership has had a chance to meet with virtually thousands of stakeholders—health providers, patients, consumers and public officials—in our communities both large and small. People of our region have shared their commitment and concern over many important health care issues. They have also expressed a great willingness to partner with us to find made-in-the North solutions to the goals of integration and improving accessibility of health care services to our North East communities.

We all acknowledge that there are great challenges in our region, economically, socially and geographically. But the North East LHIN, in partnership with our many stakeholders, is committed to lead the local transformation of the health care system. Together we can overcome both geography and circumstance to create an equitable, effective and efficient health-care system of which we can all be proud.

A handwritten signature in black ink, reading "Mathilde Gravelle Bazinet". The signature is fluid and cursive.

Mathilde Gravelle Bazinet
Board Chair, North East LHIN

Message from the CEO

As with any new start-up operation, the first year has been a busy and eventful period for the North East LHIN. The outfitting of office space and the recruiting of staff are ongoing. While we have had a small staff over the past few months, they have been very effective at moving many of our major undertakings forward, specifically the development of our Community Engagement Strategy and the foundational work on the Integrated Health Service Plan.

One of the most exciting undertakings throughout the year has been the opportunity to travel across our vast and breathtaking region.

The frequent trips across the region help to remind me of why we choose to live in this remarkably gifted part of Ontario and how it is our responsibility and duty to ensure that the citizens of this area will be treated to equity of access to health services that the rest of the province enjoys.

Many of the challenges are unique to our area because of geography, a shifting economic base and relatively poor health status. The solutions to these challenges will also largely be found within our own region. We can develop and implement our own solutions through the co-operative efforts of our 239 health service providers, their boards and our community leaders.

Out of necessity, the providers in our area have always had many innovative partnerships and co-operative efforts. We are fortunate that the vast majority of our providers already identify as regional partners and willingly look at issues from a district and regional perspective. This has been evident in the collaborative approach to information technology through the ONE-Health initiative, a committee of health service providers committed to implementing a comprehensive information technology and communications plan for Northern Ontario. The ambitious initiative covers ours as well as a neighbouring LHIN.

The digital imaging Picture Archiving Communications project based in Timmins and Sudbury that revolutionized the transmission of diagnostic images, will soon be serving 18 communities across our area. The regional cancer centre's outreach program serving many smaller communities across our LHIN is another example of the many programs aimed at offering equity and access of services to residents across our region.

Lastly, I must recognize the outstanding contribution of Mathilde Gravelle Bazinet our chair and Margaret Ashcroft our vice-chair, who have assisted in many facets of the operation during this first year when we had little staff support to undertake many of our key responsibilities. Their efforts were vitally important in getting the North East LHIN launched.

The first year has been eventful and the next few years will be just as busy, but the tangible results of our co-operative efforts will be of lasting benefit to all in our great region.



David Murray
Chief Executive Officer, North East LHIN



Our Leadership Team

Mathilde Gravelle Bazinet (North Bay)

Chair of the Board of Directors

(Term: June 8, 2005 to June 7, 2008)

Mathilde Gravelle Bazinet, a member of the Law Society of Ontario, entered the law profession after a successful twenty year career in the field of Nursing Education and Health Care Administration at the community college and university level within the Provincial and Federal Public Sector.

Ms. Bazinet has served on numerous professional Committees, Boards and Commissions. Among others are: Ontario Health Review Panel (Evans Commission), Ottawa-Carlton District Council, University of Ottawa, Post-Graduate Medical Program, Loeb Medical Research Institute and North Bay's St. Joseph's Hospital Board. In June 2004, she was appointed Commissioner for Ontario Northland Transportation Commission. In June 2005, she was appointed the Founding Chair of the North East Local Health Integration Network.

After the Call to the Bar of the Law Society of Ontario, Ms. Bazinet served as Lead Counsel for Medical Services

Branch of Health Canada, then from 1996 to 2004 she established the Federal Centre for Conflict Resolution for the Federal Department of Justice. As Executive Director, she provided conflict resolution, teaching the management of investigation of harassment and abusive authority in the workplace throughout Canada as well as in South Africa.

Ms. Bazinet is the author of several publications in the field of Conflict Resolution, Health Care Administration and Emergency Services.

Margaret Ashcroft (Sudbury)

Vice-Chair

(Term: May 17, 2006 to May 31, 2008)

Margaret Mary Ashcroft was employed for 26 years with the Sudbury Catholic District School Board in the capacity of principal, vice-principal and teacher. Her community involvement includes past chair and member of the Executive Committee at St. Joseph's Health Centre. From 1993 to 1997, Ashcroft served as a board

member with the Sudbury General Hospital. She was also one of the original co-chairs of the Luncheon for Breast Cancer Research.

Kim Christianson (Hearst)

(Term: May 17, 2006 to June 16, 2007)

Kim Christianson is a native of Northern Ontario, who holds a master's in health studies leadership from Athabasca University. Christianson is currently pursuing a PhD in population health at the University of Ottawa and she is also enrolled in a bachelor of education program at Laurentian University. She completed an honours bachelor of science at the University of Waterloo in 2001. Earlier in her career, Christianson worked as a registered dental hygienist in private practice. Over the years Christianson has served on various boards, coalitions and committees, including as board director and treasurer at Hearst Hospital and Notre Dame Hospital and as board director on the Foyer des Pionniers. She has also served as board director of the Ontario Dental Hygiene Association and on the board of the Hearst Community Living Association and the Cochrane District Health Council.

Marc Dumont (Timiskaming Shores)

(May 17, 2006 to June 16, 2007)

Marc Dumont has had a long career in education. He has been a teacher, vice-principal and principal at Ecole Secondaire Ste. Marie. Dumont has worked for the Catholic School Board of Grandes Rivières as a strategic planner and for the Ministry of Education, as an education officer in the North Bay/Sudbury district. Dumont was a teaching assistant for the Laurentian University Faculty of Education. He has served on the board of the Timiskaming Hospital and as regional president of the foundation at the Collège Boréal. Dumont currently is president of the Centre de Santé Communautaire du Témiskaming.

(Front row, left to right)

*Johanne Labonté, Peter Vaudry,
Mathilde Gravelle Bazinet,
Margaret Ashcroft*

(Back row, left to right)

*Dr. Donald Stemp, Marc Dumont,
Kim Christianson, Claus Ott*



Johanne Labonté (Timmins)

(Term: January 5, 2006 to February 4, 2007)

Johanne Labonté has been a Community Development Officer with the Northeastern Ontario Medical Education Corporation for the past 6 years, assisting communities with recruitment and retention of physicians and allied health care professionals. Recently, Labonté has accepted the position of Administrative Financial Officer at the Conseil scolaire catholique du district des Grandes Rivières. Labonté truly understands the importance and the challenges in delivering quality health care services in Northern Ontario. Labonté was instrumental in the founding of the Centre de santé communautaire du Témiskaming, a francophone community health centre in existence since 1995. In February 2005, she was appointed Chair of the Northeast Northern Development Council by the Minister of Northern Development and Mines, Rick Bartulocci.

Labonté has been very active in the community of Timmins since her arrival in 2000. She served as president of the Porcupine Big Brothers and Big Sisters Association from 2001 - 2005. Labonté is also a Big Sister. She also served as a director of the College Boréal Board of Governors and the Centre de Counselling Familiale de Timmins.

Labonté was born and raised in Belle Vallée, Ontario and currently resides in Timmins with her spouse. Labonté has two daughters, Pascale and Dominique.

Claus W. Ott (Elliot Lake)

(Term: January 5, 2006 to January 4, 2008)

Claus W. Ott has been a certified management accountant since 1968. During his tenure with two major Canadian companies, Dunlop Canada and Uniroyal Canada Ltd., he held several increasingly responsible positions in management and finance up to 1969. In 1969, he joined with other founding members to start an inner tube manufacturing company. As part owner, he served as vice-president of finance and secretary treasurer for Trent Rubber Group of Companies until 1992. From 1992-2004 he served as corporate vice-president overseeing operations with an emphasis on merger and acquisitions. For 10 years, Ott served as vice-chair and treasurer on the board of the Ross Memorial Hospital in Lindsay. Ott is an active Rotarian, past president, who was named Paul Harris Fellow for his support of the organization's educational program.

Dr. Donald Stemp (North Bay)

(Term: May 17, 2006 to May 16, 2008)

Dr. Don Stemp was born and raised in Copper Cliff, Ontario. He received his medical degree from the University of Toronto in 1967 and interned at the Hamilton General Hospital in 1968. Dr. Stemp practiced medicine in Caledonia, Ontario, 1968-1969 and in Prince George, BC, 1969-1972. Since 1972, he has been in general practice in North Bay. Dr. Stemp has served in many capacities at Nipissing University College, including member of the board of governors, chair of the Plant

and Property Committee, chair of the Salary Negotiating Committee and chair of the board of directors. Dr. Stemp was district representative to council for the Ontario Medical Association from 1980-1995. He was president of the Joint Medical Staff in 1992 and chair of the Bylaws Committee, 1993-1994, for St. Joseph's General and North Bay Civic Hospitals. Dr. Stemp was chief of staff at the North Bay General Hospital, 1996-1999. From 1996 to the present, he has been vice-chair of the Terry McKerrow CAT Scan Fund. Recently Dr. Stemp has been involved as an interviewer for the North Eastern Family Practice Residency Program.

Peter Vaudry (Sault Ste. Marie)

(Term: May 17, 2006 to May 31, 2008)

Peter Vaudry is a retired steel worker and was employed at Algoma Steel for 37 years. His past community involvement includes being chair of the Ontario division board of directors at the Canadian Cancer Society, as well as, past board member of Cancer Care Ontario and Sault Area Hospital. He also served two terms as a councillor (1997-2003) for the City of Sault Ste. Marie. He is currently a member of the Algoma University Foundation Board and chairs the Sault Ste. Marie Youth Opportunities Council and the Sault Ste. Marie Physician Recruitment and Retention Committee. He is treasurer for the Barrier Free in Algoma Association and is chair of Community Groups and Special Events for the New Sault Area Hospital Campaign.

David Murray

CEO

David Murray was president and CEO of the Sault Ste. Marie and District Group Health Association. The association is the not-for-profit corporation, which partners with the Algoma District Medical Group in the well-known Group Health Centre. The centre serves over 60,000 patients and is a multi-specialty, multi-disciplinary ambulatory care facility with Canada's largest primary care electronic medical record installation. Murray has worked in the health care field in northern Ontario for over 15 years in areas of integration, planning, governance and operations. He was involved in the ministry's Comprehensive Health Organization program. He was a health planner for the Rainy Lake Tribal Health Authority involving the federal health transfer process. He has also served as executive director of the Kenora - Rainy River Community Care Access Centre. Murray holds an honours bachelor of commerce degree from Lakehead University in Thunder Bay, a MBA from the Canadian School of Management and holds the certified health executive designation from the Canadian College of Health Service Executives.

Inside the North East LHIN

POPULATION

Nearly 600,000 people reside in the vast boundaries of the North East LHIN. The region has a higher proportion of older individuals, partly due to the southern migration of younger residents in search of economic and educational opportunities. This has reduced the size of the population among residents 20 to 39 years of age.

During the 1994-2004 time period the North East region's population declined by 0.6 per cent, compared to a 1.5 per cent increase in Ontario during the same time.

The region has the largest francophone population in the province; about one-quarter of the residents are French-speaking. Aboriginal and First Nations communities make up 8 percent of the North East.

Relative to the rest of Ontario, the North East LHIN has a much smaller percentage of immigrants and visible minorities living in the area.

The majority of residents live in the major centres of Sudbury, Sault Ste. Marie, North Bay and Timmins. The remainder of the population is dispersed across rural and often remote communities, some with populations as small as 100 people.



The Honourable Minister David Ramsay, Mathilde Gravelle Bazinet, North East LHIN Chair, MPP Monique Smith, Nipissing District, discuss the North East LHIN Region Map.

It is known that health is related to social and economic factors. The North East region faces challenges in this regard. The population copes with higher unemployment and low-income rates relative to the province. Education levels are lower, including the proportion of residents who did not complete high school.

The distinguishing characteristics of the region have to be taken into account for effective planning and delivery of health care services.

HEALTH STATUS

Residents of the North East LHIN are challenged by various health realities. The population has a significantly lower life expectancy, compared to provincial rates. Residents experience higher rates of chronic conditions like arthritis, rheumatism, high blood pressure, diabetes and heart disease. Hospitalization rates are also higher, often due to circulatory disease.

A lower proportion of residents report their health as being excellent or very good, compared to the provincial rate. At the same time, a higher percentage of the population report being restricted in their activities by a chronic physical or mental condition or health problem.

HEALTH PRACTICES & PREVENTATIVE CARE

A number of health practices in the North East LHIN vary from the province as a whole. The combined percentage of residents considered to be overweight or obese is significantly higher than the rest of the province, 56.6 per cent, compared to 48.5 per cent. The numbers of individuals, who smoke daily and are considered heavy drinkers, also exceed the provincial rate.

On the preventative health care side, residents in the North East LHIN seek out services, like mammograms and flu shots, at rates similar to the provincial average. However, a lower proportion of residents had at least one contact with a medical doctor in the past year.

BUILDING ON LOCAL SUCCESS

The North East LHIN is fortunate to have many dedicated health care professionals and providers already taking a leadership role in developing innovative approaches to enhance the accessibility, quality and sustainability of services to address the many challenges faced by the region. Here is a sampling of several exciting initiatives.

Isolated Patients Electronically Linked With Specialists

An elderly woman was suffering from abdominal pains in Moose Factory, an isolated community on an island in James Bay. Her attending physician was unclear of the cause of her discomfort. In the past, her doctor would have had to wait two to three weeks for feedback on the patient’s x-ray after sending it off to a major centre in the region.

Health status

	NORTH EAST	ONTARIO	LHIN Range
Female life expectancy at birth (years), 2001†	80.5* (±0.5)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	75.0* (±0.5)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.4%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)†‡	5.2 (±1.3)	5.4 (±0.2)	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+)#	53.7%* (±2.0)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+)#	28.3%* (±1.7)	24.6% (±0.6)	19.3 - 30.0%

* Significantly different from provincial average based on assessment of 95% confidence intervals.

Data sources: † Ontario Vital Statistics, Mortality Database ‡ Ontario Vital Statistics, Livebirths Database # Canadian Community Health Survey, 2003

However, on this occasion 4 years ago, the Moose Factory physician transmitted a digital image of the patient's x-ray and moments later hundreds of kilometres away at Timmins District Hospital, Dr. Claude Vezina, medical director of diagnostic imaging, examined the image on his computer and was able to make a diagnosis. The treating physician was quickly able to decide on the appropriate care for his patient.

This was the first vivid example of the impact of the revolutionary Picture Archives Communication System (PACS). "It occurred the first week the system was connected," Dr. Vezina said. "It's made a radical change on the delivery of care. Images can be readily transmitted from location to location and across geographic areas. It's given patients in remote communities ready access to a radiologist 24/7, 365 days a year," Dr. Vezina said.

PACS uses digital radiology technology to replace traditional film in capturing diagnostic image, such as x-rays or ultrasounds. The high-resolution information can then easily be transmitted via high-speed computer to be examined by a radiologist located just about anywhere. PACS initially connected a small group of community hospitals in areas like Wawa, Kirkland Lake and Moose Factory, with the Timmins District Hospital.

It was expanded under the umbrella of the Northeast Health Services Alliance and now takes in about 15 hospitals in the Cochrane and James Bay districts, delivering health services to 100,000 people spread across 240,000 square kilometres. Other areas of the region have been moving towards adopting the PACS system as an important innovation in the equitable delivery of health care.

Dr. Vezina was the visionary and driving force behind the introduction of PACS into the region. "When I got here in 1994, I was trying to overcome the difficulty of giving an answer to someone who is hours away. We were using the equivalent of the Pony Express to move information."

The sheer size of the geography and isolation of some communities has always made it difficult for staff at remote medical facilities to quickly access the expertise of a specialist. PACS has greatly changed this reality. The system brings access to quality care for residents living in isolated communities, equivalent to that received by patients in a more urban area of the province.

"This is about buying into a solution to improve health care, not about buying a technology". Dr. Vezina is also medical director for Northern Radiology (NORrad) PACS and is responsible for 17 diagnostic centres. He hopes the North East LHIN will continue to provide leadership to expand the use of PACS in order to better serve and connect the region's rural and remote communities with clinical services on a timely basis.

This made-in-the-North solution increases positive patient outcomes, reduces expensive emergency evacuations, leverages limited health care resources, overcomes challenges of geography and supports community hospitals.

Technology Connects Vast Geographic Region

Good communication is a key prerequisite of achieving the goal of an integrated health system. The North has been making great strides in connecting a range of health service providers since 2004. The Northern Ontario Information & Communication Technology Planning Project (ICT Blue Print) launched two years ago, involved working with health service providers from several sectors in Northern Ontario to develop an integrated vision for information and communication technology. This project was the first of its kind in the province.

The project designed a plan to link hospitals, community health centres, community care access centres, regional in-patient mental health hospitals/programs and regional cancer centres. Spearheaded by the three former northern district health councils, it involved 52 organizations, representing a major portion of the Northern health care budget.

The aim of the project was to determine the current state of information communication technology at the various organizations involved. The project identified opportunities to partner and strengthen ICT linkages between Northern health care providers and sectors. It developed a common vision and strategic blueprint for action for ICT in Northern Ontario.

When the project started, about two-thirds of the health organizations involved were at varying degrees of technological readiness, with some still limited to basic paper records, stated Phil Kilbertus, Senior Integration Consultant for the North East LHIN. Phase I of the program helped organizations with their decision-

making process in upgrading their technology. It took an inventory of the existing system and devised a coherent regional plan. It identified opportunities for partnerships and priorities for investment and overall looked at ICT coordination. Kilbertus was involved in Phase I of the project. The phase I plan was the first of its kind in Ontario to cover such a large part of the health system over such a large geographic area. It established a vision for ICT in Northern Ontario that included the development of an electronic health record.

Through the ONE-Health initiative, the North East LHIN, in collaboration with the North West LHIN, is involved in Phase II of the project launched in June 2006. The second phase of the project will involve over 200 organizations, including community mental health and addiction centres; long-term care facilities, public health units, children's treatment centres and primary group practices.

Phase II will also look at the ICT integration needs of community support service providers and opportunities to build patient self-management tools into the regional system.

The nine-month project will be completed by March 2007. Key components of the project will involve merging the work of the two phases into an overall North East LHIN system plan and developing system-wide coordination/governance options for the future.

It is envisioned that Phase III will involve the tactical ICT plan for implementation of the development of an electronic health record for Northern Ontario.

Integrated Care Improves Patient Access

For seniors in the North, accessible health care can make the difference whether they are able to remain in their own community as they age and their needs for services increase.

For a patient recovering from surgery, it can mean the difference between driving hundreds of kilometres for a post operation appointment or being able to see a physician for follow-up a reasonable distance from their home.

“Access to care is the crux of everything,” said Gisele Guenard, CEO of Espanola General Hospital. “It’s all about access and the gaps that are being filled by the way we do things,” Guenard said.

This is why Guenard spearheaded an expansion of Espanola General Hospital to include a new Family Health Team, which will bring a range of well-needed services under the same roof to the local community. “The obvious solution for the best local integration was to go after a Family Health Team and bring together as many services as possible,” Guenard said. The Espanola and Area Family Health Team will initially include six physicians, two nurse practitioners, three nursing positions, a dietitian and a social worker. Other specialists will be recruited on a part-time basis or as needed to complement the team’s core staff. The hospital also hopes to bring a major mental health partner into the new facility.

Espanola General Hospital is situated about 45 minute to

an hour’s drive west of Sudbury along Highway 17.

The construction is set to begin in September on the new home for the Family Health Team and it is hoped the accommodations will be ready to be occupied by February or March 2007. The greater level of services and programs the new team will provide will be invaluable to the local community.

The CEO saw it as important for the Family Health Team to be joined to the hospital to better leverage the capacity of the continuum of services provided to the community. “We’re trying to really take an under one roof approach,” Guenard said.

This has been a vision for the Espanola institution since the hospital was built in the mid-1980s beside an existing seniors’ apartment complex. In 2004, Espanola added a 32-bed long-term care facility, providing senior residents ready access to a range of medical services. “If a senior in the long-term care facility needs to see a doctor, they see one the same day,” Guenard said. The hospital complex also includes an 18-bed assisted living residence and separate, but located just across the street, is a group home for physically and mentally challenged adults. “We wanted to provide as many services as possible close to where the most needy of our community resides.”

Including the surrounding First Nations communities, Espanola General Hospital serves 12,000-16,000 residents. With just 47 beds receiving funding under the hospital umbrella, including 15 acute care beds, Espanola is considered to be a small hospital. Yet, Guenard points out that with the hospital’s diverse components “130 people go to bed at night in our facility”.

"Think of the cost to society if all these services were separate, you'd end up having three or four different administrative bodies to pay for." For some small communities integration of health services is a key solution and not only from the standpoint of patient care.

"For some communities it could mean economic stability and some growth," Guenard said. "Lack of health services is one of the reasons people leave small communities in the North, particularly as they age."



MAJOR ACHIEVEMENTS

This has been an eventful first year. The North East LHIN is proud to have reached out and connected with so many stakeholders across the region. It has been met with a spirit of collaboration and welcomes the immense feedback it has received. The North East LHIN has forged a rapport and trust with many individuals, which will serve it well as it moves forward.

The North East Local Health Integration Network: The Year in Review



OBJECTIVES AND ACCOMPLISHMENTS

The North East LHIN is pleased that the Central LHIN accomplished all of the performance objectives outlined in the 2005/06 Memorandum of Understanding with the Ministry of Health and Long-Term Care.

The key achievements included orientation and support for the six current board directors and recommendation of the final three board members. The set up of the LHIN office was completed, including the selection of senior management staff and support staff.

A strong foundation was laid across the North East LHIN as it connected with many stakeholders, including providers, consumers, patients, clients and others deeply committed to the future of our health system. These connections will serve the North East LHIN well as it moves forward and continues the process of realizing the Integrated Health Service Plan.

The North East LHIN held a successful forum involving small hospitals in the region.

The forum explored many important and unique issues facing these institutions that serve the small and more remote communities.

Through the ONE-Health initiative, the North East LHIN, in collaboration with the North West LHIN, is involved in Phase II of the Northern Information & Communication Technology project to plan and implement an integrated communication technology system for Northern Ontario.

The North East LHIN moves forward sharing the commitment and passion of its partners to build a quality and accessible health care system that the residents deserve.

OPERATIONAL STARTUP

There was much work to be done once the Ontario government established a policy framework and Local Health Integration Networks were chosen as the model for integration. First, it was time to launch LHINs as 14 crown corporations. In June 2005, 14 news conferences were held across the province to publicly announce the 14 LHINs chairs, 42 founding board members and 14 CEOs.

CEOs began work in August 2005 and worked alongside the board chairs increasing their knowledge of the communities they serve. LHIN leaders hosted 36 sessions across the province with 1,500 leaders of health care organizations during the summer of 2005.

To ensure cost-effective and efficient operations, LHINs established a common administration process to deliver payroll, financial and human resource services for all the LHINs.

LHIN offices were open for business by the fall of 2005. Four staff members were recruited in each LHIN. The CEO

actively recruited in the fall of 2005, two senior directors and one executive assistant. Richard Joly, Senior Director of Performance, Contracts and Allocation, and Lianne Bettiol, Executive Assistant to the CEO joined the LHIN in January 2006. Ann Matte, Senior Director of Planning, Integration and Community Development joined the LHIN in February 2006.

At this point, until the LHINs are able to hire additional full-time staff, the North East LHIN continues to provide some contract work for individuals to support the implementation of the work plan for community engagement and the Integrated Health Service Plan.

A business operations manual was created to provide basic policies and procedures related to LHIN business operations. This included government directives that LHINs must follow, a summary of legislative requirements that govern LHIN practices and standard policies and activities required by the ministry for all LHINs.

Extensive orientation sessions were held in 2005 for the founding LHIN board members and staff. As part of their professional development, LHINs and the ministry hosted several 'think tanks' on topics such as funding models, planning, corporate governance, ethics and a framework for ethical decision-making. Discussion forums were held to tackle such issues as physicians' relationships with LHINs and LHIN cross-boundary issues.

Accountability agreements between each LHIN and the ministry were developed for the years 2005/06 and 2006/07, setting out the key activities for which the LHINs are responsible. LHINs received templates and guidelines for filing quarterly reports to the ministry.

GOVERNANCE

The Board of Directors is responsible for overseeing the affairs of the North East LHIN so as to fulfil its mandate and responsibilities. These are set out in the letters patent, bylaws, approved business and strategic plans, the relevant government and ministry directives, guidelines and policies and procedures set out in the Memorandum of Understanding. The Board must also adhere to any performance agreement with the Minister or any responsibilities that may be established and communicated by the Minister to the LHIN.

The Board, through the Chair, is accountable to the Minister for the LHIN's use of public funds and for results in terms of goals, objectives and performance of the local health system.

BOARD DEVELOPMENT AND STRUCTURE

With the passage of the Local Health System Integration Act, 2006, there is ongoing discussion about which committees will be included in the regulations. Discussion has also occurred at the chairs and CEOs group, supported by the Governance Task Force, to determine options for governance models, including structures and committees.

ORIENTATION ACTIVITIES

The three founding board members had six full days of orientation on issues of governance and responsibilities as well as on a broad scope of issues involving the North East LHIN.

It was decided the North East LHIN Board, with its current eight board directors, would have a day and a half retreat to continue orientation and to review the contents of the orientation manual provided by the Ministry of Health and Long-Term Care. This meeting was scheduled from June 21 to June 23, 2006.

The orientation session included an overview of LHINs, an in-depth session on governance and an introduction to the proposed seven planning areas in the North East LHIN. This last session included a review of population profile and contextual information unique to each catchment area.

The North East LHIN will continue ongoing board development and education. There will be a component of board education, development and evaluation at every board meeting.

A combined Finance and Audit Committee has been established. As the North East LHIN moves forward this will likely be separated into two distinct committees. Other committees will be formed as the critical work facing the board continues.

COMMUNITY-BASED RECRUITMENT

The initially appointed board members and the CEO held public meetings in the following communities throughout the North East LHIN area: Sault Ste. Marie, Kapuskasing, Timmins, North Bay, Timiskaming Shores, Sudbury, Elliot Lake and Parry Sound. The purpose of these meetings was to educate the general public on the LHIN development process, the governance structure and to invite local representatives to become involved in the nomination process.

In total, over 200 people attended these sessions. Over 60 nomination applications were received from the area, representing one of the highest rates of interest of any of the LHINs. A Nominating Committee was set up, comprised of the LHIN Chair, one other board member as well as three members of the community. The committee reviewed the applications for the remaining community board member positions. The Nominating Committee screened all the applications and identified a number of potential nominees.

About 16 interviews took place over a period of six weeks. The Nominating Committee recommended four potential candidates to the Board and reference checks were completed. The Board approved the four candidates and their names were forwarded to the Public Appointments Office of the Minister of Health and Long-Term Care in November 2005.

PERFORMANCE AGREEMENT

The chair and CEO of the North East LHIN entered into a Performance Agreement with the Ministry of Health and Long-Term Care. The agreement formed the basis of the objectives for the North East LHIN as well as for the CEO.

CONFLICT OF INTEREST GUIDELINES

The Ministry of Health and Long-Term Care has provided LHINs with conflict of interest guidelines. The LHIN Board will have ongoing responsibility for monitoring and ensuring compliance. The purpose of the guidelines is to foster public confidence and trust in the LHIN and

to promote a standard of conduct that will establish the integrity, objectivity and impartiality of the affairs and decision-making process of the LHIN. The guidelines also enables the LHIN to recognize and to avoid, mitigate or manage conflict of interest situations and to ensure that all real, perceived or potential conflicts of interest are resolved for the benefit of the public.

CEO PERFORMANCE EVALUATION

A consultant was hired to assist in developing the performance evaluation process for the LHIN CEOs. The Board Chairs and all CEOs have agreed to an initial CEO performance review process on a short-term basis. A more comprehensive performance review is currently being developed for future years.

The chair completed the CEO performance review process for the North East LHIN for 2005/2006. This review included consultations with stakeholders in the North East LHIN, permanent employees of the LHIN and a member of the Board.

Integration Priorities

In November and December 2004, the Ministry of Health and Long-Term Care hosted community workshops in each of the proposed LHIN locations as a first step in engaging communities to prepare for the transition to LHINs. Out of this process came the North East Local Health Integration Network Priorities Report, which was submitted to the ministry in February 2005.

On April 11, 2006, the North East LHIN staff members met with 35 individuals who were leaders in drafting the Priorities Report. The task was to revisit the ten priorities identified in the earlier report. The leaders were also requested to provide feedback on the North East LHIN's Community Engagement Strategy. The feedback from this session identified themes that will be reflected in the Integrated Health Service Plan (IHSP). Some of the themes include patient-centred service delivery, prevention and promotion programs, chronic disease management, primary care services and information technology. Feedback on the strategy has been positive. A representative from this session commented that the engagement strategy is ambitious for such a large geographic area.

Integrated Health Service Plan

The Integrated Health Service Plan (IHSP) team has been working diligently on its development. The process to date includes: an environmental scan, the development of the IHSP vision, values and proposed priorities. The North East LHIN has utilized both primary and secondary research in the process by surveying existing networks and consulting the community at large.

All community engagement activities for May and June 2006 throughout North East Ontario were specifically linked to the IHSP process. The proposed priorities were validated through this broader community consultation.

The vision for the IHSP entails an integrated health care system that achieves an equitable distribution of resources. The goal is to create a culture of mutual accountability and improved access that will collectively lead to better health outcomes for individuals.

It is important that integration be understood in terms of local realities in the North East region. There are tiny communities in the area, which require access to a certain level of services within their immediate vicinity. As a result, a three level approach to integration has been devised. At the community level, people need to be able to access certain services where they live, even in areas with very small populations.

Other kinds of services must also be provided at the district level. Individuals need access to emergency and surgical services located within a reasonable distance from their homes, particular during the winter when harsh weather conditions can hamper transportation. Where possible, it may require pulling services that have been centralized back into certain communities. On a regional level, there has to be reliability and consistency of what is available.

The North East LHIN values equity and access, quality and efficiency, health promotion and disease prevention and information, communication and technology.

A review of provincial priorities, blended with preliminary feedback from stakeholder community members throughout North East Ontario have resulted in the following list of priorities: reduced wait times, francophone services, First Nations/Aboriginal services, primary care reform, health human resources needs, chronic disease management and prevention and coordinated information, communication and technology system. It is important to note that these proposed priorities are a starting point and will be built upon.

The North East LHIN is currently working on a draft for an Integration Health Service Plan. Focus testing will be conducted on various components of the draft plan, including evaluation by representatives of First Nations communities and health service providers. The important feedback received on the draft IHSP will help the North East LHIN delve deeper into the plan's priorities.



Community Engagement

The North East LHIN is working to develop and foster positive stakeholder and community relationships and to encourage involvement in all aspects of its activities. A Community Engagement Strategy Draft has been proposed. This strategy may be refined based on ministry directives and community stakeholder input.

The North East LHIN is committed to ongoing engagement with stakeholders and communities that have a stake in, or will be impacted by its actions. This includes members of the public, patients and clients, service providers and others. Community engagement is a means for the LHIN to obtain feedback and seek recommendations on service gaps and opportunities for co-ordination and integration. The North East LHIN has held over 137 stakeholder engagement sessions, including public forums, community 'meet and greets' and sessions with providers.

Given the sheer size of the North East LHIN, community engagement entails travelling considerable distances to meet with key stakeholders.



The goal is to ensure that stakeholders' concerns are consistently understood and considered. It is a process of building partnerships and relationships. To do so, the North East LHIN has developed principles upon which it proposes to operate and to be accountable. The Community Engagement Strategy principles are: transparency, timeliness, inclusiveness, appropriateness, accessibility, balance, equity and accountability.

A Regionalized Approach to Community Engagement in the North East LHIN

The North East region is expansive and diverse. Given the sheer size of the region, distances between communities as well as the unique characteristics of the population, requires an approach to community engagement tailored to intra-regional differences. At the same time, it must balance the need to create economies of scale in the delivery of engagement activities.

The North East LHIN is large and diverse in terms of its geographic, cultural and socio-economic characteristics. There are also many distinctions among the 239 health service providers that strive to address the population’s health needs.

To keep the community engagement meaningful and relevant, the North East LHIN plans to engage with stakeholders in different parts of the catchment area. Seven geographic planning areas will be used as an initial approach to community engagement. It is understood that this approach does not assume that the populations in these areas have similar needs or characteristics. Rather, they are in close proximity to each other. The designation of these geographic planning areas is an initial strategy, which may be modified in the future once a more thorough analysis of population characteristics and service consumption patterns can be conducted.

It is important to consider which communities need to be targeted in order to reach the largest number of people.

The seven proposed geographic planning areas for the NE LHIN are as follows.

COMMUNITY ENGAGEMENT

A Regionalized Approach to Community Engagement in the North East LHIN

GEOGRAPHIC PLANNING AREAS/NETWORKS	POPULATION 2001 CENSUS
1 Algoma	119,000
2 Sudbury – Manitoulin	191,000
3 Parry Sound	40,000
4 Nipissing	83,000
5 Timiskaming	34,500
6 Cochrane	85,000
7 James Bay Coast	9,000

During May and June 2006, the North East LHIN focused community engagement sessions on the development of the Integrated Health Service Plan. By hosting six town hall sessions and 35 community engagement meetings, stakeholders, providers and the public have had the opportunity to provide input to the North East LHIN. The Social Planning Council in Sudbury, the established planning groups in Parry Sound, North Bay, Sault Ste. Marie as well as the regional mental health and addictions planning tables, long-term care providers, Network 13 in Cochrane and the regional family health council, have made it possible for the North East LHIN to reach out to a broad spectrum of representatives. Some 1,200 participants attended the presentations during May and June 2006.

The Chair, other board members and the CEO have all been involved in meeting with leaders from health service providers, other health related organizations, clinicians, community groups, municipalities and local politicians over the fall and winter of 2005/2006. These meetings will be ongoing. In addition to the public sessions that were held, there have been meetings with over 120 health service providers and representatives from many municipalities.

In March 2006, the Board approved a Community Engagement Strategy framework, to be used as the basis for engaging the public and health care service providers and other health related organizations. To date, over 350 English and 100 French copies of the Community Engagement Strategy Draft along with feedback forms have been distributed to health care workers, municipalities and other interested parties.

Engaging Small Hospitals

The North East LHIN hosted a day and a half Small Hospitals' Forum in Sudbury in March 2006. The North East has the highest number of small hospitals in Ontario. Some of these hospitals may have as few as six beds and an emergency room. The next closest hospital might be a few hundred kilometres away.

Nineteen hospitals from the North East were represented at the Small Hospitals' Forum by CEOs, board members and staff. The purpose of the forum was to discuss the future role of small hospitals and what opportunities can be maximized within the climate of transformation. Associate Deputy Minister Hugh MacLeod, Dr. Raymond Pong from the Centre for Rural and Northern Health Research, Dr. Michael Rachlis and Chris Helyar of Hay Group were guest speakers at the sessions.

The forum focused on the role of small hospitals, the

services they provide and the challenges they face. It considered ways to redefine the role of small hospitals to help fill gaps in services in local communities. It looked at innovative models and ways to increase the flexibility and strength of these institutions. The North East LHIN plans to set up an advisory committee on small hospitals to ensure ongoing input and dialogue.

The North East LHIN is committed to bring physicians to the planning table. It is exploring ways to support primary care as well as attract, retain and develop services that support the region's physicians. As mandated, a Health Professional Advisory Committee to give physicians an ongoing and formal voice in the planning process will be established.

NEXT STEPS

The North East LHIN Community Engagement Strategy is intended to be inclusive, reaching out to as many stakeholders as possible. Over the summer months it will host two focus groups. One will be composed of representatives from First Nations communities to provide input and advice to the North East LHIN regarding the IHSP. The second focus group will review the work plan attached to the IHSP.

The engagement strategy will involve stakeholders in different ways in advising the North East LHIN and in facilitating 'buy-in' to the LHIN's decisions. The development of this Community Engagement Strategy is a fluid process that will continue to be modified as the North East LHIN evolves and gains more knowledge and expertise.

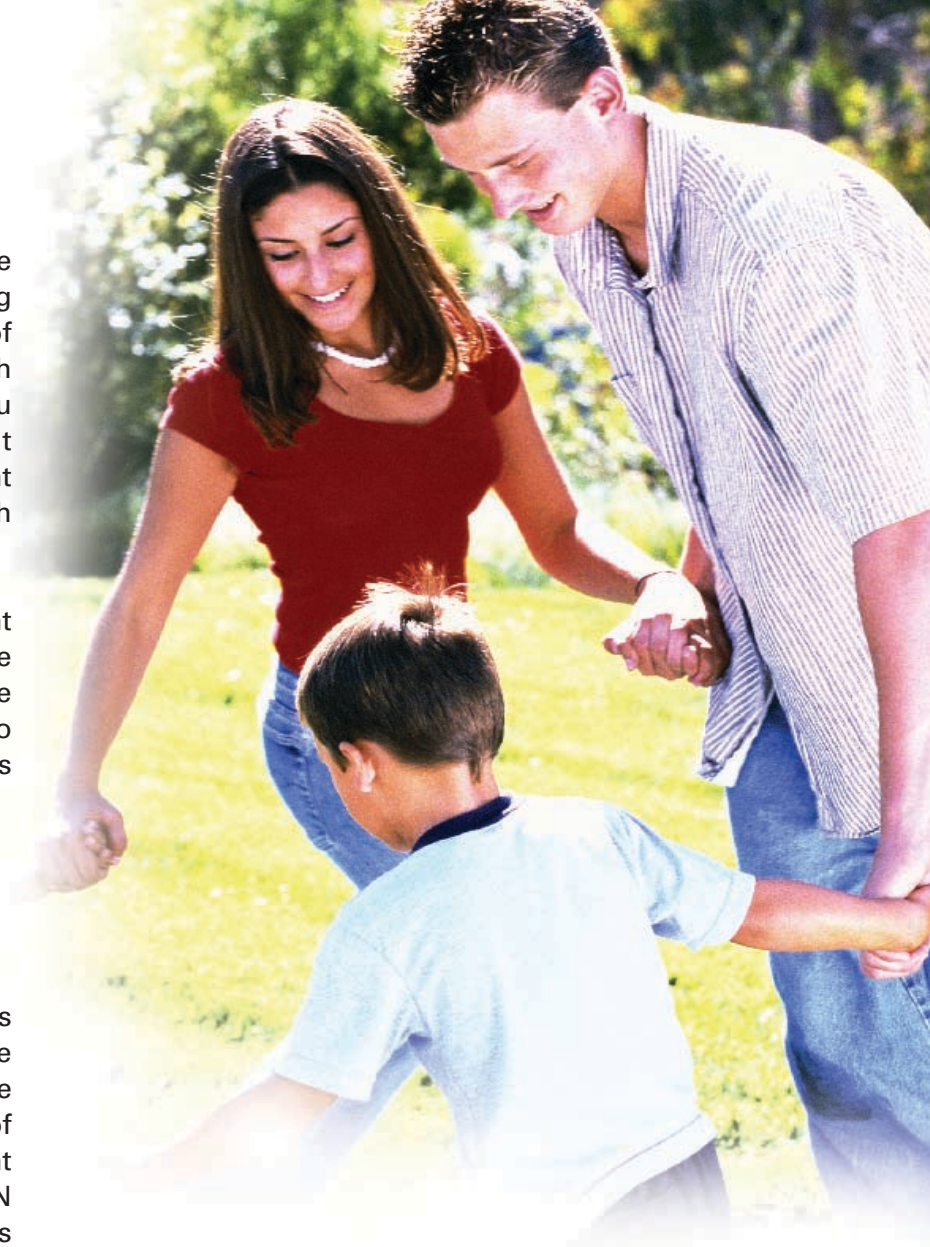
Community Engagement--French Language Services

The North East LHIN recognizes the importance and benefits of engaging with French speaking communities, which make up such a significant part of its region. The North East LHIN is actively working with both the Réseau du Nord de l'Ontario and the Réseau de santé en français du Moyen-Nord de l'Ontario. It looks forward to incorporating some of their current planning activities and research findings into the North East LHIN Integration Health Service Plan.

The North East LHIN is committed to obtain relevant information and advice from French language organizations at the provincial and local level. There will be opportunities for French-speaking residents to influence decisions concerning their health care needs in local communities across the North East.

Community Engagement-Aboriginal and First Nations

The Local Health Integration Act, 2006 also mandates the creation of an Aboriginal Advisory Committee. The North East LHIN recognizes the special needs of the First Nations communities and the difficulties many of these residents have in accessing culturally relevant services within their communities. The North East LHIN is committed to working with aboriginal communities in developing a strategy to best meet the needs and challenges of this unique population.



Financial

Analysis of the North East LHIN's Financial Performance

The North East LHIN successfully started operations in 2005/06, within the allocated budget provided by the Ministry of Health and Long-Term Care.



Statement of Financial Position

March 31, 2006

ASSETS	\$
Cash	29,036
Capital assets (Note 3).....	1
	29,037

LIABILITIES AND NET ASSETS	\$
Accounts payable and accrued liabilities (Note 4)	-
Net assets	29,037
	29,037

APPROVED BY THE BOARD

Statement of Operations and Changes in Net Assets

Period from the date of incorporation

July 9, 2005 to March 31, 2006

REVENUE	\$
Ministry of Health and Long Term Care ("MOHLTC") Funding	3,000
MOHLTC payroll reimbursement	206,146
	209,146

EXPENSES (Note 5)	
Salary and benefits.....	177,179
Office supplies	868
Postage and courier	214
Computer supplies	329
Catering	55
Other.....	1,464
	180,109

EXCESS OF REVENUE OVER EXPENSES	29,037
NET ASSETS, BEGINNING OF PERIOD	-
NET ASSETS, END OF PERIOD	29,037

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Notes to the Financial Statements

March 31, 2006

1. DESCRIPTION OF BUSINESS

Formation and status

The Local Health Integration Network of North East was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "Ministry"). Funding of the LHIN by the Ministry in the fiscal year ended March 31, 2006 was made pursuant to the terms of a Performance Agreement.

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The North East LHIN boundaries were smoothed to include the Districts of Nipissing, Parry Sound, Sudbury, Algoma, and Cochrane. The North East LHIN also includes the eastern portion of the District of Kenora, which it shares with the North West LHIN.

Fiscal period

These financial statements represent the activities of the LHIN from July 9, 2005, the date of incorporation, to March 31, 2006.

2. SIGNIFICANT ACCOUNTING POLICIES

Financial statement presentation

The financial statements have been prepared in accordance with the accounting standards for not-for-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

Revenue recognition

Ministry of Health and Long-Term Care funding is recognized as revenue in the year in which the related expenses are incurred. Any designated funds from which the expenses have not been incurred are recorded as deferred revenue.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates

3. CAPITAL ASSETS

The LHIN office maintains a record of assets purchased in its behalf by the Ministry. The nature of these assets includes:

- Leaseholds (arranged by Ontario Realty Corporation)
- Furniture and equipment
- Computer software and equipment

These assets have been reflected at a nominal dollar value of \$1, as the payment for these assets have been included in the expenditures of the MOHLTC.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The Ministry has included all accounts payable and accrued liabilities totaling \$229,089 to its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 7.

5. EXPENSES

All other operating expenses, other than those disclosed on the statement of operations were approved and paid for on behalf of the LHIN by the Ministry.

Notes to the Financial Statements (Cont'd)

March 31, 2006

These expenditures for the period ended March 31, 2006 are as follows:

Salary and benefits	\$	68,101
Accommodation		1,087,919
Common services		42,126
Information technology		89,859
Other expenditures		332,422
		\$ 1,620,427

6. GUARANTEES

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

(ii) From the inception of the LHIN up to March 28, 2006 each director of the LHIN received the benefit of an indemnity from the Ministry. An indemnity for the Chief Executive Officer was provided directly by the LHIN. Between March 28, 2006 and March 31, 2006, the directors, officers and employees of the LHIN received the benefit of Section 35 of the Act, but no indemnity coverage.

7. STATEMENT OF CASH FLOWS

A statement of cash flows has not been provided, as the information it would contain is readily determinable from the accompanying statements.

Remuneration: \$47,158.65

Staff Members

David Murray

Chief Executive Officer

Richard Joly

Senior Director – Performance, Contracts & Allocation

Ann Matte

Senior Director – Planning, Integration & Community Engagement

Lianne Bettiol

Executive Assistant to the CEO

Acknowledgements

Maureen Murray

Editor

On behalf of the Board of Directors of the North East Local Health Integration Network, we are pleased to submit the Annual Report for the period ended March 31, 2006.

North East

LOCAL HEALTH INTEGRATION NETWORK

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www.lhins.on.ca/english/northeast/northeast.asp

http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html