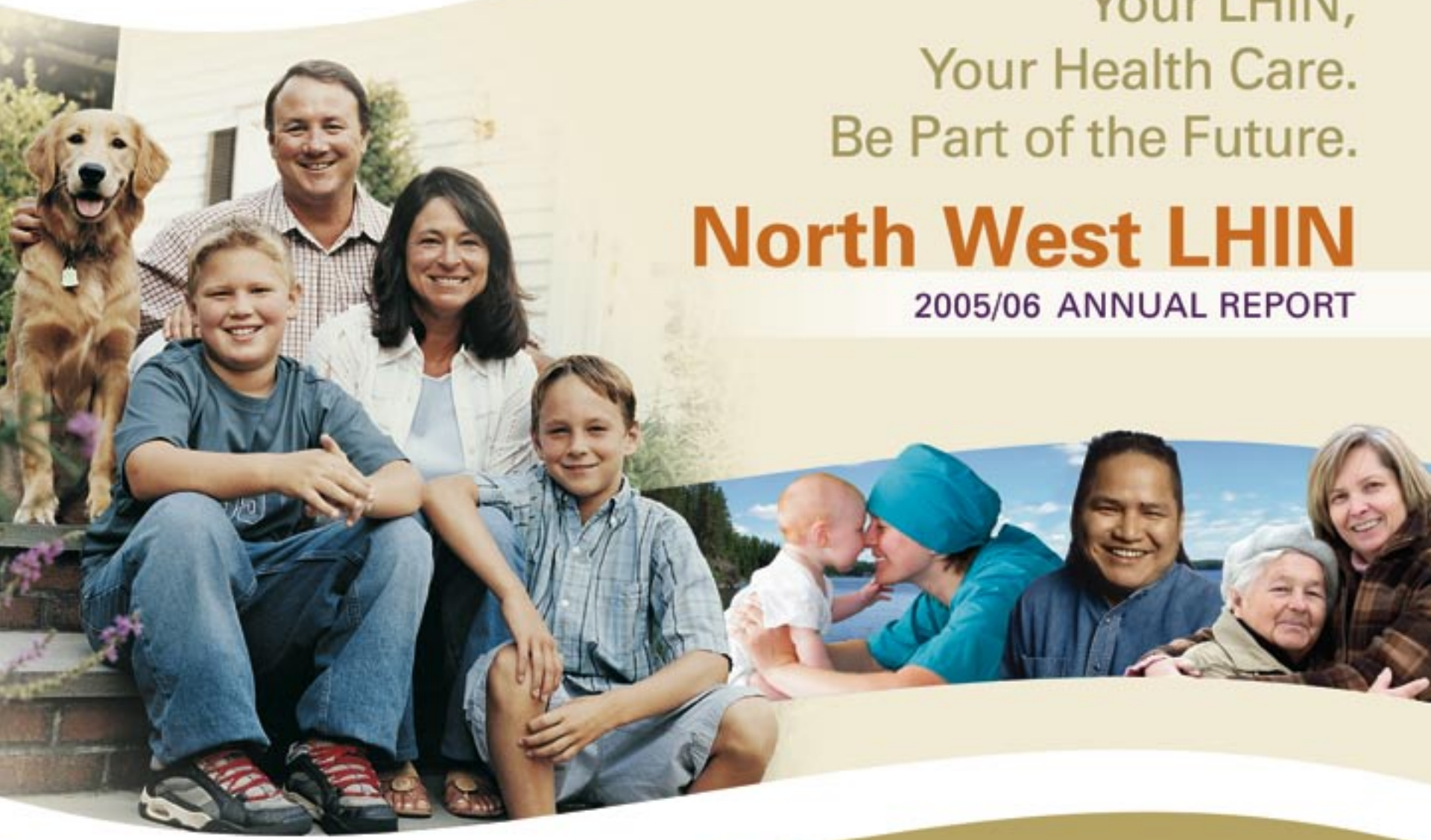
North West
LOCAL HEALTH INTEGRATION NETWORK

Your LHIN,
Your Health Care.
Be Part of the Future.

North West LHIN

2005/06 ANNUAL REPORT



Ontario

Introducing Local Health Integration Networks

In 2004, the Ontario Minister of Health and Long-Term Care announced a series of health transformation initiatives that included the creation of 14 Local Health Integration Networks (LHINs) across the province. LHINs are not-for-profit organizations designed to plan, integrate and fund local health services within specific geographic areas. They are a key element in the government's vision to build a health care system that helps people stay healthy, delivers good care when they need it and will be there for our children and grandchildren.

Why Were They Created?

LHINs are changing the way our health care system is managed and 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. The goal is to create 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.

What Will LHINs Do?

LHINs will have responsibility for planning, integrating and funding 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. They will not directly provide services.

LHINs are based on the principle that community-based care is best planned, coordinated and funded in an integrated manner at the local level, by people who know the needs and priorities of their communities. LHINs will determine the health service priorities required in their local community and will work with local health providers and community members to develop an integrated health services plan for their local area. They will eventually be responsible for funding and ensuring the accountability of local health service providers.

LHINs will oversee nearly two thirds of the health care budget in Ontario – nearly $21 billion. They will also ensure that health care dollars are spent in the most efficient and effective way possible, yielding the best results possible. Accountability agreements between health care providers and LHINs, and between LHINs and government, will foster the responsible use of precious health care resources, and the sustainability of the health care system for generations to come.

As LHIN roles evolve over the next few years, the immediate benefits will be unprecedented opportunities for community input into health care planning. Moreover, LHINs will help eliminate barriers that patients face in accessing services at the local level.

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 local level.

The Act gives LHINs the power to plan, coordinate and fund health care providers in 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 to set needs and priorities;
- **Based on partnerships** - creates links between the Minister, Ministry, LHINs and service providers
- **Forward looking** - emphasizes planning and priority setting;
- **Efficient** - allocates funding to achieve priorities;
- **Accountable** - has clearly defined expectations and measures of achievement; implements monitoring and public reporting to provide checks and balances in system
- **Integrated** - coordinates health care to focus on client needs.

The Act sets out the Ministry and the LHINs' responsibilities and authorities in the areas of: planning, community engagement, funding, accountability and integration to provide the best health care system possible for Ontarians.

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 local planning entities to develop an Integrated Health Services Plan for their local health system. Community is broadly defined in the Act and includes patients, health service providers, employees, and other members of the community. The Act identifies some of the methods LHINs would use to engage their community 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 geographic boundaries of LHINs do not restrict the availability of health care to individuals in any way. The Local Health System Integration Act ensures that people can access care outside of the LHIN in which they live.

When LHINs have received 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 enable a coordinated health system, LHINs may facilitate integration discussions between health care providers (e.g. 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 merge services where they believe it is in the public interest. The Act also includes mechanisms to protect employees when services are integrated.

As of June 2006, not all parts of the Act have been proclaimed in force. A full copy of the legislation is available on e-laws at www.e-laws.gov.on.ca/home.

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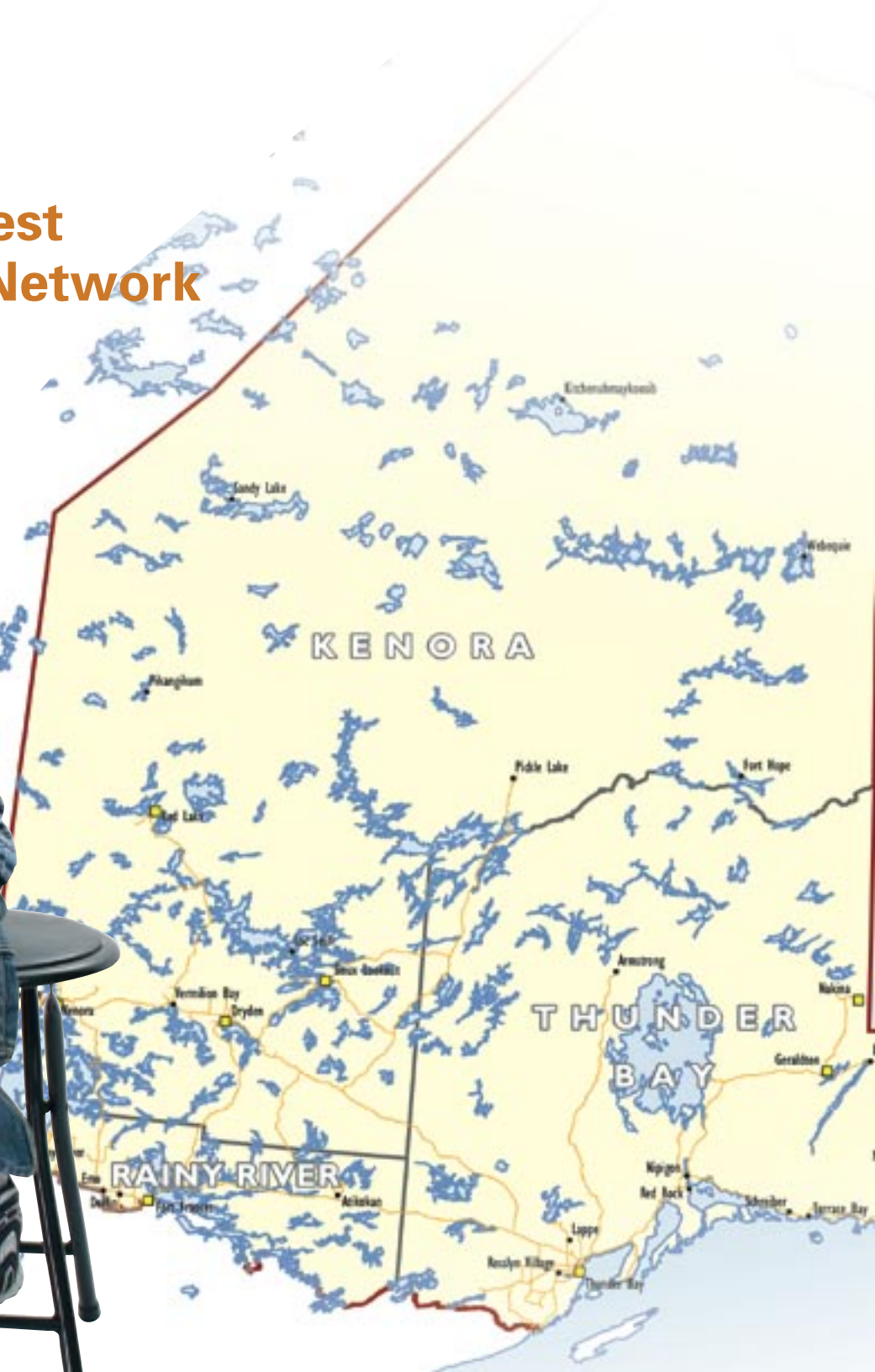
Welcome to the North West Local Health Integration Network



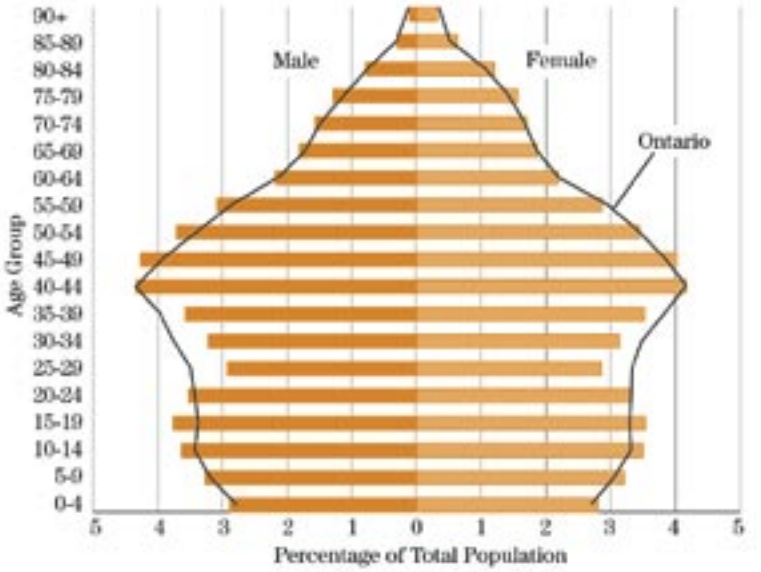
The North West Local Health Integration Network, with a land mass of 47% of Ontario extends from White River in the east to the Manitoba border in the west and from James Bay and Hudson Bay in the North down to the United States Border in the south. The distance between the eastern and western boundaries is slightly over 1,000 km.

The NW LHIN region is comprised of numerous small towns and First Nation communities spread throughout rural and remote areas. The geographic location of these towns and communities creates numerous challenges in planning, delivering and accessing health services.

The North West LHIN is home to 242,500 people, or 2.0% of the population of Ontario. Between 1994 and 2004, the population of the Northwest decreased, on average, by 0.4% each year. By contrast, the population of Ontario increased by 1.5% annually during the same period. Compared to the provincial population, the Northwest has a slightly higher proportion aged 65 or older. The proportion of residents who are Francophone (i.e., who claim French as their mother tongue) is similar to the province as a whole (4.1% versus 4.7%). The percentage of the population of Aboriginal identity is substantially greater in the Northwest (13.9%) than the province (1.7%). At the same time, the percentage of immigrants and visible minorities is far smaller in the Northwest compared to the province. The unemployment rate in the Northwest is higher than the provincial rate, while participation and low-income rates are lower than provincial levels. Education levels are also lower than those for the province. Just under 44% percent of adults (age 20+) have attained post-secondary education credentials compared to almost 49% for the province. As well, 32% of the Northwest's residents have not completed high school, whereas only 25.7% of Ontario adults do not have a high school certificate.

Chart 1 shows the population structure of the North West LHIN. The black line provides the Ontario population distribution for comparison. The population pyramid shows that the population structure of the Northwest area is similar to the provincial age structure at older ages. But the percentage of those in the 10 to 19 age group actually exceeds the provincial structure, the reduction of those aged 25 to 39 in the Northwest, relative to the province, suggests the out-migration of males and females in this age range.

Chart 1: Age-sex population distribution



Data Source: 2004 Population estimates, Statistics Canada

Message from the Chair and CEO

As Chair and CEO of the North West Local Health Integration Network (NW LHIN), we have experienced an exciting and rewarding launch of this new organization. We look with enthusiasm to the next year and the further development of this truly exciting transformation of the health system.

Over the past year, a number of major events have provided a solid foundation for the NW LHIN:

- Developing a Community Engagement Strategy and initiating the community engagement process throughout the Northwest.
- Meeting with over 1,200 individuals, groups and organizations in communities throughout the region.
- Building partnerships with health care providers and consumers throughout the Northwest.
- Establishing a strong LHIN Board and leadership team.
- Passage and Royal Assent of Bill 36, the Local Health System Integration Act, 2006 that gives LHINs the mandate to plan, integrate and, in the future, fund local health services.
- Moving into our premises at 975 Alloy Drive, Suite 201 in Thunder Bay.
- Witnessing a strong presence and excellent presentations by organizations and groups from across our LHIN at the recent *Celebrating Innovations in Health Care Expo* in Toronto.

It has been a privilege to meet so many committed individuals, groups and organizations. Building strong, collaborative relationships is the cornerstone of our Community Engagement Strategy. The collective input and feedback of consumers and providers will be pivotal as we finalize our inaugural North West LHIN Integrated Health Services Plan this fall.

In our presentations, we have often quoted anthropologist Margaret Mead who stated:

> *"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed it is the only thing that ever has."*

The Northwest has been traditionally known for its perseverance and innovation. We are convinced that together with all of our health partners, we can truly make a difference---and build a robust, sustainable health system.

We appreciate the tremendous commitment and interest of residents and members of Northwest health communities. Your time, advice, encouragement and support has motivated us as we advance the work of the LHIN. We look forward to working with you as we collectively build a coordinated, seamless health system which meets the present and future needs of residents in the Northwest.

John Whitfield, Ph.D.
Chair

Gwen DuBois-Wing
Chief Executive Officer

Our Leadership Team

Each LHIN is governed by an appointed Board of Directors of up to nine members. Board members live within the geographic area served by their LHIN and are selected based on their skills and abilities as well as the needs of the LHIN. Members are not representative of specific groups or areas.

Information about LHIN boards, director requirements and downloadable application forms are available on the Public Appointments web site at www.pas.gov.on.ca.

The current members of the North West LHIN Board are:

Dr. John Whitfield

(Thunder Bay) - Chair

Dr. John Whitfield is a Professor Emeritus, Lakehead University, where he served for 36 years as a professor of mathematics prior to retirement in 2001. While at Lakehead, John held several senior administrative positions including Dean of Arts and Science, Vice-President Academic, Interim President and Vice-President Research and Development. Dr. Whitfield also facilitated the corporate merger of two acute care hospitals in Thunder Bay and has served on many boards and committees including Contact North, Northern Ontario School of Medicine, Thunder Bay Community Foundation and the Northwestern Ontario District Health Council. John's term runs from June 8, 2005 to June 7, 2008.

Janice Beazley

(Fort Frances) – Vice Chair

Janice Beazley, a Certified Health Executive and Lifestyle Coach, has 25 years of health care experience which focused on planning and executing strategic initiatives. From 1999 to May 2005, she worked at Trillium Health Centre in Mississauga on the executive team where one of her primary responsibilities was to execute the redesign of a new governance structure. Prior to that, she was Foundation Director at Riverside Foundation for Health Care in Fort Frances and also served , from 1990 – 1998 as Assistant Executive Director, Corporate & Special Services at Riverside Health Care Facilities from 1990 – 1998 providing leadership in that portfolio across a multi-site organization. Jan is a graduate of the University of Minnesota in Health Services Administration and has taken business studies from the University of Manitoba and Lakehead University. She is a member of the Canadian College of Health Service Executives, and has been actively involved in a number of community, regional and provincial initiatives and boards. She is currently self-employed and operates the Loon's Call Bed and Breakfast on Rainy Lake. Jan's term runs from June 1, 2005 to and including May 31, 2008.

Ennis Fiddler

(Sandy Lake) - Secretary

Ennis Fiddler, a Native languages teacher and CBC radio broadcaster, was involved with the organizational development of the Sioux Lookout Health Authority, and Tikinagan Child and Family Services. He was Chief of the Sandy Lake First Nation from 2000 to 2002, and band councilor from 1998 to 2000. Previously, he was chair and a member of the Meno-Ya-Win Health Centre in Sioux Lookout where his focus was the hospital's amalgamation of Native and non-Native services in Sioux Lookout, and the planning of a new hospital. In acknowledgement of his outstanding community involvement and leadership, he was awarded the Queen's Jubilee Medal in 2003. Ennis's term runs from June 1, 2005 to May 31, 2008.

Kevin Bähm

(Terrace Bay)

Kevin Bähm has been employed as a police officer with the Terrace Bay Police Service and the Ontario Provincial Police since 1988. During this time, he served as acting police chief with Terrace Bay Police Service and gained experience in the fields of administration, media relations, community service and exhibits management. From 1986 to 1988, he was employed as director of commercial contracts/security and investigations with Pinkerton Security Limited. Prior to this, through progressive advancement, he worked as a police officer and then detective/investigator with the Metro Toronto Police. His community involvement has included serving as a member of the Schreiber and Terrace Bay Chamber of Commerce, board chair and member of the McCausland Hospital, and board chair of the Lake Nipigon Health Network. Kevin's term runs from January 5, 2006 to and including January 4, 2008.

N/A

Marleen Wong

(Kenora)

Marleen Wong holds a Bachelor of Science in Nursing degree from the University of Ottawa and a Masters of Health Science degree in Health Administration from the University of Toronto. She has been representing Northwestern Ontario since 2003, serving as a Medical Member of the Office of the Commissioner of Review Tribunals for Canada Pension Plan/Old Age Security. Prior to this, she was provincial director of clinical and diagnostic support services for the Provincial Health Services Authority in B.C. Earlier in her career, she was regional director of provincial programs and strategic initiatives for the Vancouver/Richmond Health Board; co-acting president and CEO, as well as vice-president of programs of The Richmond Hospital; vice-president, patient care, at St. Vincent's Hospital (Vancouver); and vice-president, nursing, at The Royal University Hospital (Saskatoon). Marleen currently serves as secretary and property committee member of the finance council at Notre Dame du Portage Roman Catholic Church and is a past surveyor with the Canadian Council on Health Care Accreditation and a member of several committees and task forces. Her term runs from January 5, 2006 to January 4, 2008.

Chantelle Bryson

(Thunder Bay)

Chantelle Bryson, of Thunder Bay, has been practicing municipal, health, aboriginal and environmental law since 2002 throughout the Thunder Bay, Kenora and Rainy River Districts. Prior to that time she was the law clerk to Chief Justice Allan Lutfy of the Federal Court of Canada, focusing her legal efforts on federal labour and employment, aboriginal, equality rights, taxation and immigration and citizenship law. She also has extensive career experience as a counselor in Northern rural communities, working primarily with aboriginal women, youth and children. Chantelle currently participates in a variety of professional, public, post-secondary and trade organizations, as an advisory board member and guest speaker, providing guidance on public entity governance and participating in a variety of community leadership, educational and fundraising initiatives for these groups and their members. She is appointed for the period May 17, 2006 to June 16, 2007.

Bob Gregor

(Marathon)

Robert (Bob) Gregor is a long-time resident of Marathon. He worked at Marathon Pulp Inc. for 32 years, where he held a number of progressively more responsible positions including employee relations administrator, manager of human resources and, over the last fourteen years of his career, as president/resident manager. Since his retirement in 2004, he operates a small consulting practice specializing in business, human resources, mediation and forest products. He has served on the boards of a number of organizations, including the Northern Ontario Heritage Fund Corporation, the Ontario Pulp and Paper Health and Safety Association, the Ontario Forest Industries Association as well as various community and recreational committees within the Marathon area. Bob is appointed for the period May 17, 2006 to May 16, 2008.

Judy Morrison

(Fort Frances)

Judy Morrison is a member of Nicickousemenecaning First Nation. Most recently she was employed by Weechi-it-te-win Family Services as the community liaison worker. She also worked as a health planner for the Fort Frances Tribal Area Health Authority and as a researcher/consultant for Unicare Comprehensive Health Organization (CHO)-Native Perspective. Judy has a long history of working with numerous community organizations. She has served as a trustee of Riverside Health Care, Mine Centre Direct Area School Board, Unicare Comprehensive Health Organization and as a member of the Women's Council. Currently, she volunteers at the United Native Friendship Centre as a mediator for the Alternative Youth Justice Program. Judy's term runs from May 17, 2006 to June 16, 2007.

Inside our LHIN

Northwestern Ontario residents face unique health issues that set us apart from the rest of the province. By looking at several commonly used measures of health, we can shed light on our general wellbeing and quality of life. Life expectancy at birth (the average years of life an individual could live based on current mortality rates) is a frequently used health indicator and current statistics reveal that in the Northwest, life expectancy is significantly lower than in Ontario overall. This reduced life expectancy is found both among males (74.7 versus 77.5) and females (79.5 versus 82.1). Self-reported health, an effective indicator of overall health status that reflects aspects of health not captured in other measures such as disease severity, also contributes to a clearer understanding of health in our region. Using this measurement, only 51% of Northwest residents report their health as "excellent" or "very good" compared to 57.4% in the province as a whole.

Health Status

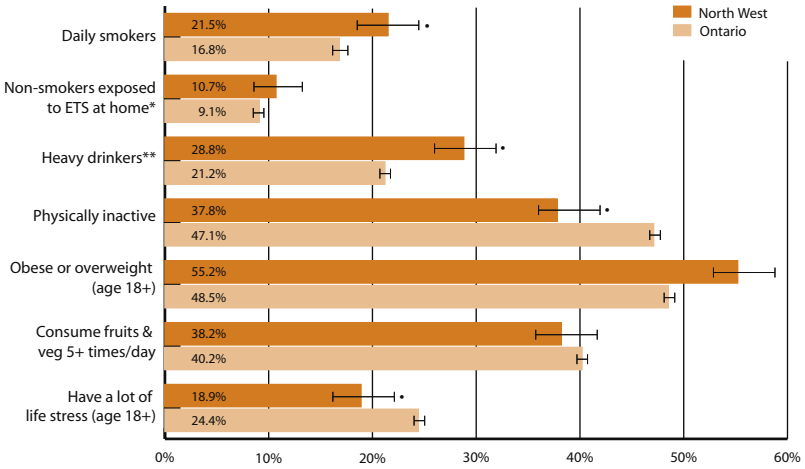
	NORTH WEST	ONTARIO	LHIN RANGE
Female life expectancy at birth (years), 2001 •	79.5* (±0.8)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (year), 2001 •	74.7* (±0.8)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001) ‡	3.7%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001) •‡	5.1 (±1.9)	5.4 (±0.2)	3.9-6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+) #	51.0%* (±3.4)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+) #	29.4%* (±2.9)	24.6% (±0.6)	19.3 - 30.0%

** Significantly different from provincial average based on assessment of 95% confidence intervals.*
Data Source: • Ontario Vital Statistics, Mortality Database, ‡ Ontario Vital Statistics, Livebirth Database
 # Canadian Community Health Survey, 2003

When compared to Ontario overall, daily smoking and heavy drinking rates are significantly higher in the Northwest.

Poor health practices, which are known to be related to the increased risk of chronic disease, mortality and disability, are more prevalent in the Northwest. In addition to smoking and alcohol consumption, there are significantly greater numbers of people with unhealthy body weights in our region. Based on Body Mass Index, 37.8% of the adult population of the Northwest is considered overweight and 17.4% are obese. The combined total of overweight/obese people in the Northwest (55.2%) is significantly greater than Ontario (47.1%). Despite this, Northwest residents are significantly less likely to be physically inactive and are less likely to self-report having a lot of life stress (18.9% versus 24.4%).

Health Practices, Population Age 12+



** ETS-environmental tobacco smoke (second-hand smoke) ** as a proportion of current drinkers*
• Significantly different from provincial average based on assessment of 95% confidence interval.
Data Sourse: Canadian Community Health Survey, 2003

The majority of people (76.4%) in the North West LHIN had at least one contact, either in person or by phone, with a medical doctor in the past year.

Another important indicator of health status is the levels of use of preventive health care services because these services can lead to early detection of disease. In terms of mammogram, pap smear (for cervical cancer screening) and flu shot rates, Northwest rates are similar to provincial rates. However, with respect to the percentage of NW LHIN residents who had at least one contact with a medical doctor last year, the rate is significantly lower than Ontario overall (81.4%).

Use of Preventive Care

	NORTH WEST	ONTARIO	LHIN RANGE
Had mammogram in past 2 years (females age 50-69)	77.2% (±6.1)	70.6% (±1.9)	65.8-77.2%
Had Pap smear test in past 3 years (females age 18+)	68.4% (±4.4)	69.2% (±1.0)	65.4-75.5%
Had flu shot in past year (age 12+)	34.0% (±3.1)	34.2% (±0.7)	30.3-39.0%
Contact with medical doctor in past year (age 12+)	76.4%* (±2.7)	81.4% (±0.6)	76.4-83.7%

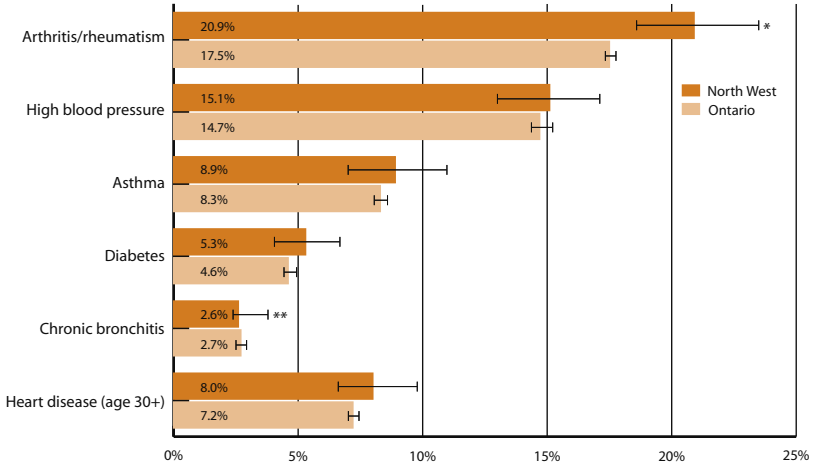
** Significantly different from provincial average based on assessment of 95% confidence intervals.*
Data Source: Canadian Community Health Survey, 2003

In the Northwest, external causes of death (i.e. injuries) contribute to more years of potential life lost than any other cause.

Our region is also confronted with higher death rates than the provincial average with 24.9% of deaths in the North West LHIN occurring before the age of 65 and 44.5% before the age of 75. (Ontario rates are 21.3% and 41.2% respectively.) The greatest contributor to years of life lost after external causes of death are neoplasms and circulatory system diseases.

The prevalence of arthritis/rheumatism is higher in the Northwest than in Ontario as a whole.

Prevalence of Selected Chronic Conditions, Population Age 12+



** Significantly different from provincial average based on assessment of 95% confidence interval.*
*** Estimated for Chronic bronchitis have a high degree of sampling variability and must be interpreted with caution*
Data Source: Canadian Community Health Survey, 2003

At a consultation hosted by the Ministry of Health and Long-Term Care in Thunder Bay on December 10th, 2004, integration priorities were established for the North West LHIN. Participants were asked to identify the top 10 priority integration opportunities (patient care and administration) in Northwestern Ontario.

Patient Care Priorities identified were:

- Integrating mental health and addiction services within the health care system
- Improving access by linking service across the continuum of care
- Developing an integrated strategy for the frail elderly across the continuum of care
- Enhancing community support services such as supportive/supported housing/living, transportation services, personal and family support services (such as respite, personal care in the home, meals to wheels and meals on wheels, etc.)
- Providing services and care close to home
- First Nations/Aboriginal health

Administrative/Support Priorities identified were:

- Implementing multi-year funding to ensure systemic sustainability
- Investing in Northern health information and communication technology planning
- Creating a regional (distributed) LHIN education strategy
- Making the 14 provincial LHINs truly local and accountable to their communities
- Integrating and coordinating health human resources planning
- Providing First Nations/Aboriginal needs-based funding

Since the December workshop, there has been significant community engagement and analysis in preparing the Northwest Integrated Health Services Plan for October, 2006.

Integration Success Stories

There are a number of health care service integration success stories in the Kenora, Rainy River and Thunder Bay districts. The following are a few examples of programs developed by groups, organizations or agencies who are working together to better serve residents of the North West Local Health Integration Network.

The **District Mental Health Services for Older Adults Program** is funded by the Ministry of Health and Long-Term Care and sponsored by the Canadian Mental Health Association – Fort Frances Branch. This unique program provides community-based psycho-geriatric services within a 1200 km radius throughout the Kenora and Rainy River districts in the communities of Fort Frances, Dryden, Kenora, Sioux Lookout, Red Lake, Atikokan and their surrounding areas. This program has proven to be very creative and innovative in service delivery and developing partnerships that meet the unique needs of seniors, their caregivers and care providers in rural and remote communities by helping to maintain individuals in their homes.

The use of telehealth technology and a partnership with Baycrest Centre in Toronto has improved access to scarce specialty resources, including client assessment, consultation and education in each of the six communities. This unique arrangement provides ongoing mentoring for local health care providers with specialists in the field of geriatric psychiatry.

The program was profiled at the "Ontario Psycho-geriatric Team Exchange" in Hamilton in June, 2004 as one of the unique psycho-geriatric teams throughout the province of Ontario. This team and model of service delivery was also profiled at the "National Best Practice Conference on Senior's Mental Health" in September, 2005 and at the "Making Gains Conference" in London in October, 2005. Since then, there have been discussions of how to present this program's model of service delivery internationally.

Northwestern Ontario Regional Knee Surgery Program: Over the past four years, Dryden Regional Health Centre has instituted an innovative and very successful knee replacement surgery program where a visiting orthopedic surgeon from Thunder Bay offers his services to the region. In June of 2005, hospitals in Kenora and Fort Frances joined with Dryden to provide 150 additional knee replacement surgeries. The three hospitals have excellent operating rooms and staffs, anesthetists and active rehabilitation departments. The three hospitals are committed to working together to provide increased access to quality care, closer to home, and improving the quality of life for a significant number of Northwestern Ontario residents.

Integrated Youth Services is an integrated service involving three different agencies (Sister Margaret Smith Centre, Children's Centre Thunder Bay and Family Services Thunder Bay) which provide a centralized point of access for youth 12 to 17 years of age and their families who are experiencing difficulties related to substance abuse and mental health issues. The Integrated Youth Services system collectively provides for the full continuum of care from initial screening and assessment through to intensive residential treatment, after care and parental support programming. The Integrated Youth Service system is supported by a formal service agreement which integrates all aspects of these three agencies from front line services through to the Board of Directors and is further supported by a Community Advisory Committee.

Information and Communication Technology: Northern Ontario is a leader in health-related information and communication technologies. Health service providers in Northern Ontario completed a **Northern Ontario Health Information and Communication Technology Blueprint** in March 2005. All of the hospitals, community care access centres, regional inpatient mental health hospitals/ programs, regional cancer centre, community health centres, health education providers, the three Northern District Health Councils and current regional ICT initiatives throughout Northern Ontario participated in the study. The Blueprint represents a common, integrated direction for ICT among health service providers across Northern Ontario. A second phase of this project is currently underway and is being sponsored by the Ministry of Health and Long-Term Care, FedNor and the North East and North West LHINs.

Operational Start-Up

The start-up phase of an organization is always exciting and challenging. For the North West Local Health Integration Network , this involved moving into our new office in November 2005, hiring our first staff and developing business processes and operational and financial reporting procedures.

Human Resources

On the human resources front, the North West LHIN successfully recruited its senior team consisting of Andy Gallardi, Senior Director of Performance, Contract and Allocation; Laura Kokocinski, Senior Director of Planning, Integration and Community Engagement; Lisa Niccoli, Executive Assistant to the CEO and Chair and Beth Stewart, Office Manager. Additional support staff have been temporarily hired through an employment agency as required.

In addition to the recruitment of on-site staff, various consultant contracts have been established for specific projects following the Ministry's outline for obtaining consulting services.

Business Processes

Office Managers in the fourteen LHINs worked together to establish common business processes including liaison with the ministry's Health Results Team for:

- payroll
- pension and benefit enrollment
- accounts payable
- contract management
- records information management
- information technology
- facilities and equipment procurement

An essential element in ensuring efficiency is the implementation of shared services across all 14 LHINs. These services will include payroll, finance and accounting, human resources administration, and information and communication technology support. Discussions were also initiated with the Health Results Team to plan for the seamless shift to a back office.

In addition, draft procedures were established to deal with month end processes, invoice processing, and expense claims.

Operational and Financial Reporting

In the North West LHIN's first year of existence, every effort was made to establish clear and transparent operational and financial reporting processes. Monthly reports, for example, are provided at every Board meeting. These reports focus on the broad categories of governance, LHIN functions, community engagement activities, integrated health services planning, and business operations. Although this fiscal year was a brief one due to the LHIN's start-up date, we completed the 2005/06 fiscal year on budget.

As we move forward in 2006, the North West LHIN will work with other LHINs and the Ministry of Health and Long-Term Care to develop additional planning, performance management, and funding reporting mechanisms. This will be particularly important as we assume our funding function as of April 1st, 2007.

Governance

A total of six highly experienced individuals comprised the North West LHIN Board as of March 31st, each residing within the LHIN geographic area. Nominations were also submitted to, and approved by, the Minister's office for three additional community members.

Community-based nominations process

The active participation of community members is critical to the vitality of LHINs. Consequently, the North West LHIN, established a Community-Based Nominating Committee consisting of two Board members and three external community members from across the Northwest. Advertising for public information sessions was placed in community newspapers throughout the region.

On October 5, 2005, the NW LHIN hosted public information sessions via videoconference across 14 Contact North sites to inform the public about its community-based recruitment process. Almost 60 people attended at various sites and learned about the North West LHIN, its Board structure and the community-based recruitment process.

The Nominating Committee held several teleconference meetings and a final face-to-face selection meeting. Six potential candidates were recommended by the Nominating Committee to the North West LHIN Board. The Board forwarded the names of three potential candidates to the Minister. Chantelle Bryson (Thunder Bay), Bob Gregor (Marathon), and Judy Morrison (Fort Frances) were subsequently appointed on May 17, 2006.

Evaluation of the community-based nomination process was positive. The use of videoconferencing technology enabled consistent messaging and the opportunity for individuals in Northwest communities to participate in the session.

Board structures and processes

Board structures, including committees, will emerge from the implementation of the Board's work plan. As well, the Board awaits development of provincial regulations outlining LHIN mandated committees. A Board retreat is scheduled for this summer to formulate sound processes and structures.

Building a solid governance foundation is a Board priority. A Governance Task Force was established on January 30, 2006. The work of building a strong Board of Directors continues through discussion of roles and responsibilities of Board members including: planning for a Board retreat, the orientation and development of members, and exposure to information and literature on good governance.

Board processes have been established such as implementation of provincially developed Conflict of Interest Guidelines, the development of performance objectives, and the implementation of a process to evaluate CEO performance. LHIN members and staff have also worked diligently to fulfil the performance objectives set out in the Performance Agreement for the start-up period covering August 22, 2005 to March 31, 2006.

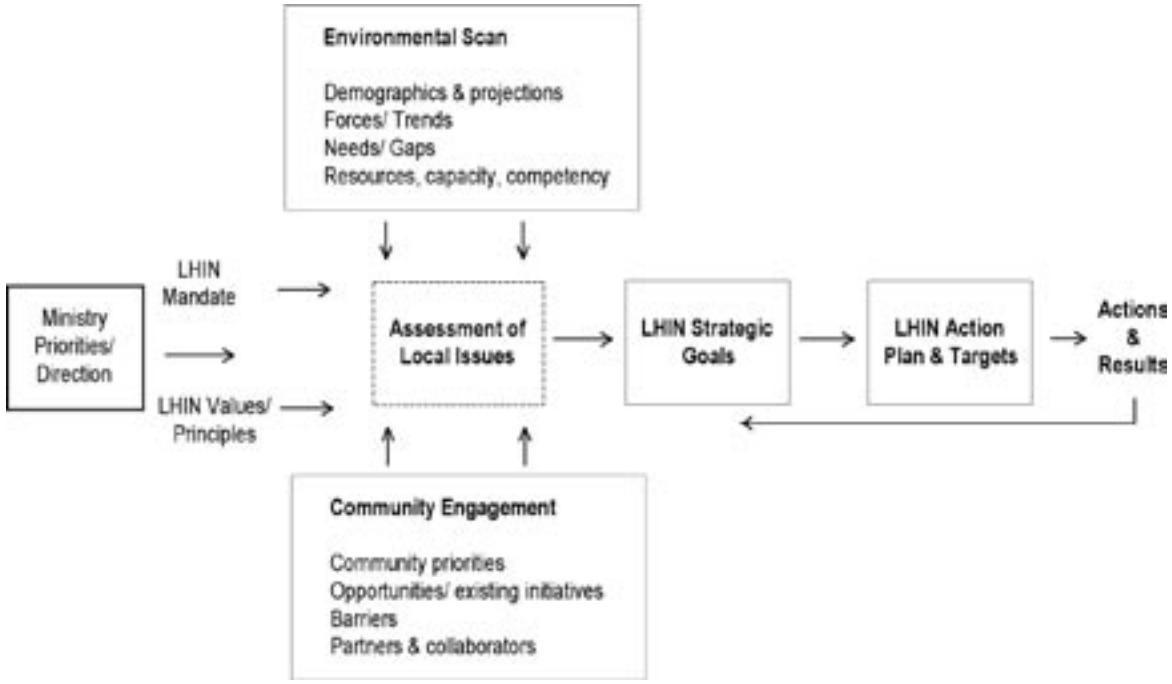
Orientation of new members

Initial orientation has been held locally for Board members to educate them about the LHINs and their roles and responsibilities. Members continue to be kept informed about local and provincial activities through regular updates and communiqués from the Chair and CEO. As well, Board meetings are structured so that there are regular opportunities for Board development and education.

Our Inaugural Integrated Health Services Plan

The North West Local Health Integration Network's initial three year Integrated Health Services Plan (IHSP) will be released in the fall of 2006.

Community engagement is vital to, and underpins, the development of the IHSP. The North West Local Health Integration Network (North West LHIN) has been working with health service providers, communities and the public to gather input for this plan. The plan will present an assessment of local issues, and set out community priorities as well as strategic goals and an action plan for a three year period beginning in April, 2007. This plan will be a "rolling and evolving" plan that will be revisited and refined annually. Building on the experience and the knowledge gained over the past year, the North West LHIN will continue to engage and work with providers and the public to develop processes and strategies to improve our local health care system. The components of the IHSP are depicted in the diagram below.



Two phases of community engagement activities were undertaken and included more than 1,200 participants. These activities focused on providing information about the North West LHIN and gathering input from providers and the public to help support the development of an IHSP for the Northwest. Six key themes emerged from these community engagement activities, namely:

- health human resources
- sustainability of the health system
- access to health services
- mental health and addiction services
- Aboriginal/First Nations health
- Long-term care services (including supportive housing, home care and long-term care beds)[1]

Community members identified e-Health, telehealth and regional programs as enablers to accessing health services and pointed to the large geographic area of Northwest Ontario and distances between communities as barriers.

"Currently, many health services are planned in isolation and are not well coordinated. Patients and their loved ones are forced to make their own way through a very complex health system as they move from one service provider to another." Provider

The Integrated Health Services Plan will provide a multi year planning model that will help to improve patient access to health care services that they need, when they need them and break down barriers currently faced by patients and their families. It will also identify ways to reduce duplication of services. Through improved integration and coordination of services the North West LHIN, together with its partners, will create a more efficient and accountable health care system in the Northwest.

[1]Note, these emerging themes have not been presented in any priority order.

Engaging our Communities

The North West LHIN is committed to ongoing engagement with stakeholders and communities that includes the public, clients, service providers and others. As part of this commitment, a draft Community Engagement Strategy was released and distributed in February 2006 to over 1,500 individuals, organizations and agencies along with a response questionnaire.

Phase one of our community engagement activities (fall, 2005) involved discussions with over 300 participants. The purpose of these sessions was to provide information about the Local Health Integration Networks and gather input from the participants regarding:

- issues/challenges and priorities for health care in the Northwest
- integration opportunities and potential "quick wins"

Six emerging themes from these sessions (presented in the Integrated Health Services Plan section of this report) were shared with providers and the public in Phase two of our community engagement activities (spring and summer, 2006). These activities included 40 provider and public sessions held in 14 communities across the North West LHIN with over 1,200 participants. The key purpose of these sessions was to collect information on emerging themes and gather opinions on how the following questions would support the development of the North West LHIN Integrated Health Services Plan (IHSP):

- What is working well in health services in Northwestern Ontario?
- What are some unmet needs for care and/or services?
- What are some opportunities to improve:
  - access to health care services?
  - organization and delivery of services?

A questionnaire incorporating these questions was distributed at all provider and public sessions and participants were encouraged to take copies and share them with their respective boards, agencies, and communities. The questionnaire was also posted on the LHIN website as another means of obtaining feedback from the community.

During the provider sessions, participants were also asked:

- What are the top three priorities for health care in your community?
- What needs to be done to address these priorities?

Our goal was to bring anyone interested in health care in Northwestern Ontario to the table. To spread word about the public sessions throughout the region, the LHIN advertised in community papers, posted flyers in a number of communities, sent e-mails to health care providers and a range of other contacts, and broadcast the public meeting schedule on local radio and television stations. The attendance of the CEO and members of our Board of Directors at all of the planned community engagement activities underscored their importance.

"If the LHIN can decrease duplication in the system, I feel that this is a very good thing." Terrace Bay Consumer

"We need to listen respectfully to what people are saying and use their feedback/ input in a meaningful and appropriate way; share what we have heard; and work together to develop an integrated health services plan that meets the needs of the people of Northwestern Ontario." John Whitfield, Chair NW LHIN

Evaluation is another important component that has been included in every planned community engagement activity. Here is what some people have said about the process:

"I enjoyed the opportunity to network with fellow health care colleagues, provide input and be heard." Provider

"Breakout groups provided the opportunity to put forth ideas – well organized." Provider

"Bringing people together through community engagement helped reinforce that we, as an agency, are on the right track. I came away feeling energized." Provider

"Health care providers work well together in our area to meet the population needs with stretched resources." Sioux Lookout Consumer

Aboriginal Community Engagement

The North West LHIN is working with the Aboriginal community to develop an Aboriginal Community Engagement Plan. Meetings with some Aboriginal leaders have already taken place. In addition, two focus group sessions were held with Aboriginal stakeholders from across the Northwest (including Treaty 3, Treaty 9 and Robinson Superior Treaty regions and Metis representatives) to discuss strategies that could assist us with the development of an Aboriginal Community Engagement Strategy.

Francophone Community Engagement

The North West Local Health Integration Network has also met with representatives of the Francophone community to discuss health care issues and strategies to address access issues for Francophone residents of Northwestern Ontario.

> *"La présentation était très bien préparée et facile à suivre. Beaucoup d'occasions de poser des questions. Merci aussi d'avoir eu un interprète." le fournisseur*

Financial Statements

The financial position of the NW LHIN for the period ending March 31, 2006 was audited by Deloitte & Touche LLP. Audited Financial Statements were presented to the Board of Directors, and approved, at a meeting in June 2006.

The NW LHIN ended the fiscal year in a surplus position with net assets of $30,808. During this period a total of $30,283 was expended as per diem remuneration to appointed Board members. This figure can be broken down as follows: John Whitfield ($18,200), Janice Beazley ($9,683), Ennis Fiddler ($2,000) and Robert Ritchat ($400).* In their report, the auditors stated that "in our opinion, these financial statements present fairly, in all material respects, the financial position of the NW Local Health Integration Network as of March 31, 2006 and the results of its operations and its cash flows for the period from the date of incorporation on June 16, 2005 to March 31, 2006 in accordance with Canadian generally accepted accounting principles".

*Deceased, May 2006

North West Local Health Integration Network

Statement of Revenue and Expenditures and Changes in Net Assets

Period from the date of incorporation on June 16, 2005 to March 31, 2006

REVENUE	
Ministry of Health and Long-Term Care (MOHLTC) Funding	$ 2,800
MOHLTC payroll reimbursement	231,254
	234,054
EXPENSES	
Payroll	198,821
Office supplies	3,178
Postage and courier	157
Catering	356
Other	734
	203,246
EXCESS OF REVENUE OVER EXPENSES	**30,808**
NET ASSETS, BEGINNING OF PERIOD	-
NET ASSETS, END OF PERIOD	**$ 30,808**

Note: A copy of the complete audited financial statements is available at the LHIN office upon request.

How to Contact Us

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