North East **LHIN**

Health and Wellness for All

2007-2008 ANNUAL REPORT

Ontario
North East Local Health Integration Network

North East **LHIN**

NE LHIN Vision and Mission Statement

Health and Wellness for All … through an innovative, sustainable and accountable system.

VALUES

Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs and opportunities and act appropriately.
Equity	Opportunity for Health and Wellness for All.
Serve	Include North East Ontario geographic, cultural, demographic and linguistic health and wellness needs in all activities.

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Introduction

A debut of accomplishments, passionate participants, and regional rapport

We are proud to document 2007/08 as the debut year of the North East Local Health Integration Network (NE LHIN) with full authority to lead the transformation of the health system for the citizens of North East Ontario.

Since our NE LHIN officially began its important mandate on April 1, 2007, we have been marking milestones with eagerness and sensitivity. We have been ever-mindful of the locally focused vision that our LHIN created to guide our responsibility to the people of North East Ontario: *Health and Wellness for All.*

Our LHIN responded to many challenges in 2007/08, and recognized the huge task of being responsible for planning, funding and integrating health care services for more than 560,000 culturally diverse people across some 400,000 square kilometres. The sheer size and geography of our region, the second largest LHIN in Ontario, shaped the way in which we could effectively operate. The establishment of seven planning areas, numerous committees, task forces and health system round tables, all allowed our LHIN to be informed and effectively make decisions for the people we serve.

Many of our NE LHIN strengths and opportunities in 2007/08 have had human faces—those of health care consumers and their family members and friends, health care providers, LHIN staff, and our Board members. Individually and collectively, they have been magnificent contributors to our first year. This report's pages describe many of our mutually achieved 2007/08 accomplishments.

In our first year, we learned that critical components of our NE LHIN's dynamic process were communication, innovation, participation, and integration. Citizens routinely expressed interest, compassion, and a willingness to collaborate with us to define health system solutions. The two-way communication established has cemented the importance of ongoing dialogue, and helped our website (www.nelhin.on.ca) to flourish.

We worked closely with more than 200 health service providers including hospitals, the North East Community Care Access Centre (CCAC), long-term care facilities, community support service agencies, mental health and addiction agencies, and consumers and their families, to discuss integrating health care practices into a model that works for the people of Ontario's North East region.

Based on 2007/08's lessons and challenges, we have gleaned many insights which will inform our important role as we move forward.

Our extraordinary strength in North East Ontario will continue to be the participation of the North East's people in shaping their health care system to address their health care needs.

Joint Message from the Chair and CEO

The pace of our 2007/08 agenda left us exhilarated at the superb possibilities attainable from the helpful contributions of our North East LHIN stakeholders, Board members and staff.

Our paramount objective was to establish reciprocal communication with North East citizens and health service providers. Through both formal and informal evaluation, we were successful in these crucial community engagement efforts. In our first official year, we laid the groundwork for ongoing dialogue to ensure that health care plans for the North East LHIN area make the best use of available resources and meet the needs of the communities served.

Each member of our Board of Directors traveled extensively throughout the year to meet with local citizens in the many communities of our region. Local Health Integration Networks are governed by an appointed Board of Directors who are bound by Accountability Agreements with the Minister of Health and Long-Term Care to carry out the responsibilities of the Local Health System Integration Act.

The 2007/08 year produced remarkable progress with the North East LHIN Integrated Health Service Plan (IHSP). The Board-approved plan for 2007-2010 was created from extensive consultation with the people and health service providers of North East Ontario. The IHSP—which identifies health care goals, opportunities and priorities—is a key framework under which the NE LHIN operates. It serves as our roadmap with seven priorities for our North East health care system:

- Aboriginal/First Nation/Métis Health Services
- Chronic Disease Prevention Management
- Information and Communication Technology/Information Management
- French Language Health Services
- Health Human Resources Needs
- Primary Care Reform
- Reduced Wait Times.

We advanced in each of these target areas in 2007/08, as evidenced by the numerous reports and releases available on our website, www.nelhin.on.ca. To ensure public accountability and access—a LHIN pledge—we post all such information on our website.

In addition to the implementation of the IHSP, other accomplishments in 2007/08 included:

- Two series of Governance/ Stakeholder Forums held across the North East to provide an opportunity for a broad spectrum of health service providers, stakeholders and consumers to engage in dialogue on North East health issues.
- The development of an interim collaboration plan with partners from the Réseau francophone de santé du Nord, Réseau de santé du Moyen-Nord and Northern Office of French Language Health Services.
- A two-day summit on Addiction & Mental Health.
- A tremendous amount of work in support of the provincial Aging at Home Strategy including the development of two plans: Aging at Home Directional Plan, Detailed Service Plan; 10 "Tea and Chat" sessions with seniors; 50 focus groups and 1,020 surveys with seniors, their family members and caregivers, and a Seniors' Summit.
- The formation of two interim Aboriginal Health Planning Groups to advise the NE LHIN on priorities and allocations for year one of the Aging at Home Strategy for the Aboriginal/First Nation/Métis communities.
- The establishment of four ALC Task Forces in the communities most affected by the ALC issue—North Bay, Sault Ste. Marie, Sudbury and Timmins; a two-day ALC Summit; a comprehensive ALC Task Force Report; and an ALC Action Plan.
- The negotiation of 25 Hospital Service Accountability Agreements (H-SAA) for the 2008-2010 fiscal years.
- The establishment of a Health Professionals Advisory Committee (HPAC).

These accomplishments—and the others you will read about in this report—illustrate the intense pace of our first official year. They also reflect terrific early collaboration with North East LHIN stakeholders, Board members, and staff. This continuing support and assistance is greatly appreciated, and crucial to real improvement in North East Ontario's health care system.

Mathilde Gravelle Bazinet
Chair

Rémy Beaudoin
CEO

Profile of the NE LHIN

Population and Health

Both our geographic region and its human face merit unique attention. These special characteristics are acknowledged and respected by the work of the NE LHIN.

The NE LHIN extends to a vast geographic area of approximately 400,000 square kilometres, with a population of more than 560,000. Our region has a culturally diverse population with 25% Francophone and 8% Aboriginal, First Nation or Métis. The NE LHIN interacts with more than 200 health service providers and 25 hospitals.

In 2007/08, we found benefit in approaching community engagement using the seven geographic planning areas identified in our Integrated Health Service Plan (IHSP):

- Algoma
- Cochrane
- James Bay and Hudson Bay Coasts
- Manitoulin-Sudbury
- Nipissing
- Parry Sound
- Timiskaming.

To ensure that services are the right fit within each planning area and community setting, we took into account critical systemic and demographic factors within the North East. These include, for example, differences between the population of the province and the North East.

Overall, relative to the province, the North East has a higher:

- percentage of the population with Aboriginal, First Nation and Métis identity
- percentage of Francophones
- proportion of older people
- unemployment and low income rate
- percentage of daily smokers
- percentage of adults who are current drinkers reporting heavy drinking
- percentage of adults who are obese or overweight
- prevalence of self-report activity limitations, arthritis/rheumatism, high blood pressure, diabetes and heart disease

… and a lower:

- rate of population growth
- percentage with postsecondary education
- percentage of immigrants and visible minorities
- proportion of pre-middle age adults
- life expectancy for males and females
- rate of contact with a medical doctor in last year.

The NE LHIN meticulously considered these statistics for our work in planning, funding, coordinating and integrating health services for North East Ontario. We are aware of areas which will exert pressure on our regional systems, including the following:

- The NE LHIN has a projected 39% increase in the population age 65+ by 2016 (Ministry of Finance, 2005). In 2006, individuals age 65+ accounted for 91,842 of the total population in the NE LHIN. As a result, the region has a higher proportion of the population age 65+ than the province, i.e. 16.3% and 13.5% respectively (2006 Census).

- There are approximately 7,700 people currently with Alzheimer's disease or related dementias in the North East. This number is expected to rise by 30% to just under 10,000 by 2016 (North East Dementia Network Coalition, June 2007).

- There are over 23,000 older persons living alone in the NE LHIN. Overall, 65% of seniors live as a family, 4% live with relatives, and 30% live alone. James and Hudson Bay Coast residents show the highest percentage of older persons living as families at 77%, compared to 65% in the NE LHIN as a whole.

- The alternate level of care (ALC) issue continues to be a challenge in the North East. In 2006/2007, the region continued to have the highest ALC rates in the province.

Operations

Capitalizing on our best assets … Our People

During the course of the year, the NE LHIN added three new positions (Senior Corporate Advisor, Financial Analyst, and Planning and Decision Support Consultant), and filled four vacancies, to bring our employee base to 22 full-time staff. These additional positions were necessary to effectively meet the growing demands placed on the NE LHIN with its full assumption of responsibilities on April 1, 2007.

Our staff are carefully recruited for a skill base that allows the organization to effectively deliver on its mission of *Health and Wellness for All*. The combined skills of our staff reflect expertise in Aboriginal/First Nation/ Métis health planning, Francophone health planning, health planning and integration within the remote and rural geography of North East Ontario, data collection and analysis, community engagement, financial processes and negotiations, and communications.

Throughout the year, several new internal processes were created to enhance our capacity to deliver programs and services at an optimum level. For example, an electronic news bulletin to health service providers, a presentation tracking system, financial tracking and reporting mechanisms, and more. Our staff also benefited from many professional development and training opportunities, as well as a two-day retreat to build awareness on working effectively as a team and appreciating the diverse strengths within the team.

Operating in a fiscally responsible manner…

The NE LHIN managed its responsibilities with a balanced budget in 2007/08 (See page 22).

A large portion of the NE LHIN budget is allocated to travel costs. With a region that spans 400,000 kilometres and is home to more than 560,000 people in rural, remote and urban communities, travel is a mainstay for NE LHIN staff and Board members.

Board of Directors' meetings are held on a monthly basis and rotate among each of the seven planning areas, allowing Board Directors to meet with stakeholders in their own communities and personally hear issues and concerns regarding the local delivery of health care services. In turn, the people of our region have the opportunity to engage with the NE LHIN and to offer input into the best approach to providing health care across a geographically dispersed and culturally diverse region.

Our people travel extensively to meet with health service providers and consumers, and to engage in meetings, presentations and one-on-one discussions. NE LHIN's Senior Management firmly believe that the deeper a staff person's understanding of the complexity of delivering health care in a Northern climate, the more tailored health services and programs can be to meet the needs of the people who call this area home.

Measuring the State of Health Care in North East Ontario

A direct link with the Ministry of Health and Long-Term Care (MOHLTC)

The *Ministry-LHIN Accountability Agreement (MLAA)* clearly defines the relationship between the MOHLTC and the LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance indicators within a pre-defined period of time.

The table on the following page outlines indicators measured during the 2007/08 fiscal year, and fiscal 2006/07 where more recent data are unavailable.

North East LHIN MLAA Performance Indicators 2007/08

Data Source: Fiscal Year (FY) 2007/08 Performance Target & Actual Performance Values

Performance Indicator (Measured in Days)	(A) Provincial Benchmark	(B) LHIN Baseline	(C) Actual Performance
90th Percentile Wait Times for Cancer Surgery [1, 2]	84	59	57
90th Percentile Wait Times for Cardiac By-Pass Procedures [1, 2]	182	57	48
90th Percentile Wait Times for Cataract Surgery [1, 2]	182	207	134
90th Percentile Wait Times for Hip Replacement [1, 2]	182	368	405
90th Percentile Wait Times for Knee Replacement [1, 2]	182	412	380
90th Percentile Wait Times for Diagnostic MRI Scan [1, 2]	28	72	94
90th Percentile Wait Times for Diagnostic CT Scan [1, 2]	28	75	37
Median Wait Time to Long-Term Care Home Placement -All Placements [2, 3]	N/A	85	122
Performance Indicator (See notes 5,6,7 for Measures).			
Readmission Rates for Acute Myocardial Infarction (AMI). [4,5]	N/A	6	6
Rate of Emergency Department Visits that could be Managed Elsewhere. [4,6]	N/A	84	82
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC). [4,7]	N/A	642	598

Notes

1 Performance corridor calculated based on FY2007/08 LHIN performance target.
2 The actual performance value is from FY2007/08 (1 April 2007 - 31 March 2008 Data).
3 Performance corridor calculated based on LHIN baseline.
4 Outstanding methodological issues by MOHLTC for calculating final values. Values from "May 15 2008 MLAA-PI reported data.xls".
5 Percentage AMI inpatient re-admission rates for hospital, age / sex standardized 3-year rates.
6 Emergency department visits for conditions that may be treated in alternative primary care settings, for patient, age standardized rates per 1000.
7 ACSC rates for patient, age standardized rates per 100,000.

COLUMN DEFINITION:

(A) Per Schedule 10 of the signed Accountability Agreement.

(B) Per Schedule 10 of the signed Accountability Agreement.

(C) Actual number as calculated from FY2007/08 Data.

COLOUR ASSIGNED BASED ON COMPARING:

- Doing Well - Below Corridor & B/L.
- Improving - In Corridor & below B/L.
- Attention - Above Corridor & above B/L - Reporting Required.
- Available data from Fourth Quarter of Fiscal 2006/2007.
- Available data from Fiscal 2006/2007.

At the end of 2007/08, the NE LHIN was unable to achieve three performance indicators identified in its MLAA.

In the area of surgeries for hip and knee replacements, the NE LHIN was still far above the Provincial target wait time of 182 days. The NE LHIN was hopeful that it could reduce its wait time average to 300 or less days, but due to high Alternate Level of Care (ALC) days in our hospitals, this target was not achievable. North East LHIN hospitals are also experiencing difficulty with recruitment and retention of professional staff. In addition, some of our communities are challenged with discharging patients due to the lack of physiotherapists in smaller communities. This scenario leads to patients staying longer in hospitals in order to receive physiotherapy services that are not readily available in the community.

The second indicator that the NE LHIN was unable to achieve was wait time for MRIs. Wait times are lengthy due to an increased demand, notably for oncology patients, and the fact that the NE LHIN currently has three old MRI machines across the region.

The third indicator that the NE LHIN was unable to achieve was median wait time for long-term care placement. This indicator was not achieved due, once again, to the high number of ALC patients in acute care beds in North East hospitals, in addition to a lack of alternative housing options across the North East.

During 2006/2007, the percentage of Alternate Level of Care (ALC) days* in NE LHIN hospitals was 20.6% as compared to the overall provincial value of 12.1%.

A first year of integration activities ...

The goals of the NE LHIN's integration activities are to improve access and the overall efficiency and effectiveness of the health care system while creating a seamless experience for the client, patient or consumer.

The means to achieve these goals are through ongoing community engagement using the framework of ***Towards Unity for Health (TUFH)*** and through the application of continuous quality improvement methodologies such as *plan*, *study*, *do*, *act* (PSDA) both at the organizational and system levels. Two examples of work underway to engage the system in discussions on integration include the Addiction and Mental Health and Aging at Home Summits where participants were provided with information on models for integration within each of these sectors. Efforts to move forward with integration in these sectors will take shape in the coming year.

In 2007/08 the NE LHIN issued three voluntary integration orders supporting the following:

1. The integration process between the Sudbury Regional Hospital and the Northeast Mental Health Centre (NEMHC), and between NEMHC and North Bay General Hospital.

2. The transfer of the West Parry Sound Health Centre operation of the West Parry Sound Health Centre Community Care Access Centre within the geographic boundary of North Simcoe Muskoka LHIN to the North Simcoe Muskoka CCAC as of July 1, 2007.

3. The integration of community support service organizations of *The Friends* and *Caregiver's Voice* into one organization by March 31, 2008.

**Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.*

Community Engagement

The North East LHIN's ***Community Engagement Strategy*** provides a framework to actively engage, empower and mobilize communities, stakeholders and the public in planning for an improved health care system. It also addresses and reflects the specific cultural needs and linguistic characteristics of the Francophone and Aboriginal/First Nation/Métis peoples.

At the onset of the North East LHIN, a ***System Planning and Implementation Cycle*** was established to ensure that all stakeholders were included in the process of identifying system level priorities and providing opportunities for implementation of strategic directions.

All aspects of this collaborative community engagement and planning approach have been integrated within the North East LHIN's planning and business cycle. This allows pertinent information and feedback to be captured in a timely manner. As identified in the diagram below, all stakeholders are included in one of the following settings:

1. Stakeholder/Community Groups: **Recommending System Improvements**
   - Communities
   - Health Managers
   - Policy Makers
   - Health Professions
   - Academic Institutions

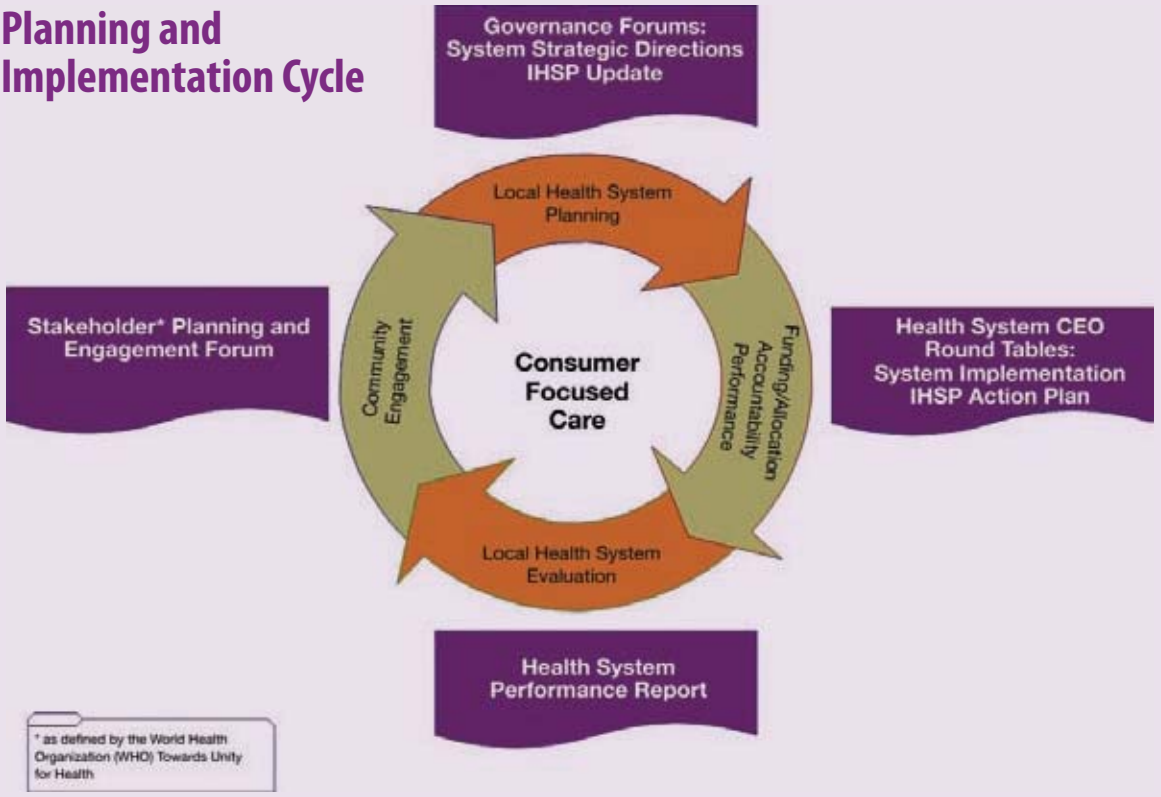
2. Governance Forums: **Setting System Directions**
   - Board members from LHIN-funded health service providers

3. Health System CEO Round Tables: **Implementing Governance Directions**
   - CEOs/EDs from health provider and partner organizations

4. Health System Evaluations: **Evaluating System Performance**
   - Consumer surveys
   - Performance evaluations

This collaborative approach is carried out under the framework entitled ***Towards Unity for Health (TUFH)*** as developed by the World Health Organization. This framework "expresses the shared will of multiple partners to shape a sustainable health service based on people's needs." It is founded on the assumption that a coordinated or integrated approach is better than any other to improve quality, equity, relevance and cost-effectiveness in health. It speaks to the importance of engaging key partners/stakeholders in order to "establish a sustainable, people-based health service in line with values of quality, equity relevance and cost-effectiveness."

Planning and Implementation Cycle



Community Engagement, continued

Community engagement in the North East LHIN throughout 2007, and the first quarter of 2008, was abundant and varied, including:

- Four summits on the topics of: Alternate Level of Care (125 delegates), Addiction and Mental Health (150 delegates), Seniors' Health and Aging at Home (140 delegates), and Francophone Health (175 delegates);
- Two series of Governance/ Stakeholder Forums (more than 400 participants from health service providers);
- Ten *Tea and Chat* sessions and 50 focus groups with seniors and their families and caregivers;
- 1,020 surveys of seniors, caregivers and their families;
- Development of a broad-based survey of North East Ontario people on health care access issues;
- Regular meetings with the North East LHIN Health System Round Tables as well as a two-day planning retreat which brought all Round Table members together for the first time (approximately 60 participants);
- Regular and ongoing presentations to community groups and organizations across the North East LHIN.

These activities provided occasions to bring together key partners to discuss elements of the health care system. The Summits were an opportunity to present information on evidence-based best practice and solicit feedback on how to implement these best practices relevant to the health care system in this region.

The purpose of community engagement is to hear from the users of the system. Through our various activities we were able to receive information from the general public on how community members perceived the system to be meeting their needs. Collectively, this information informs the NE LHIN on how to better achieve its vision of ***Health and Wellness for All***.

As community engagement is not a point-in-time activity, but an ongoing activity of LHINs, we have been able to develop new partnerships and collaborations that will support our work in the coming years. For example, further to the Addiction and Mental Health Summit we will be working with a regional committee of health service providers to understand opportunities for further integration. Similarly, our Health System Round Tables will continue as a chief mechanism to implement the strategic directions of the IHSP.

As we continue our community engagement activities, we will monitor and evaluate how we are doing to ensure that our five key stakeholder groups are actively engaged in a meaningful and outcome-oriented manner.

Integrated Health Service Plan (IHSP) of the North East LHIN

The North East LHIN's ***Integrated Health Service Plan (IHSP)*** was created with the input of more than 2,500 health care providers and consumers in North East Ontario, in addition to an extensive literature review. The IHSP is pivotal to the operation of the North East LHIN and is the foundation to which all North East programs, services and activities are aligned.

The Plan identifies seven priorities for an improved health care system in North East Ontario, including:

- **Aboriginal/First Nation/Métis Health Services**
- **Chronic Disease Prevention and Management**
- **French Language Health Services**
- **Health Human Resource Needs**
- **Information and Communication Technology/ Information Management**
- **Primary Care Reform**
- **Wait Times.**

In 2007/08, we moved forward with these priorities in a variety of activities noted below:

Aboriginal/First Nation/Métis Health Services

- Interim planning groups were formed to assist the North East LHIN with planning for this population. The planning groups are interim until such time as the *Local Aboriginal Health Planning Entity* is in place.
- An Aboriginal Health Summit was planned for spring 2008 to explore how to use technology in health care planning and delivery and work towards identifying appropriate Aboriginal health planning bodies and processes.
- 15% of first-year *Aging at Home Strategy* funding was dedicated to Aging at Home planning for the region's Aboriginal/First Nation/ Métis people.

Chronic Disease Prevention Management (CDPM)

- A project charter for rolling out CDPM was developed. A North East LHIN CDPM strategy will be initiated during 2008.

French Language Health Services

- An FLS Working Group, comprised of the Réseau francophone de santé du Nord, Réseau de santé du Moyen-Nord, the Northern Office of French Language Health Services (MOHLTC), and the NE LHIN was formed and worked to develop an interim collaboration plan which outlines roles and responsibilities of the main planning partners. This collaboration plan will form the basis for supporting the planning activities of the French Language Services Planning Entity.
- The NE LHIN, in collaboration with the Northern Office of French Language Health Services of the MOHLTC, included the FLS equity index indicator in the Hospital Accountability Process.
- A Francophone Health Summit was held and focused on the management and prevention of chronic diseases, health of Francophones, the importance of cultural competency, and citizen engagement and participation.

Health Human Resource Needs

- A project charter was developed.
- A regional steering committee to oversee the development of a health human resources plan will be established during 2008.

Information and Communication Technology System and Information Management

- The Northern ICT blueprint was completed along with a tactical plan for its deployment.
- A joint Project Management Office (NE and NW LHIN) was established to move forward with the strategies outlined in the Blueprint, including such projects as a diabetes registry, diagnostic imaging, and others.

Primary Care Reform

- The main thrust of primary care will be in implementing the CDPM strategy.

Reduced Wait Times

- An expert Advisory Panel was established to monitor performance and make recommendations for surgical programmatic changes.
- Work also began on a surgical optimization study with an initial focus on Cancer Care Ontario's thoracic oncology standards and then all other surgical programs across the North East.

Community Engagement and our Francophone Population

Engagement activities with our Francophone stakeholders take place on an ongoing basis through the regular stream of NE LHIN community engagement activities. NE LHIN public information is published in a bilingual format, our website is maintained in French, our Governance and Stakeholder forums were bilingual, and surveys and focus groups are always held in a bilingual manner. At all public events, the opportunity is provided for Francophone participation and input. The NE LHIN's Health System Round Tables consult on a regular basis with the Francophone health partners within their planning area.

Parallel to the community engagement activity process, the ground work is being laid to move forward with a planning process that will serve to address the specific needs of our Francophone population. An interim French Language Service (FLS) Working Group was formed for this purpose. This group has met on five occasions since the fall of 2007 to develop an interim collaboration plan outlining their roles and responsibilities as key planning partners. They have also identified three main objectives that will form the basis of guiding the planning activities of the French Language Services Planning Entity. These objectives are:

- Continuous improvement of quality, access, accessibility and integration of French language health services.
- Community empowerment and continued community engagement in order to impact the overall health system and improve health status.
- Accountability of health service providers to their community.

While awaiting the establishment of the Ministry of Health and Long-Term Care FLS Planning Entity, the NE LHIN has created an interim FLS Planning Entity. The interim Planning Entity will build on the work completed to date by the FLS Working Group. The FLS Working Group was given the mandate to develop a project charter for the Entity, which the NE LHIN will establish in the spring of 2008.

A major achievement for the NE LHIN as it relates to FLS is the inclusion of a FLS equity index in the Hospital Service Accountability Agreement (H-SAA) process. This was done in collaboration with the Northern Office of French Language Health Services. Twenty-two of the 25 NE LHIN hospitals are identified or designated under the French Language Services Act and have in their H-SAA a FLS equity index. We are proud to report that two of our hospitals, Hôpital Notre-Dame Hospital in Hearst and Smooth Rock Falls Hospital, have attained the FLS equity index of "1." For hospitals that have not attained the FLS equity index of "1," the goal is to improve their 2007/08 reported index by 10% by March 31, 2010. The FLS equity index is used to measure the equity of access to and accessibility of hospital programs/services in French for the Francophone population.

The NE LHIN and the Réseau francophone de santé du Nord ended the year with a Francophone Summit – *Healthy Francophones in our Communities…Achieving Health Together*. The Summit focused on three main themes:

- The management and prevention of chronic diseases;
- Health for Francophones and the importance of cultural competency; and
- Citizen engagement and participation.

Over 175 participants from across the North East attended the Summit, held in Timmins. The results from this Summit will assist the NE LHIN and the interim Planning Entity in planning for the health care needs of the Francophone population.

Community Engagement and our Aboriginal/ First Nation/Métis People

During 2007 and continuing in 2008, the NE LHIN focused on building meaningful relations with Aboriginal/ First Nation/Métis communities to help improve the health status and services to this NE LHIN population group which represents 8% of the overall population.

In 2007, the NE LHIN established two Interim Aboriginal Health Planning Groups. One has representatives across the NE LHIN and the other is focused on the James Bay and Hudson Bay Coasts Planning Area. These groups meet on a regular basis and advise the NE LHIN on priorities and allocations within the Aging at Home Strategy for the Aboriginal/First Nation/Métis communities, and health planning priorities in general while waiting for the Local Aboriginal Health Planning Entities (LAHPEs) to form. Over the next year, the NE LHIN intends to formalize this health planning structure to stabilize Aboriginal health planning for strong development across the region.

NE LHIN Engagement Activities with Aboriginal/ First Nation/Métis People in 2007 and early 2008:

- Held a seniors' engagement process to support the Interim Planning Groups and the *Aging at Home Strategy*. The engagement included 14 focus groups and 10 one-on-one interviews with Elders and seniors. A total of 140 Aboriginal/First Nation/ Métis seniors participated.
- Met and engaged with all key Health Directors/Managers on Manitoulin Island to discuss issues related to access to CCAC.
- Presented NE LHIN information to North Shore Tribal Council Health Board with seven First Nation Health Directors and engaged with them about their current health planning priorities.
- Presented NE LHIN information to the Aboriginal Health Access Centres at their annual strategic planning meeting.
- Presented LHIN information at a Chiefs of Ontario, Health Director's, quarterly, Health Coordination Meeting with five PTO Health Directors.
- Ongoing discussions with an urban Health Policy and Program Developers Group with membership from Ontario Federation of Indian Friendship Centres, Ontario Native Women's Association and Métis Nation of Ontario.
- Hosted a joint Board/Staff Community Forum in Moosonee for the James and Hudson Bay Coast communities about the proposed development of the Weeneebayko Area Health Authority and the Integration Agreement.
- Named five Aboriginal Representatives to NE LHIN Planning Area Health System Round Tables.
- *The Aging at Home Strategy* supported projects in 13 First Nation communities and seven urban Aboriginal communities. It is estimated that over 2,300 units of service will be provided within eight urban centres across the NE LHIN, and to 900 seniors across the James and Hudson Bay Coasts, along with 1,150 clients.
- The NE LHIN is a partner in a First Nation ICT Project whereby 14 First Nation communities along the North Shore and on Manitoulin Island are developing an electronic health record. It is anticipated that additional First Nations areas will participate.
- Invited to support the *Our Health Counts* project which is a comprehensive, urban-based strategy to include Aboriginal people in health records across the health system in Ontario.
- Conducted a literature review, analyzed existing programs and population data sets including the Regional Health Survey, Aboriginal Health Survey and health questions from the Census specific to the NE LHIN, and provided options on how to correct health information for improved health planning.
- Assisted with the coordination of a MOHLTC lead, health service provider 'dialogue' session about how to create Local Aboriginal Health Planning Entities (LAHPE).
- Created a culturally appropriate *Evaluation Framework* for the *Aging at Home Strategy*.
- Committed to producing a *Health Provider Profile, Literature Review* and *Supportive Housing Options* report that is reflective of this population base.
- Made plans to host an Aboriginal Health Summit (May 2008) to determine how to develop a formal Aboriginal health planning structure for the NE LHIN and how to use technology to improve health planning and delivery in the North.

North East LHIN Aboriginal/First Nation/Métis Interim Planning Group Members:

Regional Interim Aboriginal Health Planning Group Participation

- James Bay General Hospital, CEO & Manager of Patient Services
- Mamaweswin Tribal Council - North Shore, Health Director
- Nipissing First Nation Health Centre, Health Director
- Wikwemikong Health Centre, Health Director
- Wabun Tribal Council, Health Manager
- United Chiefs and Councils of Manitoulin - M'Chigeeng First Nation Health Centre, Health Director
- Wikwemikong Nursing Home, CEO
- Noojmowin Teg Health Access Centre, Executive Director
- N'Mninoeyaa: Community Health Access Centre
- Shkagamik-Kwe Health Centre
- Métis Nation of Ontario, LTC Health Manager
- Ontario Federation of Indian Friendship Centres, LTC Manager
- Ontario Federation of Indian Friendship Centres, Regional Representative
- North Bay Indian Friendship Centre, Executive Director
- Union of Ontario Indians
- M'naamodzawin Health Services Inc.
- Weeneebayko General Hospital

James and Hudson Bay Coastal Area Interim Aboriginal Health Planning Group Participation

- James Bay General Hospital, Patient Care Manager & Assistant Executive Director, Patient Care
- James Bay Mental Health Program, Director
- Weeneebayko General Hospital, Director of Patient Care
- James Bay and Weeneebayko General Hospitals, Chief of Staff
- First Nations Inuit Health Branch, Community Care Services, Zone Officer
- Moose Cree First Nation, Long-Term Care Manager, Health Director
- Mushkegowuk Tribal Council, Health Director
- Peetabeck Health Services Fort Albany First Nation, Health Director
- Peawanuck Health, Health and Wellness Coordinator
- Attawapiskat First Nation, Health Director
- Moosonee Indian Friendship Centre, Executive Director
- Sagashtawao Healing Lodge, Executive Director
- Public Health Unit, Nurse
- CCAC, Nurse and/or Personal Support Worker

Governance - NE LHIN Board of Directors

The nine-member NE LHIN Board of Directors had two vacant positions at the end of the 2007 fiscal year. All Local Health Integration Networks are governed by an appointed Board of Directors. Each Board member is appointed by an Order-in-Council.

The NE LHIN Board of Directors holds open monthly board meetings across the NE LHIN. Three standing committees report directly to the Board: Governance Committee, Audit Committee and the newly formed Health Professionals Advisory Committee (HPAC).

Randy Kapashesit
NE LHIN Planning Area: James & Hudson Bay Coasts
(September 2006 to September 2009)

Mathilde Gravelle Bazinet
Chair
NE LHIN Planning Area: Nipissing
(June 2005 to June 2009)

Johanne Labonté
NE LHIN Planning Area: Cochrane
(February 2007 to February 2010)

Marc Dumont
NE LHIN Planning Area: Timiskaming
(May 2006 to June 2010)

Dr. Donald Stemp
NE LHIN Planning Area: Nipissing
(May 2006 to July 2009)

Gisèle Guénard
NE LHIN Planning Area: Manitoulin-Sudbury
(January 2008 to January 2010)

Peter Vaudry
NE LHIN Planning Area: Algoma
(May 2006 to May 2011)

North East LHIN Special Initiatives - 2007

Aging at Home

In August 2007, the Minister of Health and Long-Term Care (MOHLTC) announced an ***Aging at Home Strategy*** to reinforce the ability of community support services to allow seniors to live healthy, independent lives in their own homes. The three-year $700 million initiative is being led by Local Health Integration Networks (LHINs). Within this strategy, the NE LHIN will see a base budget increase of $18.8 million by 2011.

Our NE LHIN responded to the Aging at Home Strategy with a tremendous amount of related work and discussion. This included four North East ALC Task Forces, an ALC Summit, Health System Round Tables, a Seniors' Summit, Seniors' engagement including focus groups, telephone surveys, and Tea and Chat sessions.

The North East LHIN developed an Aging at Home Directional Plan (October 2007) and Detailed Services Plan (February 2008) to help determine the allocation of the North East LHIN's *Aging at Home Strategy* funding.

The Detailed Service Plan identifies initiatives to be implemented in 2008/09 with a total allocation of $4.2 million in funds. The NE LHIN is now in the process of identifying strategies to implement new and innovative programs in our 2009/10 and 2010/11 budget years.

Urgent priority funding

In December 2007, the North East LHIN allocated the majority of its $1.6 million in urgent priority funding to ALC initiatives. A wide range of programs and services were funded including: expansion of the use of the Identification of Seniors at Risk (ISAR) tool, enhancement of ALC support programs to the hospital sector; community support services; community care access centre (CCAC) programs; a Regional geriatric program; hospice programs; transportation services, and others. In addition, the North East LHIN provided close to $500,000 for local program needs within the mental health and addiction sector.

Alternate Level of Care (ALC)

In 2007/08, provincial statistics continued to indicate that the hospitals in the NE LHIN area had the highest percentage of Alternate Level of Care (ALC) days in Ontario. Historical attempts to address the issue with "quick fix" solutions have not been successful.

In an effort to assist with the resolution of ALC pressures experienced by hospitals, the NE LHIN established four ALC Task Forces in the communities most affected by the ALC issue—North Bay, Sault Ste. Marie, Sudbury and Timmins.

The Joint Review of Alternate Level of Care Pressures in North East Ontario: Findings and Recommended Strategies (ALC Task Force Report) was completed and released in December 2007.

Comprehensive local and regional strategies that span the continuum of care have been developed by the Task Forces, along with cost estimates, where known. To achieve long-term improvement for ALC challenges, research suggests there must be a comprehensive understanding of issues and needs in order to examine prevention opportunities as well as alternate service capacity issues. The system also needs to be directed towards an integrated and comprehensive service delivery system, which includes:

- policy and legislative changes;
- coordinated approaches to assessment, discharge planning and case management;

- increased community support service systems;
- support for innovative service options; and
- financial investments to increase system capacity.

The ALC Task Force Report also complemented the development of the NE LHIN's broader December 2007 *ALC Action Plan* that sets clear targets and strategies to address this critical issue across the region.

Health System Round Tables

In mid-2007, inaugural meetings of the NE LHIN's Health System Round Tables took place in six of the seven planning areas across the region. These Round Tables (comprised of representation from all LHIN-funded sectors and a number of health partner sectors e.g. public health, primary care, social services) were established to provide system-level advice to the North East LHIN on the health care needs of their communities, local planning and priority setting, evaluation and performance monitoring – including the identification of opportunities for the integration/coordination of health care services.

The Round Tables provided an invaluable contribution to the decision-making process for the NE LHIN's Annual Service Plan, local priorities for the first year of the *Aging at Home Strategy*, and 2007/08 urgent one-time funding allocations.

In March 2008, a two-day planning retreat with all members of the Round Tables was held in North Bay to review and update the Tables' terms of reference, establish a shared ethical decision-making framework and discuss how to address issues that span the region as a whole.

Highlights and Achievements, 2007/08

January 2007

- New CEO Rémy Beaudoin begins.

February

- Announcement of $3.3 million to help ease hospital overcrowding and increase community-based care in North East Ontario.

March

- Board of Directors meet in Moose Factory and endorse the creation of Health System Round Tables. The Round Tables include members from across the North East health care system and are established to become the operational arm of the North East LHIN.

- Four Alternate Level of Care (ALC) Task Forces are formed in North Bay, Sault Ste. Marie, Sudbury and Timmins. ALC Task Forces meet over the next nine months and conduct a detailed analysis of the ALC issue in North East Ontario.

April

- North East LHIN assumes full responsibility for planning, funding and integrating local health services across North East Ontario with a budget of $1.1 billion.

May

- Sault Ste. Marie Group Health Centre wins the Health Care Innovation Expo Award in the Improving Quality and Patient Safety category.

June

- First Governance Forum is held in North Bay to provide health service providers, stakeholder representatives, and health care consumers and their families with the opportunity to learn more about the NE LHIN and roles and responsibilities within Ontario's new health care system.
- Alternate Level of Care (ALC) Summit is held in Sudbury. It brings 125 stakeholders together to receive information and discuss strategies to mitigate the ALC situation in North East Ontario.

July

- Mark Fisher of Parry Sound is appointed to the NE LHIN Board of Directors. He joins the other eight members who reside across North East Ontario.

August

- Marc Dumont (Temiskaming Planning Area) and Johanne Labonté (Cochrane Planning Area) are re-appointed to the NE LHIN Board of Directors.
- NE LHIN submits its first multi-year Annual Service Plan (ASP) to the MOHLTC. The ASP helps to determine how the NE LHIN will address the health care needs of North East Ontario through its Integrated Health Service Plan (IHSP) and the level of funding required for the NE LHIN to meet its priorities for 2008/09 and 2009/10.

Continued on next page

- Province announces Aging at Home Strategy which provides $33 million over three years to the North East LHIN to develop strategies that will enable seniors to reside in their own homes longer.
- Agreement is reached to implement the Flo Collaborative in the North East beginning in September 2007. The aim of the provincial Flo Collaborative is to help local health care systems provide the care that aging seniors need to make the transition from acute hospitals to other settings.
- The Minister of Health and Long-Term Care (MOHLTC) George Smitherman tours the North East LHIN region with Board Chair, Mathilde Gravelle Bazinet, during which time he signs the Agreement with the federal Minister of Health, Tony Clement to integrate the James Bay General Hospital and the Weeneebayko Hospital in Moose Factory.

September

- Northern Ontario e-Health Information and Communication Technology (ICT) Tactical Plan is approved. The Plan calls for the creation of a Project Management Office (PMO) to plan, execute, co-ordinate and monitor e-health strategies across the North East, partnering with the NW LHIN. The goal of the PMO is to be the "one-stop shop" for Northern Ontario health service providers with respect to their e-health needs.

October

- e-Health Information and Communication Technology (ICT) office (PMO) is established.
- NE LHIN submits Aging at Home Strategy Directional Plan to the MOHLTC. The Plan speaks to the issues and recommendations for a North East ALC Strategy. It is based on the work of ALC Task Forces, ALC Summit and Annual Service Plan.
- Two Interim Aboriginal Health Planning Groups meet for the first time. One has representatives from across the NE LHIN and the other is focused on the James and Hudson Bay Coasts Planning Area. The groups will advise the NE LHIN on priorities and allocations for year one of the Aging at Home Strategy for the Aboriginal/First Nation/Métis communities, while waiting for the Local Aboriginal Health Planning Entities (LAHPEs) to form.

November

- NE LHIN meets with the provincial Bureau des services de santé en français and the two Francophone networks, Réseau francophone de santé du Nord de l'Ontario and Réseau francophone de santé du Moyen-Nord de l'Ontario, to discuss a draft collaboration plan on how the four organizations can best work together to meet the health care needs of Francophones in the North East.
- Board of Directors receive an ALC Emerging Strategies report.
- Dr. Allan Hudson, Lead, Access to Services and Ontario Wait Time Strategy, provides an update on the Strategy results for the North East LHIN to the Board of Directors. Dr. Hudson also noted that the province will add emergency room performance to its Wait Times Strategy and that a goal has been set to reduce emergency room visits to fewer than four hours.

December

- Hospital CEOs from across North East Ontario meet to plan for the first NE LHIN Hospital Annual Planning Submission (HAPS) covering a two year period (2008/09 and 2009/10). HAPS is the process by which hospitals submit their budgets for approval to the NE LHIN. Central themes include planning, measurement and evaluation of health services, and organizational performance.
- NE LHIN hosts an Addiction and Mental Health Summit in Sudbury which draws more than 150 delegates.
- Board of Directors receives full report with recommendations to allocate funding towards ALC initiatives across North East Ontario.

January 2008

- A new HAPS/H-SAA page under the *For Health Service Providers* section is posted to the NE LHIN website with all relevant information on the 2008-2010 Hospital Service Accountability Agreement (H-SAA) process. Over the next several weeks, NE LHIN staff meet with hospital leaders from all 25 area hospitals as part of a province-wide Hospital Annual Planning Submission (HAPS) process.

February

- The North East Local Health Integration Network (NE LHIN) Board of Directors meet with area health care providers while holding their monthly open Board meeting in Moose Factory. A Community Forum, hosted by the NE LHIN, provided information on the progress being made with the Weeneebayko Area Health Integration Framework Agreement and next steps.
- NE LHIN Tea and Chat sessions begin in various communities to engage local seniors and their families in health planning. These continue through March.
- The North East LHIN hosts an Aging at Home Community Innovation Exchange.

March

- Announcement that new beds, more surgeries, and lower wait times are being targeted with a $31.7 million boost for North East Local Health Integration Network (LHIN) hospitals – a 4.3 per cent increase over the previous year.
- The NE LHIN hosts a Seniors' Health Summit – Aging at Home Successfully, in Sault Ste. Marie.
- The North East LHIN's 12 inaugural members of its Health Professionals Advisory Committee (HPAC) meet for the first time to begin their crucial role. Governed under a regulation of the *Local Health System Integration Act, 2006*, the committee will serve as a collective voice of health professionals to the NE LHIN Board.
- Membership of the North East Health System Round Tables come together to discuss common issues at a two-day retreat in North Bay.

North East **LHIN**

Financial Statements of

North East Local Health Integration Network

March 31, 2008

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Ontario
North East Local Health Integration Network

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www.deloitte.ca

Auditors' Report

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

We have audited the statement of financial position of the North East Local Health Integration Network (the "LHIN") as at March 31, 2008 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the North East Local Health Integration Network as at March 31, 2008 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 9, 2008

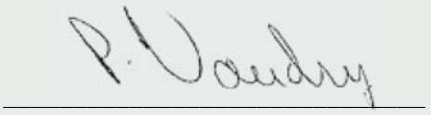
North East Local Health Integration Network

Statement of financial position
as at March 31, 2008

	2008	2007
	$	$
Financial assets		
Cash	**1,167,075**	312,860
Accounts receivable	**-**	2,231
Due from MOHLTC	**1,686,710**	-
	2,853,785	315,091
Liabilities		
Accounts payable and accrued liabilities	**1,092,476**	172,537
Due to MOHLTC (Note 10b)	**66,646**	57,803
Due to the LHIN Shared Services Office (Note 3)	**7,953**	84,751
Due to Health Service Providers ("HSP")	**1,686,710**	-
Deferred capital contributions (Note 4)	**388,750**	423,612
	3,242,535	738,703
Net debt	**388,750**	423,612
Non-financial assets		
Capital assets (Note 5)	**388,750**	423,612
Accumulated surplus	**-**	-

Approved by the Board

_____ Director



_____ Director

North East Local Health Integration Network

Statement of financial activities
year ended March 31, 2008

	Budget (unaudited) (Note 6)	2008 Actual	2007 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,109,601,200**	**1,115,633,592**	-
Operations of LHIN	**3,963,454**	**3,802,494**	3,025,083
E-Health (Note 9a)	**-**	**275,000**	181,000
Emergency Department Lead (Note 9b)	**-**	**37,500**	-
Aging at Home (Note 9c)	**-**	**202,000**	-
Aboriginal Engagement (Note 9d)	**-**	**100,000**	-
Wait Time Strategy (Note 9e)	**-**	**70,000**	-
Amortization of deferred capital contributions (Note 4)	**-**	**195,823**	142,169
	1,113,564,654	**1,120,316,409**	3,348,252
Expenses			
Transfer payments to HSPs (Note 7)	**1,109,601,200**	**1,115,633,592**	-
General and administrative (Note 8)	**3,963,454**	**3,997,235**	3,109,449
E-Health (Note 9a)	**-**	**274,739**	181,000
Emergency Department Lead (Note 9b)	**-**	**30,000**	-
Aging at Home (Note 9c)	**-**	**202,000**	-
Aboriginal Engagement (Note 9d)	**-**	**100,000**	-
Wait Time Strategy (Note 9e)	**-**	**70,000**	-
	1,113,564,654	**1,120,307,566**	3,290,449
Annual surplus before funding repayable to MOHLTC	**-**	**8,843**	57,803
Funding repayable to MOHLTC (Note 10a)		**(8,843)**	(57,803)
Annual surplus	**-**	**-**	-
Opening accumulated surplus		**-**	-
Closing accumulated surplus	**-**	**-**	-

North East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2008

	2008	2007
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(160,961)**	(62,532)
Amortization of capital assets	**195,823**	142,169
Decrease in net debt	**34,862**	79,637
Opening net debt	**(423,612)**	(503,249)
Closing net debt	**(388,750)**	(423,612)

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2008

	2008	2007
	$	$
Operating		
Items not affecting cash		
Amortization of capital assets	**195,823**	142,169
Amortization of deferred capital contributions (Note 4)	**(195,823)**	(142,169)
Changes in non-cash working capital		
Decrease (Increase) in accounts receivable	**2,231**	(2,231)
Increase in due from MOHLTC	**(1,686,710)**	-
Increase in accounts payable and accrued liabilities	**919,939**	172,537
Increase in due to MOHLTC	**8,843**	28,766
Increase (Decrease) in due to the LHIN Shared Services Office	**(76,798)**	84,751
Increase in due to Health Service Providers ("HSP")	**1,686,710**	-
	854,215	283,823
Investing		
Acquisition of capital assets	**(160,961)**	(62,532)
Financing		
Increase in deferred capital contributions (Note 4)	**160,961**	62,532
Net change in cash	**854,215**	283,823
Cash, beginning of year	**312,860**	29,037
Cash, end of year	**1,167,075**	312,860

North East Local Health Integration Network

Notes to the financial statements
March 31, 2008

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 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 income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

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

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2008.

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

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

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

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of assets and losses in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

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

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

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

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

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

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

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

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

2. Significant accounting policies (continued)

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. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portions of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

4. Deferred capital contributions

	2008	2007
	$	$
Balance, beginning of year	**423,612**	503,249
Capital contributions during the year	**160,961**	62,532
Amortization for the year	**(195,823)**	(142,169)
	388,750	423,612

5. Capital assets

			2008	2007
	Cost	**Accumulated amortization**	**Net book value**	Net book value
Furniture and fixtures	**70,404**	**36,844**	**33,560**	47,641
Computer equipment	**73,074**	**32,653**	**40,421**	16,590
Leasehold improvements	**709,077**	**394,308**	**314,769**	359,381
	852,555	**463,805**	**388,750**	423,612

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2007. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding of $1,115,633,592 is made up of the following:

	$
Initial budget	**1,109,601,200**
Adjustment due to announcements made during the year	**6,032,392**
Total budget	**1,115,633,592**

The total operating of $4,647,954 is made up of the following:

	$
Initial budget	**3,963,454**
Additional funding received during the year	**684,500**
Total budget	**4,647,954**

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,115,633,592 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2008 as follows:

	$
Operation of Hospitals	**701,409,702**
Grants to compensate for Municipal Taxation - Public Hospitals	**244,950**
Long Term Care Homes	**156,362,614**
Community Care Access Centres	**88,054,570**
Community Support Services	**20,531,038**
Assisted Living Services in Supportive Housing	**7,241,600**
Community Health Centres	**6,530,373**
Community Mental Health	**47,223,620**
Addictions Programs	**18,355,753**
Specialty Psychiatric Hospitals	**69,659,347**
Grants to compensate for Municipal Taxation - Psychiatric Hospitals	**20,025**
	1,115,633,592

The LHIN did not authorize any funding to various HSPs in 2007.

8. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2008	2007
	$	$
Salaries & Wages	**1,795,529**	1,122,548
HOOPP	**180,254**	99,935
Other Benefits	**178,330**	142,196
Staff Travel	**204,862**	155,227
Governance Travel	**69,131**	74,444
Communications	**138,332**	40,949
Other	**58,047**	115,159
Accommodation	**156,509**	164,661
Advertising	**40,234**	24,402
Banking	**554**	907
Consulting Fees	**287,336**	408,711
Conflict of interest commissioner	**-**	7,857
Equipment Rentals	**18,818**	7,229
Governance per Diems	**118,258**	107,420
Insurance	**15,930**	-
LHIN Shared Services Office	**300,000**	290,201
Other Meeting Expenses	**95,405**	49,572
Other Governance Expenses	**2,132**	26,647
Printing & Translation	**24,533**	14,412
Staff Development	**46,863**	12,070
IT Equipment	**25,451**	-
Office Supplies & Equipment	**44,904**	102,732
Amortization	**195,823**	142,169
	3,997,234	3,109,449

9. a) E-Health expense

The E-Health office of the Ministry of Health and Long-Term Care provided $275,000 to the LHIN. The LHIN had a contract and retained the services of the Group Health Centre (the "GHC") during 2008. The GHC provided services and deliverables as described in the contract. In return, the LHIN agreed to reimburse the GHC for expenses incurred during the performance of this work. The total amount of expenses reimbursed during the duration of this contract was $274,739.

b) Emergency Department Lead (ED Lead)

The Ministry of Health and Long Term Care announced they would be providing the LHIN an additional $75,000 in one-time funding to (a) pay the LHIN ED Lead $5,000 per month as well as (b) money to reimburse the LHIN ED Lead for any expenses. This money is being split with $37,500 being received in 2008 and again in 2009. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2008 are $30,000.

9. c) Aging at Home

The Ministry of Health and Long Term Care announced the LHIN would receive $202,000 to help in the planning and implementation of the Aging at Home Strategy. The LHIN contracted consultants to complete this work on their behalf with the total of $202,000 being spent in full.

d) Aboriginal Engagement

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations with the North East LHIN. The LHIN had contracts with numerous Aboriginal Consultants to help with this engagement.

e) Wait Time Strategy

The Ministry of Health and Long Term Care provided $70,000 in one-time funding to support wait list management activities. The LHIN had a contract and retained the services of the North Bay General Hospital (NBGH) during 2008. The NBGH provided services and deliverables as described in the contract. In return, the LHIN agreed to reimburse the (NHBG) for expenses incurred during the performance of this work. The total amount of expenses reimbursed during the duration of this contract was $70,000.

10. Funding repayable to the MOHLTC

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

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

	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	1,115,633,592	1,115,633,592	-
LHIN operations	3,998,317	3,997,235	1,082
E-Health	275,000	274,739	261
Emergency Department Lead	37,500	30,000	7,500
Aging at Home	202,000	202,000	-
Aboriginal	100,000	100,000	-
Wait Time	70,000	70,000	-
	1,120,316,409	1,120,307,566	8,843

b. The amount due to the MOHLTC is made up of the following components:

	2008	2007
	$	$
Opening balance	**57,803**	-
Funding repayable to the MOHLTC (Note 10a)	**8,843**	57,803
Closing balance	**66,646**	57,803

North East Local Health Integration Network

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March 31, 2008

11. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of all members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2008 was $180,254 (2007 - $99,935) for current service costs and is included as an expense in the Statement of Financial Activities.

12. Guarantees

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

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

13. Commitments

The LHIN has commitments under various operating leases related to office space and equipment. Lease renewals are likely. Minimum lease payments due in each of the next three years are as follows:

	$
2009	169,640
2010	166,580
2011	44,866

The LHIN does not have any funding commitments to HSPs associated with accountability agreements.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

15. Comparative figures

Some comparative figures have been reclassified to conform to the current year's presentation.