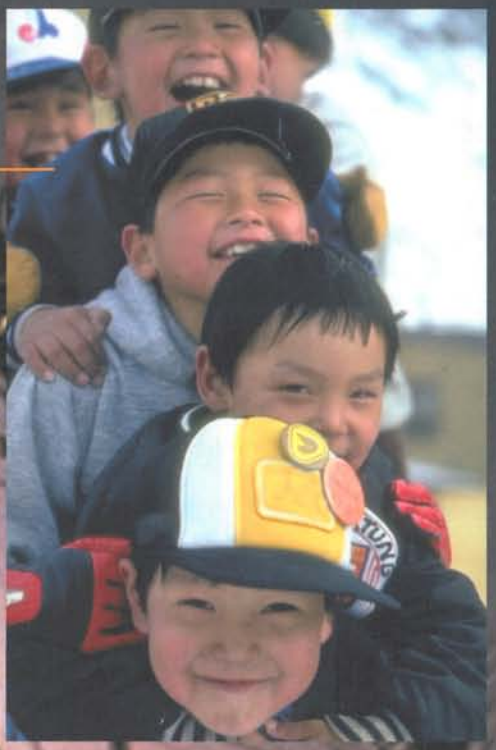
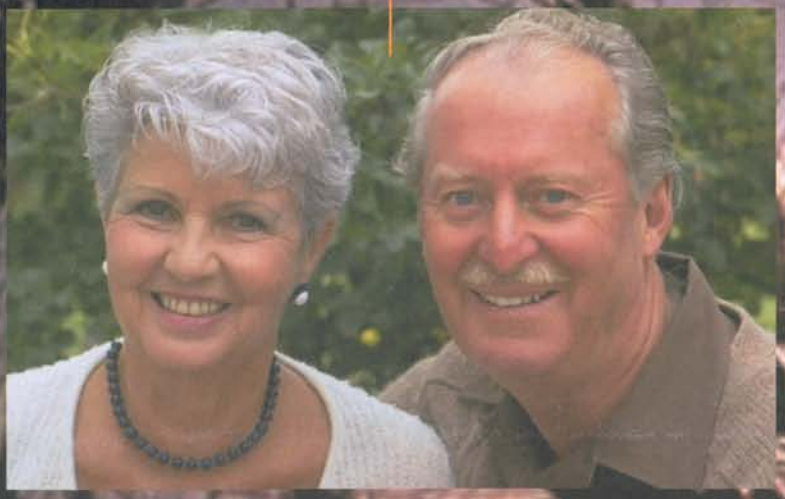
Waterloo Wellington

LOCAL HEALTH INTEGRATION NETWORK





ANNUAL REPORT

2005 | 2006

BENEFITS OF LHINs

Health care choices by the community, for the community

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

We're all in this together

The health care system belongs to the people of Ontario; they're the ones who depend on it and who pay for it. LHINs will, for the first time, involve Ontarians in the health care conversation, giving them a chance to participate in decisions about the health care system in their communities.

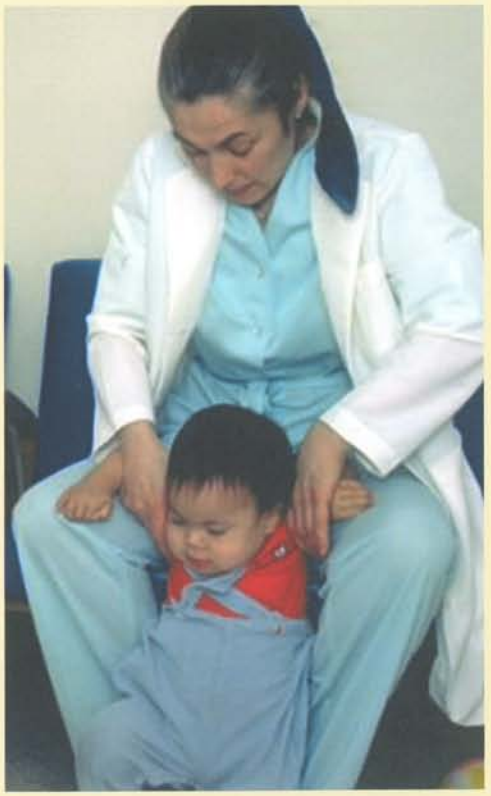
Transparency, accountability and responsibility

LHINs will 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 ensure the responsible use of precious health care resources, and the sustainability of the health care system for generations to come.

A system with patients at the centre

The health care system has not always been an easy one to figure out. LHINs will change that, breaking down the barriers that patients face and ensuring that decisions are made in the interests of patient care.

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



INTRODUCING LOCAL HEALTH INTEGRATION NETWORKS

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

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

Why were they created?

LHINs were created to fix the piecemeal way Ontario's health care system was organized. The goal is to 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. LHINs are changing the way our health care system is managed.

What will LHINs do?

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

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

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

Ontario

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 by local health integration networks.

The Act continues 14 Local Health Integration Networks (LHINs) as Crown Agencies of the Ministry of Health and Long-Term Care. It gives LHINs the power to plan, coordinate and fund health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specified geographic areas. It sets out the corporate organization of the LHINs, the powers of the LHIN Boards of Directors, and requires the LHINs to have an accountability agreement with the Minister of Health and Long-Term Care.

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

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

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

Planning and Community Engagement

The Minister must develop a provincial strategic plan for the health system and make the plan public. Each LHIN is required to engage their community and Aboriginal and French Language local planning entities to develop an Integrated Health Service Plan for their local health system. Community is broadly defined in the Act and includes patients and others, health service providers, and employees. The Act identifies some of the methods LHINs would use to engage their community, including communty meetings, focus groups, and advisory committees.

Funding and Accountability

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

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

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

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WATERLOO WELLINGTON LHIN ANNUAL REPORT 2005-2006

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"WWLHIN is very grass roots — everyone contributing ideas for health care in our community. There is a lot of positive buzz and excitement about WWLHIN."

Sandra Hanmer, CEO

WELCOME TO THE WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

WWLHIN is the short form of the Waterloo Wellington Local Health Integration Network. It is a non-profit organization funded by the government of Ontario, through the Ministry of Health and Long Term Care. It is one of fourteen local health integration networks established in Ontario, each with specific geographic boundaries.

WWLHIN includes 5 geographic planning areas:

Urban Guelph — includes the City of Guelph, Township of Guelph/Eramosa, Township of Puslinch

Urban Waterloo and Rural Waterloo South — includes the City of Waterloo, City of Kitchener, City of Cambridge, Ayr, Roseville, Branchton

Rural Waterloo — includes Townships of Woolwich, Wellesley, Wilmot, North Dumfries

Rural South Grey and North Wellington — includes the Town of Minto, Township of Mt. Forest-Arthur-West Luther-Arthur

Rural Wellington — includes the Townships of Mapleton, Centre Wellington, Town of Erin

Vision

A health care system that will help keep Ontarians healthy, will get them good care when they are sick and will be there for their children and grandchildren.

Guiding Principles

WWLHIN will be focused on citizens, develop strategic partnerships, facilitate community engagement, use evidence-based decision making, operate with a high level of transparency, foster change through incentives, work with provider boards and create partnerships of equals.

Responsibilities

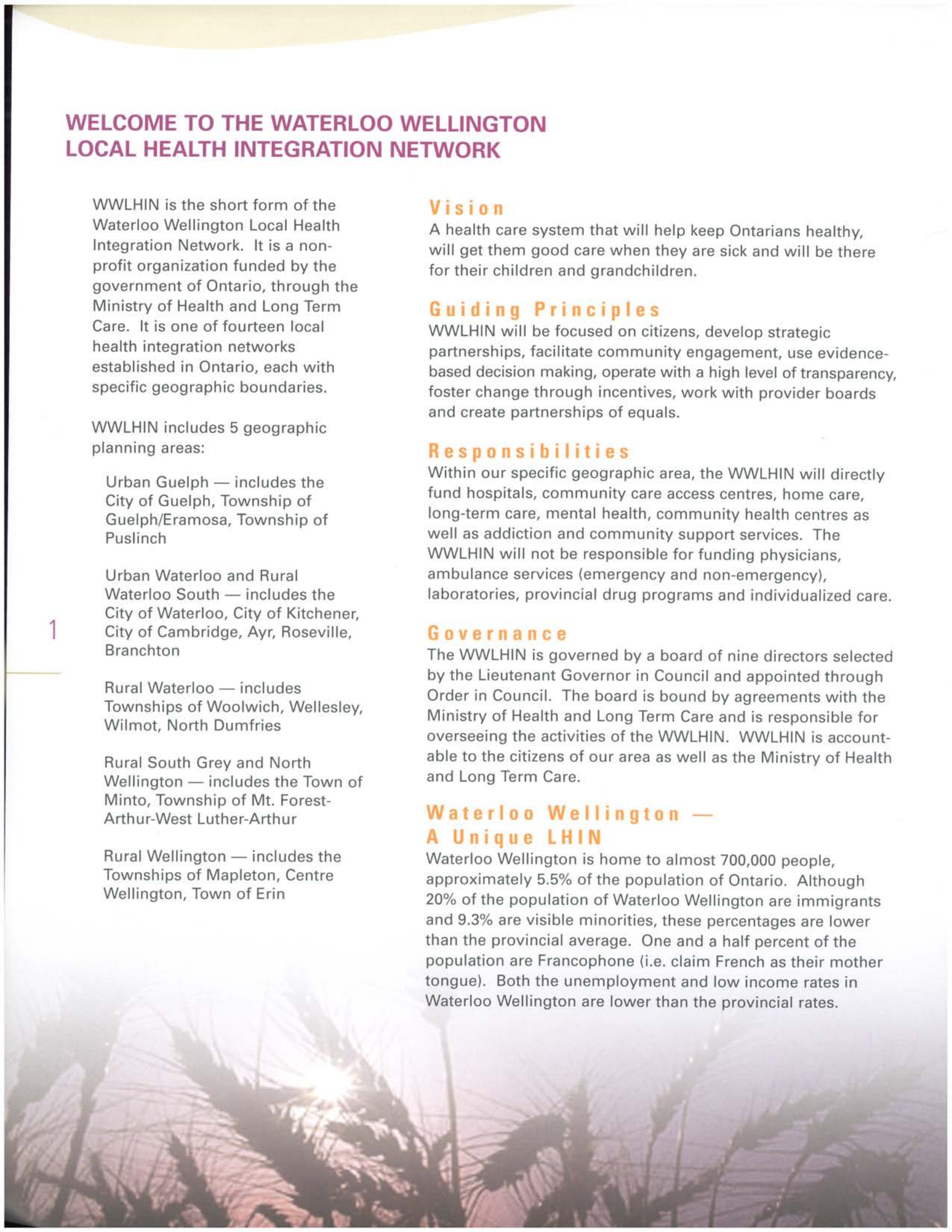
Within our specific geographic area, the WWLHIN will directly fund hospitals, community care access centres, home care, long-term care, mental health, community health centres as well as addiction and community support services. The WWLHIN will not be responsible for funding physicians, ambulance services (emergency and non-emergency), laboratories, provincial drug programs and individualized care.

Governance

The WWLHIN is governed by a board of nine directors selected by the Lieutenant Governor in Council and appointed through Order in Council. The board is bound by agreements with the Ministry of Health and Long Term Care and is responsible for overseeing the activities of the WWLHIN. WWLHIN is accountable to the citizens of our area as well as the Ministry of Health and Long Term Care.

Waterloo Wellington — A Unique LHIN

Waterloo Wellington is home to almost 700,000 people, approximately 5.5% of the population of Ontario. Although 20% of the population of Waterloo Wellington are immigrants and 9.3% are visible minorities, these percentages are lower than the provincial average. One and a half percent of the population are Francophone (i.e. claim French as their mother tongue). Both the unemployment and low income rates in Waterloo Wellington are lower than the provincial rates.



WELCOME TO THE WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

Geographic Focus

Area	Geographic Planning Area	Municipal Entities within Geographic Planning Area
1	Urban Waterloo & Rural Waterloo South	City of Waterloo, City of Kitchener, City of Cambridge, Ayr, Roseville, Branchton
2	Urban Guelph	City of Guelph, Township of Guelph/Eramosa, Township of Puslinch
3	Rural Waterloo	Townships of Woolwich, Wellesley, Wilmot, North Dumfries
4	Rural - South Grey & North Wellington	Town of Minto, Township of Mt. Forest-Arthur-West Luther-Arthur
5	Rural Wellington	Townships of Mapleton, Centre Wellington, Town of Erin

Forty-seven percent of adults (age 20+) have attained post secondary education credentials, and almost 27% have not completed high school. Waterloo Wellington is home to four institutions of higher learning.

Compared to the province Waterloo Wellington has a slightly greater proportion of the population in the 0-44 age groups and a smaller proportion of seniors (ages 60-74 in particular).

Relative to the province Waterloo Wellington has a higher proportion of the population who say their health is "excellent or very good." Waterloo Wellington has lower hospitalization rates for some conditions (e.g. circulatory diseases) and higher rates for others (e.g. mental disorders, maternal conditions, respiratory diseases and injuries).

The point of access for most medical care is through a primary care physician. The majority of people (77.5%) in Waterloo Wellington had at least one contact, either in person or by phone with a medical doctor in the past year; a proportion that is significantly lower than the provincial average of 82.4%.

"The rural/urban mix of the WWLHIN presents challenges and opportunities. In our contacts with the communities, we have seen a huge willingness to look at the challenges and opportunities in new ways and have heard many creative ideas for change."

Sandra Hanmer, WWLHIN CEO

OPERATIONAL START UP

Staci Bartlett, Office Manager in the Wilmot Meeting Room. Art by Guelph Artist Carolyn Riddell "Day of Momentum"

Once the policy framework was established by the Ontario government and Local Health Integration Networks (LHINs) were chosen as the model for integration in this province, it was time to launch LHINs as 14 corporations.

In June 2005, 14 news conferences were held across the province to publicly announce the 14 LHIN's chairs, 42 founding board members and 14 Chief Executive Officers.

CEOs began work in August 2005 and worked along side the board chairs to start getting to know the communities they serve. That summer LHIN leaders hosted 37 "Meet and Greet" sessions across the province with 1500 leaders of health care organizations.

"It is very exciting to be part of a start-up organization. Developing the infra-structure, recruiting board and staff, becoming acquainted, or reacquainted with service providers in the area, spreading the message - it has been rewarding to see the WWLHIN created." Sandra Hanmer, CEO

Fourteen offices were set up across the province. WWLHIN opened our office at 55 Wyndham Street North, Suite 212, Guelph. The office is centrally located in Waterloo Wellington and easily accessible. The office reflects Waterloo Wellington; meeting rooms are named the Waterloo Wellington Room, Wilmot Room, Woolwich Room and Wellesley Room. These meeting rooms are available for use by the community. The artwork throughout the office has been created by local artists.

In addition to CEO Sandra Hanmer, four staff members were hired: Sue Southwell, Executive Assistant; Donnamarie Dunk, Senior Director Planning, Community Engagement and Integration; Bruce Lauckner, Senior Director Performance, Contracts and Allocations and Staci Bartlett, Office Manager. Support staff were hired in early 2006 through a temporary contract agency and project team members were contracted to assist with the development of the Integrated Health Services Plan (IHSP). Recruitment of the remainder of the staff will occur early in fiscal 2006/07.

To ensure cost-effective and efficient operations, LHINs established a common administration process and have retained a company, CGI, to deliver payroll, financial and human resource services for all LHINs. A business operations manual was created to provide basic policies and procedures related to LHINs' business operations. This included government directives that LHINs must comply with, a summary of legislative requirements that govern LHINs' practices and standard practices required by the Ministry for all LHINs.

Extensive orientation sessions were held for the founding LHIN board members and staff. As part of their professional development, LHINs and the Ministry hosted several 'Think Tanks' on topics such as funding models, planning, corporate governance, ethics and a framework for ethical decision making.

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BOARD CHAIR and CEO REPORT

"We are asking people to think differently, step up to the plate to help, ask the tough questions, share best practices and leverage integration opportunities. That's the key to dynamic, creative and innovative health care in Waterloo Wellington." Kathy Durst, Board Chair

We are proud of the work that has been accomplished at the Waterloo Wellington Local Health Integration Network in just a few months. Our work began in June 2005 and continued throughout the summer when the three newly appointed board members started to introduce WWLHIN to the community. We met with many individuals and groups, to both give and gather information, start building new relationships, initiate new conversations and engage the community.

In August 2005 Sandra Hanmer became CEO and began the process of developing our WWLHIN. We had five key areas of focus:

- establish LHIN governance policies, practices and relationships (including board recruitment)
- develop strategic relationships and a Community Engagement Framework
- develop an approach to the creation of an Integrated Health Services Plan
- recruit staff
- implement business processes and operational and financial reporting

We are pleased to report that these priorities have all been successfully addressed and are detailed in this annual report.

When LHINs were first introduced throughout the province of Ontario, the concept was met with some skepticism and suspicion. It was important that we address concerns by informing and engaging our community. We wanted to introduce WWLHIN and create a forum where people could actively participate by providing input to the many activities the WWLHIN will be addressing. We wanted all stakeholders to have an equal voice in the transformation of the health care system — providers, public, consumers, caregivers, and suppliers — all sharing knowledge and discussing innovative solutions.

Staff and board members (by the end of March 2006, we had a board complement of five) visited more than 160 provider sites. We hosted six 'meet and greets' and provided 60 presentations to local health networks, associations and community groups. We developed a Community Engagement Framework with feedback requested from over 250 service providers, members of the public and elected officials and facilitated 10 town hall

Kathy Durst, Chair and Sandra Hanmer, CEO

workshops. We wanted the widest consultative process and met with special interest groups — Aboriginal, seniors, disabled, youth councils, the Multicultural Society etc. As well, we met many other local and provincial health service providers.

The community has responded to what we have had to say and we have learned a great deal. Our communities are willing to work together to create a health care system that enables us to live and live well in Waterloo Wellington.

Thank you to everyone who took the time to share your stories, tell us about your organization or participate in our activities

We are looking forward to a future of continued community engagement and the development of the Integrated Health Services Plan leading to improving access to a system of services and the health of individuals in our communities.

Kathy Durst, *Chair*

Sandra Hanmer, *Chief Executive Officer*

BOARD OF DIRECTORS

Kathy Durst was appointed Chair, through Order in Council effective June 2005 for a three-year term. She recently retired as Director of Human Resources/Assistant Chief Administrative Officer at the City of Waterloo after a 30-year career with the city administration. She is a member of several professional organizations and is presently involved in a number of community organizations including Habitat for Humanity (Waterloo Region), and the St. Louis Out-of-the Cold Homeless Program. Until recently, Kathy also served as a member of St. Mary's Hospital Board Resource Planning and Utilization Committee and the Catholic Family Counselling Centre.

Jay Paul Truex was appointed Director through Order in Council effective June 2005 for a three-year term. He also serves as Vice Chair of the board. Paul is retired from Johnson & Johnson. His 33-year career included leadership positions in information management, finance, and talent management. Paul has a long history of community engagement. He served as president of the Rotary Club of Guelph, president of Family & Children's Services for Guelph-Wellington, board chair of the River Run Centre, board chair of Crime Stoppers of Guelph and Wellington County, and board member of the Wellington-Dufferin Community Care Access Centre. He currently chairs the Guelph Hydro Inc. Board of Directors.

Paul Holyoke was appointed Director through Order in Council effective June 2005. Paul was the General Counsel and Vice President of Legal Services of the Workplace Safety and Insurance Board (WSIB) of Ontario until September 2003. Prior to that, he held several other executive roles with the WSIB. Paul is currently pursuing a PhD in Health Policy at the University of Toronto. He is a Fellow in the Medicare to Home and Community Research Unit and holds a Doctoral Research Award from the Canadian Institutes for Health Research. He previously chaired the Community Stakeholders Group for Health Professional Recruitment and Retention in Fergus/Elora, and is a former member of the Board of Directors, Redwood Shelter for Abused Women, Toronto.

William (Bill) Blackie was appointed as a Director through Order in Council effective January 5th 2006 for a thirteen-month term. Bill is a retired educator. Throughout his career he held many teaching and administrative positions with the Upper Grand District School Board. He has a BSc in Biology from the University of Toronto and a MEd (Computer Applications) from OISE/ U of T.

Bruce Schieck was appointed as a Director through Order in Council effective January 5th 2006 for a two-year term. Bill is the owner/operator of a 350-head dairy and cash crop farm. He has served as a trustee on the Upper Grand District School Board for over 10 years. In addition he has served on many local and Provincial Agricultural Committees and Task Teams.

GOVERNANCE

"In my view, the transformation of our health system depends on our collective abilities to build sustainable relationships throughout the system. I think we have an exciting and wonderful opportunity to make a real difference for future generations." Paul Truex, Vice Chair

One of the WWLHIN performance objectives during the start up period of August 2005 to March 2006 was to establish a governance board and governance policies, practices and relationships.

The WWLHIN will be governed by a board of nine (9) directors selected by the Lieutenant Governor in Council and appointed through Order in Council. The board is bound by agreements with the Ministry of Health and Long Term Care and is responsible for overseeing the activities of the Waterloo Wellington Local Health Integration Network. The board is a skills based board drawing on individuals with a variety of experiences and expertise. Costs for the board (June '05 - March '06) were $26,312.11.

By the end of March 2006 five board members were in place: Kathy Durst, Chair; Paul Truex, Vice Chair; Paul Holyoke, Bill Blackie and Bruce Schieck, (appointed by the Public Secretariat).

In September 2005 WWLHIN created a nominating committee to identify three community member nominees for appointment to the board. The committee included Ms. Durst, Mr. Truex as well as non-board members Joan Fisk, Bob Emerson and Robin Norris. Advertisements were placed in newspapers across the WWLHIN and information sessions were held. Twenty-six applications were received. In November three candidates were recommended for consideration by the Minister. It is anticipated that the four additional board members will be announced early in fiscal 2006-07.

The Chair and CEO met with each board member to provide an initial orientation and review of the orientation package developed by the LHIN support team. On an ongoing basis, board members will also attend orientation sessions provided by the Ministry. To complement the orientation sessions, the WWLHIN implemented a board development process. This process focuses on providing board members with an understanding of their role and key provincial and local health care issues. Board meeting agendas are designed to provide an opportunity for ongoing education.

Working groups of LHIN Chairs and CEOs are developing:

- Board Governance Policy Manual including recommendations regarding board structures and committees
- Conflict of Interest guidelines
- Performance objectives and a process to assess and evaluate CEO performance in each of the LHINs

The working groups are scheduled to complete these tasks early in fiscal 2006-07. As well, the WWLHIN Board of Directors will be creating nominating, audit and other committees as required.

"For a long time I have been interested and concerned about health care. I have developed skills in Human Resources and serving on the WWLHIN gives me the opportunity to put these skills to work with the goal of improving local health care. It is an opportunity I could not pass up."

Bill Blackie, Board Member

Our Population

Executive Summary: The Population Health Profile report provides an overview of the Waterloo Wellington LHIN using the most recently available data on social and demographic characteristics, health status, health practices and outcomes of the population. Rates or proportions for Ontario are provided as a comparator.

Relative to the province, Waterloo Wellington has a higher

- proportion of the population who say their health is 'Excellent' or 'Very Good'
- proportion of the population consuming fruits and vegetables five or more times per day

and a lower

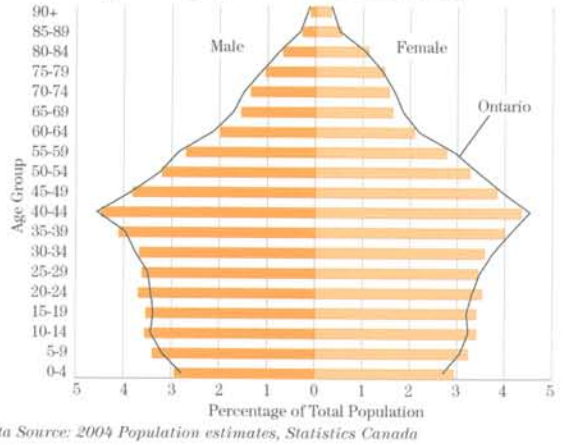
- proportion of seniors, immigrants and visible minorities
- proportion of the population having consulted with an MD in the past year
- all-cause mortality (age-standardized) and PYLL rates
- unemployment rate

The Waterloo Wellington LHIN has a relatively young population with high labour force participation and low unemployment. While health practices and health outcomes are similar to the province, the population in this LHIN has the highest prevalence of residents assessing their health as very good or excellent.

The Population: Waterloo Wellington is home to 685,400 people; 5.5% of the population of Ontario. During 1994-2004 the population of Waterloo Wellington increased, on average, by 1.7% each year. The population of Ontario increased by 1.5% annually during this same time. Table 1 provides an overview of the social and demographic characteristics of this population. Although almost 20% of the population of Waterloo Wellington are immigrants and 9.3% are visible minorities, these percentages are lower than the provincial average. One and a half percent of the population is Francophone (i.e. claim French as their mother tongue). Both the unemployment and low income rates in Waterloo Wellington are lower than provincial rates. Forty-seven percent of adults (age 20+) have attained post-secondary education credentials, and almost 27% have not completed high school.

Chart 1 shows the population structure of Waterloo Wellington. The black line provides the Ontario population distribution for comparison. The population pyramid shows that the population structure of Waterloo Wellington is somewhat younger than the provincial age structure. Compared to the province Waterloo Wellington has a slightly greater proportion of the population in the 0-44 age groups, and a smaller proportion of seniors (ages 60-74 in particular).

Chart 1: Age-sex population distribution



Data Source: 2004 Population estimates, Statistics Canada

Health Status: Life expectancy at birth is the average years of life an individual could live on the assumption that current, cross-sectional age-specific mortality rates remain constant over the life span. Life expectancy among males and females in Waterloo Wellington is similar to life expectancy for Ontario overall (see Table 2). Low birthweight is an important determinant of infant morbidity and mortality. In Waterloo Wellington 5.1% of infants born in 1999-2001 were of low birthweight. Infant mortality is a long-established measure, not only of child health, but also of the

Table 1: Socio-demographic characteristics

	WATERLOO WELLINGTON	ONTARIO	LHIN Range
Total population (2004)†	**685,400**	**12,392,700**	**242,500 - 1,542,900**
Senior population, age 65+ (2004)†	11.6%	12.8%	9.4 - 15.7%
Population with English mother tongue	80.1%	71.9%	55.7 - 92.2%
Population with French mother tongue	1.5%	4.7%	1.2 - 25.1%
Population who are immigrants	19.8%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	2.9%	4.8%	0.3 - 9.7%
Population who are visible minorities	9.3%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	0.7%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	71.8%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	5.1%	6.1%	5.0 - 9.8%
Population in low income	10.2%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	20.6%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	8.7%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	26.6%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	47.0%	48.7%	42.4 - 55.8%

Data Source: †2004 Population estimates. Remaining indicators based on 2001 Census of Canada

well-being of a society. The infant mortality rate in Waterloo Wellington of 5.1 per 1000 livebirths is slightly lower than the provincial experience but the difference is statistically significant. Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures, such as disease severity, aspects of positive health status, physiological and psychological reserves and social and mental function. Residents of Waterloo Wellington are significantly more likely than Ontarians overall to rate their health as "Excellent" or "Very Good". One in four residents report being limited in their activities because of a physical or mental condition or health problem which has lasted or is expected to last longer than six months.

Health Practices and Preventive Care: Poor health practices are known to be related to increased risk of chronic disease, mortality and disability. Chart 2 shows that Waterloo Wellington has

Table 2: Health status

	WATERLOO WELLINGTON	ONTARIO	LHIN Range
Female life expectancy at birth (years), 2001†	82.0 (±0.5)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	77.8 (±0.5)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.1%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)†‡	5.1 (±1.0)	5.4 (±0.2)	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+) #	61.5%* (±2.5)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+) #	24.7% (±2.3)	24.6% (±0.6)	19.3 - 30.0%

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

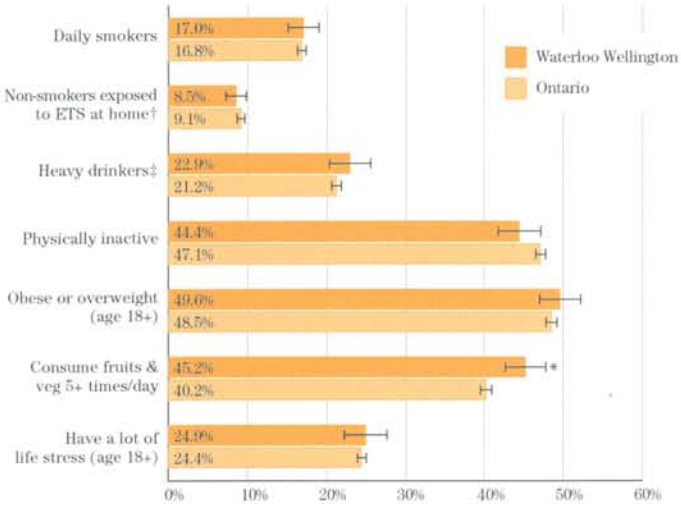
rates of daily smoking, heavy drinking, exposure to ETS, physical inactivity and overweight/obesity that are similar to the province. Based on Body Mass Index 32.6% of the adult population of Waterloo Wellington is considered overweight and 17.0% are obese. A significantly higher proportion of the Waterloo Wellington population (compared to Ontario) consume fruits and vegetables 5 or more times daily. Waterloo Wellington residents are just as likely as Ontarians to report that they have a lot of life stress.

The use of preventive health care services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality. The rates of preventive care use for mammography, Pap smears and flu shots in Waterloo Wellington are not significantly different from the province.

The point of access for most medical care is through a primary care physician. Medical doctors also play a key role in coordinating care and managing chronic conditions. The majority of people (77.5%) in Waterloo Wellington had at least one contact, either in person or by phone, with a medical doctor in the past year; a proportion that is significantly lower than the provincial average of 81.4%.

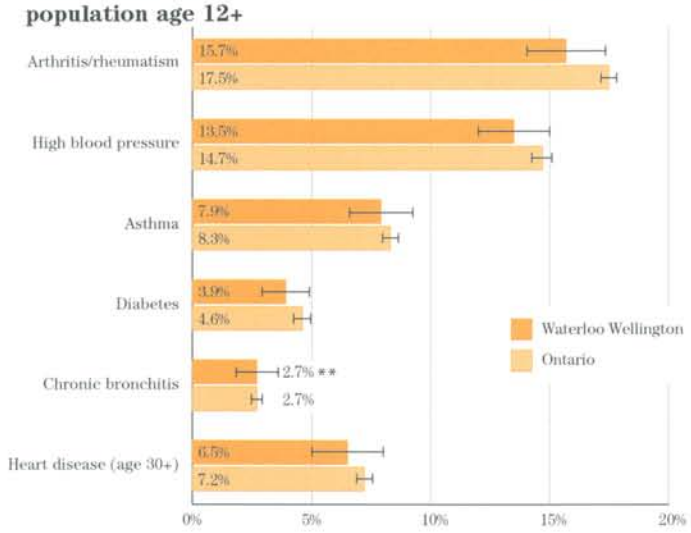
Morbidity and Mortality: Chronic conditions place a high burden on the health care system and reduce the quality of life of those who suffer from the condition. Chart 3 shows that, compared to Ontario, Waterloo Wellington has a slightly lower prevalence of most chronic conditions including arthritis/rheumatism, asthma, diabetes, heart disease, and high blood pressure but the difference is not statistically significant. Note that

Chart 2: 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 Source: Canadian Community Health Survey, 2003

Chart 3: Prevalence of selected chronic conditions, population age 12+



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

the prevalence estimate for chronic bronchitis must be interpreted with caution because of high sampling variability. Prevalence rates presented in Chart 3 are not age-standardized, and therefore areas with a high proportion of seniors will tend to have higher rates of chronic conditions.

[For a copy of the Population Health Profile Waterloo Wellington, please contact the WWLHIN office.]

Integration Priorities

In February 2005 a report outlining system integration opportunities was released. The report identified the top eleven integration initiatives identified by our community. These priorities included: Health Personnel Planning, Optimal Care Guidelines, Public Report Cards, Integrated Electronic Health Records, Integration of Access, Assessment, Care Management and After-care, Administrative Support Coordination, Integration of Community Health with Mental Health and Addiction Programs, Community Support Provider Organizations, Continue Network Planning, Local Health Hubs, and Mental Health System.

These priorities were reviewed in March 2006 at Town Hall Workshops where many were reaffirmed and additional themes introduced. (Refer to the Integrated Health Services Plan, page 13).

The report also identified unique features about Waterloo Wellington. The population density for Waterloo Region is 344.7 persons/square kilometer, and for Wellington County it is 76.4 persons/square kilometer. Waterloo and Wellington have reached a population threshold that is conducive to the development of specialty regional programs and services.

Currently health services in Waterloo Wellington include:

Services	Number
Hospital Sites (8 Hospital Corporations)	10
Community Care Access Centres	2
Community Support Services	31
Community Mental Health and Addictions Services	19
Community Health Centres (with 3 satelites)	4
Long Term Care Homes	34
Family Health Teams	9
Numerous other non-transfer payment health service providers	

Stakeholders in Waterloo and Wellington have a long history of using volunteer-based networks as mechanisms for service coordination, planning and the ongoing development of services and service relationships.

Local Transportation Provider Groups' Collaboration

The Waterloo Wellington Community Support Services Network (WWCSS) project consists of 23 agencies providing volunteer-based Transportation, Meals, Adult Day Programs, Caregiver Support or Attendant Outreach. These services encompass a range of health and social services aimed at helping older adults and people with disabilities live as independently as possible in the community. The network, formed in September 2005, aims to ensure optimal access to these community based services for the WWLHIN.

The Transportation Standardization and Access Increase Working Committee (one of 6 WWCSS committees) has been working since January 2006. In just three months, the group has achieved admirable results. Consisting of organizations within the WWLHIN that provide transportation services, the committee has come together to address their mandate: to develop consistent and standardized service eligibility criteria, service processes and definitions for all community transportation services to increase service access in WWLHIN.

The transportation provider organizations have collaborated to share information about the services they offer, share best practices, and identify the gaps in transportation services in the community.

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COMMUNITY ENGAGEMENT

Community engagement is a process that involves activities that support the two-way interaction between WWLHIN and its communities. Consultation, involvement and participation are all integral to community engagement activities.

The WWLHIN Community Engagement Framework is founded on five basic principles.

Shared Vision
We will work with our communities to develop and implement plans that are citizen centered.

Mutual Respect
We recognize different people will bring different levels of health care knowledge to the table. We will do our best to make sure our community engagement activities are designed to best gather that knowledge, perspective and experience.

Accountability
Together we will be accountable for the outcomes associated with changes brought into our health system. In addition, we will have timely, meaningful discussions, consultation and feedback on our activities.

Transparency
We will clearly state the purpose, goals, expectations, constraints and the manner that the information gathered will be used in decision-making.

Commitment
We are dedicated to working with the citizens of the WWLHIN areas towards the achievement of a people centered, sustainable health care system.

Community engagement is a dynamic process involving three strategies:

Effective Communication
We will provide timely and relevant information to ensure community members are informed of events, activities and project updates. In addition, we will actively seek out and gather information for decision-making purposes regarding planning and evaluation.

Sharing the Knowledge
We will share the knowledge we collect by creating and supporting Communities of Interest to promote dialogue with the goal of finding creative solutions.

Evaluating
We will evaluate our results, seeking input and introducing improvement on an ongoing basis.

Community Engagement Activities

Community engagement activities have been a key focus of activities in fiscal 2005/06 and have been taking place since WWLHIN was established in summer 2005. Board members, the CEO and senior staff met with provider agencies and networks, individuals and community groups, took part in tours of facilities, and attended public 'Meet and Greets'. Approximately 160 provider sites were visited and 60 presentations were made to health networks, local service clubs and associations. The goal of these activities was to introduce WWLHIN to the various communities, begin to establish key relationships, and begin the learning and sharing process.

The WWLHIN also brought together groups in new discussion forums; one such forum resulted in Guelph being awarded its first Family Health Team (beginning April 2006). As well we brought together two Regional Geriatric Networks and these groups are now working together sharing ideas and best practices and finding new opportunities for service delivery.

In January 2006 WWLHIN developed a formal Community Engagement Framework (CEF) to define our approach to community engagement. The draft framework was sent for comment to over 250 service providers, members of the public, and elected officials. Modifications were made based on feedback.

The final document was released in March during ten Town Hall Workshops. Development of the Integrated Health Services Plan, and our approach to integration and performance management will be achieved utilizing this framework.

[For a copy of the Community Engagement Framework please contact the WWLHIN office.]

Town Halls

Almost 400 citizens within the area serviced by the WWLHIN participated in ten Town Hall Workshops between March 21 and March 29.

The objectives were to:

- Validate and update priorities identified in prior data gathering exercises
- Determine whether the perception of WWLHIN's population health match the statistical reality that it is relatively good compared to Ontario averages
- Provide an opportunity for citizens to weigh in and be heard thus building community acceptance and commitment to common goals

Third party facilitators asked attendees to first imagine the 'ideal' health system for our area and what gaps needed to be addressed to move from the current situation to their concept of the ideal future. These gaps were then discussed by breakout groups followed by the common themes being considered by the entire group. Thirteen themes and four 'key enablers' were identified (they are outlined in detail on page 13).

In addition to identifying the local themes, the meetings were a success in diffusing concerns - whether they were citizens, patients, providers or caregivers, their concerns about change were addressed and demystified. Many people expressed their appreciation for receiving information and the ability to participate.

Looking Forward

Community engagement activities planned for fiscal 2006-07 include a focus on input about the identified local themes.

The general public will be surveyed for input on these local health themes. As well, input will be sought from 'Communities of Interest' - individuals and/or organizations that directly or indirectly influence or impact program or service delivery outcomes or who are impacted by such outcomes.

Communities of Interest within WWLHIN include residents of Waterloo Region, Wellington County and the southern region of Grey County, service providers (both funded and non-funded) special interest and community groups, labour and professional associations and others.

Special interest groups include:

- Aboriginal
- First Nations
- Youth - Rural and Urban
- Homeless/low income
- Multicultural
- Seniors
- New immigrants and refugees
- Mennonite community
- Gay/lesbian/transgender
- Francophone

While many of these Communities of Interest have already played an active role in the WWLHIN community engagement activities, they will also be invited to participate in surveys and/or in customized focus group sessions.

In late summer the announcement of the local 'themes' will be made followed with opportunities for feedback. The Integrated Health Services Priorities document will be announced in September, community input will be invited in September and October with a final Integrated Health Services Plan released in late fall.

THE INTEGRATED HEALTH SERVICES PLAN

A New Model
A New Approach
A New Discussion

When presented in fall 2006, the Integrated Health Services Plan (IHSP) will be the first Waterloo Wellington Local Health Integration Network document to publicly set out priorities and strategies for the three-year period beginning April 2007. The IHSP will describe the vision, set the direction and identify the integration priorities and initiatives to be delivered.

The IHSP will represent a new approach for planning our local health system. It will be based on the following principles:

Community Engagement
A set of processes and activities designed to have local groups of individuals, agencies and organizations involved in the development of the IHSP. Engagement will continue through the delivery and ongoing evaluation of health care services.

Be the foundation for future plans
Each year, WWLHIN will review, refine and revise the IHSP. By building on experience and knowledge gained, WWLHIN will continue the process of improving our local health system.

Identify priorities for integration
The first IHSP will communicate key integration opportunities and local priorities.

Demonstrate achievement of Ministry strategic directions
The WWLHIN will work with the Ministry of Health and Long Term Care to ensure the IHSP is aligned with the common goals and objectives to be identified in the Ministry's 10 year strategic plan.

Optimize available resources
The IHSP will set out ways to use available local health care resources to their fullest potential.

CREATING THE WWLHIN INTEGRATED HEALTH SERVICES PLAN (IHSP)

The WWLHIN IHSP will incorporate data analysis of local population health demographics and trends. It will also include input from individuals, community groups and communities of interest (individuals and/or organizations that directly or indirectly influence or impact program or service delivery outcomes or who are impacted by such outcomes).

The creation of the IHSP began in August 2005 with the commencement of community engagement activities (refer to Community Engagement, page 11).

Through more than 160 visits to provider sites, 60 presentations to local health networks, associations and community groups, and 10 Town Halls, the WWLHIN Board, CEO, and senior staff shared information and received valuable input from members of the health care and broader communities. Key to the creation of the IHSP is the identification of local 'themes'.

Local Themes

Four hundred members of the public, patients, clients and providers attended Town Hall Workshops in March 2006. These sessions were held in ten locations across the WWLHIN. The Town Hall Workshops introduced the concept of integrated health services planning and served as a forum to review the priorities described in the Integration Priority Report of February 2005 (based on a November 2004 Community Providers Workshop). The priorities included:

- Health Personnel Planning
- Optimal Care Guidelines
- Public Report Cards
- Integrated Electronic Health Records
- Integration of Access, Assessment, Care Management and After-care
- Administrative Support Coordination
- Integration of Community Health with Mental Health and Addiction Programs
- Community Support Provider Organizations
- Continue Network Planning
- Local Health Hubs
- Mental Health System

The themes that were identified at the March 2006 workshops reaffirmed many of the themes from the November 2004 workshops and introduced additional themes.

Themes from the March 2006 Town Hall workshops:

- Accessibility to Care and Services
- Access to Health Records/Information
- Caregiver Support
- Chronic Disease Management
- Community Services
- Hospice/Palliative Care
- Mental Health and Addiction
- Primary Care
- Promotion and Prevention
- Public Awareness and Health System Navigation
- Quality of Care
- Services for Seniors
- Services for Specific Populations

Four Key Enablers: Coordination, E-Health, Funding, Health Human Resources Planning

Looking Forward

As part of the community engagement process that leads to the creation of the IHSP document, WWLHIN will go back to our communities to solicit input on the themes that were identified in March and their priority in the IHSP plan.

This will include:

- Provider and Provider Network surveys (May '06)
- Citizen surveys (May '06)
- Consultations and focus group sessions with special interest groups (May - June '06)
- Public announcement of themes (July/August '06)
- Input for IHSP Priorities (Sept/Oct '06)
- Public announcement of WWLHIN 2006 IHSP - draft (Sept/Oct '06)
- Final IHSP document released (late fall '06)

LOCAL HEALTH SYSTEM INTEGRATION ACT 2006

continued from page III

Integration

To enable a co-ordinated 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 require integration where they believe it is in the public interest. The Act also includes mechanisms to protect employees when services are integrated.

[As of 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 http://www.e-laws. gov.on.ca/home_E.asp?lang=en].

Waterloo Wellington
Local Health Integration Network
Annual Report 2005-2006

Approved by

Kathy Durst, Chair

Paul Holyoke, Secretary

OPERATIONAL START UP **continued from page 3**

Discussion forums were held to discuss such issues as physicians and LHINs and LHINs' cross-boundary issues in the community sector. WWLHIN staff also participated in tours of facilities, meeting with service providers, and accompanied community staff on home visits.

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

LOCAL TRANSPORTATION PROVIDER GROUPS' COLLABORATION **continued from page 10**

The committee has: looked at ways of standardizing practices, identified issues (such as volunteer recruitment and retention and high gas prices), confirmed their commitment to ensuring appropriate transportation options are available and looked at gaps in services.

The Transportation Committee is well on its way to developing a model for service delivery that will be effective in the long term.

Some photos from Health Canada website and media Photo Gallery, Health Canada, www.hc-sc.gc.ca. Reproduced with the permission of the Minister of Public Works and Government Services Canada 2006.

Deloitte.

To the Members of the Board of Directors of the
Waterloo Wellington Local Health Integration Network

We have audited the statement of financial position of the Waterloo Wellington Local Health Integration Network (the "LHIN") as at March 31, 2006 and the statements of operations and changes in net assets for the period from the date of incorporation June 2, 2005 to March 31, 2006. 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 Waterloo Wellington Local Health Integration Network as at March 31, 2006 and the results of its operations and its cash flows for the period from the date of incorporation June 2, 2005 to March 31, 2006 in accordance with the Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants

Toronto, Ontario
May 29, 2006

FINANCIAL STATEMENTS
Waterloo Wellington Local Health Integration Network

STATEMENT OF FINANCIAL POSITION
March 31, 2006

ASSETS		
Cash	$	26,177
Capital assets (Note 3)		1
	$	26,178

LIABILITIES AND NET ASSETS		
Accounts payable and accrued liabilities (Note 4)	$	—
Net Assets		26,178
	$	26,178

Approved by the Board of Directors

Kathy Durst, *Chair*

Paul Holyoke, *Board Secretary*

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
Period from the date of incorporation, June 2, 2005 to March 31, 2006

REVENUE		
Ministry of Health and Long Term Care ("MOHLTC") Funding	$	2,500
MOHLTC payroll reimbursement		231,097
		233,597

EXPENSES (Note 5)	
Salaries and benefits	203,181
Office supplies	2,547
Postage and courier	1,070
Catering	448
Other	173
	207,419

EXCESS OF REVENUE OVER EXPENSES		26,178
NET ASSETS, BEGINNING OF PERIOD		—
NET ASSETS, END OF PERIOD	$	26,178

1. DESCRIPTION OF BUSINESS

Formation and status

The Waterloo Wellington Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Waterloo Wellington Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

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

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Waterloo Wellington LHIN includes all of the County of Wellington, the Region of Waterloo, and the City of Guelph. This LHIN contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs.

Fiscal period

These financial statements represent the activities of the LHIN from June 2, 2005, the date of incorporation, to March 31, 2006.

2. SIGNIFICANT ACCOUNTING POLICIES

Financial statement presentation

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

Revenue recognition

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

Use of estimates

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

3. CAPITAL ASSETS

The LHIN office maintains a record of assets purchased on its behalf by the MOHLTC. The nature of these assets incudes:

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

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

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $195,456 in its records on behalf of the LHIN as at March 31, 2006. Theses expenses are included in the amounts disclosed in Note 5.

5. EXPENSES

All other operating expenses, other than those disclosed on the statement of operations, were approved and paid for on behalf of the LHIN by the MOHLTC. These expenses for the period ended March 31, 2006 are as follows:

Salaries and benefits	$	94,358
Accommodation/occupancy		1,231,217
Common services		42,126
Information technology		95,733
Other expenditures		211, 124
	$	1,674,558

6. GUARANTEES

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

(ii) An indemnity for the Chief Executive Officer was provided directly by the LHIN. Between March 28, 2006 and March 31, 2006, the directors, officers and employees of the LHIN received the benefit of Section 35 of the Act.

7. STATEMENT OF CASH FLOWS

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

LIVE AND LIVE WELL IN WATERLOO WELLINGTON

WATERLOO WELLINGTON
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ISSN 1911-2963 5M June/06