



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

Central East LHIN – 2005/06 Annual Report

Introducing Local Health Integration Networks

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

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 better organize the way Ontario's health care system is structured. The goal is to create local links between health care services and health care providers and to make it easier for people receiving health care 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 oversee 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 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, people requiring health care can expect to see better access.

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 involve Ontarians in the health care conversation, giving them a chance to participate in decisions about the health care system in their community.

Transparency, accountability and responsibility

LHINs will ensure that health care dollars are spent in the most effective and efficient 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 people requiring health care face and ensuring that decisions are made in their interests.

For more information visit the Central East LHIN's web site at www.centraleastlhin.on.ca

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Message from our Chair and CEO

Almost six years ago, Peggy Leatt and colleagues wrote an article titled: “Towards a Canadian Model of Integrated Healthcare.” We were impressed by the foresight of the six strategies Peggy describes for achieving Integrated Health Systems. These are stated as follows:

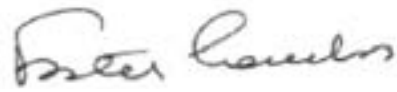
- Focus on the individual
- Start with primary healthcare
- Share information and exploit technology
- Create virtual networks at local levels
- Develop practical needs-based funding models
- Implement mechanisms to monitor and evaluate

These strategies could be summarized simply as: “It’s about the people!”, which is a refreshing place to start as most health policy begins either with providers or financing. We found ourselves struck by the roadmap-like quality of these six strategies when comparing the directions the Province has recently undertaken. In the six years since the article was published, Ontario has created virtual networks at local levels – Local Health Integration Networks (LHINs). This report outlines the progress to date of the Central East LHIN from 2005 to March 31, 2006. With the support of the provincial government our LHIN has launched three Family Health Teams to enhance primary care services. In February 2006, our LHIN received funding from the Ministry to support our eHealth initiatives that closely align with the Province’s eHealth Strategy. Our LHIN is committed to achieving the vision of: “a health care system that helps people stay healthy, delivers good care when they need it and will be there for their children and grandchildren”. Over the last seven months, we have also:

1. Created and launched an interim website www.centraleastlhin.on.ca that now serves as a model for our sister LHINs.
2. Developed and launched a comprehensive Framework for Community Engagement and Local Health Planning along with a feedback form that has been circulated to over 230 health service providers, members of the public and elected officials.
3. Discussed integration opportunities and areas of focus in over 100 meetings with community organizations
4. Established the Central East LHIN office and related business operations .
5. Identified three potential community nominees for the Board who joined our Board in May, 2006.
6. Recruited two Senior Directors and two Office staff who actively contribute to the desired organizational culture defined by teamwork.
7. Identified draft areas of focus through a Board retreat, that built upon those articulated in: “Taking Stock: Setting Integration Priorities in the Central East Local Health Integration Network Area” (February 2005).

This report represents both a milestone for Ontario's LHINs and a marker for future activities as we collectively move toward achievement of the last two strategies that Peggy and her colleagues wrote about. In 2006, we are focused on the completion of our Integrated Health Services Plan. Following that, we will devote our energies toward the development of a funding model, as well as a robust performance and accountability framework to support our goals for integration. Organizationally, we have had the pleasure of being complimented on the high caliber, committed Central East LHIN team. Indeed, with this team and the leadership of the Board, we will be a learning organization that produces results. As one of our team mates recently acknowledged, our mantra is simple: "Failure is not an option".

Sincerely,



Foster Loucks
Chair



Marilyn Emery
CEO



Highlights of the 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 creates 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, co-ordinate 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 specific 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 in order 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 their employees. The Act identifies some of the methods LHINs would use for community engagement, including 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 community, in accordance with the LHIN’s accountability agreement with the Minister.

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

Welcome to the Central East LHIN

The Central East LHIN is one of the fastest growing geographic regions in the Province and home to 12% of Ontario's population. Since the 2001 Census, the population has grown by almost one-and-one-half percent, making the LHIN 1.4 million people strong. Our LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km²). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, our LHIN stretches from Victoria Park to Algonquin Park! The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics. The large land area, population distribution and the resulting complexity of how services are delivered and used will present formidable challenges for understanding the health needs of the Central East community. Not surprisingly, the variation in geography that characterizes our LHIN is accompanied by variation in the health status of our population.

Compared to the province, Central East has:

- A higher proportion of visible minorities (72% of the residents of the former city of Scarborough are visible minorities)
- A higher proportion of the population who are physically inactive (49% versus 46% in Ontario - 2005)
- A lower proportion of the population who consume 5 or more servings of fruit and vegetables daily (38% versus 41% in Ontario – 2005)
- A lower proportion of adults reporting “a lot of life stress” (21% versus 23% in Ontario 2005), and
- A lower age-standardized hospitalization rate (74 per 1000 versus 77 per 1000 population in Ontario 2004-05).



Photo Credit: Ross Memorial Hospital

The residents of the Central East LHIN vary socio-demographically as well. The unemployment rate in Central East is slightly higher than the provincial rate (6.7% versus 6.1% in Ontario). The same applies to the percentage of our population with low income rates (14.8% versus 14.4% in Ontario). Forty-six percent of adults (age 20+) have attained post-secondary education credentials, and 27% have not completed high-school.

The above is meant to offer a quick sketch of our LHIN. Of relevance are the implications of these statistics on our health services planning and our community engagement initiatives. More importantly, it is these unique characteristics and the attention that the Central East LHIN will pay to them that will enable our mandate for **locally relevant** health system planning (Table 1).

Table 1:
Socio-demographic
characteristics

	Northumberland- Havelock	Peterborough City & County	Kawartha Lakes	Durham West	Durham East	Durham North/Central	Scarborough Agincourt - Rouge	Scarborough Cliffs - Scarborough Centre	Haliburton Highlands	LHIN TOTAL	ONTARIO TOTAL	LHIN Range
Total population (2001)	72,527	121,377	69,179	248,305	208,885	49,711	272,149	289,799	15,085	1,347,017	11,410,046	606,990 - 1,352,394
Senior population age 65+ (2001)	17.7%	17.9	19.0	7.8	11.3	13.6	11.5	13.9	24.1	12.8%	12.9%	9.4 - 15.7%
Population with English mother tongue	94.6	94.0	95.0	85.4	88.6	93.6	45.7	59.3	94.2	74.4%	71.9%	55.7 - 92.2%
Population with French mother tongue	1.4	1.3	1.1	1.8	2.6	0.9	1.0	1.3	0.9	1.5%	4.7%	1.2 - 25.1%
Population who are immigrants	9.7	9.0	8.4	24.3	14.3	10.4	61.7	49.6	10.0	32.2%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996 - 2001)	0.5	0.6	0.2	1.8	0.9	0.5	12.1	12.3	0.5	5.7%	4.8%	0.3 - 9.7%
Population who are visible minorities	1.8	2.4	1.0	20.5	5.3	2.1	71.9	50.2	0.4	30.4%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	1.8	2.6	1.1	0.6	1.2	1.0	0.2	0.6	0.9	0.9%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	61.6	61.9	60.3	75.1	69.2	70.2	64.8	63.3	50.8	66.3%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.6	7.2	6.9	5.1	6.4	4.6	7.5	8.0	5.3	6.7%	6.1%	5.0 - 9.8%
Population in low income	9.3	13.6	9.9	6.9	10.8	6.3	19.4	24.7	13.2	14.8%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	22.1	25.1	20.5	18.9	24.6	17.1	24.3	31.9	20.3	24.5%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	7.3	6.8	7.7	3.9	6.7	6.0	10.3	9.5	10.7	7.7%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	30.6	27.2	33.6	18.2	28.4	26.8	25.7	28.6	36.0	26.4%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	42.4	46.6	40.3	52.8	43.7	44.8	48.2	43.8	39.4	46.2%	48.7%	42.4 - 55.8%

Data Source: Census of Canada, 2001

Health Status

Low birthweight is an important determinant of infant morbidity and mortality. In Central East 5.9% of infants born in 1999-2001 were of low birth weight (Table 2). 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. Fifty-six percent of the Central East population rated their overall health as “Excellent” or “Very Good”, similar to the Ontario average of 57.4%. Almost 25% of the Central East population 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.



Table 2: Health status

	Central East	Ontario	LHIN Range
Female life expectancy at birth (years), 2001†	●	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	•	77.5 (± 0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.9%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)† ‡	●	5.4 (± 0.2)	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+)#	55.9% (± 2.5)	57.4 (± 0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+)#	24.9% (± 1.9)	24.6% (± 0.6)	19.3 - 30.0%

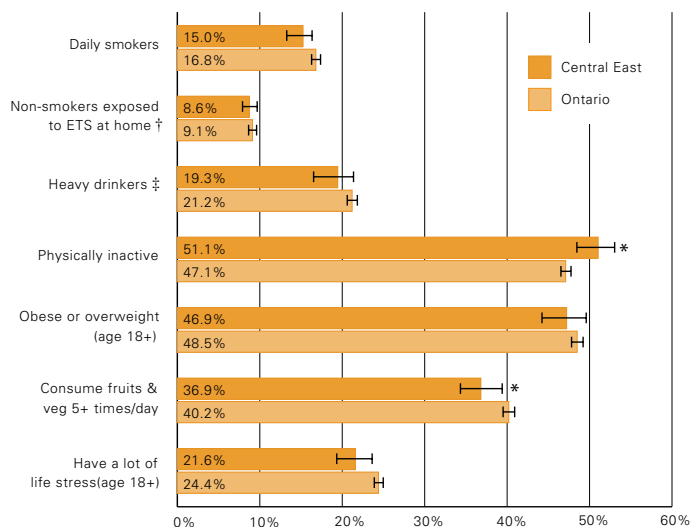
Not calculated due to data quality issues.
Data sources:† Ontario Vital Statistics, Mortality Database, ‡ Ontario Vital Statistics, Livebirths Database
Canadian Community Health Survey, 2003

Health Practices and Preventive Care

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability. Table 3 shows that, relative to the province, those in Central East are significantly more likely to be physically inactive and less likely to consume an adequate amount of fruits and vegetables. However, the prevalence of daily smoking, heavy drinking and exposure to ETS (Environmental Tobacco Smoke) is slightly lower than the Ontario average, but these differences do not reach statistical significance. Based on Body Mass Index 33.0% of the adult population of Central East is considered overweight and 13.0% are obese. The combined prevalence of overweight/obesity in Central East is similar to that in Ontario. The proportion of adults in Central East reporting that they have a lot of life stress (21.6%) is significantly lower than the provincial average (24.4%). The use of preventive health care services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality. Mammography, Pap smear and flu

shot rates for Central East are similar to provincial rates (Table 4). 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 the population (82.1%) in Central East had at least one contact, either in person or by phone, with a medical doctor in the past year.

Table 3: Health practices, population age 12+



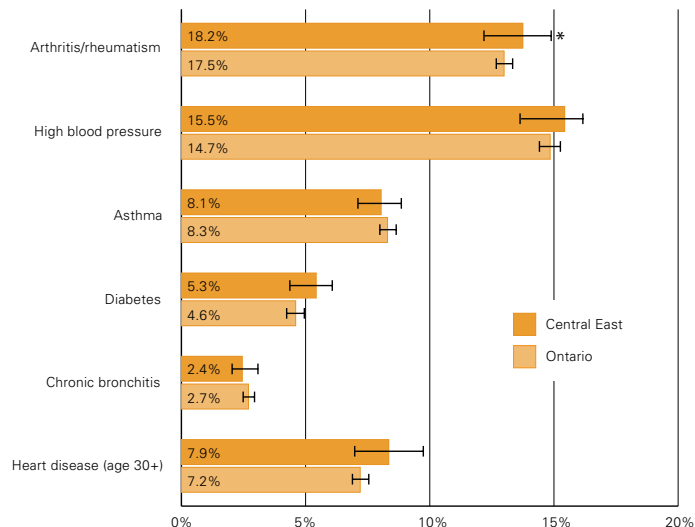
† ETS - environmental tobacco smoke (second-hand smoke)

‡ 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

Prevalence of selected chronic conditions, population age 12+



Data Source: Canadian Community Health Survey, 2003



Table 4: Use of preventive care

	Central East	Ontario	LHIN Range
Had mammogram in past 2 years (females age 50-69)	68.3% (±6.0)	70.6% (±1.9)	65.8 - 77.2%
Had Pap smear test in past 3 years (females age 18+)	66.8% (±3.7)	69.2% (±1.0)	65.4 - 75.5%
Had flu shot in past year (age 12+)	33.5% (±2.3)	34.2% (±0.7)	30.3 - 39.0%
Contact with Medical Doctor in past year (age 12+)	82.1% (±1.9)	81.4% (±0.6)	76.4 - 83.7%

Data Source: Canadian Community Health Survey, 2003

The Central East LHIN's Planning Zones

Experience has taught us that it is difficult to plan for large and diverse populations using aggregate information. For example, 13% of our residents are 65 years of age and older compared to the 12.8% in Ontario. On average, the elderly as a population are known to have higher rates of chronic conditions. Chronic conditions place a heavy burden on the health care system and reduce the quality of life of those who suffer from the conditions. Within our LHIN, over 25% of the population in Haliburton is over the age of 65 years. It is precisely statistics such as these that remind us that when information is applied equally across a large area, our understanding of the differences amongst smaller populations is often masked.

It is important to remember that LHINs 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.

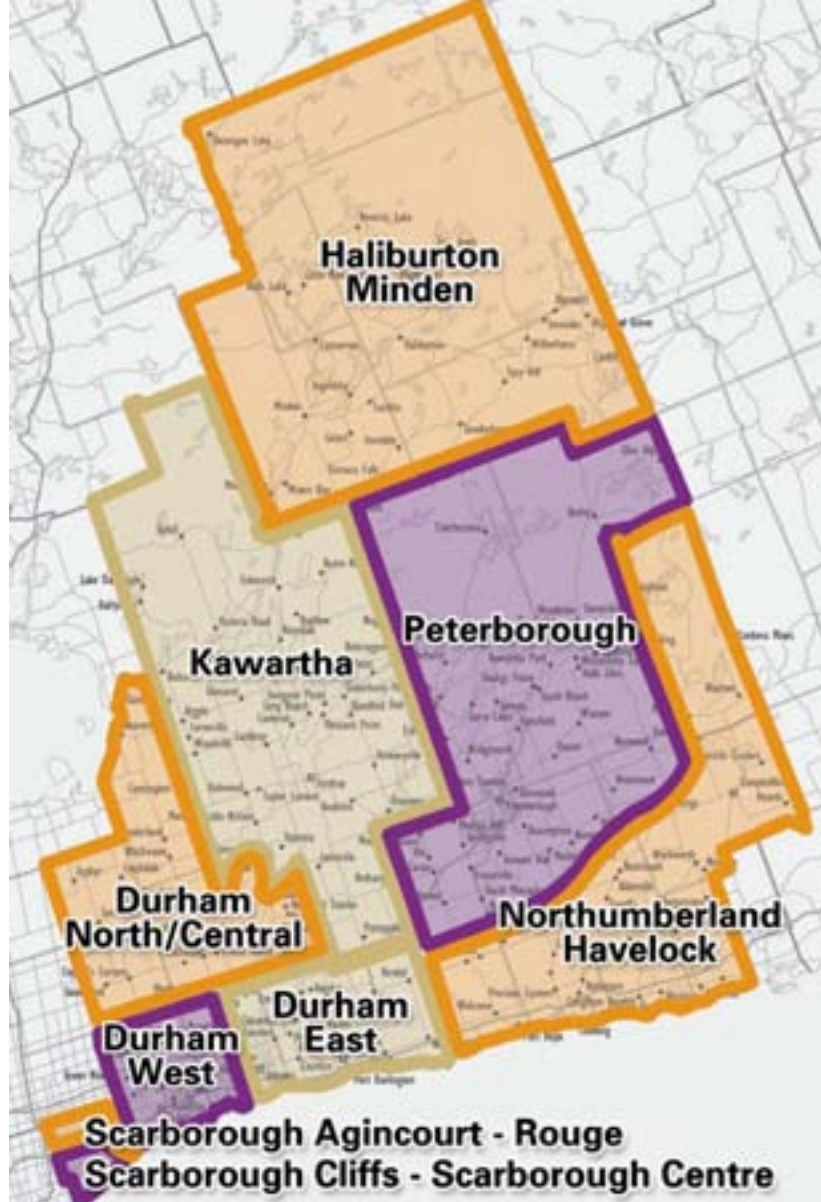
Therefore the Central East LHIN has divided its large geography into nine geographic "planning and engagement zones". We recognize that these zones are not similar in all of their population characteristics, patterns of service use and that the residents in each zone do not have the same access to services as the other

zones in our LHIN. Quite frankly, this also is in part why LHINs were created: to ensure the uniqueness of areas within the Central East LHIN community is considered.

These zones were designed based on an initial assessment of several characteristics. These include the size and distribution of the population, travel distances, commonly understood patterns of service use by citizens (i.e., health or other services), municipal boundaries and, where available, information on the socio-economic characteristics of the populations by zone.

The zones will be evaluated and, where appropriate, modified over time as our knowledge of the characteristics of these zones grows. The LHIN also understands, that people requiring health care will seek services wherever they choose to obtain it within the LHIN in which they live or neighbouring LHINs. We also recognize that some health service provider agencies deliver services within our LHIN and in other LHINs. **Therefore, these zones should be seen as a mechanism to support the engagement of local stakeholders, facilitate our collective planning efforts and in no way limit or restrict the use and delivery of health services.**





Community Planning & Engagement Zone (Lower Tier Municipalities – Boundaries)	Population 2001 Census
Haliburton Highlands Dyset-Dudley-Harcourt-Guilford-Harburn-Burton-Havelock-Erye-Clyde, Highlands East, Minden Hills, Sherbourne, Stanhope, McClintock, Livingstone, Lawrence, Nightingale	15,085
Kawartha Lakes City of Kawartha Lakes	69,179
Peterborough City & County Galway-Cavendish-Harvey, North Kawartha, Smith-Ennismore-Lakefield, Douro-Dummer, Cavan-Millbrook-North Monaghan, Otonabee-South Monaghan, City of Peterborough	121,377
Northumberland-Havelock Campbellford/Seymour-Percy-Hastings, Cobourg, Cramahe, Alnwick, Haldimand, Hamilton, Port Hope and Hope, Havelock-Belmont-Methuen	81,976
Durham - East Oshawa, Clarington	208,885
Durham - West Whitby, Ajax, Pickering	248,305
Durham - North/Central Scugog, Uxbridge, Brock	49,660
Scarborough Agincourt – Rouge* Boundary (Clockwise): South of Steeles and East of Warden – Lake Ontario – East of Highland Creek – East of Morningside Ave – North of Hwy 401 – East of Warden. (Includes University of Toronto / Scarborough Campus)	272,165
Scarborough Cliffs – Scarborough Centre Boundary (Clockwise): South of Hwy 401 – West of Morningside Ave – West of Highland Creek – Lake Ontario – East of Warden	321,100

Nizar Ladak,
*Senior Director,
Performance, Contract
and Allocation*

Marilyn Emery,
CEO

James Meloche,
*Senior Director,
Planning, Integration and
Community Engagement*



Our Leadership Team

Marilyn Emery

Chief Executive Officer

Marilyn is a senior health care executive with sixteen years experience leading hospitals in producing outstanding results. As President and CEO of Markham Stouffville Hospital (1989–1997), the first hospital to receive the National Quality Institute Canada Award of Excellence, Marilyn became known for her commitment and strategic expertise in quality service, performance indicators and empowered work environments. At St. Joseph's Health Centre (1997–2003), Marilyn led a turnaround in both financial and business performance, as well as a transformation in patient satisfaction that has been heralded as unprecedented in Ontario.

As a member of the first group of women named Canada's Top 100 Women, she received national recognition as a leader in the public sector. From 2003 to 2005 Marilyn consulted to Boards of Directors and senior executives in health care organizations, universities and government. She has been a significant contributor to the Joint Policy & Planning Committee work on Hospital Accountability Agreements. In March of 2005, Marilyn was appointed one of ten Lead Reviewers for the Ministry of Health and Long-Term Care Peer Review Process designed to assist hospitals in developing a Balanced Budget Plan.

James Meloche

Senior Director, Planning, Integration and Community Engagement

James is the key individual responsible for the development of strategic planning that focuses on the accessibility, quality and integration of health care services within the diverse region of the Central East LHIN. Planning is conducted through an active process of community engagement and leveraging the knowledge, expertise and resources within the health care community.

Prior to this position, James was the Manager for Health Transformation Policy, and Business Lead, Critical Care Transformation Strategy, reporting directly to Hugh MacLeod, Associate Deputy Minister, Health Results Team of the Ministry of Health and Long-Term Care. In other positions within the Ministry, James served as the District Health Council provincial coordinator, and provided strategic directions on accountability systems, including performance evaluation and management. Prior to the Ministry, James worked in the non-profit sector assisting U.S. health care organizations in organizational governance and ethics.

Nizar Ladak

Senior Director, Performance, Contract and Allocation

Nizar Ladak's team is responsible for the development of accurate and reliable performance measures and the allocation of funding to support health service delivery in the Central East LHIN. Prior to this position, Nizar was Director, Health Services Information at the Canadian Institute for Health Information (CIHI). In that role, Nizar was responsible for managing all operational activities relating to CIHI's products and services for many of the Institute's national databases as well as related standards and effective data quality mechanisms. From 1996 to 1999 Nizar served as Technical Planning Consultant and, subsequently, as Executive Director (Acting) of the Ontario Joint Policy and Planning Committee. In this capacity he led initiatives in hospital funding, health system reform and decision support that have gained national recognition. His additional accomplishments include re-engineering Canada's inpatient database and initiating the development of a population needs based funding methodology. Nizar is also an Assistant Professor at the University of Toronto and University of Waterloo working on topics such as eHealth, Performance Management and Integrated Health. He has contributed to his field of expertise through numerous publications, reports and presentations.

Our Leadership Team

Following the completion of the process for Public Appointments, the Board of the Central East LHIN reached its full complement in May, 2006. Nine highly experienced individuals currently comprise our Board.

Chair

Foster Loucks (Haliburton)

From 1995 until 2002, Foster Loucks was the CEO of Haliburton Highlands Health Services. Prior to that, he was the administrator of Lakehead Psychiatric Hospital in Thunder Bay, a position he held from 1986 to 1995. He was also executive director of the former Thunder Bay District Health Council from 1982 until 1986. Loucks is a past trustee of the Ontario Hospital Association's Board of Directors and a past member of the Board of Directors of the Thunder Bay Children's Aid Society.

Vice-Chair

Joseline Sikorski (Port Perry)

Joseline Sikorski is currently the President & CEO of the Ontario Safety Association for Community and Healthcare (OSACH), a position she has held since 2003. She is a Certified Healthcare Executive who has held senior executive positions with the Lakeridge Health Corporation, St. Joseph's Health Care Hamilton, Winchester District Memorial Hospital, KPMG Consulting, Centenary Health Centre and the University of Ottawa Heart Institute. She is also a past surveyor with the Canadian Council on Health Services Accreditation, has held joint appointments with the Faculty of Health Sciences at the University of Ottawa and McMaster University and is a past President of the Ontario College of Nurses. Sikorski has served on many councils and boards including the Toronto Cardiac Care Network, the Ottawa Heart Institute Advisory Council, the Ottawa Regional Cancer Centre Advisory Council, the National Blood Transition Board, the Ontario Occupational Health and Safety Council, the Minister of Labour's Health Care Advisory Panel, the Advisory Committee for the Centre of Research Excellence in Occupational Diseases, the Mohawk College Health Sciences Advisory Committee and the Hamilton-Wentworth Visiting Homemakers Association.

Member

Jean Achmatowicz MacLeod C.M. (Ashburn)

Jean Achmatowicz MacLeod has a long history of volunteerism in health care. She chaired the Oshawa General Hospital during its restructuring process, chaired the Board of Whitby Mental Health Centre during the

period of planning for a new hospital and served as the inaugural Chair of the Grandview Rehabilitation and Treatment Centre. Jean was also a founding chair of both the Hospital Council of Durham Region and the GTA/905 Healthcare Alliance. Jean is a past Board member of the Ontario Hospital Association and Cancer Care Ontario and was Chair of the Central East Mental Health Implementation Task Force. Jean has received many awards throughout her years as a volunteer, including the Order of Canada in 2002.

Member

Eva Nichols (Northumberland Havelock)

Eva Nichols of Hamilton Township served as chair of Northumberland Hills Hospital's board. Nichols was the principal of Clarke High School in Orono, the founder of the adult school (The Centre for Individual Studies), course director of York University's Faculty of Education, president of the Continuing Education School Board Administrators for Ontario, and president of the Ontario Co-operative Education Association. Nichols has also served as a board member for the Northumberland United Way, the Art Gallery of Northumberland, the Cobourg District Senior Services, the Police Services Committee for Hamilton Township, and the Canadian Federation of University Women (Northumberland Branch).

Member

Novina Wong (Scarborough)

Novina Wong is a long-time resident of Scarborough. She served as the first clerk of the newly amalgamated City of Toronto from 1997 until her retirement in 2001. Prior to that, she was the clerk of the former Municipality of Metropolitan Toronto and held various senior administrative and executive positions at the municipal level. She is currently a management consultant. Wong's expertise in governance and her extensive management experience in public service were put into full use in her community volunteer endeavours which have included the Scarborough Hospital Board of Directors, the Scarborough Chinese Outreach Committee, the Community Advisory Board of the Scarborough Mirror, and the City Governance Task Force of the Toronto Board of Trade.



Member

Stephen Kylie (Peterborough)

Stephen Kylie was past-chair of the St. Joseph's Care Group. He is a life-long resident of the City of Peterborough where he has practised law for 26 years. He is on the board of directors of three of Peterborough's electric corporations, an active Rotarian and chair of the Mayor's Centennial Celebrations Committee for the City of Peterborough. Kylie has also served as a member of the Board of Trustees of the Catholic Health Association of Ontario, chair of the Kawartha Pine Ridge Lung Association, director of the Ontario Lung Association, chair of the 1998 Ontario Winter Games and Legacy Fund Committee, chair of Peterborough's Bid to Host the 2001 Canada Summer Games, and chair of Peterborough's Bid to Host an Olympic Youth Camp in cooperation with the City of Toronto's Olympic Bid. He is a recipient of the Queen's Golden Jubilee Medal and many other awards of recognition.

Member

William (Bill) H. Gleed (Kawartha Lakes)

From 1984 to 1998, Bill Gleed was the President and Chief Executive Officer of the Citadel Assurance Company of Canada, a general life and health insurance provider company with more than 2,000 employees and distribution network of 1,400 insurance brokers across Canada. Prior to that, he was the President and CEO of Colonia Life Insurance Company from 1981 to 1984 and served as a Regional Vice President of London Life from 1971 to 1981. He was a founding director of the Canadian Blood Services Board of Directors, where he served as Vice Chairman and then Chair and has held leadership positions on other boards including the Alliance for Drug Free Canada, the North York General Hospital where he also served as Treasurer, the Palliative Care Foundation of Canada and the Canadian Cancer Society. Bill has also served on numerous industry association boards and was chair of the Life Office Management Association board. He is an Honorary Director of the Canadian Baseball Hall of Fame and Museum and was instrumental in founding and building the St. David's Non-Profit Housing Corporation. He is also a past member of the Executive Board of the Ontario Safety League.

Member

Dr. Alexander Hukowich (Cobourg)

Dr. Alexander Hukowich has a long career as a physician, beginning in South Porcupine, Ontario in 1971 and later becoming the Medical Officer of Health for the Porcupine Health Unit in 1978. In 1993, Dr. Hukowich became the Medical Officer of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit and upon his retirement in 2004, continued on a part-time basis for six months as the Medical Officer of Health for the Muskoka Parry Sound District Health Unit at the request of the Ministry of Health. While in General Practice and as Medical Officer, Dr. Hukowich has played a leadership role at local, regional and provincial levels of various professional organizations. Dr. Hukowich is a former member and President of the Timmins Rotary Club and Charter member and President of the Rotary Club of Porcupine.

Member

Ronald Francis (Scarborough)

Ronald Francis is a professor in the School of Accounting and Finance at Seneca College where he has taught Business Studies, Marketing and Accounting since 1977. Chair of Seneca's School of Accounting and Finance from 1995-2000, Ronald has also served as a volunteer board member for a number of organizations including the North York General Hospital Board from 1998-2004, the North York Branson Hospital Board from 1993-1998 and the Canadian University College Board from 1996 until the present time. Ronald became a Certified General Accountant in 1976 and was awarded his FCGA Fellowship in 1998. He was elected to the Board of Governors of CGA Ontario in 1993 and served as president and Chair of the Board in 2003-04. At the national level he was a member of the National Education Committee of CGA Canada 1996-1998 and during the latter year was Chair of the Panel of Examiners. He served on the Board of CGA Canada from 2000-2003. In 2002-2004 he joined the Board of the Canadian Academic Accounting Association and was the Chair of the Education Committee. A founding member of the Seneca Association of Black Educators and a chaplaincy speaker at the Bendale Acres Home for the Aged, Ronald has extensive experience in working with teams on consensus building, change management and strategic alliances.

Governance

The development of a process to establish Board Policies and Structures including committees

Two tasks were assigned to a working group of LHIN CEOs and Board Chairs. The first was the development of LHIN Board Conflict of Interest Guidelines. Draft Guidelines were presented to the Board in March 2006. The second was the development of performance objectives for the LHIN CEO and implementation of a process to evaluate CEO performance. A framework for the evaluation of LHIN CEOs was presented to LHIN Board Chairs for their consideration and use in 2006.

Board structures including committees will emerge from implementation of the Board's work plan. A working group of LHIN CEOs issued a Request for Proposal for consulting assistance on the development of a Governance Best Practices manual including options for Board structures. The Central East LHIN Board will also consider the impact of any regulatory requirements as they may relate to Board Committees that emerge from the Local Health Systems Integration Act 2006.

In the Spring 2006, a Board retreat was organized resulting in the outline of a work plan and identified areas of focus to guide our community engagement sessions held in April and May of 2006. A draft Vision, Mission statement and mandate that complement the Ministry of Health and Long-Term Care's vision for Ontario's health system

were developed to recognize the geographic and cultural diversity that characterizes the Central East LHIN.

In order to realize the Government's vision for the health care system, the Board of the Central East LHIN is committed to achieving:

"...a health system that is accountable with shared responsibilities across providers and consumers alike and one which is easy to navigate. A system where there is less talk about how much things cost and more talk about quality care and what that means to consumers and providers. The Board is committed to achieving regional collaboration and partnerships that are working to create an integrated, seamless system of care. It will be managed in a manner that is reasonable with fair decisions that are understood by all".

The development and implementation of an orientation for new Board members

In preparation for our Public Board meetings, the Board, during the late winter of 2006, initiated a robust process for the design and management of board meetings including meeting evaluations. These practices were modeled after those used by the Conference Board of Canada's 2004 Governance award winner for public-sector Boards. These meeting processes allow for broad input into meeting agendas and discussion topics, and have initiated practices that will effectively serve the Board as

they progress toward public meetings. Monthly meetings have been scheduled for the fiscal year 2006-07. Monthly progress reports to the Board in the form of a dash-board were initially instituted to keep Board members apprised of the progress against deliverables.

The Board Chair and CEO have met with each of the Board members to provide an initial orientation and reviewed the initial orientation package developed by the LHIN Support Team. During orientation, each Board member received a comprehensive Board Orientation binder containing relevant documents. It was developed to complement the comprehensive Governance Manual and the Binder of LHIN Briefing Documents provided by the Ministry of Health and Long Term Care. While it was planned during

the period reflected by this Annual Report, a formal half-day education session was delivered to Board members in the early summer 2006 following the appointments of all nine Board members.

In the late spring, Board members requested monthly opportunities for customized education that assist them with developing an emerging understanding of their roles and key provincial and local health care issues.

Community-based recruitment and nomination process

In June 2005, three founding board members were appointed for the Central East LHIN by the Minister's Office and Public Appointments Secretariat. Following a review by Cabinet and the Legislative Assembly's Standing Committee on Government Agencies, the next three board members were appointed in the Spring of 2006. The final three board members were recommended by the Central East LHIN to the Minister's Office through a community-based nomination process. They were accepted by the Minister's Office and their appointment was subsequently announced in June 2006.



Photo Credit: Rouge Valley Health System



Photo Credit: Peterborough Regional Health Centre

Building on Local Success



Funding helps create new project to further women's health issues in Northumberland County

Community partnerships really work. One case in point is in Northumberland County where several agencies and volunteers have initiated Northumberland Women's Health Matters.

The partners are working towards becoming the centre for women's health issues in the County. With a \$9,350 grant from the Canadian Breast Cancer Foundation, Ontario Chapter, the partnership will first tackle the breast health needs of women in Northumberland.

"I see this project as an invaluable way to meet the health needs of women in our community," said Clare Briggs of Northumberland County Community and Social Services.

"We know that women's information and resource needs can vary based on a range of factors, including geography," said Sharon Wood of the Canadian Breast Cancer Foundation, Ontario Chapter. "That's why we support community initiatives like this."

The idea of creating Northumberland Women's Health Matters stemmed from a May 2005 meeting in Port Hope attended by eight organizations, explained Anita Baayen, a Public Health Nurse with the Haliburton, Kawartha, Pine Ridge District Health Unit.

"The group's aim is to plan and implement activities that improve the health and wellness of women in Northumberland County," she said.

The group is laying the groundwork by:

- Researching and reporting on the success of similar projects in other parts of Ontario. Learning from the experience of other initiatives in promoting women's breast health and breast cancer prevention.
- Carrying out a comprehensive survey of women's health needs in Northumberland County to determine where action is most needed.

Groups involved in the project are:

- Northumberland County Community and Social Services
- Body Image Coalition
- Northumberland Services for Women
- Northumberland Hills Hospital
- Survivor Thrivers Breast Cancer Dragon Boat Team
- Regional Cancer Program of Southeastern Ontario
- Northumberland Services For Women
- Haliburton, Kawartha, Pine Ridge District Health Unit.

Building on Local Success

Campbellford health care providers unite to help patients of congestive heart failure

Health care providers in the Campbellford area are uniting to educate and monitor patients with congestive heart failure (CHF), one of the most frequent conditions resulting in readmission to hospital.

Last March, Campbellford Memorial Hospital joined with the three Community Care Access Centres in its service area (Haliburton Northumberland Victoria, Peterborough and Hastings) and with the Victorian Order of Nurses (VON) to address this issue.

Together they began developing an education and self-management program for patients with a primary diagnosis of congestive heart failure. The objective is to teach patients to take responsibility

for their condition and help them learn to manage the disease, instead of the disease managing the patients.

It's working

Alan Cavell, Executive Director, VON Central East District says the joint initiative has been successful. "The development of a CCAC Case Manager role in the hospital and innovative approaches in community nursing has allowed many persons to return home quickly and benefit from professional nursing services at home while also ensuring support of family members."

Community Care Kawartha Lakes and Ross Memorial form patient transportation partnership

Community Care City of Kawartha Lakes and Ross Memorial Hospital have developed a unique partnership for the transportation of patients.

The Non-Emergency Transfer Vehicle, owned by Community Care, provides a fee-for-service program of transportation to medical clients, who are stable and do not require the emergency services of an ambulance. It is equipped with a stretcher and wheelchair capabilities and a support person accompanies all stretcher transfers.

"This service has allowed Ross Memorial Hospital to ensure that patients have safe transport while it also assists in alleviating strained Emergency Medical Services transportation resources," said Anthony Vines, President and Chief Executive Officer of the Lindsay hospital.



Durham's Hospice and Community Care working together to ensure care to those in need

Durham Region is known for the partnerships that exist between community services, say Cheryl MacLeod and Brent Farr, Executive Directors of Hospice Durham and Community Care Durham, respectively.

For instance, the two community organizations have partnered to help one family cope with their elderly cancer-ridden matriarch.

"Sometimes circumstances present opportunities for unique service responses with unanticipated outcomes," Cheryl said.

Her son and his family are looking after the elderly woman. "As is typical in these situations, the family is doing what they can, but work and other obligations prevent them from meeting all of the emotional needs of their loved one."

Hospice Durham had a volunteer who had much in common with this woman and after meeting her, it was apparent that the match was ideal. "The unique needs of this client meant that there was no other volunteer who

could meet the requirements, but distance and lack of viable transportation prevented the match from occurring," Cheryl said.

It was at this point that a plan was hatched that benefited everyone, Brent says. "One volunteer helped another volunteer care for an individual in need and that was absolutely great."

Every week, a volunteer driver from Community Care Durham transports the volunteer from Hospice Durham to the client's home and back again. The family is relieved of some of the care-giving burden, the client looks forward to the visit which is the highlight of her week, and all of the volunteers involved have learned about other services which exist in the community for the benefit of clients.

Partnerships with agencies, families and volunteers like this serve as a model of what integration is all about, Cheryl and Brent agree. "Working together, we ensure the neediest receive the care they need," Cheryl said.

New Cancer Centre will see new partnerships across the Central East LHIN

Ontario's newest full service cancer centre, the R.S. McLaughlin Durham Regional Cancer Centre in Oshawa, opens in about a year.

In anticipation of the opening, the Cancer Centre has been operating a cancer clinic two evenings a week at the Rogers Street site of the Peterborough Regional Health Centre. A radiation oncologist and a medical oncologist from Lakeridge Health's Oncology Program and the R.S. McLaughlin Durham Regional Cancer Centre, in collaboration with local physicians, see new patients. Lakeridge Health oncologists also assess patients at Rouge Valley Centenary, in Scarborough, twice a week complementing the multi-disciplinary team at both hospitals.

Building on Local Success

Three Durham healthcare providers launch HIV/AIDS Awareness Campaign

Three Durham healthcare organizations partnered last spring to launch a campaign to increase public awareness of HIV/AIDS services in the community.

The collaboration involved Durham Region Health Department, AIDS Committee of Durham Region and Lakeridge Health's Positive Care Clinic. The campaign received more than \$10,000 from the Ministry of Health and Long Term Care, as part of its Community Planning Initiative.

The campaign, which included brochures, posters and advertisements, was unveiled at the AIDS Committee of Durham Region Spring Conference in Oshawa attended by Health Minister George Smitherman.

Certified education – closer to home thanks to Northumberland Hills and Sir Sanford Fleming

Northumberland Hills Hospital and Sir Sanford Fleming College in Peterborough have joined forces and developed a certificate course in Palliative Care that is offered by video conferencing.

The first class was offered last fall when 26 registered nurses and registered practical nurses from Northumberland Hills, Ross Memorial Hospital and Peterborough Regional Health Centre enrolled in this innovative project.

The eight courses, of at least 11 weeks, will be offered weekly during a two-year period. The teachers will be conducting the class from the hospital most convenient to them and the students attending in the same manner, all connect through the video network.

It is a great way to go to obtain further education without having to drive great distances, agree Janet Burn, the Palliative Care Unit's Clinical Practice Leader, and Rosemary Goodacher of Sir Sanford Fleming.

Janet explains that when the hospital established a Palliative Care Unit two years ago, there was a desire and commitment on behalf of the staff of the unit to obtain specialized education in the field of palliative care nursing.

When investigation into courses available was disappointing, Janet met with Rosemary to discuss partnering to develop a palliative care certificate course, that could be offered by video conference via the North Network to all hospitals in the region.

Participating in the development of the course were regional experts in Palliative Care and representatives of North Network.



Rouge Valley focuses on families and partnerships

Rouge Valley Health System is already making 2006 the year of accessibility for patients and families and with health care partners within the Central East LHIN area.

Families welcome at any time

The best time to visit a family member or friend in the hospital is any time that is good for the patient.

That's the essential philosophy behind a major change and paradigm shift in not only visiting hours at Rouge Valley Health System, but also in the overall health care milieu for patients at its east Toronto and west Durham hospitals.

Visiting hours throughout all departments of Rouge Valley Health System have now been removed. Families in Whitby, Ajax, Pickering and Scarborough are now experiencing this unique approach at both hospital sites: Rouge Valley Ajax and Pickering; and Rouge Valley Centenary. Visiting times will now be determined relative to what is best for each patient in partnership with patient families.

Hip and knee patients get home sooner

Rouge Valley Health System's Total Joint Initiative, supported by the Total Joint Network (TJN), is enjoying many successes – not the least of which is getting patients home sooner.

Hip and knee surgery patients also have decreased wait times as a result of the venture initiated in October 2005, in a joint announcement with The Scarborough Hospital.

The collaboration – of 10 acute care hospitals, five rehabilitation hospitals and eight community care access centres – is achieving its goal is to deliver efficient and effective care as part of the Ministry of Health and Long Term Care's wait list strategy.

Rouge Valley and Scarborough partner for patient safety

Rouge Valley Health System and The Scarborough Hospital have partnered up to improve patient safety and efficiency in the administration of intravenous medication.

"By using the latest in technology, we are able to improve patient safety at both hospitals," says Hume Martin, President and Chief Executive Officer of Rouge Valley. "This partnership is also well aligned with our goals and those of the province to work increasingly within our Local Health Integration Network (LHIN) area."

"We are fortunate to have this opportunity to replace and upgrade approximately 615 pumps using this new technology at both Rouge Valley and The Scarborough Hospital," said Dr. Hugh Scott, President and Chief Executive Officer of The Scarborough Hospital. "This technology ensures and promotes our hospitals' position of excellence in the provision of patient care."

The Central East Local Health Integration Network: *The Year in Review*

On January 12, 2006, the Honourable George Smitherman, Minister of Health, and the Chairman of the Board for Central East Local Health Integration Network (LHIN), Foster Loucks, co-signed an accountability agreement between their respective organizations. The agreement outlined the performance objectives for the Central East LHIN during its start-up period August 22, 2005 to March 31, 2006. The objectives are categorized into 3 broad areas:

1. Establishment of LHIN Governance policies, practices and relationships
2. Implementation of LHIN Functions
3. Establishment of LHIN Business Operations

The following pages describe our progress against these performance objectives.



Photo Credit: Ross Memorial Hospital

Operational Start-Up

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 chairs, 42 founding board members and 14 CEOs.

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

Fourteen offices were set up across the province. 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 the LHINs.

By the fall of 2005, all LHIN offices were open and ready-for business. Four staff members were recruited for each LHIN and by January 2006, each LHIN had two senior directors, an executive assistant and an office manager in place. Additional staff will be recruited in the near future. To support due diligence and transparency in our recruitment practices, interview protocols and a quantitative weighting scale were designed to ensure an objective process is used when recruiting candidates. In addition, to provide for broader learning opportunities, secondment agreements were designed and are currently in use for the CE LHIN among its team.

A business operations manual was created to provide basic policies and procedures. This included government

directives that LHINs must comply with, a summary of legislative requirements that govern LHIN practices and standard practices required by the ministry for all LHINs.

Starting in the summer of 2005 and continuing throughout the year, 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. Discussion forums were held to discuss such issues as physicians and LHINs and LHIN cross-boundary issues in the community sector.

Accountability agreements between each LHIN and the ministry were developed for the years 2005/06 and 2006/07 setting out the key activities for the LHINs.



Progress Toward eHealth

During the priority planning process organized by the Ministry of Health and Long-Term Care in 2005, it was recommended the Central East LHIN “Initiate development of an information management and information technology strategy for the Central East LHIN”.

Currently, we are engaging with our community stakeholders and receiving their input and feedback to six priority areas. One of these is Shared Services/ Back Office Transformation. Electronic health (e-health) initiatives are one topic within this area of focus. We are equally pleased that the Ontario Health Quality Council concluded in its first annual report that: *“investing in e-health – using information technology to manage health, arrange, deliver and account for care, and manage the health-care system – will do the most to improve all the attributes of a high performing health system”.*

One of the key first steps to develop our e-health strategy is to survey all of the organizations in the LHIN about their current Information Technology and Information Management (IT-IM) infrastructure. The Central East LHIN is collecting an IM/IT/e-Health Inventory of existing infrastructure for all its health provider agencies that will be used to identify:

- 1) Information for delivering care;
- 2) Information for managing care; and
- 3) Technology used to support the above categories.

The survey was customized to minimize the effort involved by the variety of organizations that will be completing it. Moreover, the Steering Committee felt it was vital to have a census of IM-IT infrastructure to inform any e-health initiatives that are sponsored by the LHIN. It is envisioned that the inventory will support the eventual design of an implementation plan to guide the Central East LHIN in the transition from strategic priorities outlined in its first IHSP to tactical plans that will be implemented in subsequent years.

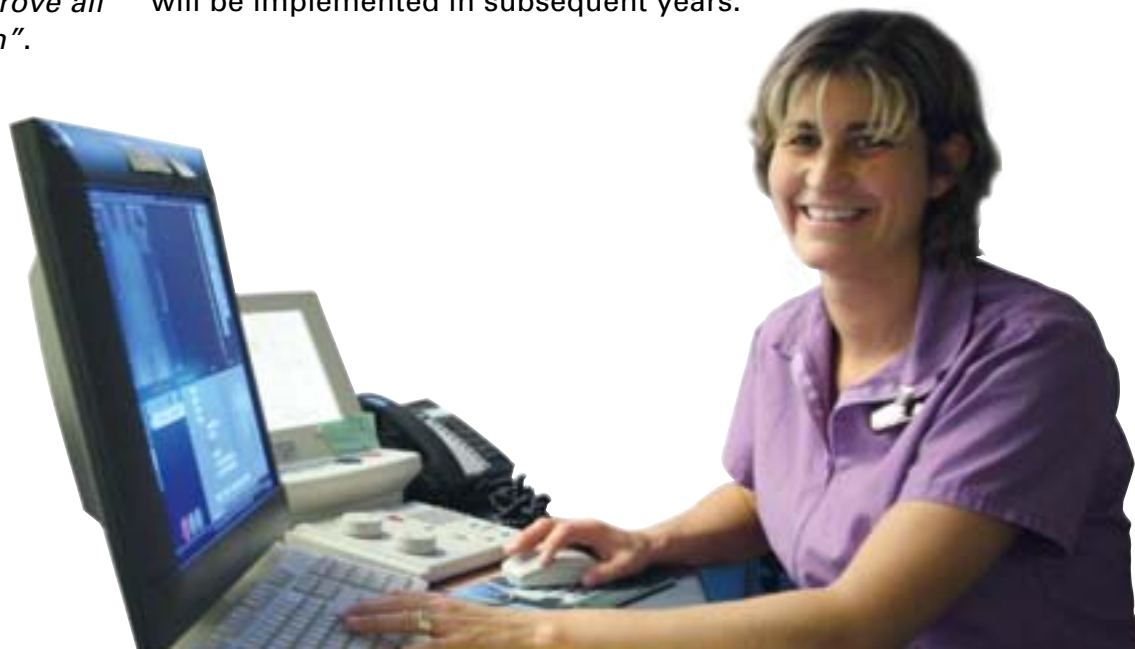


Photo Credit: Ross Memorial Hospital

Community Engagement

A Framework for Community Engagement Strategy and Local Health Planning was approved by the Board. The Framework can be seen at <http://www.centraleastlhin.on.ca/pdfs/framework.pdf>. In recognition of their past efforts, the Framework for Community Engagement was presented to participants of the Integration Priority Report process on March 7, 2006. Approximately, 30 individuals responded to the invitation and warmly endorsed the Framework. Over 230 copies of the Framework along with an evaluation form were distributed to all health care providers, local and regional governments, service clubs and other interested parties on March 2, 2006.

As of April 7 2006, 40 individuals have expressed interest in joining one of nine community engagement collaboratives. The list of interested people continues to grow daily. In addition, written and verbal feedback on the Framework is extremely favourable with 95% of those completing a written feedback form, strongly agreed that the proposed engagement structures will:

- Identify issues which are influencing the effectiveness of healthcare;
- Identify gaps in local health care capacity and,
- Improve coordination between service providers.

Once translated into French, the Framework was posted on the Ministry of Health and Long Term Care website. As well, local expertise from the Central East community of health services providers were seconded into the LHIN office to develop a Communications Strategy focusing

on community engagement and LHIN activities. This was completed in March and endorsed by the Board. As part of that strategy, the Central East LHIN has retained the services of an independent journalist firm to investigate, and write stories about the public's reaction to the LHIN transformation. Those stories can also be read at: www.centraleastlhin.on.ca/newsroom/newsroom.html.

A Central East LHIN database has been created for all media contacts, service group contacts and local government relations contacts and has been shared with communicators across all Central East LHIN sectors.

A visual identity and interim Central East LHIN website was also developed to support community consultation efforts. Real time capture of feedback and ideas generated from consultations are immediately posted on the Central East LHIN website creating the standard for transparency that the Board and Senior Team have committed to guide their interactions with the Community.

As of the end of this reporting period, the LHIN has initiated a total of seventeen community forums in nine locations congruent to our "Planning and Engagement Zones". The structure of our Community Engagement and Local Health Planning involve eight forums to gather detailed community input into LHIN operations and its health care areas of focus. An additional nine forums are open to the broad public for an introduction to the LHIN, its plans for involving the community in its activities, and a report back on what was heard during the eight detailed workshop sessions. These are also immediately transcribed and

posted on the Central East LHIN's interim website. Most notably, a two minute video that is streamed from the website captures the energy and involvement from the community sessions. Two additional videos are planned and will be found on the website.

As part of broader outreach with our health services agencies, over 100 engagement opportunities have been conducted by Board and staff members during the reporting period for this report.

For example, a meeting of the Ontario Community Services Association was the first meeting where community support services were brought together across the Central East LHIN. A meeting with Four Chapters of Alzheimers Society brought together LHIN wide stakeholders to address Alzheimers and related dementia. Many more such meetings have been organized by the LHIN, self-organized by the health services providers within the LHIN and other forums, where the topics of integration and service delivery were discussed. For a detailed listing and a summary of these inaugural events, see the newsroom on our website (www.centraleastlhin.on.ca/newsroom/newsroomstory).

Finally, in recognition of the vital role that physicians will play in the achievement of local health system integration, the Central East LHIN has embarked on a broad physician engagement strategy with the assistance of a Physician Consultant with broad experience in regional environments. Physicians are recognized as important partners in the LHIN transformation and to this end we are establishing meetings with leading physicians and their associations. Already, dividends from these efforts are being realized. For example, the Chiefs of Staff from the LHIN's three largest acute care hospitals have volunteered to hold a joint meeting of their Medical Advisory Committees, and in order to ensure its success, have offered their planning time to the event.

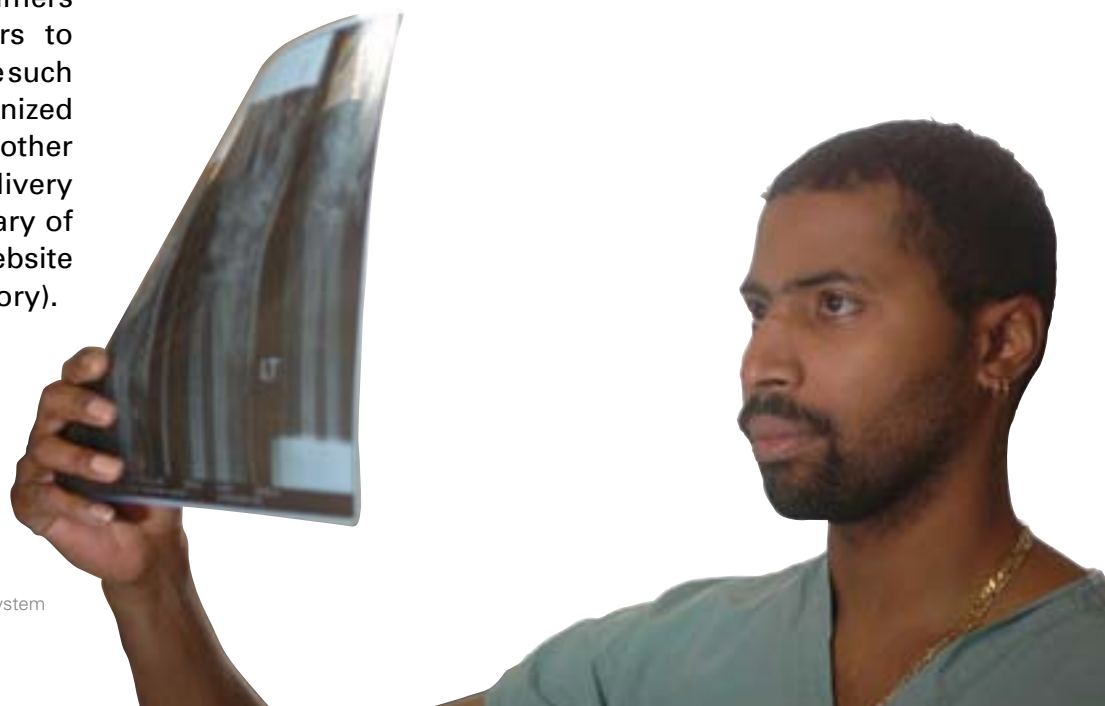


Photo Credit: Rouge Valley Health System

Aboriginal Engagement

According to the 2001 Census, less than one percent (0.9%) of the residents of the Central East LHIN were persons of Aboriginal Identity compared to 1.7% of Ontario's population.

Four First Nations are located within the Central East Community - Mississaugas of Scugog Island, Curve Lake, Hiawatha and Alderville. In the spring of 2006 letters of introduction were sent to all First Nation band chiefs inviting them to meet with the Chair and staff of the CE LHIN in their respective communities. Initial contact was made with the Hiawatha First Nation at an Association of Iroquois and Allied Indians meeting in Orillia. In addition, there was a joint meeting of the Alderville First Nation and CE LHIN leadership at which the CE LHIN leadership was honoured to participate in a traditional smudging ceremony.

The CE LHIN Framework for Community Engagement does not specifically address structures or processes for First Nation/Aboriginal engagement since it is important to find a mechanism that meets the needs and expectation of the First Nations themselves. This was the main discussion topic at the Alderville First Nation meeting. Also discussed were the range of community health services provided by the First Nation community to registered band members and challenges in meeting the health needs of the community.

The CE LHIN looks forward to continuing to engage with all the First Nations within its catchment area, and will continue to work with its leaders to find specific ways of involvement in the LHIN engagement and planning process.

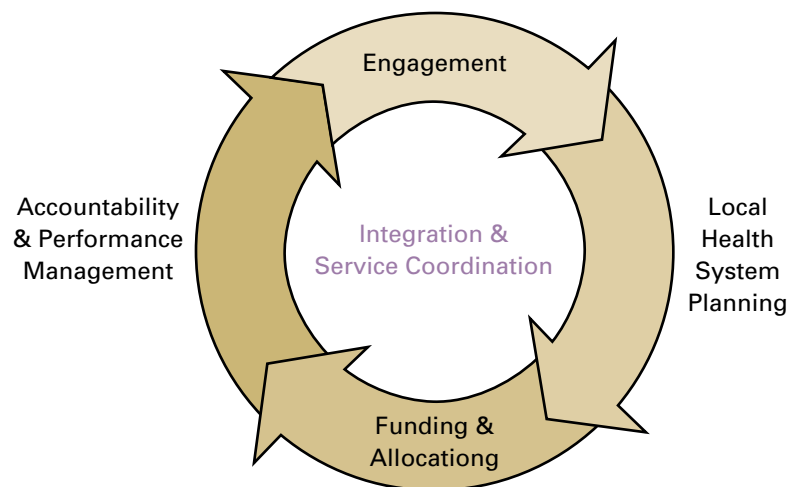


Integrated Health Service Plans

The Local Health System Integration Act received royal assent in March 2006. It outlines expectations for an end state, mature system of planning and integration in Ontario. The end state will not be achieved immediately and will require careful planning for the creation of start-up and transitional products and processes. The Integrated Health Services Plan (IHSP) to be delivered by all LHINs in October 2006 will be the first public presentation of the LHINs priorities and strategies for the 3-year period starting April 2007. As the initial plan in a complex planning cycle, it will provide a first step in the phased implementation of LHINs' functions.

In any normal business cycle, everything starts with a plan. The strategic plan for an organization routinely outlines the activities and initiatives that will structure the work of the organization for a specified period of time. The Central East LHIN has purposely modified its business planning cycle and started with engaging the people and communities within its LHIN to identify our priorities and areas for attention (see figure #1). LHINs are based on the 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. Consequently, one of the Central East LHIN's first tasks was to initiate planning and community engagement activities that will lead to the creation of its first Integrated Health Service Plan.

Figure #1: Central East Business Planning Cycle

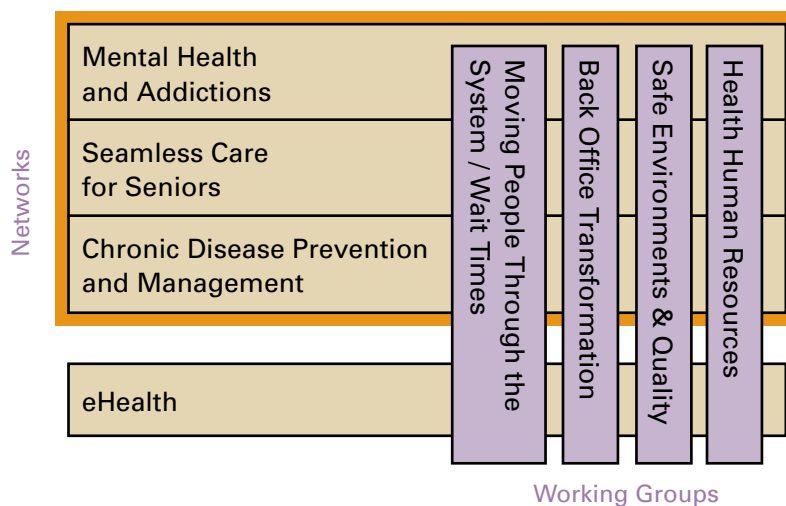


Integration Priorities

The Central East Integration Priority Task force report titled: "Taking Stock: Setting Integration Priorities in the Central East Local Health Integration Network Area" (February 2005) was used as the basis for identifying areas of focus. For the Central East LHIN, Mental Health and Addictions, Seamless Care for Seniors and Chronic Disease Prevention and Management were highlighted as themes requiring priority attention across the LHIN. This report along with information gained from the over 100 sessions held with service providers provided the foundation for the areas of focus that will be discussed and vetted during the community engagement consultations. Finally, in the context of creating a system, these areas of focus also align with current and known priority areas of the Ontario Government/Ministry of Health.

Assuming, there is endorsement of these areas of focus, our Framework for Community Engagement and Local Health Planning proposes an elaborate, yet elegantly simple structure for continued input to achieve integration. During the Community Engagement sessions referenced elsewhere in this report, the LHIN proposed that three Health Interest Networks be formed comprised of local experts to advise the LHIN on initiatives and activities that would advance our health interests toward integration across the local health network (ie., Health Interest Networks). Supporting each of these would be four to five task groups, each with a particular focus whether that would be to identify opportunities to achieve integration through shared service opportunities or help people navigate and move through the health system more effectively. As a foundation across all of these groups is a concerted focus on eHealth (see figure #2 below).

Figure #2: Priority Areas



eHealth

Electronic Health or eHealth includes creating electronic health records for all patients, health-information management systems and telehealth – the use of technology to deliver care at a distance. According to Ontario’s Health Quality Council, more widespread and integrated use of technology will mean: improved decisions about care, more effective diagnosis and treatment, fewer medical errors, greater safety, increased efficiency, better access to services, better research on both care and how to run the system, and information to support continuous quality improvement.

Environmental Scan

While eHealth is seen as the foundation for Health System improvement, the environmental scan that will be contained in the Central East’s IHSP will serve as the foundation for our local health system planning. A comprehensive profile of the local health system will be a critical input to LHIN planning and local priority-setting. Our environmental scan will assist the LHIN and our local stakeholders to develop a shared understanding of the characteristics of: (1) the populations that the LHIN serves and (2) the providers that the LHIN oversees. The environmental scan will use a blend of qualitative and quantitative approaches to systematically review the current landscape in the Central East LHIN including population health and need assessments and an inventory of health services, programs and resources.

Health Interest Networks and Collaboratives

Equipped with the latest information on the community engagement and planning zones within the Central East LHIN, our Health Interest Networks and Collaboratives – the array of community based working groups and expert panels will initiate the processes for evidence-based decision making. That is, evidence from our environmental scan will enable our groups to: a) identify opportunities toward integration and b) focus specifically on issues and priorities that emerge from their own local knowledge and information that stems from the environmental scan.

Drafting the Plan and Next Steps

According to the Project Plan and GANTT charts that are being developed by the Central East Senior team, it is envisioned that most of the above described activity will reach fruition by the late summer 2006. The first series of drafts of the IHSP will then be completed and circulated for review. Following the release of the Central East IHSP, the activities of the Health Interest Networks, Collaboratives and Task groups will move toward setting clear directional priorities and multi-year workplans. The Central East team has an array of experience with various methodologies for prioritization and planning and envisions using their “tool-kit” of techniques to assist the networks. These methodologies include: gap analysis, strategy mapping, SWOT (Strengths, Weakness, Opportunities and Threat) analysis, PEEST (Political, Economic, Environmental, Sociological and Technical issues) analysis and Scenario building which offers a way of thinking about and preparing for alternative future environments. Working together, these tools foster a shared understanding of the drivers for change and developing a common approach for action.



Financial Statement

The Central East LHIN successfully started its operations in fiscal 2005-06 within the allocated budget provided by the Ministry of Health and Long-Term Care. A financial audit of the Central East LHIN will be conducted by Deloitte and Touche (D & T) on May 29th, 2006. The establishment of a General Ledger and financial reporting systems are to be standardized through the creation of a shared back-office function for all LHINs. During the period covered by this report, all financial transactions were tracked through the MOHLTC financial reporting systems.

Quality controls and signing authorities specific to the Central East LHIN that comply with Generally Accepted Accounting Practices (GAAP) and will stand the scrutiny of Generally Accepted Auditing Practices have been developed for the Central East LHIN. These will be reviewed by the Board at its June 2006 meeting. Progress Reports and financial statements are being designed to support variance reporting to the Board on a quarterly basis along with other LHINs. Monthly variance reports are also being designed to support Management's understanding of its financial obligations and situation.

Total annual remuneration of Board members for the fiscal year

In compliance with the Management Board of Cabinet directive, the Central East LHIN hereby discloses that the remuneration paid to its existing Board of Directors as of March 31, 2006 was: \$58,375 in per diems in accordance with the Government Appointees Directives and \$19,539.60 in travel, accommodation and related expenses incurred in the performance of their duties as the LHIN Board of Directors.





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Auditors' Report

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

We have audited the statement of financial position of Central East 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 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 Central East 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 Canadian generally accepted accounting principles.

Chartered Accountants

Toronto, Ontario
May 29, 2006

Member of
Deloitte Touche Tohmatsu

Statement of Financial Position

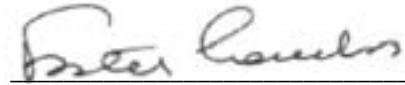
As at March 31, 2006

Assets

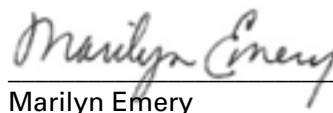
Cash	\$ 30,465
Capital assets (Note 3)	1
	\$ 30,465

Liabilities and Net Assets

Accounts payable and accrued liabilities (Note 4)	\$ –
Net Assets	30,466
	\$ 30,466

Approved by the Board

Foster Loucks



Marilyn Emery

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	\$ 4,000
MOHLTC payroll reimbursement	246,296
	250,296

Expenses (Note 5)

Salaries and benefits	\$ 217,210
Office supplies	776
Catering	808
Other	1,036
	\$ 219,830

Excess of Revenue over Expenses	\$ 30,466
Net Assets, Beginning of Period	–
Net Assets, End of Period	\$ 30,466

Notes to the Financial Statement

1. Description Of Business

Formation and status

The Central East 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 Central East Local Health Integration Network (the “LHIN”) and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

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

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN boundaries include all of Durham Region, Kawartha Lakes, the Haliburton Highlands, most of Northumberland County, and Peterborough County. Central East also contains part of the eastern City of Toronto (the portions east of

Warden, south of Steeles, north of Eglinton and east of Victoria Park, south of Eglinton).

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-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

Revenue recognition

Ministry of Health and Long-Term Care funding is recognized as revenue in the year in which the related expenses are incurred. Any designated funds 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 includes:

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

These assets have been reflected at a nominal dollar value of \$1, as the 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 \$60,475 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in 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	\$ 74,360
Accommodation/occupancy	1,232,710
Common services	42,126
Information technology	93,710
Other expenditures	170,750
	\$ 1,613,656

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.

Staff Members

Marilyn Emery

Chief Executive Officer

Nizar Ladak

Senior Director, Performance,
Contract and Allocation

James Meloche

Senior Director, Planning, Integration
and Community Engagement

Musy Chan

Executive Assistant

Leslie Dalliday

Office Manager

Karen Landriault

Administrative Assistant

Karen O'Brien-Monaghan

Consultation Coordinator

Katie Cronin-Wood

Communications Lead

Jeanne Thomas

Planning Consultant

Kate Reed

Planning Consultant

John Lohrenz

Decision Support Specialist



Back Row (left to right): Karen Landriault, Kate Reed, Karen O'Brien-Monaghan, John Lohrenz, Jeanne Thomas, Katie Cronin-Wood

Front Row (left to right): Leslie Dalliday, James Meloche, Marilyn Emery, Nizar Ladak, Musy Chan

Central East
LOCAL HEALTH INTEGRATION NETWORK

In keeping with our mandate to improve access to coordinated quality health care services for the people and communities of Ontario, the Central East Local Health Integration Network (LHIN) will develop and implement local plans and priorities for improving health care. Our commitment and recent track record should confirm that these will be established through an inclusive and transparent process of consultation, collaboration that will make use of the people, knowledge, and resources – both known and yet-to-be discovered within our community. If you would like to learn more about the Central East Local Health Integration Network, you can contact us at:

Telephone:

905-427-5497
1-866-804-5446

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314 Harwood Avenue South, Suite 204A
Ajax (Ontario) L1S 2J1

Website:

www.centraleastlhins.on.ca

Email:

centraleast@lhins.on.ca