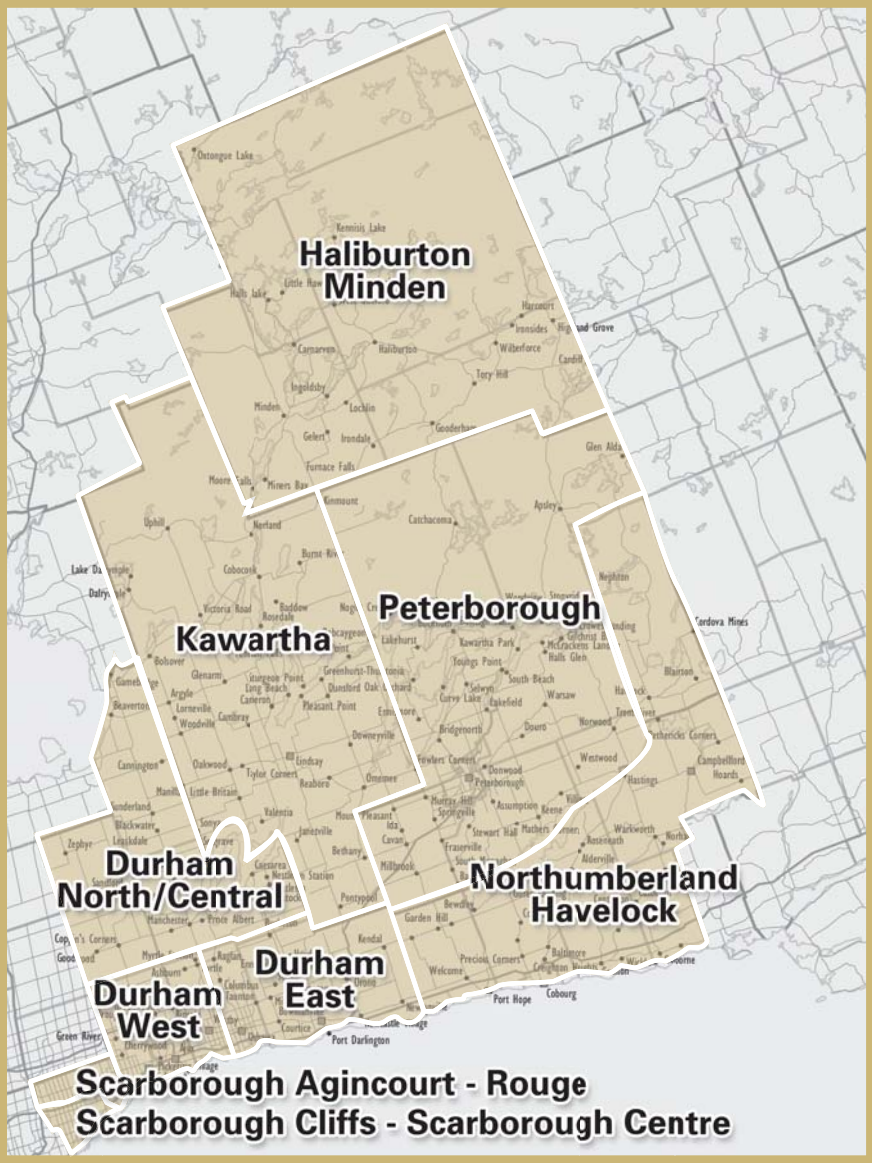
Central East
LOCAL HEALTH INTEGRATION NETWORK

Engaged Communities. Healthy Communities.

Central East **LHIN – 2006/07 Annual Report**

Ontario

Central East Local Health Integration Network (9)



The Local Health Services Integration Act, passed in March 2006, is intended to provide 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 (LHINs). LHINs are responsible for planning, integrating and funding 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.

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

Message from our Chair and CEO

Engaged Communities. Healthy Communities.

Local Health Integration Networks were created by the province of Ontario to bring decisions about your health care system closer to home. Local people who experience, use and provide health services are better able to make informed decisions about their health care system.

As our name suggests, your LHIN seeks to improve the integration or coordination of health services – such as hospital care, community services, home care – in a way that improves local access to health services that are of high quality, efficiently provided, and available to your children and grandchildren.

Community engagement is the foundation of all of our activity. Being more responsive to local needs and opportunities requires on-going dialogue and planning with those who use and deliver health services. While much of the public focus since the creation of LHINs has centred on the "I" for Integration, of equal or greater importance is the meaning of "N" for Network. It is the position of the Central East LHIN Board and Staff that they are but a lead component of a broader network or community of patients, residents, clients and providers working together to create a better integrated health system and, as a result, healthier communities. Creating such a network requires leadership, commitment and a plan that delivers your voice and experience to the point where decisions are made. **As such, community engagement and the creation of the Integrated Health Service Plan were the focal points of 2006-07 for the Central East LHIN.**

This Annual Report provides an overview of challenges and accomplishments achieved in 2006-07. Based upon our accountabilities to the Minister of Health and Long-Term Care, the Report chronicles our strategies, efforts and successes in fulfilling our legislated mandate. It is an overview of our concentrated efforts to create a new environment of engaged leadership, innovation and cooperation in the delivery of health services. Finally, the Report provides a high-level account of preparations made for the eventual devolution of funding and accountability responsibility from the Minister and Ministry of Health and Long-Term Care to the Central East LHIN Board on April 1, 2007.

We think you will agree that 2006-07 has been a productive year that will be remembered by all those involved well into the future. We extend our gratitude to all those who have contributed to this success – notably the volunteers from across all our communities and health care providers, health care professionals, the staff of the Central East LHIN, and the staff of the Ministry of Health and Long-Term Care and its Regional Offices. Nevertheless, we have only just begun. There is a tremendous amount of work to be done to make your health system a better one. Based on the remarkable abundance of talented people working in your LHIN, sharing your vision for a vibrant public health care system, and working hard to deliver the necessary change – you should expect nothing less than success. Only a few months ago we proclaimed that "optimism abounds!" Today, confidence abounds!

Foster Loucks,

Chair

Marilyn Emery,

CEO

Members of the Board

Foster Loucks
Term of Office: 06/01/05 – 05/31/08

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.

Joseline Sikorski
Term of Office: 06/01/05 – 05/31/08

Joseline Sikorski, a Certified Healthcare Executive, is currently the President and CEO of the Ontario Safety Association for Community and Healthcare (OSACH), a position she has held since 2003.

Jean Achmatowicz MacLeod
Term of Office: 06/01/05 – 05/31/08

Jean Achmatowicz MacLeod has a long history of volunteerism in health care. Jean has received many awards throughout her years as a volunteer, including the Order of Canada in 2002.

Eva Nichols
Term of Office: 01/05/06 – 02/04/08

Eva Nichols of Hamilton Township served as chair of Northumberland Hills Hospital's board. Nichols, who has made significant contributions in the field of education, was the principal of Clarke High School in Orono.

Novina Wong
Term of Office: 01/05/06 – 02/04/07
Reappointed: 02/05/07 – 02/04/10

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.

Stephen Kylie
Term of Office: 03/01/06 – 02/29/08

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 and is an active Rotarian.

Dr. Alexander Hukowich
Term of Office: 05/17/ 06 – 06/16/07
Reappointed: 06/17/07 – 06/16/10

Dr. Alexander Hukowich of Hamilton Township has over 30 years of health care experience. Most recently he served as medical officer of health for the Muskoka Parry Sound District Health Unit.

William Gleed
Term of Office: 05/17/06 – 06/16/07
Reappointed: 06/17/07 – 06/16/10

William Gleed, a resident of Kawartha Lakes, was the President, Chief Executive Officer and Director of The Citadel Assurance where he was responsible for underwriting, claims, investments, marketing and corporate affairs.

Ronald Francis
Term of Office: 05/17/06 – 05/16/08

Ronald Francis of Scarborough is a full-time professor in the School of Accounting and Finance at Seneca College and a part-time lecturer in professional accounting programs conducted at York, Ryerson and the University of Toronto.

For a detailed biography of all Board members, please visit the Central East LHIN web site at

www.centraleastlhin.on.ca

Introduction

Beyond the requirements set out by legislation, the Central East LHIN has specific obligations to the Minister and Ministry of Health and Long-Term Care as set out by the 2006-07 Ministry-LHIN Accountability Agreement. The purpose of the Agreement is to communicate the mutual expectations and obligations between the Ministry and the Central East LHIN during the 2006-2007 fiscal year.

The Agreement sets out four main areas for LHIN performance and reporting:

- Corporate governance
- Community engagement
- Integrated health service plan
- Local health system performance
- Funding and Allocation

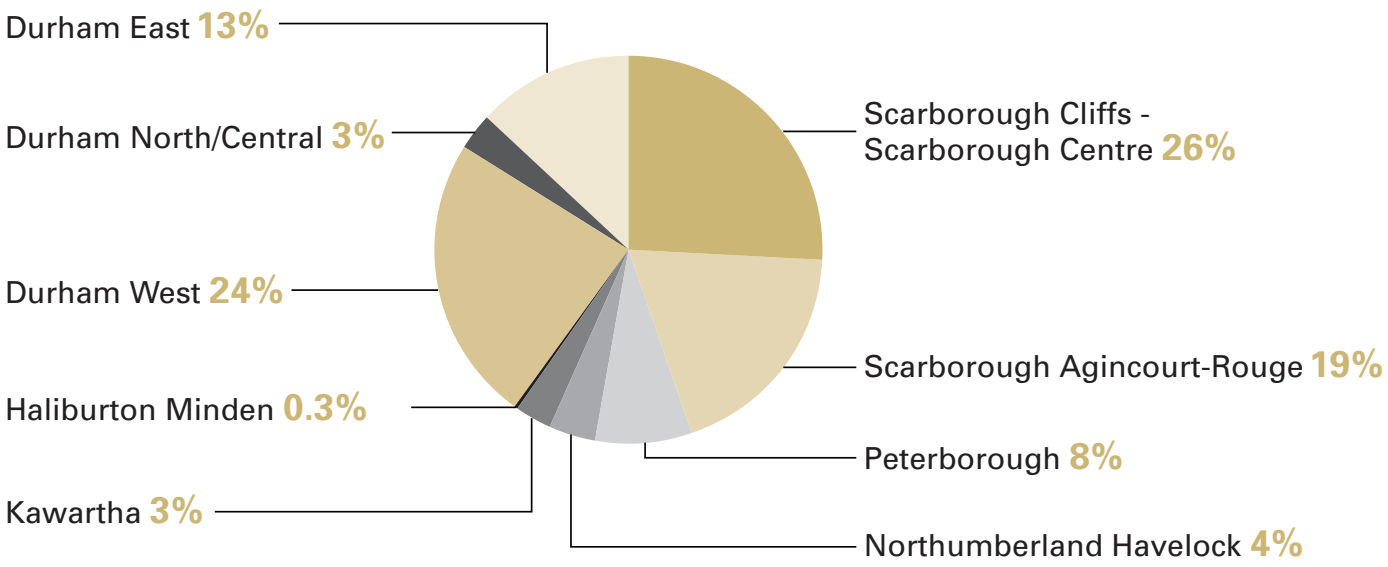
What follows in this Annual Report is a statement of your LHIN's performance against each one of these objectives and accountabilities for the time period of April 1, 2006 to March 31, 2007.

Health and Population Profiles

"Understanding the environment in which the LHIN will plan and deliver health services was essential to the success of the Integrated Health Service Plan (IHSP)."

The Central East LHIN is one of the fastest growing geographic regions in the Province and home to 11% of Ontario's population. Based on the 2006 Census, the population has grown by five percent, making the LHIN 1.4 million people strong. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East 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.

Central East Planning Zone Populations (%) for 2006



Understanding the environment in which the LHIN will plan and deliver health services was essential to the success of the Integrated Health Service Plan (IHSP). An environmental scan was developed based on what we heard during community consultations, by adopting a broad population based definition of health and by the population and health system characteristics of the LHIN. The Central East LHIN Environmental Scan can be found on the website at www.centraleastlhin.on.ca. The following graphics illustrate some of the population and health population findings in the Central East LHIN.

Tables are based on Ministry of Health and Long-Term Care (HSIP, Discharge Abstract Database, 2001)

HEALTH OUTCOMES INDICATORS	Central East	ONTARIO
% Low birth weight babies (1999-2001)	5.9%	5.6%
Preterm birth rate per 1000 (1999-2001)	70.7	70.9
Infant mortality rate per 1000 livebirths (1999-2001)	5.0	5.4
Total Crude mortality rate per 100,000 (2000-2001)	611.3	685.7
Age-standardized mortality rate (ASMR) per 100,000	530.9	602.6
ASMR by ICD-10 chapter (top 5 chapters), rate per 100,000 (2000-01)		
Circulatory system diseases	179.9	209.1
Neoplasms	166.2	181.4
Respiratory system diseases	39.8	45.4
External causes of mortality	27.3	32.6
Endocrine, nutritional & metabolic diseases	22.5	26.1
% of all deaths that occur before age 65	21.1%	21.3%
% of all deaths that occur before age 75	42.2%	41.2%
Neoplasms	1,446.9	1,590.3
Circulatory system diseases	756.2	852.9
External causes of mortality	699.9	834.3
Perinatal conditions	236.9	266.5
Symptoms, signs not elsewhere classified	262.6	234.0

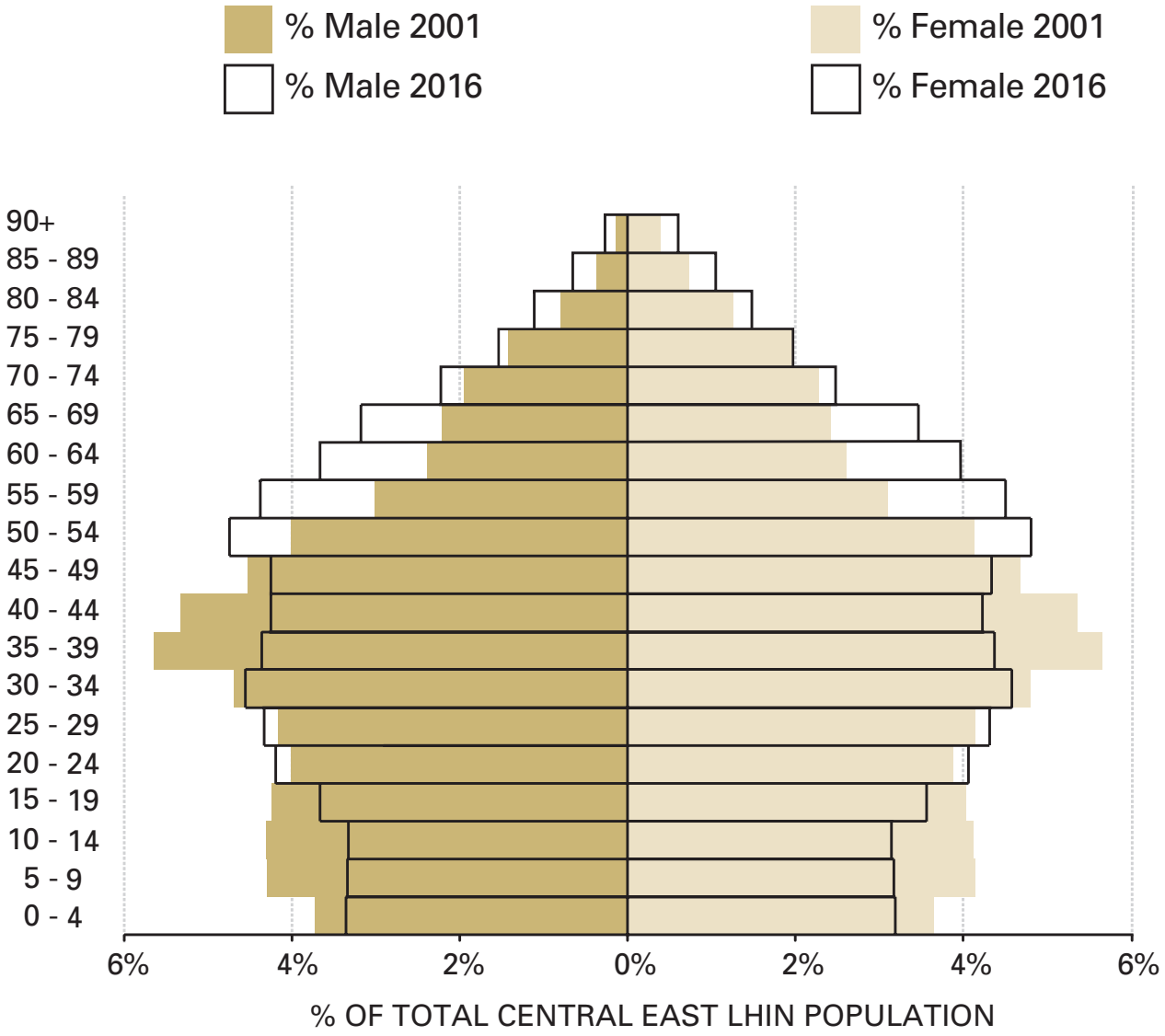
Tables are based on 2001 Statistics Canada Census of population.

SOCIAL & DEMOGRAPHIC CHARACTERISTICS	Central East	ONTARIO
Annual Population Growth Rate 1994-2004 (%)	3.1%	1.5%
Dependency Ratio (2004)	42.6	45.4
Senior Population: % aged 65+ (2004)	13.4%	12.8%
% of all Census families, with children, headed by Lone parent	24.5%	23.4%
% of Lone parent families headed by Female	83.2%	82.5%
% of Lone parent families headed by Male	16.8%	17.5%
% population reporting English mother tongue	74.4%	71.9%
% population reporting French mother tongue	1.5%	4.7%
% of population who are Immigrants	32.1%	26.8%
% of population who are Recent Immigrants (1996-2001)	5.7%	4.8%
% of population who are visible minorities	30.4%	19.1%
% population of Aboriginal identity	0.9%	1.7%
Labour force participation rate (% population in labour force)	66.3%	67.3%
Unemployment rate	6.7%	6.1%
Incidence of low income (% population age 15+ below LICO)	14.8%	14.4%
% of population (age 20+) with less than grade 9 education	7.7%	8.7%
% population without high school graduation certificate	26.5%	25.7%
% population with completed post-secondary education	46.2%	48.7%
General Health Status Indicators		
% Population (age 12+) with Excellent or Very Good health	55.9%	57.4%
% Population (age 12+) with an Activity Limitation	24.8%	24.6%
Female life expectancy at birth	83.4	82.1
Male life expectancy at birth	78.9	77.5

Tables are based on Ministry of Health and Long-Term Care (HSIP, 2001)

HEALTH STATUS GENERAL HEALTH	Central East	ONTARIO
Life Expectancy, 2001		
Female life expectancy at birth	83.4	82.1
Male life expectancy at birth	78.9	77.5
Female life expectancy at age 65	21.6	20.4
Male life expectancy at age 65	18.3	17.3
Self rated Health		
Population (age 12+) reporting Excellent or Very Good health	703,100	5,903,100
Total population (age 12+)	1,258,000	10,278,700
% Population (age 12+) with Excellent or Very Good health	55.9%	57.4%
Population with Activity Limitation		
Population (age 12+) with an Activity Limitation	312,300	2,533,600
Total population (age 12+)	1,258,000	10,278,700
% Population (age 12+) with an Activity Limitation	24.8%	24.6%

Central East LHIN Population Pyramid 2001 vs. 2016



The Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation and Mississaugas of Scugog Island First Nation are present in the Central East LHIN with a total of approximately 12,000 residents. Less than one percent (0.9%) of the residents of the Central East LHIN are persons of Aboriginal identity, compared to 1.7% of Ontario's population. While unique needs and their solutions will be determined by Aboriginals for Aboriginals, the board and staff of the Central East LHIN continued to reach out to our Aboriginal partners in 2006-07 by welcoming Aboriginal participation in the LHIN-wide Networks so that the actions of the LHIN were informed by their lived experience and focus on holistic health and community healing.

LHIN Corporate Governance:
Modelling Expectations of Health Care Leadership

The Ministry-LHIN Accountability Agreement required the Central East LHIN Board to establish a corporate governance model that fulfills its legislated mandate and promotes public confidence in the transparency and accountability of its operations. The Central East LHIN Board has successfully met and exceeded this standard of performance.

By June 2006, we had recruited our 9 Board members. Two months later, all LHINs were legislatively required to hold their first public Board meetings. In preparation, LHIN Corporate Services led the way by establishing a Board Orientation manual and workshop. The Central East LHIN hosted all the other LHINs in a parliamentary training session to equip them in the finer points of public meeting procedures. With regards to the logistics management of our meetings, many LHINs have subsequently adapted their own Board meeting procedures to mirror those used within the Central East LHIN.

In keeping with our desire to transparently engage all communities in the Central East LHIN area, open board meetings have and will continue to occur at locations throughout the region. During this reporting period, your LHIN has conducted three successful Public Board Meetings (Whitby, Port Perry, and Cobourg) that were observed by approximately 200 residents and local media. The Central East LHIN has established four Board Committees whose meetings are also open to the public. Finally, in demonstrating their commitment to being a learning organization, the Central East LHIN regularly holds Board Education sessions for its members on topics of local and provincial importance such as primary care.

Preparing for the Transition from Ministry to LHINs

April 1, 2007 marked an important milestone in the developmental history of Local Health Integration Networks as well as the renewal of the Ministry of Health and Long-Term Care. On this day all LHINs assumed the accountability and funding relationships formerly held between the ministry and health service providers; meaning that, through Service Accountability Agreements, the LHINs have the authority to fund and hold accountable for performance the local health service providers (e.g., hospitals, long-term care, community mental health and addictions programs, community mental and addiction programs, community support services and the Central East Community Care Access Centre). Such relationships will be guided by parameters defined in legislation, provincial policy and the Ministry-LHIN Accountability Agreement.

"All Board members of the Central East LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy."

In anticipation of this devolution of authority and responsibility to the LHINs, the Deputy Minister of Health and Long-Term Care directed the ministry to engage LHIN leadership in a readiness assessment and risk management project. Using a modified Gateway analysis tool, the ministry and individual LHIN assessments were conducted by an external risk management team early in 2007. Overall, the results of the assessment were positive and areas requiring greater preparation identified. In the end, the assessment provided a useful base line of where the LHINs and ministry were in terms of their development, and what remained to be done for a smooth transition.

Both in anticipation and reaction to the completed assessments, a ministry LHIN Coordination Project Team conducted three multi-day "knowledge transfer" sessions that would prepare LHIN leadership and staff with the knowledge and tools necessary for a smooth transition. As well, the Central East LHIN management team met frequently with ministry regional office staff during 2006-07 in an effort to increase knowledge of the local health service delivery system. **Ministry regional office staff should be commended for their commitment to supporting the emerging LHINs while at the same time undertaking the difficult task of winding-down their own operations.**

The Central East LHIN was well positioned to provide effective management of your local health system by March 31, 2006, thanks to the support of the Ministry of Health and Long-Term Care and local providers.

Establishing a Foundation for Action through Community Engagement

The 2006-07 Ministry-LHIN Accountability Agreement required the Central East LHIN to implement a process of community engagement that promotes:

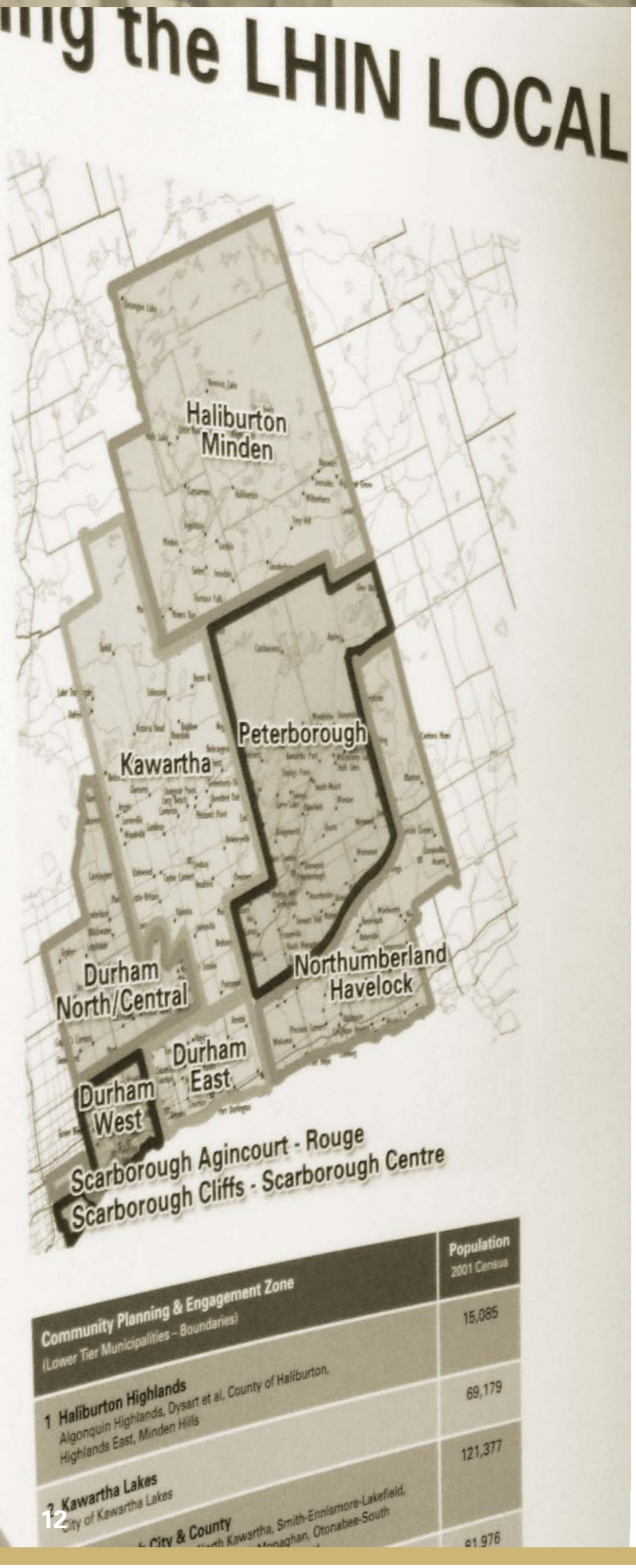
(i) community participation in decisions about the local health system;
(ii) the commitment to equity and respect for diversity in communities;
(iii) evidence-based decision-making by the LHIN; and
(iv) transparency in its decision-making.

Your LHIN's initial statement of commitment to community engagement can be found in the *Central East LHIN Framework for Community Engagement and Local Health Planning (March 2006)*.[1] The Framework signalled an innovative and sustainable approach to involve the community – patients, residents, care givers, health professionals and providers – in LHIN planning activities. At the core of the Framework is a Central East LHIN conviction that engaged communities are stronger and healthier communities. In the Fall of 2006, after months of speaking to and learning from thousands of local residents and health care providers, this belief was re-affirmed by the Board-approved Central East LHIN vision statement of "**Engaged Communities. Healthy Communities.**"

In addition to meeting the above requirements of the Accountability Agreement, the Central East LHIN created additional goals for community engagement, including:

- To renew and maintain a focus on the people who use health care
- Enhance local responsiveness and accountability
- Balance competing priorities
- Develop system capacity & sustainability
- Build Confidence in our Public Health Care system
- Prepare the foundation to establish and implement the **Integrated Health Service Plan (IHSP)** and its priorities for change

1 http://www.centraleastlhin.on.ca/pdfs/framework.pdf



Delivering on our commitment to community engagement prior to, and as a part of, the creation of the first Central East LHIN Integrated Health Service Plan (ISHP) can be considered as the single most important activity of 2006-07. To achieve this ambitious goal of engagement and creating a system plan for such a diverse region as ours – and within a relatively short timeframe – required the full commitment of the Board and staff. Guiding the process was a complex project management plan which was marked by three distinct phases.

Phase One: Listening for Direction

The objectives were to:

- Communicate the Central East LHIN vision, roles, responsibilities, and initial areas of health care focus;
- "Fact-find" more about peoples' concerns about the health care system and/or LHINs in particular;
- Obtain direction on health care needs, challenges and opportunities;
- Build momentum and support for partnerships to execute ongoing community engagement/ planning activities.

To meet these objectives, the LHIN conducted 17 community consultations (8 workshops and 9 open forums) across the region, starting in Port Perry (April 24, 2006) and finishing in Ajax (May 18th, 2006). Over 1,000 residents attended these sessions that provided a forum to inform the public about LHINs, which in turn allowed the Central East LHIN to be informed about local opportunities and challenges. In July 2006, the Central East LHIN Board was presented a detailed **Summary Report on Findings from the Community Consultations**. This 114 page report provided a comprehensive synthesis by LHIN and its individual communities on health care

priorities, as well as on ways to ensure the success of further community proposed mechanisms for further community engagement and local planning.

In addition to this formal consultation series, the Central East LHIN conducted dozens of other engagement opportunities, small and large. These meetings were focused on getting the input of hard to reach communities such as youth, seniors, Aboriginals, area francophones and new Canadians. The board and staff of the Central East LHIN have met with the management, front line staff, unions and boards of your local health system. And of particular note, the Central East LHIN has spent significant effort to engage local area physicians providing services in all settings in order to pave the way for their active participation in the LHIN planning and engagement processes. We are pleased to report that physicians have responded to this challenge and are now active participants in LHIN activities.

In summary, during this early stage of priority setting and informing (April to September, 2006), your LHIN engaged over **4,000 local community residents and health care providers** in an effort to learn more about your community, and your current and desired health care system. Despite the diversity of our community, there was strong consensus across all regions on the priorities for system change that would be included in the first Integrated Health Service Plan (IHSP).

Phase Two: Building Capacity for Change

The emphasis of phase two shifted from one of fact-finding and building community awareness to a process of establishing sustainable and effective community engagement mechanisms. By creating new planning partnerships in your community, your LHIN sought to harness local expertise in the identification of opportunities for health care improvements.

As equally important, these teams provided a means so that credible, relevant and achievable directions could be provided to the Central East LHIN in a way that was inclusive and transparent. By bringing people together to form new partnerships with new possibilities – transcending the traditional barriers of localism and individual institutions – a new and vibrant culture of care in the Central East LHIN has firmly begun to take hold.

2006-07 was focused on getting these planning partnerships established:

- **9 Planning and Engagement Collaboratives** (Early Summer 2006). Collaboratives, or local advisory teams representing the individual communities of our LHIN were first established by early summer of 2006. A Collaborative consists of 9 to 15 people who provide and/or receive health care services in a specific community. Collectively, these teams approximate the continuum of the health care system with members from primary care, hospitals, community services, mental health and addictions services, long-term care, physicians, and pharmacists. Local residents interested in the public health system are also participating.

- **LHIN-wide Health Interest Networks.** Like Collaboratives, Network membership represents the continuum of health care services. Unlike the Collaboratives, however, Networks bring together a single team from across the LHIN on a specific priority area identified in the IHSP. Networks are guided by a steering committee of 12 to 15 individuals with specific interests and skills related to the priority. For the most part,

Networks are the generative bodies for new strategic directions that will improve service integration and quality of care for their priority communities.

- *Seamless Care for Seniors Network* (Aug 2006). Steering Committee of 13, with a full Network Membership of 120 individuals and/or organizations.
- *Chronic Disease Prevention and Management Network.* Recruitment of Steering Committee began in the spring of 2007, with a 14-strong Steering Committee announced in April 2007.
- *Mental Health and Addictions Network:* The community of service providers had formed a Network and leadership prior to the establishment of the Central East LHIN. As of April 2007, that Network is being renewed with broader leadership that includes consumers and survivors.

Each one of these planning partnerships were established through an open and public "expression of interest" form, which asked interested applicants to describe their working and volunteer experience, their knowledge and/or experience in the health system and meeting the needs of youth, adults, older adults and hard-to-serve populations. Applicants were asked to describe ways in which they work together in teams and provide local leadership. All applicants were reviewed by a special purpose review panel consisting of LHIN Board members and staff, as well as objective observers internal and external to the Central East LHIN.

For more information on the work of these planning partnerships, or to find out how you can participate, visit our website at www.centraleastlhin.on.ca

Phase Three: Creating our Shared Plan for the Future – The Integrated Health Service Plan

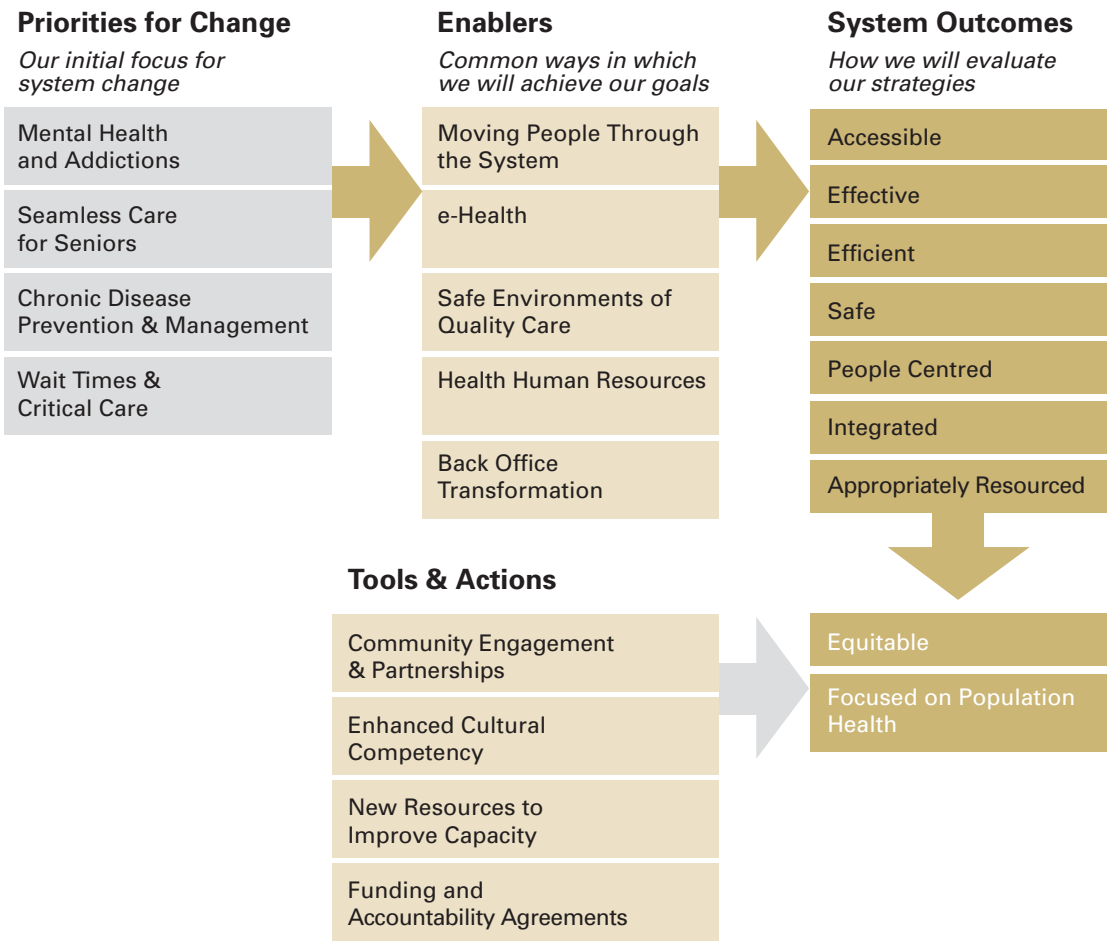
The third and on-going phase of community engagement relates directly to the creation and implementation of the Central East LHIN Integrated Health Service Plan or IHSP.

The creation of the Central East Region health care plan was a principle requirement of the 2006-07 Ministry-LHIN Accountability Agreement. That agreement required the eventual Central East LHIN IHSP to:

- be a key enabler for the LHIN's work over the three year term of the plan;
- promote the integration of the local health system to provide appropriate, coordinated, effective and efficient health services; and,
- communicate to the public intended integration strategies.

Again, thanks to the success of our community engagement strategy and the commitment of our planning partners, the Central East LHIN ably met and exceeded these objectives. In fact, collaboratives and network members contributed over 8,100 hours of their time providing direction to the IHSP.

The 2006-2009 Central East LHIN Integrated Health Service Plan sets the course for health care improvements in priority areas identified by the community. As depicted in the "Strategy Map" on the following page, the IHSP focuses on four priorities for change, along with supporting strategies, enablers and tools that will improve the performance of the local system. The impact of the IHSP and its supporting strategies will be monitored and evaluated against expected system level outcomes such as access, equity and efficiency.



Sharing and Validating the Draft Integrated Health Service Plan

In September 2006, the Central East LHIN Board approved a draft of this Integrated Health Service Plan to be shared with community residents for comment prior to its final adoption. To successfully get feedback from the general public, the Central East LHIN conducted 8 awareness events in high-traffic, high-exposure areas (such as shopping malls) across the region.

At each event, Central East LHIN board members, staff and, most importantly, volunteers from your community were on hand to distribute materials, listen to residents, and answer questions related to your health system, LHINs and the Integrated Health Service Plan. Hundreds of conversations were held, and 2500 copies of an "IHSP Quick Facts" were distributed to community residents, along with a feed back form that provided an opportunity for residents to comment. Interactions with the community indicated a high level of support for these priorities, as well as new ones. For example, as a result of this phase of engagement, the Central East LHIN strengthened its commitment to support improvements in primary care and emergency department wait times and performance.

The Central East LHIN Board approved, published and distributed copies of the final IHSP in November 2006. You can obtain a copy of the IHSP and its supporting documents, such as the Central East LHIN Environmental Scan, on-line at www.centraleastlhin.on.ca

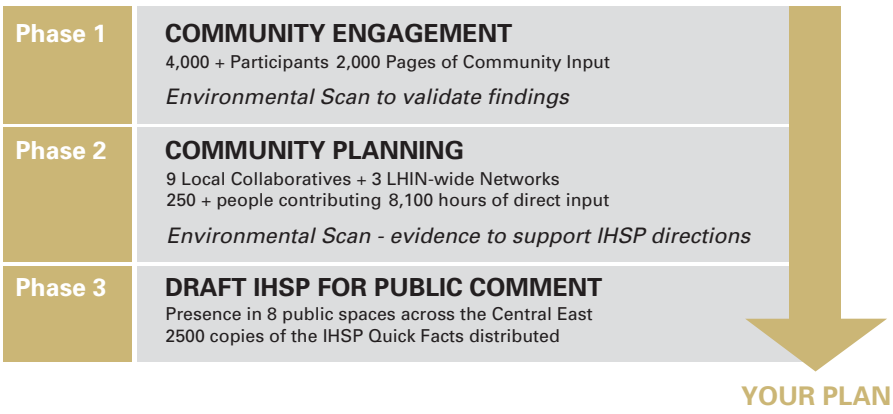
February 16, 2007 – The Central East Local Health Integration Network (LHIN) is increasing access to local health services for frail seniors in its community and enhancing geriatric expertise in the Emergency Department. A $1.35 million project will create an innovative *geriatric emergency management partnership between* five Central East LHIN hospitals- Peterborough Regional Health Centre, Lakeridge Health Corporation, Ross Memorial, Rouge Valley Health System, The Scarborough Hospital.

Implementation of the Integrated Health Service Plan

While identifying actions related to the priority areas, the IHSP *did not directly address the process of implementation, monitoring and evaluation.* Full implementation of the outcomes intended by the IHSP will be achieved through future Service Accountability Agreements between the Central East LHIN and health service providers (hospitals, long-term care homes, the community care access centre, community support services, community mental health and addictions services, and community health centres).

Nonetheless, the work of implementing the IHSP has already begun. In January 2007 the board endorsed a draft IHSP work plan which is now being further matured for board consideration. The work plan also called for the establishment of specific time-limited task groups; this process was begun in Spring 2007 and will be completed in May 2007.

In summary, the articulation of local priorities for change, the development of the IHSP, obtaining feedback on the planning drafts, and the eventual implementation and achievement of the IHSP action steps and goals, is rooted in a continual process of community engagement. The IHSP was created by the community through grassroots initiatives. Stakeholders, including health care providers and community residents, have been involved as never before in the development of this Plan to identify local needs, local priorities and local actions to make our system more truly people-centred. By leveraging local voices and expertise to create solutions that matter to you and your health system, we have and will continue to make progress towards our shared goals.



Health Care is Changing!

Improving Local Health System Performance: Reducing Wait Times

The Central East LHIN is an active partner with the Ministry of Health and Long-Term Care and local health care providers in reducing wait times in five surgical areas and two diagnostic procedures: cancer surgery, cardiac surgery, hip and knee total joint replacement, cataract surgery, MRI and CT scans. This responsibility is captured in the Ministry-LHIN Accountability Agreement which requires this LHIN to *"facilitate new behaviours"* in the local health system that will *"improve access and support the MOHLTC's Wait Times Strategy, improvement in surgical throughput, and critical care capacity development."*

Wait time data is available to the public at www.ontariowaittimes.ca. An examination of the latest reported wait time data (Feb/Mar 2007) demonstrates that progress is being made in the Central East LHIN in reducing wait times in all areas except MRI testing.

The table below illustrates the change in wait time performance during this reporting period (March 2006 – March 2007). It should be noted that the wait times have decreased significantly more than what is reported here when comparing current data against the baseline data collected at the beginning of the Wait Times strategy (Sept 05).

Service	90% of all Cases Completed Within						
	Previous Year (Feb/Mar 06)	Current (Feb/Mar 07)	Access Target*	% Complete within Target	Current vs. Previous Year		LHIN Rank**
	In days				Net change (in days)	% Change	
Cancer Surgery	74	55	84	95%	-19	-25.7%	3
Cardiac Surgery							
Angiography	32	14	-	-	-18	-55.6%	1
Angioplasty	14	18	-	-	+4	+28.6%	7
Cataract Surgery	280	197	182	89%	- 83	- 29.6%	12
Hip Replacement	313	302	182	80%	- 11	- 3%	12
Knee Replacement	299	284	182	73%	- 15	- 5%	6
MRI	69	113	28	30%	+ 44	+63.8%	11
CT	54	57	28	75%	+ 3	+5.6%	8

*Priority Level 4 Access Target

**LHIN Rank (1 = shortest, 14 = longest) indicates how the LHIN's current value compares against all other LHINs in the province.

March 9, 2007 – The government is supporting a new orthopaedic assessment centre at The Scarborough Hospital that will reduce wait times and improve access to total hip and knee joint replacements for up to 6,000 patients a year, Health and Long-Term Care Minister George Smitherman announced today. A specially trained team of multidisciplinary staff will assess patients and provide care planning and referral to services. This results in orthopaedic surgeons spending less time in the office and more time in the operating room, which helps increase the number of cases performed and improves access for patients. The assessment team will operate one-day per week out of the Rouge Valley Ajax Pickering site in order to provide better access to local residents.

Cooperative efforts within and across organizations is resulting in reduction of wait times for these and related services provided by Central East LHIN hospitals and the Community Care Access Centre. Some systemic challenges remain including access to the appropriate human resources such as anaesthetists and diagnostic technicians, as well as the physical limitations such as limited capacity for surgery and recovery. In an effort to meet these challenges, the Central East LHIN is implementing new solutions that will improve access to specialized services, such as the Scarborough and Rouge Valley Orthopaedic Assessment Centre.

Improving Critical Care in the Central East LHIN

Critical Care has been identified as a Central East LHIN priority, and efforts are being made to improve the access, quality and management of hospital ICUs. With the support of the Central East LHIN Critical Care Lead, Dr. Howard Clasky (an intensivist at The Scarborough Hospital), your LHIN has made significant gains in the area of improving the capacity and system behaviour of this region's critical care resources.

In 2006-07 Dr. Clasky visited all Central East LHIN hospitals to conduct a detailed inventory of existing resources and health professionals working in our ICUs. With the support of Dr. Clasky and the direction setting of the Central East LHIN, significant progress has been made to establish improved access to intensivist models of care. Provincial coaching teams have also visited most of the Central East LHIN hospitals in an effort to improve patient-flow into and out of the ICU. Finally, upon an assessment of emergency department performance as it is impacted by a lack of critical care resources, the Central East LHIN successfully obtained funding for three new ICU beds for the Rouge Valley Health System, Ajax Pickering site. **Those beds will be fully operational in late summer, 2007.**

An Update from Corporate Services

The Ministry-LHIN Accountability Agreement required the LHIN to establish financial management processes that will support prudent fiscal management of its operations. While the later accountability agreements will expand this responsibility to the financial management of the local health system, the initial Ministry-LHIN Accountability Agreement focused on financial practices internal to the LHIN. The Central East LHIN has successfully met and exceeded all financial performance accountabilities.

The challenge of a start-up is that operational processes need to be designed, adapted and simultaneously implemented. In April 2006, we began to establish our Business Processes in Finance, Operations and Human Resources. Utilizing best practices and accessing (where available) tools that had jointly been developed by our LHIN colleagues and our LHIN Shared Services Organization, we began the processes of adapting policies and establishing procedures in our operational areas.

In June 2006 the senior management received their budget and needed to exercise due diligence in their monitoring and adherence to solid financial practices. Hence, budget statements and variance reports needed to be designed along with appropriate reports to the board to enable them to exercise their fiduciary responsibilities. All without the benefit of expenditure trends and past patterns, we developed our variance reports and forecasts ending the year in a small surplus.

In the area of Human Resources, senior management was set with a task of creating a new and high performing team of no more than 24 individuals. To assist in this process, interview protocols and orientation materials were created in order to meet the challenge of recruiting and training a large number of team members in a compressed time frame. By April 2007 we were 20 people strong, had established financial processes that mirror industry best practices and had elevated the board and management's confidence in the administration of these areas. Indeed, fiscal 2006-07 had its fair share of challenges, but importantly the team is now equipped with a set of lessons learned and practices that will sustain our organization in the longer-term.

Deloitte.

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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, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, these financial statements present fairly, in all material respects, the financial position of Central East Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
May 4, 2007

Statement of Financial Position

March 31, 2007

	2007	2006 (Note 3, 14)
FINANCIAL ASSETS		
Cash	**$ 587,980**	$ 30,466
Accounts receivable	**281,000**	-
	868,980	30,466
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	**648,723**	-
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**181,019**	30,466
Due to the LHIN Shared Services Office (Note 5)	**88,832**	-
Deferred capital contributions (Note 6)	**442,532**	492,756
	1,361,106	523,222
NET DEBT	**(492,126)**	(492,756)
Non-Financial Assets		
Prepaid expenses	**49,594**	-
Capital assets (Note 7)	**442,532**	492,756
	492,126	492,756
ACCUMULATED SURPLUS	**$ -**	$ -

APPROVED BY THE BOARD

Chairman

Board Member

Statement of Financial Activities

Year ended March 31, 2007

	2007		2006
	Budget (unaudited) (Note 8)	**Actual**	Actual (Note 3, 14)
REVENUE			
MOHLTC funding	**$ 3,377,629**	**$ 3,235,703**	$ 250,296
E-Health funding	**281,000**	**281,000**	-
Amortization of deferred capital contributions (Note 6)	**-**	**155,150**	134,765
	3,658,629	**3,671,853**	385,061
EXPENSES			
General and administrative (Note 9)	**3,377,629**	**3,329,249**	354,595
E-Health (Note 10)	**281,000**	**161,585**	-
	3,658,629	**3,490,834**	354,595
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	-	**181,019**	30,466
FUNDING REPAYABLE TO THE MOHLTC	-	**(181,019)**	(30,466)
ANNUAL SURPLUS	-	-	-
OPENING ACCUMULATED SURPLUS	-	-	-
CLOSING ACCUMULATED SURPLUS	**$ -**	**$ -**	$ -

Statement of Changes in Net Debt

Year ended March 31, 2007

	2007	2006 (Note 3, 14)
ANNUAL SURPLUS	$ -	$ -
ACQUISITION OF TANGIBLE CAPITAL ASSETS	(104,926)	(627,521)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	155,150	134,765
CHANGE IN OTHER NON-FINANCIAL ASSETS	(49,594)	-
DECREASE (INCREASE) IN NET DEBT	630	(492,756)
OPENING NET DEBT	(492,756)	-
CLOSING NET DEBT	$ (492,126)	$ (492,756)

Statement of Cash Flow

Year ended March 31, 2007

	2007	2006 (Note 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
Operating		
Annual surplus	**$ -**	$ -
Add (deduct) items not affecting cash		
Amortization of deferred capital contributions (Note 6)	**(155,150)**	(134,765)
Amortization of capital assets	**155,150**	134,765
	-	-
Uses		
Increase in accounts receivable	**281,000**	-
Increase in prepaid expenditures	**49,594**	-
	330,594	-
Sources		
Increase in accounts payable	**648,723**	-
Increase in due to MOHLTC	**150,553**	30,466
Increase in due to LHIN Shared Services Office	**88,832**	-
	888,108	30,466
Net Cash Generated from Operations	**557,514**	30,466
Capital Transactions		
Acquisition of tangible capital assets	**(104,926)**	(627,521)
Financing Transactions		
Increase in deferred capital contributions (Note 6)	**104,926**	627,521
NET INCREASE IN CASH	**557,514**	30,466
CASH, BEGINNING OF YEAR	**30,466**	-
CASH, END OF YEAR	**$ 587,980**	$ 30,466

Notes to the Financial Statements
March 31, 2007

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 income taxation.

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

The LHIN has also entered into an annual Accountability Agreement for the 2006/07 fiscal year with the Ministry of Health and Long Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

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 covers the Region of Durham, City of Kawartha Lakes, the Haliburton Highlands, most of Northumberland County and Peterborough County. The Central East LHIN also contains part of the east city of Toronto (south of Steeles, the portions east of Victoria Park & south of Eglinton, the portions east of Warden & north of Eglinton).

2. Significant Accounting Policies

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

BASIS OF ACCOUNTING

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

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

MINISTRY OF HEALTH AND LONG-TERM CARE FUNDING

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

GOVERNMENT TRANSFER PAYMENTS

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

DEFERRED CONTRIBUTIONS

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

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized over the useful life of the asset reflective of the provision of its services. This amortization revenue is in accordance with the amortization policy applied to the related capital asset recorded.

TANGIBLE CAPITAL ASSETS

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

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

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

Computer equipment
3 years straight-line method

Leasehold improvements
Life of lease straight-line method

Office furniture and fixtures
5 years straight-line method

Web development
3 years straight-line method

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

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. Adoption of Public Sector Accounting Recommendations

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted Canadian generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $492,756 on the Statement of Financial Position. On the Statement of Financial Activities amortization of deferred capital contributions increased by $134,765 as did general and administrative expenses. On the Statement of Changes in Net Debt acquisition of tangible capital assets increased by $627,521 amortization of tangible capital assets increased by $134,765 and closing net debt increased by $492,756.

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 9 related to the prior period.

5. Related Party Transactions

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

The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs.

6. Deferred Capital Contributions

	2007	2006
Balance, beginning of year	**$ 492,756**	$ -
Capital contributions received during the year	**104,926**	627,521
Amortization for the year	**(155,150)**	(134,765)
	$ 442,532	$ 492,756

7. Capital Assets

	2007			2006
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Office furniture and fixtures	**$ 273,427**	**$ 99,107**	**$ 174,320**	$ 177,687
Computer equipment	**73,440**	**47,632**	**25,808**	46,303
Web development	**27,858**	**4,441**	**23,417**	-
Leasehold improvements	**357,722**	**138,735**	**218,987**	268,766
	$ 732,447	**$ 289,915**	**$ 442,532**	$ 492,756

8. Budget Figures

The total operating budget of $3,377,629 has been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

9. General and Administrative Expenses

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes. These expenses 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

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transaction, amounts totalling $108,504 of prior period expenses were not accrued. For the year ended March 31, 2007, these amounts were included in the Statement of Financial Activities of the LHIN.

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

	2007	2006
Salaries and benefits	**$ 1,648,608**	$ 217,210
Occupancy	**209,651**	-
Amortization	**155,150**	134,765
Shared services	**298,058**	-
Public relations	**392,105**	-
Consulting services	**233,731**	-
Supplies	**88,896**	776
Board member expenses	**210,538**	-
Mail, courier and telecommunications	**6,155**	-
Other	**86,357**	1,844
	$ 3,329,249	$ 354,595

10. E-health Expenses

During fiscal 2007, the Central East LHIN was provided funding in the amount of $281,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic E-Health Plan as defined in its Integrated Health Services Plan. During the year, $161,585 was used on consulting services related to the E-Health project.

11. Pension Agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 17 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2007 was $90,801 (2006 – $20,504) for current service costs and is included as an expense in the Statement of Financial Activities.

During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting.

12. Guarantees

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

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

13. Commitments

The LHIN has commitments under various operating leases. Minimum lease payments due in each of the next four years are as follows:

2008	$ 124,886
2009	124,736
2010	123,626
2011	72,540
	$ 445,788

14. Comparative Figures

The prior period figures are from the date of incorporation, June 2, 2005 to March 31, 2006.

During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

Staff Members

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Central East
LOCAL HEALTH INTEGRATION NETWORK

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