

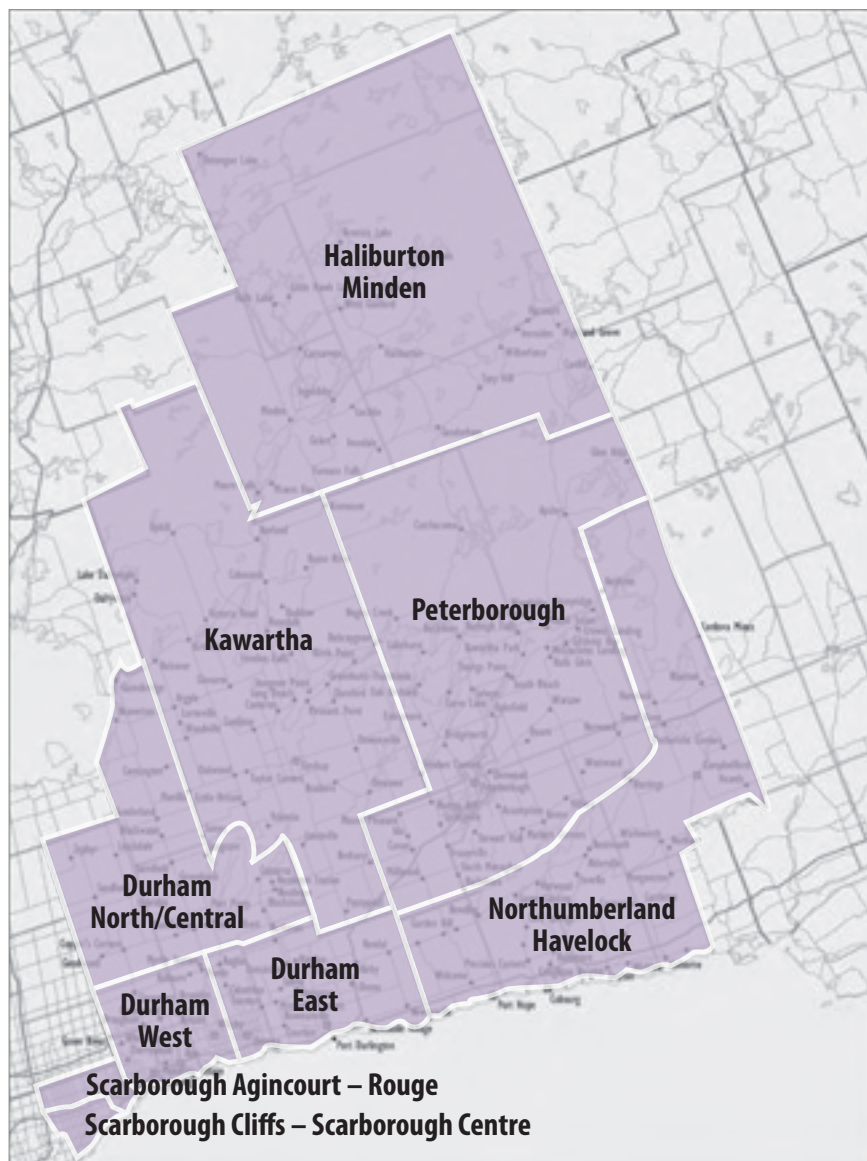


From Planning to Action

Engaged Communities. Healthy Communities.

Central East LHIN 2007-08 Annual Report

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. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the first Annual Report for the LHINs with their full authorities.

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

April 1, 2007 was the day on which LHINs assumed their funding and accountability authority as devolved from the Minister of Health and Long- Term Care. Like similar transitions in government and agencies, the public and providers experience of health care administration changed little. This is because the LHIN transformation has consistently been evolutionary rather than revolutionary.

Over the past year, the Central East LHIN organization has worked with health service providers to meet the public's expectation of:

- Increased integration and improved service coordination
- Increased local decision-making about funding and allocation
- Greater emphasis on local health system planning
- Increased community engagement
- Enhanced accountability

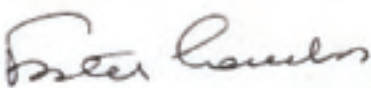
Given that local health service provider boards have remained intact, it should be the public's expectation that these goals will be achieved by the Central East LHIN in leadership, and support of, the health service providers within the LHIN area. Accountability, coordination, and input to decision making - these are common expectations of the public for their health care delivery system – not just of the LHIN.

Now is the time to create the capacity for change, and wherever the LHIN can, remove obstacles that have hindered our collective ability to do better for our patients, residents and families. Right from the start, much attention and fear has been generated by some regarding the integration mandate of the LHINs. We hope that our health care community is growing in confidence that the LHIN is committed to transparency, will reward behaviour that is inclusive rather than divisive and will reward and recognize efforts in innovation and quality improvement by our health service providers.

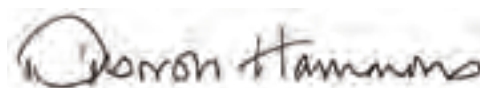
Our actions and plans have demonstrated a commitment to engaging our diverse communities, and to providing equitable access to an integrated system of care across the LHIN. In recognition of these efforts, we have received a great deal of support from the public and health service providers over the past year. We have been recognized by our peers for our innovation and progress.

While such support is encouraging, it is important for all of us to be reminded that the LHIN is fundamentally a network of funded health service providers and interested stakeholders working in unison towards meeting our citizen's expectations about their public health system. This is not to distract from the important role the LHIN Board and Staff play in providing leadership to remove those barriers that divide our community of care. What will make the LHIN so successful, so unstoppable, is our collective abilities to work and achieve together as a network. This is the kind of leadership you should expect from your LHIN.

Confidence abounds! Thank You.

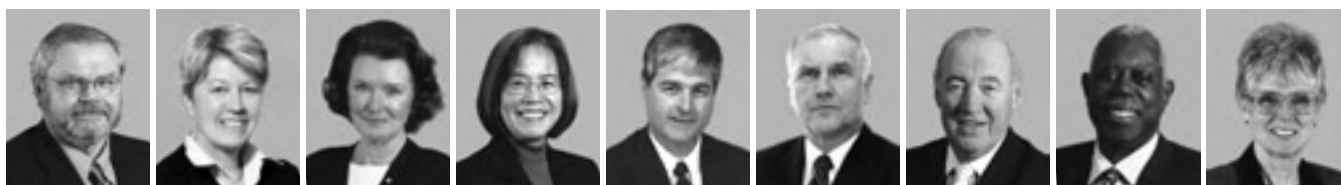


Foster Loucks
Chair



Deborah Hammons
CEO

MEMBERS OF THE BOARD



Foster Loucks

Term of Office: June 1, 2005 – May 31, 2008

Joseline Sikorski

Term of Office: June 1, 2005 – May 31, 2008

Jean Achmatowicz MacLeod

Term of Office: June 1, 2005 – May 31, 2008

Novina Wong

Term of Office: January 5, 2006 – February 4, 2007

Reappointed: February 5, 2007 – February 4, 2010

Stephen Kylie

Term of Office: March 1, 2006 – February 29, 2008

Reappointed: March 1, 2008 – February 28, 2011

Dr. Alexander Hukowich

Term of Office: May 17, 2006 – June 16, 2007

Reappointed: June 17, 2007 – June 16, 2010

William Gleed

Term of Office: May 17, 2006 – June 16, 2007

Reappointed: June 17, 2007 – June 16, 2010

Ronald Francis

Term of Office: May 17, 2006 – May 16, 2008

Eva Nichols

Term of Office: January 5, 2006 – February 4, 2008

Reappointed: January 5, 2008

Resigned: February 10, 2008

(Resignation approved and order in council revoked: March 19, 2008)



INTRODUCTION

A Strategy to Strengthen Your Health Care System and to Help You Improve Your Health

Since its inception, the Central East LHIN has been working with community residents, caregivers, health service providers, the provincial government and other local health integration networks in establishing and implementing a local strategy that will not only improve the public health care system, but help you and your family stay healthy, and receive services as close to home as possible.

2007-2008 marked the continued evolution of the Central East LHIN as local health system managers. In its first year (2006-07), activities were focused on community engagement and planning that resulted in the development of the first Central East LHIN Integrated Health Service Plan (IHSP).

Delivering on the Integrated Health Service Plan, which was developed through extensive community engagement to determine what matters most to people in our communities, required the coordinated effort of the Central East LHIN and the local health service providers. The legislative and policy foundation of this coordinated or integrated effort is the Local Health Services Integration Act which places expectations on both the LHINs and health service providers. Specifically, new requirements of local health service providers are to:

- Align their strategic and service planning within the overall LHIN framework, with specific reference to the priorities identified in the Integrated Health Service Plan
- Participate in LHIN planning exercises and provide the input and necessary information for the development of LHIN plans
- Identify integration opportunities and demonstrate continuous improvement in service integration, coordination and quality
- Implement the directions for integration laid out in the accountability agreements with LHINs

To assist the LHIN and local health service providers meet these expectations of quality, accountability, consistency and transparency, the Central East LHIN has continued to develop local policy, strategic directions and tools that will guide the integration and decision making process. 2007-08 demonstrated continuous development in this area, notably with the development of the Central East LHIN Strategic Directions, the draft Decision Making Framework, and Service Accountability Agreements.

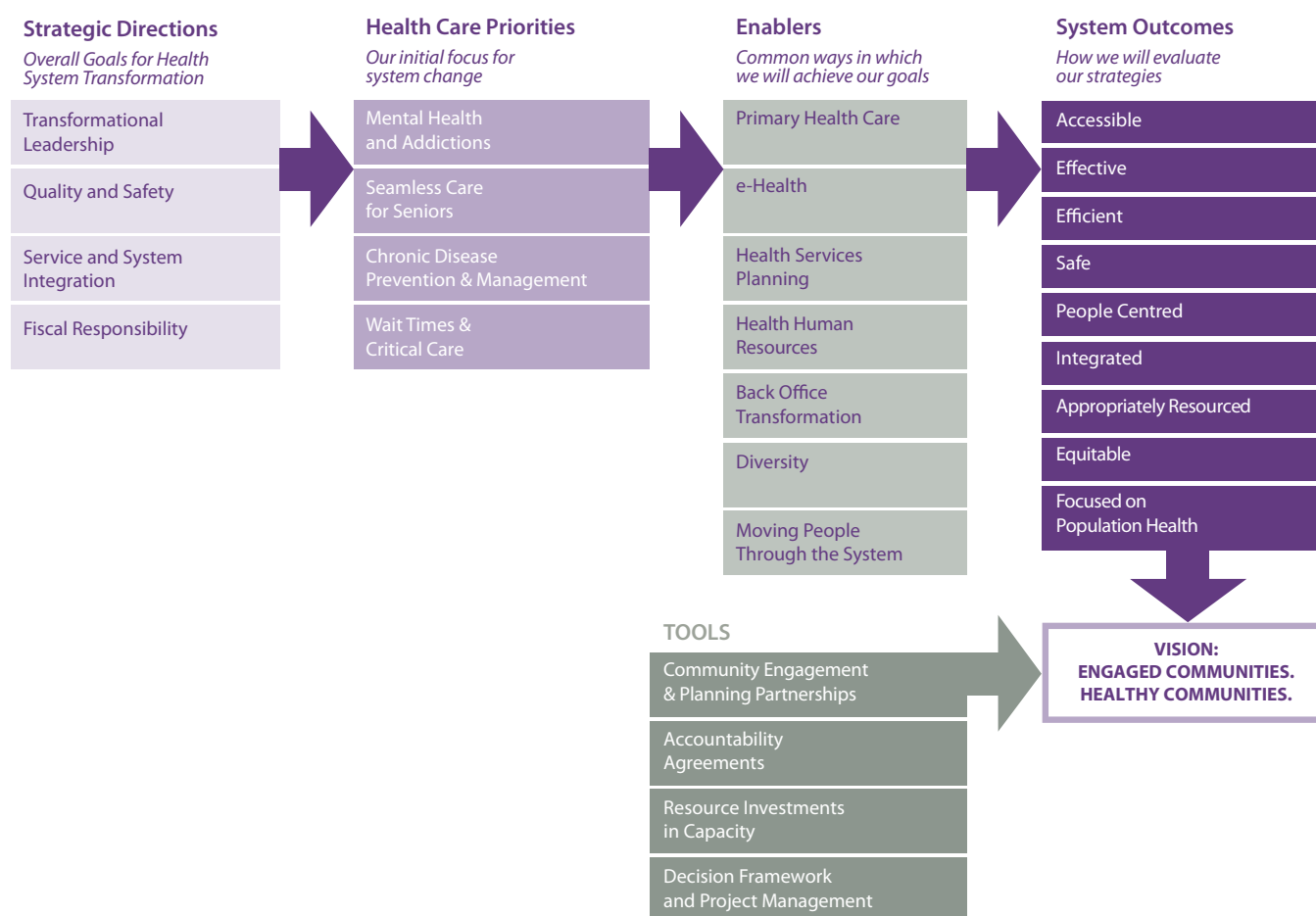
The table on the next page summarizes these key Central East LHIN decision and accountability documents, including direction on where to find more information about them.

Policy/Accountability Document	Description	Focus
2007-08 Ministry-LHIN Accountability Agreement (MLAA) http://www.centraleastlin.on.ca/Page.aspx?id=132	Establishes mutual accountabilities, performance goals and funding between the Ministry of Health and Long-Term Care and the CE LHIN.	Focus is on alignment and consistency between CE LHIN and provincial goals, roles and responsibilities.
Central East LHIN Vision http://www.centraleastlin.on.ca/Page.aspx?id=2538&ekmsel=e2f22c9a_72_184_2538_1	“Engaged Communities. Healthy Communities.” Establishes the long-term goal of the CE LHIN Organization. First articulated in the Integrated Health Service Plan (2006).	Focus is on alignment of CE LHIN goals and objectives for the local health system.
Central East LHIN Strategic Directions http://www.centraleastlin.on.ca/Page.aspx?id=2540&ekmsel=e2f22c9a_72_184_2540_2	Sets overall strategic directions for the CE LHIN organization and the entire Central East LHIN under four areas: • Transformational Leadership • Service and System Integration • Safety and Quality • Fiscal Responsibility Approved by the Central East LHIN Board in August 2007.	
Central East LHIN Integrated Health Service Plan http://www.centraleastlin.on.ca/IntegratedHealthServicePlan.aspx?ekmsel=e2f22c9a_72_204_btnlink	Sets health care priorities for change, common enablers, system outcomes , action plans and performance monitoring framework. Published: Nov 2006.	
Central East LHIN Framework for Community Engagement and Local Health Planning http://www.centraleastlin.on.ca/uploadedFiles/Home_Page/Integrated_Health_Service_Plan/Framework.pdf	Establishes goals, objectives and processes of community engagement in the CE LHIN. Includes CE LHIN planning partnerships (e.g., Collaboratives, LHIN-wide Health Interest Networks, and Task Groups). Published: March 2006.	Focus is on agreement with CE LHIN expectations for transparent, objective and collaborative decision making.
Central East LHIN Decision Making Framework (draft) http://www.centraleastlin.on.ca/Page.aspx?id=94&ekmsel=e2f22c9a_72_206_94_2	Assists LHIN decision makers in reviewing funding requests, innovation or integration proposals. Assists health service providers in assessing the merits of their funding requests, innovation or integration proposals. Presented: Aug 2007.	
Central East LHIN Business Supports	• Project Management Office • Health Service Improvement Pre-Proposal (HSIP).	

On April 1, 2007 Ontario's LHINs assumed their funding and accountability authority as devolved from the Minister of Health and Long-Term Care. Such responsibility required on-going fiscal and performance oversight of local health service providers, with increasing responsibility for negotiating **Service Accountability Agreements** with local health service providers. These agreements are required in order for the LHIN to provide funding to a health service provider.

The **Strategy Map** (below) captures how our strategic directions, our IHSP health care priorities and enablers, and tools "fit" together in supporting our vision and desired outcomes for the local health system.

The **Strategy Map** was revised in 2007-08 to include the Central East LHIN Strategic Directions, as well as reflect some of our evolving knowledge of what is required to meet your goals for the health care system.

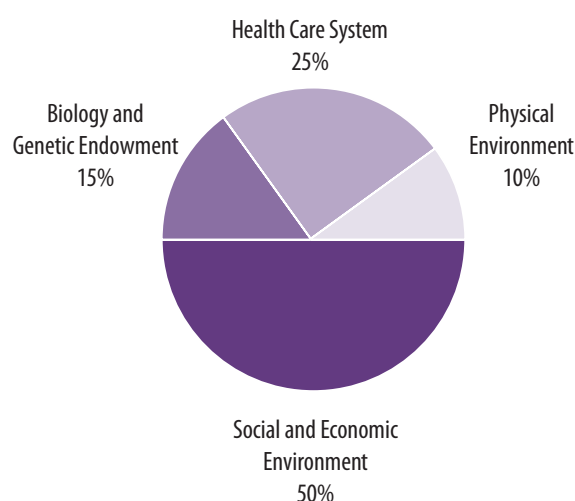


HEALTH AND POPULATION PROFILE

Social Determinants of Health

Social determinants of health (e.g., income, education, social environment) are a significant contributor to the development of disease and the burden of the illness on an individual and their family¹. Lack of social supports, social exclusion and unhealthy, polluted environments contribute to poor health². Factors such as gender, culture, social status, and ethnicity can be related to issues of social justice, access to services and the risk of becoming ill or developing a disease¹. Factors that contribute to maintaining health such as adequate income, safe/secure housing and the ability to access affordable transportation are inconsistently considered in the management of illness and disease, yet have a significant impact on clients' ability to effectively manage their care. An effective system of care includes a focus on health promotion and wellness that considers the determinants of health.

Estimated Impact of Determinants of Health on the Health Status of the Population



Source: As cited by MOHLTC (Keast) in presentation April 2006
Estimated Impact of Determinants of Health on the Health Status of the Population

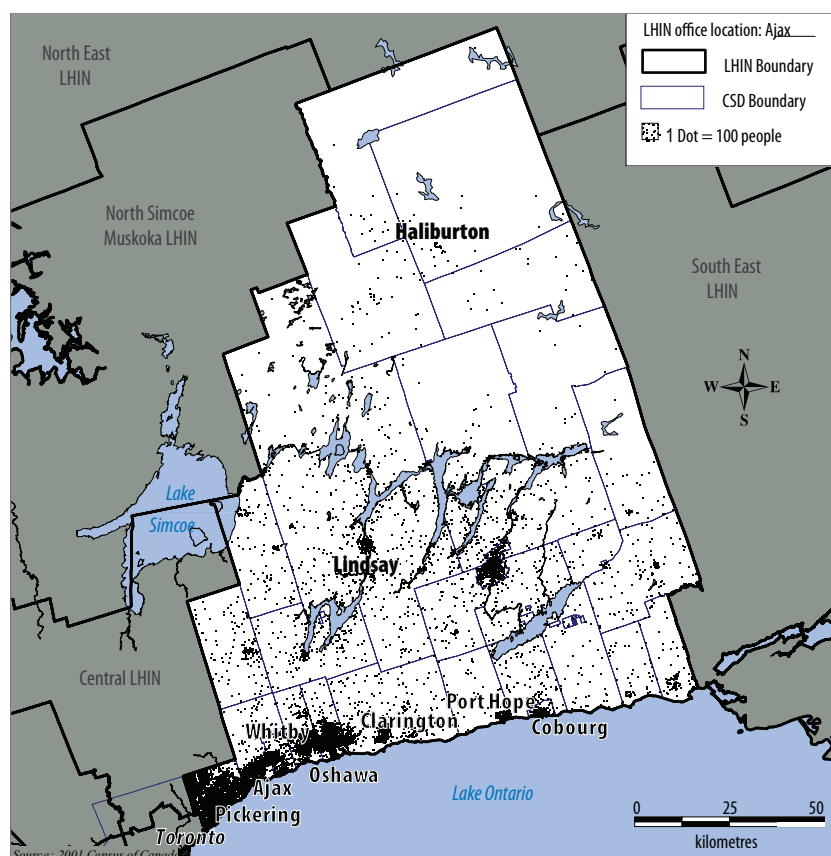
¹ Integrated Health Service Plan, November 2006
² Chronic disease in Ontario and Canada

Social-Demographic Characteristics

	CENTRAL EAST	ONTARIO	LHIN Range
Total population (2006)[†]	1,484,300	12,687,000	238,000 - 1,604,900
Senior population, age 65+ (2006) [†]	13.2%	12.9%	9.0 - 16.7%
Population with English mother tongue	74.5%	71.9%	55.7 - 92.2%
Population with French mother tongue	1.5%	4.7%	1.2 - 25.1%
Population who are immigrants	32.0%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	5.7%	4.8%	0.3 - 9.7%
Population who are visible minorities	30.2%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	0.9%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	66.3%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.7%	6.1%	5.0 - 9.8%
Population in low income	14.8%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	24.4%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	7.7%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	26.5%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	46.2%	48.7%	42.4 - 55.8%

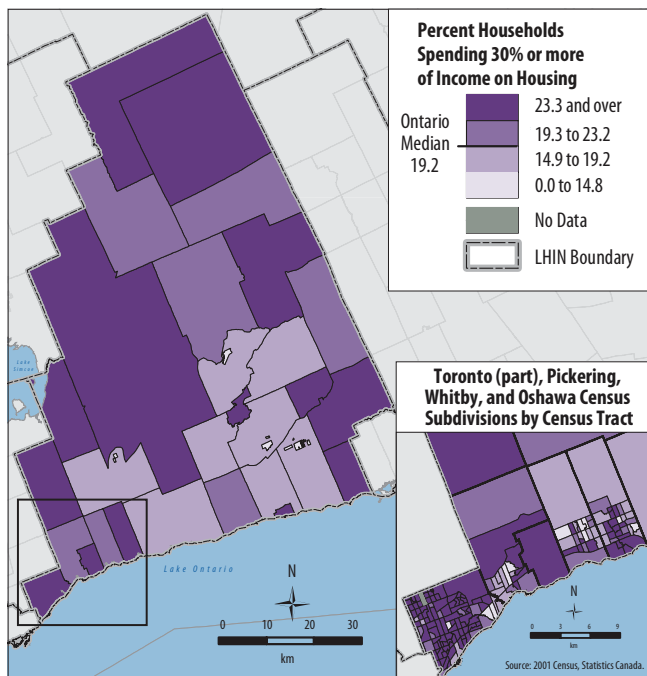
Source: [†]2006 Population estimates. MOHLTC Provincial Health Planning Database. Remaining indicators based on 2001 Census of Canada.

Population Map



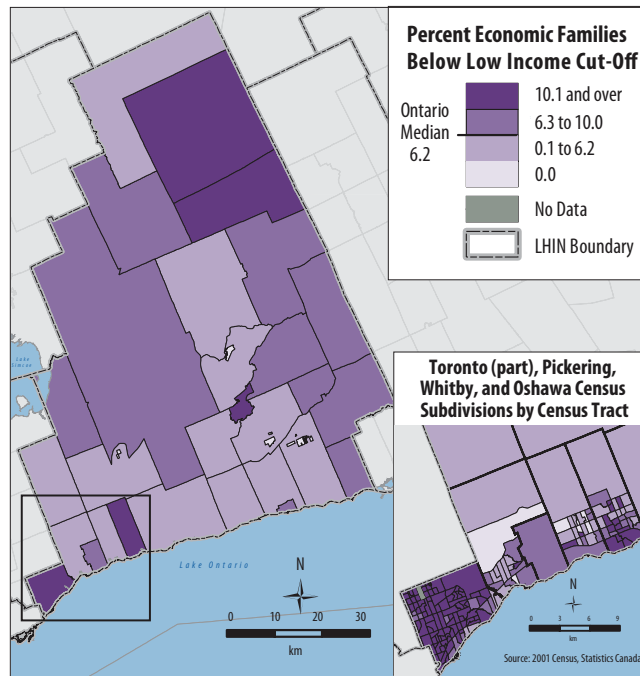
Source: MOHLTC Health Analytics Branch.

% Households Spending 30% or more of income on Housing



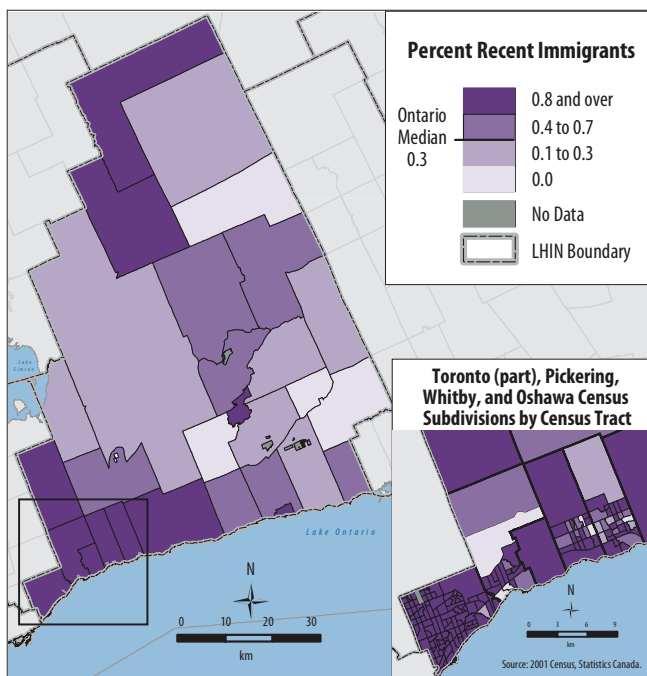
Source: MOHLTC Health Analytics Branch.

% Economic Families Below Low Income Cut-Off



Source: MOHLTC Health Analytics Branch.

% Recent Immigrants



Source: MOHLTC Health Analytics Branch.



COMMUNITY ENGAGEMENT PROPELS THE CENTRAL EAST LHIN

The activities of the Central East LHIN are supported by the commitment, knowledge and passion of hundreds of local individuals participating on our Planning Partnerships. These Partnerships were established as a result of the Central East LHIN Framework for Community Engagement and Local Health Planning, and include LHIN-wide **Networks**, local Planning and Engagement **Collaboratives** and topic-specific **Task Groups** or **Working Groups**.

Planning and Engagement Collaboratives (9)

A Collaborative is a local advisory team consisting 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 addiction services, long-term care, physicians, and pharmacists. Local residents interested in the public health care system are also participating.

LHIN-wide Networks (3)

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. 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.

Networks are guided by a steering committee of 12 to 15 individuals with specific interests and skills related to the priority. The steering committee acts as a conduit between the LHIN and the broader Network – which can also be defined as a community of interest. The broader Networks are not limited in their size.

Task Groups/Working Groups

Task groups are time-limited action teams established to address common issues or opportunities common to the Networks (i.e., priority areas) and Collaboratives. They consist of members with specific expertise related to the subject, and are drawn from all corners of the Central East LHIN. For example, the Primary Care Working Group consists of physicians, nurses and other allied health professionals that serves as a leading primary care resource on issues related to our health care priorities. In 2007-08, over 74 health care experts were engaged through various Task Groups or Working Groups.

The Collaborative and Network membership and involvement in local health planning continued to grow in 2007-08, while new Task Groups were formed based on the direction of the Integrated Health Service Plan, including:

- Emergency Department Performance Task Group
- Alternate Level of Care Task Group
- Rehabilitation Services Task Group
- Primary Care Working Group
- eHealth Steering Committee

The Central East LHIN First Annual Symposium: Planning to Action!

In June of 2007, the Central East LHIN invited planning partners, community residents and health care providers from across the entire region to a three day “Planning to Action” Symposium at the University of Ontario Institute of Technology (UOIT) in Oshawa. The event was an overwhelming success with over three hundred in attendance at the opening night reception. In addition over two hundred planning partner volunteers participated in workshops and planning meetings on the following days. Not only were these workshops intended to support our planning partners with information and tools to assist their efforts, it was also used as an opportunity to set priorities for the coming year.

Symposium participants were asked to prioritize activities found within the Integrated Health Service Plan. Knowing the importance of all of these IHSP activities – because the public told us directly – the prioritization was based less on what participants thought was important, and more on what they were prepared to commit themselves to make happen. In other words, who was prepared to lead? who was prepared to implement? This prioritization of commitment resulted directly in the first wave of Priority Project Charters funded through the Central East LHIN Urgent Priorities Fund.

“The three days I spent at the Symposium verified for me that this new direction and path that LHINs have created is the path that is going to lead to a successful, integrated and transparent health care system.” Symposium Participant

A summary of the accomplishments and activities of the Planning Partners and their Priority Project Charters is provided later under the heading “Making Progress on the Integrated Health Service Plan.”

Engaging our Francophone and Aboriginal Communities

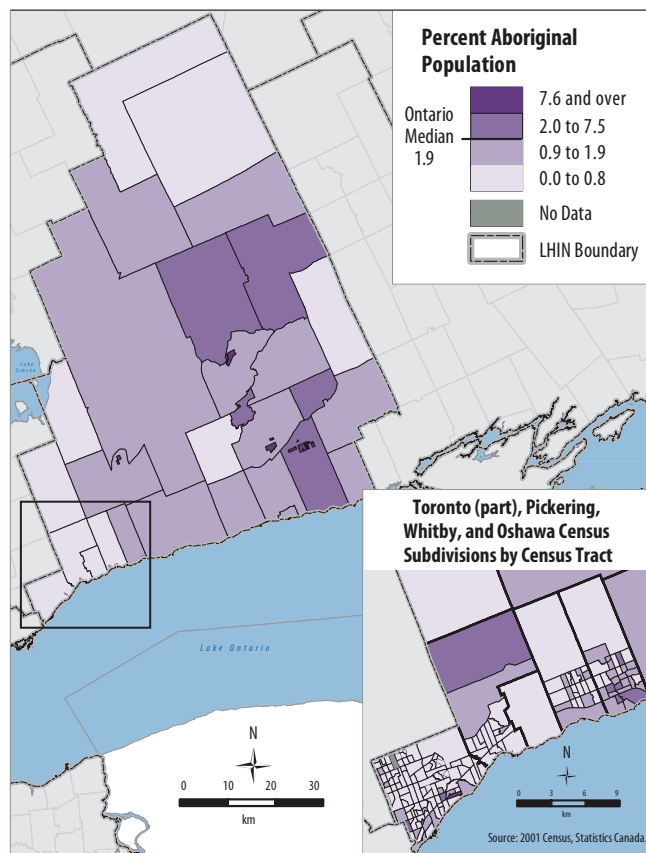
Recognizing our cultural and social heritage, the Central East LHIN continues to explore meaningful ways to engage our Francophone and Aboriginal Communities.

Central East LHIN staff participate in a Greater Toronto area French Language Health Services Planning and Support Committee. This committee brings together the five GTA LHINs, local health service providers and planners in an effort to improve the coordination and access to French language services. Complementing this initiative, the Central East LHIN identified the establishment of a Francophone Planning Collaborative within its Integrated Health Service Plan. This planning partnership will incorporate the perspectives and expertise from across the Central East LHIN in order to address local challenges and opportunities. The planning to set up this Collaborative began in 2007-08, and will be implemented in the upcoming year.

Similarly, the Central East LHIN has been reaching out to local First Nations and Aboriginal communities to identify opportunities for better communication and collaborative planning. Central East LHIN staff have met with local Aboriginal Leaders to discuss the potential for an Aboriginal “health council” whose mandate would be largely self-determined by Aboriginal persons to best reflect their cultural, linguistic, spiritual and healing traditions. These efforts will be supported through new provincial funding available to the Central East LHIN targeted for this purpose.

In the absence of these formal mechanisms for community engagement, the Central East LHIN continues to pursue opportunities to improve access to health care services for Aboriginal peoples. This includes an innovative **Chronic Kidney Disease Early Intervention and Outreach program**. This program, funded through the LHIN Urgent Priorities Fund, will be delivered by the Peterborough Regional Health Centre with the goal of identifying populations at-risk for kidney disease, with a specific focus on the Curve Lake First Nation.

% Aboriginal Population



Source: MOHLTC Health Analytics Branch.



MAKING PROGRESS ON THE CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN

Health Care Priority

Seamless Care for Seniors

Community Engagement

Steering Committee: 13 persons

Network Membership: 180 persons and/or agencies.

Activities

This year marked significant promise for improving the system of care and supports for seniors and their caregivers in Central East.

The Network's Steering Committee, chaired by Dr. John Peto (Rouge Valley Health System), led the creation of a draft Planning Framework for seniors which has since been adopted as a common template by the Steering Committees of the Chronic Disease Prevention and Management and Mental Health and Addictions Networks. This is just one example that highlights the important synergies between these three Health Interest Networks.

The LHIN's June 2007 Symposium provided the backdrop for our communities to identify the LHIN's first priorities to action from the Integrated Health Service Plan (IHSP) - and the direction was clear for the seniors' portfolio.

Our communities want action in areas such as community support services, caregiver supports, supportive housing and transportation. The LHIN and its planning partners in the community set to work in establishing Priority Project Charters for these, and other, IHSP priorities.

This activity was further heightened in the fall when the Honourable George Smitherman, Minister of Health and Long-Term Care announced the "**Aging at Home Strategy.**" This Strategy is intended to enable seniors to maintain their independence in the community for as long as possible, with dignity and respect. Central East LHIN will, over the three years of the Strategy, invest over \$20M into community supports for seniors and their caregivers. The first year's allotment of \$4.6M is targeted and aligned to the three priority areas identified above: community support services, caregiver supports and supportive housing. There is much excitement across the LHIN on the opportunities, through partnerships and innovation that will leverage this landmark investment!

Accomplishments

The Central East LHIN extends congratulations to the **Geriatric Emergency Management (GEM) Project Team** of the LHIN. This team, with funding made available through the Province's "**Emergency Department Support Fund**", successfully recruited, hired, trained and mentored five new GEM nurses for five Emergency Departments across Central East! This project, one of the LHIN's first examples of how working collectively really does make a difference, is laying a solid foundation for an improved system of geriatric care within the LHIN. This project was aptly managed and well linked to the Regional Geriatric Program of Toronto. Despite being in early stages of development, over 800 frail seniors visiting Central East hospital emergency departments were seen by these GEM nurses in 2007-08.

Other Seamless Care for Seniors/Aging at Home Priority Projects initiated in 2007-08:

Supportive Housing Priority Project that will:

- Establish an on-line inventory of supportive housing services in Central East;
- Research, explore and recommend best practice models/ approaches to supportive housing;
- Develop a fair, transparent and supportable basis for determining where supportive housing should be available/ enhanced in Central East;
- Identify the barriers and offer potential solutions to the uptake of supportive housing;
- Explore, document and recommend best practice approaches to intake and assessment for supportive housing that is more integrated and client centred;

- Develop a means of collaborative exchange of resource information, training opportunities and best practice models for service providers of supportive housing; and
- Raise awareness of supportive housing as a critical component of the continuum of care.

Community Support Services Review Priority Project in order to:

- Assess current Community Support Service (CSS) infrastructure and resources (i.e. what do we have now and what do we need?);
- Recommend where to invest in the CSS sector by geography and service type;
- Identify barriers and opportunities to investing in the CSS sector, including innovative initiatives;
- Recommend strategies for enhancing integration both within the CSS sector and with the broader systems of health and human services.

Caregiver Supports Priority Project aimed to:

- Guide investments to strengthen the caregiver support system in CE LHIN including a Best Practices review (agencies/literature) and design of an Evaluation process; and
- Design and implement a pilot Caregiver Support Resolution program to respond to and resolve complex and problematic care giving situations.

Rural Transportation Priority Project that will:

- Conduct an environmental scan on rural transportation services provided by the five Community Cares in Central East as well as a profile of other successful models (Ontario based) worthy of exploring.

Central East LHIN-wide Home at Last (HAL) Priority Project that:

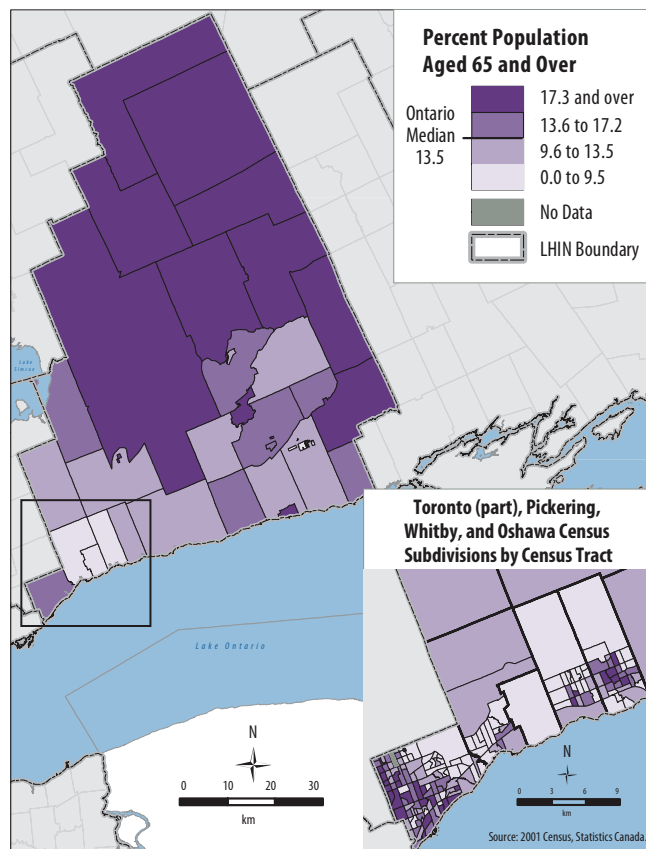
- will assist frail seniors and other vulnerable, isolated individuals with safe and supported transition from hospital to community. This will be achieved by providing a “wrap around” service at the time of hospital discharge. This service, geared to the specific needs of the individual and family, may include transportation home, having a Personal Support Worker assist with picking up medications at the pharmacy, getting the individual settled at home, preparation of light meals, light housekeeping, initial home safety check as well as a follow-up telephone call within 1 week.

Aug 24, 2007

Central East LHIN approves 42 new supportive housing spaces in Peterborough

The Central East LHIN Board of Directors approved funding for assisted living supports to 42 new supportive housing spaces in Peterborough, part of the St. Peter's and Marycrest redevelopments.

Percent Population Aged 65 and over



Source: MOHLTC Health Analytics Branch.

Chronic Disease Prevention and Management

Community Engagement

Steering Committee: 15 persons

Network Membership: 80 persons and/or agencies.

Chronic Disease Facts:

Among residents in the Central East LHIN, cancer, diabetes, depression, heart disease, hypertension, stroke, asthma, COPD and arthritis accounted for:

- 1 out of 4 inpatient hospital separations
- 1 in 10 emergency department visits
- 1 in 5 visits to general practitioners or family physicians

36% of Central East LHIN residents had one of the above chronic conditions. Arthritis and hypertension are the most prevalent.

Activities

The CDPM Network's mission statement is instructive: "Together we will create a system that promotes health, prevents and manages chronic disease through effective coordinated planning, delivery of best practices and continuous improvement." Initial priority disease conditions include vascular/stroke, chronic kidney, diabetes, arthritis and respiratory.

The 15-member Network Steering Committee is co-chaired by Dr. George Buldo, a Nephrologist (Lakeridge Health Corporation) and Dr. Don Harterre (Lead Physician, Peterborough Family Health Team). Network Membership has grown to 80 individuals/agencies with various perspectives on CDPM from consumer and caregivers to pharmacy and recreation therapy.

To increase opportunities for information and collaboration, the Steering Committee launched a web-based Network Members Home Page. The Home Page is a key vehicle for communication of messages from the Committee, new disease management resources, and educational opportunities. Through the Home Page, Network members provided input to the Lung Associations' Chronic Obstructive Pulmonary Disease (COPD) strategy.

Network activities focus on strategies to action the provincial CDPM Model. Through supporting productive interactions and relationships amongst CDPM stakeholders the following outcomes are being pursued:

- Activated communities and prepared proactive community partners;
- Informed, activated individuals and families;
- Prepared, proactive practice teams.

The Central East LHIN CDPM Planning Framework articulates a local Mission, Guiding Principles and relates the IHSP actions to the key components of the CDPM model. The Framework encourages pursuit of integration opportunities to create one-stop coordinated access to screening, education and self-management support across multiple disease programs.

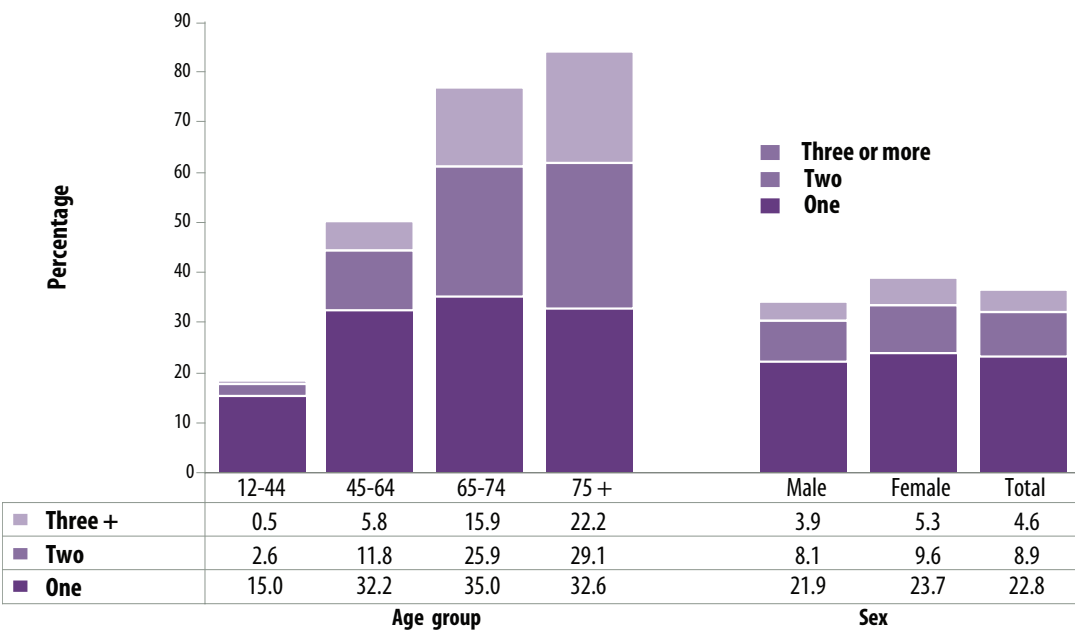
Accomplishments

Priority Projects from this Network are advancing several components of the CDPM Model.

Provider Decision Support: Diabetes

The newly formed CE LHIN Diabetes Network is guiding the **Strengthening Diabetes Care: Clinical Practice Guidelines 2008 Uptake** project. This initiative will improve awareness of diabetes, local resources and best-practice care.

Population aged 12+ reporting one, two or three or more of selected chronic conditions, by age groups and sex, Ontario, 2005



Source: 2005 Canadian Community Health Survey, Statistics Canada, Ontario Share File.

Delivery System Design: Stroke

The **Unified Central East Stroke System** initiative led to the endorsement from the Ontario Stroke Steering Committee for a province-wide examination of the alignment of the OSS boundaries to LHIN boundaries and development of a District Stroke Centre to serve Durham Region. This project identifies the need for improved access to t-PA, particularly in Durham Region, the need for a fulsome continuum of stroke care and expansion of tele-stroke support. This project was also supported by the Northumberland-Havelock Collaborative.

Delivery System Design: Chronic Kidney Disease

Durham, Scarborough and Haliburton Kawartha Pineridge (HKPR) renal programs have formed the **Central East LHIN Regional Renal Network**. The Network is partnering with other disease providers to pursue strategies to align programs and ensure quality renal care for residents through:

- consistent service components, costing metrics, quality indicators and reporting methodologies;
- development of a LHIN emergency/contingency plan for dialysis and a transplant follow-up clinic, and;
- a demand-capacity plan for dialysis services.

Chronic Disease Facts:

50% of Central East LHIN residents (aged 12+) were physically inactive and over 40% of those aged 18+ were either overweight or obese.

The Regional Renal Network is leading a **Chronic Kidney Disease Early Intervention and Outreach** program. Strategies include early identification and supports to delay or prevent the progression to dialysis such as self-management, education and condition monitoring. The diverse needs of rural and cultural communities and the reality of co-morbid conditions will be addressed.

Personal Skills and Self-Management

The CDPM Network led the introduction of a consistent **Chronic Disease Self-Management Model (Stanford Model)** for the Central East LHIN. The initiative will engage consumer/caregiver and health service providers in education and leader training. This program was supported by the Durham North Central Collaborative.

Health Public Policy

The Steering Committee hosted the Ontario Health Quality Council and staff for a discussion on Central East LHIN CDPM initiatives. LHIN progress was applauded and OHQC support for pursuit of quality of care and outcome monitoring was received.

Health Care Priority

Mental Health and Addictions Steering Committee

Community Engagement

Steering Committee: 15 persons

Network Membership: 100 persons and/or agencies.

Activities

2007/2008 was an active year for the Mental Health and Addictions Steering Committee. In April of 2007 the Steering Committee was reconstituted to mirror the composition and structure of the Steering Committees for the other LHIN priorities, and to be more closely aligned with the planning processes of the LHIN.

Mental Health and Addictions Facts (Ontario):

- 36,485 individuals were treated in non-residential and 8,392 in residential treatment programs for substance abuse (2006-07)
- Nearly 22% of Community Care Access Centre clients had a mental health diagnosis. Among clients with a mental health diagnosis and a defined service goal, 85.7% had a goal of in-home service, while 14% had a goal of residential treatment (2005-06)
- There were 189,283 emergency department visits in Ontario hospitals for mental health conditions
- Mental health conditions accounted for 108,286 alternate level of care days

Jan 31, 2008

\$3.2 Million Chronic Disease Funding targets Kidney Disease, Diabetes and Self Management

With chronic disease having a significant impact on residents and health care providers in the Central East LHIN, the board of the Central East LHIN has approved and funded three priority projects focused on improving care for chronic disease patients and their families.

The broader network membership selected Dr. Peter Prendergast (Whitby Mental Health Centre) and Donna Rogers (Four Counties Addictions Services) as co-chairs for the Steering Committee. The membership of the Steering Committee was selected after an extensive volunteer application process and includes 16 agency, professional and consumer members from across the LHIN. During the year the MHA Steering Committee met a number of milestones by establishing priorities within the MHA sector, reviewing and endorsing several LHIN Priority Projects and providing input to several other projects including the ED and ALC Task Group reports.

In addition, the Steering Committee has drafted a planning framework for endorsement by the Mental Health and Addictions Network and held an initial planning/engagement meeting for the broader network of 100 members.

Accomplishments

Several key Mental Health and Addiction Priority Projects were moved forward in 2007 through the use of Central East LHIN Urgent Priority Funding, including:

- **Early Intervention for Youth Strategy with Mental Health and/or Addictions Needs**
- **Addictions Environmental Scan**
- **Disordered Eating**
- **Cultural, Diversity and Equity Priority Project**

Acute Mental Health Separations, Days & Average Length of Stay (ALOS), Central East & Ontario Hospitals

Hospitals	Separations	Acute		Total	
		Days	ALOS	Days	ALOS
Durham					
Lakeridge Health-Bowmanville	48	186	3.9	253	5.3
Lakeridge Health-Oshawa‡	1,184	13,465	11.4	14,696	12.4
Lakeridge Health-Port Perry	31	234	7.5	418	13.5
Markham Stouffville-Uxbridge Site	32	183	5.7	183	5.7
Rouge Valley Health System-Ajax Site‡	645	6,763	10.5	7,652	11.9
Haliburton					
Haliburton Highlands Health Services-Haliburton	12	78	6.5	78	6.5
Kawartha Lakes					
Ross Memorial	116	1,175	10.1	1,392	12.0
Northumberland					
Campbellford Memorial	72	537	7.5	1,051	14.6
Northumberland Hills	98	503	5.1	668	6.8
Peterborough					
Peterborough Regional Health Centre‡	905	11,664	12.9	12,948	14.3
Toronto					
Rouge Valley Health System-Centenary‡	1,379	13,263	9.6	13,418	9.7
Scarborough Hospital-Grace Site‡	840	8,915	10.6	9,678	11.5
Scarborough Hospital-Scarborough General Site‡	1,028	8,022	7.8	8,932	8.7
Total Central East	6,390	64,988	10.2	71,367	11.2
Ontario	57,683	621,495	10.8	696,049	12.1

Source: Inpatient Discharges data, MOHLTC, Provincial Health Planning Database, 2004/05.

‡Had acute psychiatry beds as at March 31, 2005.

Health Care Priority

Wait Times and Critical Care

The Central East LHIN continued to make progress on the reduction of priority area wait-times throughout fiscal year 2007/08. Priority Areas are:

- Cancer Surgery
- Cardiac Surgery (Angioplasty and Angiography)
- Cataract Surgery
- Hip and Knee Total Joint Replacement
- MRI/CT Scan

For example, the 90th percentile wait-time for Cataract Surgery across the Central East LHIN reduced from 222 days in 2006/07 to 140 days in 2007/08. Similarly, 90th percentile wait-times for Hip and Knee Replacements reduced 13 days year-over-year (to 258 days) and 17 days year-over-year (to 284 days) respectively. More modest reductions in wait-times for CT Scans were achieved year-over-year as well (down 4 days to 52 days). Additionally, waits for Cancer Surgery reduced to 48 days (down 24 days in total) from the previous annual level.

These reductions in wait-times can be attributed to the hard work and ongoing commitment of our service providers that all openly offer their expert counsel with regards to volume allocations and reallocations processes, data quality improvement initiatives and methodology refinement.

On the other hand, in-line with broader Provincial trends, wait-times for MRI Scans continued to be a problem area in the Central East LHIN. In fact, the 90th Percentile wait-times for MRI Scans across the Central East LHIN in 2007/08 increased 21 days (to 112 days). In order to improve MRI wait-times, the Central East LHIN is advocating for the approval of additional MRI equipment within our boundaries.

Going forward, particularly as the Central East LHIN's wait-times strategy continues to evolve, the Wait Times Working Group's involvement will become critical in pressing for changes to practice and overall system optimizations and quality improvements. Just for example, the data quality review will result in a plan to cleanse wait lists of inaccuracies that skew wait-time data upwards. Also, the group will attempt to shift away from systems monitoring towards one of systems management which, in turn, is likely to breed innovation.

Wait Times Performance Summary

Service	90% of all Cases Completed Within					
	in Days			Current vs. Previous		LHIN Rank**
	Previous Year (April 2006-March 2007)	Current Year (April 2007-February 2008)	Provincial Access Target*	Net Change (in days)	Percent Change	
Cancer Surgery	72	48	84	-24	-33.3%	2
Cardiac Surgery						
Angiography	18	15	-	-3	-16.7%	2
Angioplasty	13	6	-	-7	-53.8%	3
Cataract Surgery	222	138	182	-84	-37.8%	12
Hip Replacement	271	264	182	-7	-2.6%	11
Knee Replacement	301	283	182	-18	-6.0%	8
MRI	91	113	28	22	24.2%	8
CT Scan	56	52	28	-4	-7.1%	10

* Priority Level 4 Access Target

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

Source: MOHLTC Health Analytics Branch.

Wait Times: Emergency Departments

Consistent throughout our community engagement process, local residents asked us to address the issue of wait times in local hospital emergency departments.

In the spring of 2007, the CE LHIN together with local hospital leadership formed the Emergency Department (ED) Task Group with the mandate to “examine internal hospital practices and strategies that will improve Emergency Department efficiency and reduce wait times.” This included patient flow practices, physician resources, team approaches to patient care, access to diagnostic services, ambulance off-load times and on-call coverage. The ED Task group was comprised of a diverse group of 17 members from a variety of health care providers and management staff from hospitals and related agencies across the Central East LHIN. Membership was selected after an extensive volunteer application process. The group selected Dr. Tom Stavro-Sholdoff (Rouge Valley Health System) as its chair and Debbie Watson (Haliburton Highlands Health System) as its vice-chair.

Through a two day project management training session sponsored by the Central East LHIN and hosted by Durham Region Emergency Medical Service, a charter was developed collaboratively by the ED Task Group, which identified the following components:

ED Task Group Vision:

“The Best Emergency Care Everywhere!”

Problem:

Increasing patient flow times for entering, treating and discharging patients through CE LHIN EDs and increasing staffing pressures.

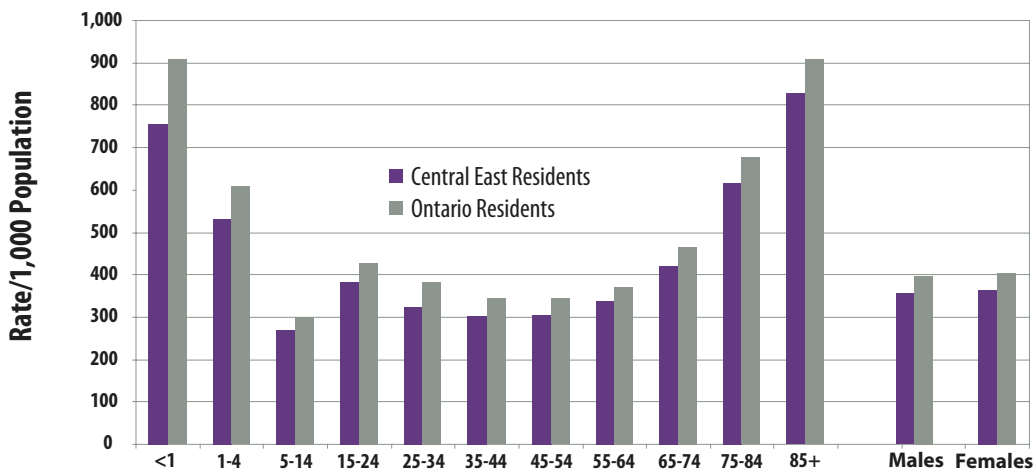
Opportunity:

To improve quality of care and patient flow and reduce wait times and staffing pressures in the ED.

Mandate:

To examine internal hospital practices and strategies that will improve Emergency Department efficiency and reduce wait times.

Age- and gender-specific emergency department visit rates, Central East & Ontario residents



Sources: Ambulatory Visits Data, Ontario Ministry of Health and Long-Term Care, Provincial Health Planning Database; Population Estimates, Ontario Ministry of Health and Long-Term Care, Provincial Health Planning Database, 2004/05.

Emergency department visits by hospital, Central East & Ontario

Area	Hospital	ED Visits
Durham	Lakeridge Health-Bowmanville	32,406
	Lakeridge Health-Oshawa	70,968
	Lakeridge Health-Port Perry	13,871
	Markham Stouffville-Uxbridge Site	12,632
	Rouge Valley Health System-Ajax Site	45,156
Haliburton	Haliburton Highlands Health Services-Haliburton	13,722
	Haliburton Highlands Health Services-Minden	13,998
Kawartha Lakes	Ross Memorial	44,541
Northumberland	Campbellford Memorial	19,956
	Northumberland Hills	27,445
Peterborough	Peterborough Regional Health Centre	85,006
Toronto	Rouge Valley Health System-Centenary	46,224
	Scarborough Hospital-Grace	36,966
	Scarborough Hospital-Scarborough General	54,650
Total Central East		517,541
Ontario		5,036,990

Source: Ambulatory Visits Data, Ontario Ministry of Health and Long-Term Care, Provincial Health Planning Database, 2004/05.

Client:

Patients

Benefits:

- Decrease ED Wait Times for Emergency Care including Off-Load Times
- Improve patient flow
- Increase patient satisfaction / Increase staff satisfaction
- Increase quality of care

Intangible Benefits of ED Task Group process:

Buy-in, support, commitment, affiliation, collaboration, integration, team building, sense of common purpose between hospital emergency departments, physicians and front-line staff.

The Task Group met over 20 times in 07/08 to develop the final report with recommendations and an implementation plan which is being prepared for completion in early summer, 2008. As part of its consultation process for the final report and recommendations, various members of the Task Group presented to planning partners across the LHIN including Collaboratives, other Task Groups and Working Groups and the Mental Health and Addictions and Seamless Care for Seniors Network Steering Committees.

Wait Times: Alternate Level of Care Task Group

Another area of growing concern for hospitals and local residents is Alternate Level of Care (ALC). An individual is considered to be ALC when, having completed their hospital or acute care treatments, they are unable to be discharged from the hospital due to a lack of accessible and appropriate community services (for example, long-term care, rehabilitation services, or home care). Not only are these clients not receiving the right care in the right place, but their pro-longed hospital stay is creating challenges in providing timely access to new patients requiring hospitalization.

The sentinel 'Percentage of ALC Days' indicator continues to trend negatively across the Central East LHIN just as in the rest of the province. Given this increasing challenge, the Central East LHIN together with local hospital leadership established the Central East ALC Task Group. This Task Group is a collaboration of 16 organizations involved in providing health care in the home, in the hospital, in long term care, and in sub-acute care settings. The ALC Task Group membership was selected after an extensive volunteer application process and includes hospitals (general and

tertiary), the Central East Community Care Access Centre, long-term care homes and community support services. The Task Group was chaired by Sheila Neuburger (Whitby Mental Health Centre) and vice-chaired by Glyn Boatswain (Rouge Valley Health System). The Task Group met over 20 times throughout 07/08 and attended a two-day project management training session in the summer of 2007 to develop a project charter.

The **overall purpose** of the ALC Task Group recommendations is to achieve better outcomes for patients who are waiting for alternate levels of care while in acute care hospitals. Better outcomes include:

- more timely moves to appropriate levels of care and fewer days waiting in hospital,
- earlier assessment of long term care needs and earlier involvement of patient and family in discharge planning, and
- enhanced community supports so that people may live in their own homes for longer periods.

Alternate Level of Care (ALC) Separations, Days, & Average Length of Stay (ALOS) by Area of Residence, Central East and Ontario Residents

Area of Residence	ALC		
	Separation	Day	ALOS
Durham	1,548	19,345	12.5
Haliburton	19	275	14.5
Kawartha Lakes	160	1,813	11.3
Northumberland	343	2,679	7.8
Peterborough	177	5,294	29.9
Toronto	1,254	15,602	12.4
Total Central East	3,501	45,008	12.9
Ontario	38,912	565,640	14.5

Source: Inpatient Discharges data, MOHLTC, Provincial Health Planning Database, 2004/05.

The **vision** developed by the Task Group:
Right Care, Right Place, Right Time

We envision a proactive system approach to ensure client/patient access to the right level of care at the right time and the right place with the right resources.

The ALC Task Group has drafted over 50 recommendations that have the potential to reduce the ALC volumes by up to 50% over the next few years recognizing that current ALC data underestimates the 'true' number of patients not receiving care in the right place and extends beyond acute care beds. Completion of the final report and implementation plan is targeted for early summer, 2008.

As part of its consultation process for the final report and recommendations, various members of the Task Group presented to planning partners across the LHIN including Collaboratives, other Task Groups and Working Groups and the Mental Health and Addictions and Seamless Care for Seniors Network Steering Committees.

Critical Care

The Central East LHIN is served by eight hospitals that provide Level III or Level II critical care services. There are four large hospital corporations which serve as the hubs for critical care in the Central East LHIN: 1. The Scarborough Hospital; 2. Rouge Valley Health System; 3. Lakeridge Health; 4. Peterborough Regional Health Centre. Services currently not provided in the Central East LHIN that impact critical care include neurosurgery, cardiac surgery, advanced trauma and burn care as well as a chronic ventilation unit.

The Central East LHIN Integrated Health Service Plan outlined this LHIN's continued involvement in the provincial Critical Care Strategy. In 2006 the Central East LHIN Critical Care Network was established. This LHIN's goals were identified in the context of a vision where the network would provide "the right care to the right patient at the right time in the right place" and to have the Central East LHIN's critical care resources working together to "function as a single system of critical care." In particular to this region, three goals were established in the Integrated Health Service Plan:

1. Intensivist-Led management model uptake at Level III ICUs (Rouge Valley Health System, Lakeridge Health, and Peterborough Regional Health Centre).
2. Health-human resource assessment.
3. "Always open" bed concept with a view to better manage local residents' critical care needs within the region, where appropriate.

Through the leadership of the Central East LHIN Critical Care Lead, Dr. Howard Clasky (The Scarborough Hospital), this region has made significant gains in improving critical care services. Notably:

- The Central East LHIN is organized as a critical care network.
- All Level III ICUs (RVHS, LHC, PRHC) are now Intensivist-Led. This is a critical success for the LHIN, health care providers and our patients.
- Northumberland Hills Hospital's Level II ICU is organized as a closed model. This is a significant success story but efforts must be made to ensure its sustainability.
- Three additional Level III beds have increased the ICU/CCU capacity at Rouge Valley Ajax Pickering hospital. Lakeridge Health Oshawa has increased to 18 Level III beds. The total number of critical care beds has increased from 128 to 133.
- ORNGE (a provincial transport service) is in the process of placing a critical care transport ambulance base in Peterborough. This will facilitate inter-facility transfers in the eastern part of the LHIN. Prior to this ambulances would only go as far as Lakeridge Health Oshawa.
- The Critical Care Response Team (CCRT) consists of health care providers who bring critical care expertise to the patient's bedside outside the ICU. A CCRT is functioning at The Scarborough Hospital (General site). A nurse-led CCRT has been implemented and internally funded by the Ross Memorial Hospital, and the Central East LHIN applauds this enhanced commitment to quality patient care!

Apr 20, 2007

Ontario Government invests in more critical care beds

The Ontario government is investing \$1.5 million so that patients will have better access to critical care services at the Ajax Pickering site of the Rouge Valley Health System.

Enabler

Primary Health Care

The best primary health care everywhere.

Community Engagement

Primary Care Working Group: 17 persons spanning the continuum of primary health care services from across the Central East LHIN.

Activities

Primary health care is frequently the first entry point to the health system for many people. Improving access to primary care services, through better integration and coordination, is a fundamental component to creating an integrated health system. The LHIN recognizes primary care as an essential cornerstone of an effective, robust health care system and the critical importance of engaging primary care providers to achieve integrated care for patients.

With the exception of Community Health Centres, much of the physician-based primary care system lies outside the accountability and funding framework of LHINs. However, making progress in our priority areas requires the development of integrated solutions and partnerships with primary care providers. There is a particular need to integrate hospital care with community-based primary health care.

To this end, the Primary Care Working Group (PCWG) was established as an on-going expert advisory body for the implementation of Integrated Health Service Plan priorities involving primary care. Membership is reflective of the range of primary care providers, practicing in rural and urban community and hospital settings including Family Health Teams, Family Health Groups, Community Health Centres, long-term care, mental health, pharmacy and public health.

Motivated by their vision “The best primary care everywhere,” the PCWG moved forward on its objectives through exploring various innovative opportunities to strengthen primary care. In 2007-08 the Working Group has been developing projects and initiatives designed to: improve access to primary care; apply innovative case management systems to streamline the patient’s journey from primary to community to specialist care; and improve access to health assessments to those without a primary care provider.

Creating a strong network amongst primary care providers within the LHIN is a core focus of the PCWG. To this end, steps to form a Primary Care Network have been initiated and the seven Community Health Centres across the LHIN have begun a collaborative and strategic dialogue. The establishment of new accountabilities with CHCs provided the opportunity for the LHIN to support the Community Engagement phase of developing CHCs and the strategic, operational and capital planning of new CHCs.

Accomplishments

Building capacity in primary care through the uptake of e-health solutions was a central objective behind the initiation of the **Timely Discharge Information Systems priority project**. The first phase of the project will improve the timely delivery of patient discharge information from hospitals to primary care providers in Peterborough and Scarborough communities. This will be achieved by reviewing and redesigning the workflow process and e-health systems to facilitate exchange of information. Lessons learned from the pilot will inform the roll-out to other LHIN communities.

Sep 7, 2007

PRIMARY CARE SERVICES TO BE EXPANDED IN CITY OF KAWARTHA LAKES

Today Foster Loucks, Chair of the Central East Local Health Integration Network, announced that the government is increasing access to community-based health care for the residents of the northern part of the Central East region, by awarding a new Community Health Centre to Community Care City of Kawartha Lakes (CKL).

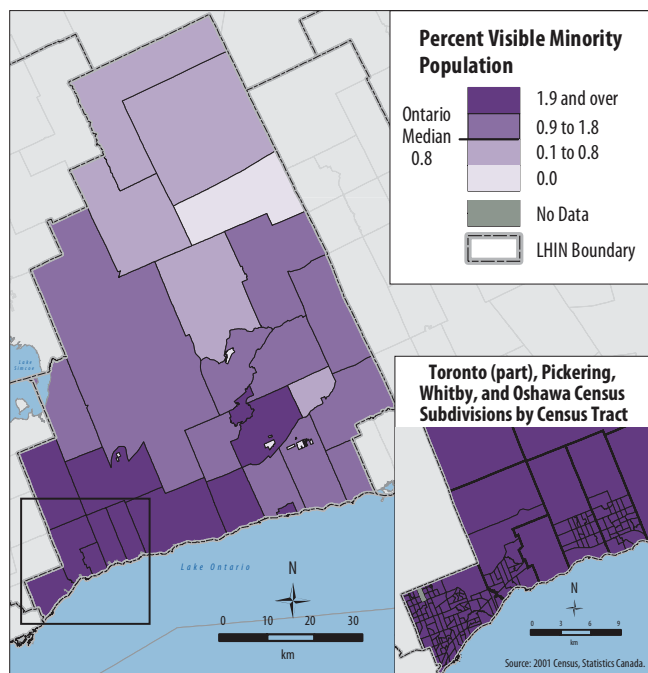
Enabler

Diversity

The Scarborough Agincourt Rouge and Scarborough Cliffs Centre Collaboratives jointly (with input from Durham West Collaborative) sponsored the **Culture, Diversity and Equity Priority Project**. This project was made possible through the use of Central East LHIN Urgent Priority Funding. A project manager has been hired and is formulating a project team and work plan aligned to the terms set out in the project charter. Key deliverables will include the following:

- Develop comprehensive diversity and equity plan for LHIN and health providers
- Will include (as identified in the IHSP) a publicly available list of services presently available to the uninsured and a publicly available inventory of existing culturally appropriate services for population groups

% Visible Minority Population



Source: MOHLTC Health Analytics Branch.

Enabler

Health Services Planning

Community Engagement

In November 2007, over 200 people providing or accessing health care in the CE LHIN came together in a 'Think Tank' to inform future **hospital clinical services planning efforts**. Health system leaders provided important information and suggestions, and identified further research needs to support future models of acute care delivery. The participants envisioned a network of acute care services that would provide the best hospital care everywhere – meaning that wherever a local resident accesses hospital services, they will be accessing the full scope of services provided across the LHIN and, indeed, across Ontario.

Activities

In August 2007, the CE LHIN Board approved the inclusion of the **Hospital Clinical Services Planning Project** as a deliverable within its 2008-2009 Annual Service Plan. The Hospital Clinical Services Plan is consistent with the priorities and objectives as set out in the Integrated Health Service Plan.

A clinical services framework and plan for a 'one acute care network' will create a vibrant and sustainable vision for all CE LHIN community hospitals – large and small. This first phase of the plan will be completed in 2008. Plans for selected services where issues of quality and access are of greatest concern, are the first priority.

It is expected that this framework and plan will:

- Promote improved quality and safety of the health care system
- Accelerate system integration in the hospital system
- Ensure fiscal responsibility of our health system, including ensuring that the hospital system is appropriately resources in the future
- Ensure that quality is in the forefront of LHIN decision making
- Demonstrate transformational leadership and innovation within the entire LHIN

At a minimum, the first five clinical services to be considered will include vascular surgery, thoracic surgery, cardiac care (including PCI), maternal and child health, and mental health and addictions services (including child, youth and family mental health). Other programs may be included based on clinical practices and evidence uncovered through the planning process.

Accomplishments

In recognition of the importance of this initiative to the Central East LHIN health care system, a nation-wide search was conducted to acquire a team of health care experts and planners to assist us as we move forward. A “Request for Proposals” was issued nation-wide and was responded to by several well-established teams across the country. Led by the Central East Community Care Access Centre, the review and evaluation process was conducted by a local panel of experts from LHIN hospitals, physician and community partners.

Enabler

eHealth

Community Engagement

Chaired by Lewis Hooper, Regional Chief Information Officer and eHealth Lead for the Central East LHIN, the E-Health Steering Committee consists of 10 individuals from health care organizations that reflect the urban and rural diversity of the Central East LHIN, a range of health care settings, community health centres, long-term care, hospitals, home care, mental health agencies and primary care.

Activities

The eHealth Steering Committee was formed in the Spring of 2007 to provide leadership in developing and implementing the LHIN-wide eHealth strategy and tactical plan to enable health care providers to leverage the potential of Information and Communications Technology (ICT). This includes the alignment of the Central East LHIN’s eHealth vision and strategic direction with the provincial and federal eHealth vision and the directions of other LHINs

Accomplishments

- Created a strategic vision for collaboration across the LHIN by creating an IM/IT Advisory group and an IT Technical Working group
- Set out a Roadmap aligned with other related initiatives within the LHIN
- Data Centre Consolidation Feasibility Study with two other LHINs
- Roll out of the Ontario Laboratories Information System (OLIS)
- Partner in Hospital Diagnostic Imaging Repository Services (HDIRS) PACS Project to share diagnostic images and reports across 33 Ontario hospital sites
- Piloted e-Referrals & Access Tracking Deployment - Client Transfer Collaboration Project (CTCP) Project at The Scarborough Hospital – to implement across all Central East LHIN hospitals
- LHIN Wide Connectivity Upgrade to provide health sector with increased bandwidth according to the individual requirements
- Ontario Drug Viewer, which enables Ontario health care providers in hospital EDs to access drug claims histories of Ontario Drug Benefit (ODB) recipients for better care, piloted at The Scarborough Hospital and expanded to other hospitals in the Central East LHIN
- Implemented an automated electronic payment service that allows individuals using the internet to make online payments.

Enabler

Back Office Transformation

In our Integrated Health Service Plan, the Central East LHIN identified Back Office Transformation as a key enabler to supporting our strategic priorities. Establishing shared services organizations are an example of what is meant by back office transformation.

At its public meeting in February 2007, the Central East LHIN Board reviewed and subsequently approved the first “notification of the intent to voluntarily integrate” under the *Local Health System Integration Act* (LHSIA).

This voluntary integration opportunity related to the establishment of a new shared services organization called the **Central Ontario Health Procurement Alliance (COHPA)**. The Alliance will include Peterborough Regional Health Centre, Ross Memorial Hospital and four other public hospitals located outside the Central East LHIN.

Effectively, when organizations agree to share services for support areas such as HR, Payroll and IT, more efficient processes and costs are envisioned. When a group of organizations agree to consolidate these services, they are able to arrange for bulk purchasing discounts. Simply put, the purchasing power of a few organizations is stronger than that of an individual organization and therefore suppliers are willing to discount their products and still maximize profits through the promise of higher sales volume.

Though in use in the private sector for more than a decade, these kinds of arrangements have become more popular in recent years within the public sector. In the Central East LHIN, the Scarborough Hospital, Rouge Valley Health System and Lakeridge Health Corporation are founding members of a shared services organization called Plexxus along with many of the larger teaching hospitals in Toronto.



LHIN OPERATIONS AND GOVERNANCE UPDATE

In keeping with our desire to transparently engage all communities in the Central East LHIN area, open board meetings have and will occur at locations throughout the region. During this reporting period, the Central East LHIN has conducted 6 successful Public Board Meetings (Kawartha Lakes, Scarborough, Minden, Ajax, Oshawa, Pickering) 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. There was one vacancy on the Board at the close of 2007-08.

Beginning in April 2007 and ending on March 31, 2008, the Central East LHIN was staffed by 20 dedicated professionals. Despite the departure of some of the founding members of the Senior Management team, the organization thrived through its unwavering commitment to the LHIN vision and mandate. The team was joined by its new Chief Executive Officer, Deborah Hammons, in November 2007.

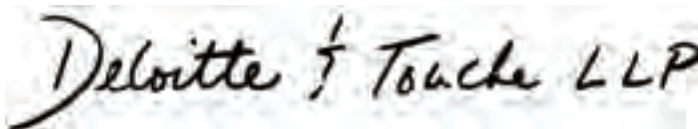
AUDITORS' REPORT

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

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

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



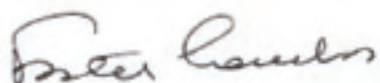
Chartered Accountants
Licensed Public Accountants
May 9, 2008

STATEMENT OF FINANCIAL POSITION

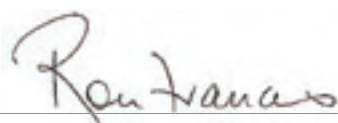
as at March 31, 2008

	2008	2007
	\$	\$
Financial assets		
Cash	1,598,513	587,980
Due from Ministry of Health and Long-Term Care ("MOHLTC")	7,013,110	-
Accounts receivable	-	281,000
	8,611,623	868,980
Liabilities		
Accounts payable and accrued liabilities	742,425	648,723
Due to Health Service Providers ("HSP")	7,013,110	-
Due to MOHLTC (Note 3b)	869,115	181,019
Due to the LHIN Shared Services Office (Note 4)	1,844	88,832
Deferred capital contributions (Note 5)	309,822	442,532
	8,936,316	1,361,106
Commitments (Note 6)		
Net debt	(324,693)	(492,126)
Non-financial assets		
Prepaid expenses	14,871	49,594
Capital assets (Note 7)	309,822	442,532
	324,693	492,126
Accumulated surplus	-	-

Approved by the Board



Director



Director

STATEMENT OF FINANCIAL ACTIVITIES

year ended March 31, 2008

		2008	2007
	Budget (unaudited) (Note 8)	Actual	Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,695,602,200	1,718,681,252	-
Operations of LHIN	3,781,106	3,741,617	3,235,703
Aging at Home (Note 10a)	-	288,000	-
Emergency Department ("ED")			
Lead (Note 10b)	-	43,800	-
Wait Time (Note 10c)	-	70,000	-
Aboriginal Planning (Note 10d)	-	20,000	-
E-Health (Note 10e)	-	475,000	281,000
Amortization of deferred capital contributions (Note 5)	-	172,200	155,150
	1,699,383,306	1,723,491,869	3,671,853
Expenses			
Transfer payments to HSPs (Note 9)	1,695,602,200	1,718,681,252	-
General and administrative (Note 11)	3,781,106	3,453,781	3,329,249
Aging at Home (Note 10a)	-	122,503	-
ED Lead (Note 10b)	-	40,043	-
Wait Time (Note 10c)	-	70,000	-
Aboriginal Planning (Note 10d)	-	-	-
E-Health (Note 10e)	-	436,194	161,585
	1,699,383,306	1,722,803,773	3,490,834
Annual surplus before funding repayable to the MOHLTC	-	688,096	181,019
Funding repayable to the MOHLTC (Note 3a)	-	(688,096)	(181,019)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

STATEMENT OF CHANGES IN NET DEBT

year ended March 31, 2008

	2008	2007
	\$	\$
Annual surplus	-	-
Acquisition of capital assets	(39,490)	(104,926)
Amortization of capital assets	172,200	155,150
Change in other non-financial assets	34,723	(49,594)
Decrease in net debt	167,433	630
Opening net debt	(492,126)	(492,756)
Closing net debt	(324,693)	(492,126)

STATEMENT OF CASH FLOWS

year ended March 31, 2008

	2008	2007
	\$	\$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	172,200	155,150
Amortization of deferred capital contributions (Note 5)	(172,200)	(155,150)
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	(7,013,110)	-
Decrease (increase) in accounts receivable	281,000	(281,000)
Increase in accounts payable and accrued liabilities	93,702	648,723
Increase in due to HSPs	7,013,110	-
Increase in due to the MOHLTC	688,096	150,553
Decrease (increase) in prepaid expenditures	34,723	(49,594)
(Decrease) increase in due to the LHIN Shared Services Office	(86,988)	88,832
	1,010,533	557,514
Capital transactions		
Acquisition of tangible capital assets	(39,490)	(104,926)
Financing		
Increase in deferred capital contributions (Note 5)	39,490	104,926
Net increase in cash	1,010,533	557,514
Cash, beginning of year	587,980	30,466
Cash, end of year	1,598,513	587,980

NOTES TO THE FINANCIAL STATEMENTS

March 31, 2008

1. Description of business

The 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 the Act.

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

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

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Region of Durham, City of Kawartha Lakes, the Haliburton Highlands, most of Northumberland County and Peterborough County. The 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). The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

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

Basis of accounting

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

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

Ministry of Health and Long-Term Care Funding

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

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

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

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

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

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as 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. The amount recorded under “revenue” in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

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

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

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

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. Funding repayable to the MOHLTC

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

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	Surplus
	\$	\$	\$
Transfer payments to HSPs	1,718,681,252	1,718,681,252	-
LHIN operations	3,913,817	3,453,781	460,036
Aging at Home	288,000	122,503	165,497
ED Lead	43,800	40,043	3,757
Wait Time	70,000	70,000	-
Aboriginal Planning	20,000	-	20,000
E-Health	475,000	436,194	38,806
	1,723,491,869	1,722,803,773	688,096

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2008	2007
	\$	\$
Due to MOHLTC, beginning of year	181,019	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	688,096	181,019
Due to MOHLTC, end of year	869,115	181,019

4. 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.

5. Deferred capital contributions

	2008	2007
	\$	\$
Balance, beginning of year	442,532	492,756
Capital contributions received during the year	39,490	104,926
Amortization for the year	(172,200)	(155,150)
Balance, end of year	309,822	442,532

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment.

Lease renewals are likely. Minimum lease payments due in each of the next four years and thereafter are as follows:

	\$
2009	124,736
2010	123,626
2011	72,540
2012 and thereafter	-
	320,902

The LHIN also has funding commitments to HSPs associated with accountability agreements.

Minimum commitments to HSPs relate to the next two years, based on the current accountability agreements are as follows:

	\$
2009	1,751,928,300
2010	1,802,562,300

7. Capital assets

	2008		2007
	Cost	Accumulated amortization	Net book value
	\$	\$	\$
Office furniture and fixtures	277,831	154,674	123,157
Computer equipment	95,829	79,574	16,255
Web development	36,100	16,474	19,626
Leasehold improvements	362,177	211,393	150,784
	771,937	462,115	309,822

8. Budget figures

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

The total HSP funding budget of \$1,718,681,252 is made up of the following:

	\$
Initial budget	1,695,602,200
Adjustment due to announcements made during the year	23,079,052
Total budget	1,718,681,252

The total revised operating budget of \$4,202,906 is made up of the following:

	\$
Initial budget as represented on the statement of financial activities	3,781,106
Additional funding received during the year for:	
Aboriginal initiative	20,000
Aging at Home initiative	288,000
ED Lead initiative	43,800
Wait Time initiative	70,000
Total budget	4,202,906

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of \$1,718,681,252 to the various HSPs in its geographic area.

The LHIN approved transfer payments to the various sectors in 2008 as follows:

	\$
Operation of hospitals	1,013,569,316
Grants to compensate for municipal taxation - public hospitals	294,975
Long term care homes	333,744,158
Community care access centres	183,460,668
Community support services	25,343,566
Assisted living services in supportive housing	10,001,649
Community health centres	8,786,926
Community mental health additions program	48,844,834
Specialty psychiatric hospitals	94,583,494
Grants to compensate for municipal taxation - psychiatric hospitals	51,666
	1,718,681,252

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

10.

a) Aging at Home

The LHIN received funding of \$288,000 (2007 - \$Nil) related to the Aging at Home project.

Aging at Home expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Consulting services	25,394	-
Salaries and benefits	73,445	-
Other	23,664	-
	122,503	-

b) ED Lead

The LHIN received funding of \$43,800 (2007 - \$Nil) related to the ED Lead project.

ED Lead expenses incurred during the year consist of \$40,043 of consulting fees.

c) Wait Time

The LHIN received funding of \$70,000 (2007 - \$Nil) related to the Wait Time project.

Wait Time expenses incurred during the year consist of \$70,000 of consulting fees.

d) Aboriginal Planning

The LHIN received funding of \$20,000 (2007 - \$Nil) related to the Aboriginal Planning project.

No Aboriginal Planning project expenses were incurred during the year.

e) E-Health

The LHIN received funding of \$475,000 (2007 - \$281,000) related to the E-Health project.

E-Health project expenses incurred during the year are as follows:

	2008	2007
	\$	\$
Consulting services	435,415	161,585
Other	779	-
	436,194	161,585

11. General and administrative expenses

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

	2008	2007
	\$	\$
Salaries and benefits	2,052,281	1,648,608
Occupancy	237,354	209,651
Amortization	172,200	155,150
Shared services	302,301	298,058
Community engagement	85,498	392,105
Consulting services	263,553	233,731
Supplies	45,994	88,896
Board member expenses	172,166	210,538
Mail, courier and telecommunications	1,213	6,155
Other	121,221	86,357
	3,453,781	3,329,249

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 19 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2008 was \$162,424 (2007 - \$90,801) for current service costs and is included as an expense in the Statement of Financial Activities.

13. 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*.

14. Segment disclosures

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



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