Mississauga Halton **LHIN**

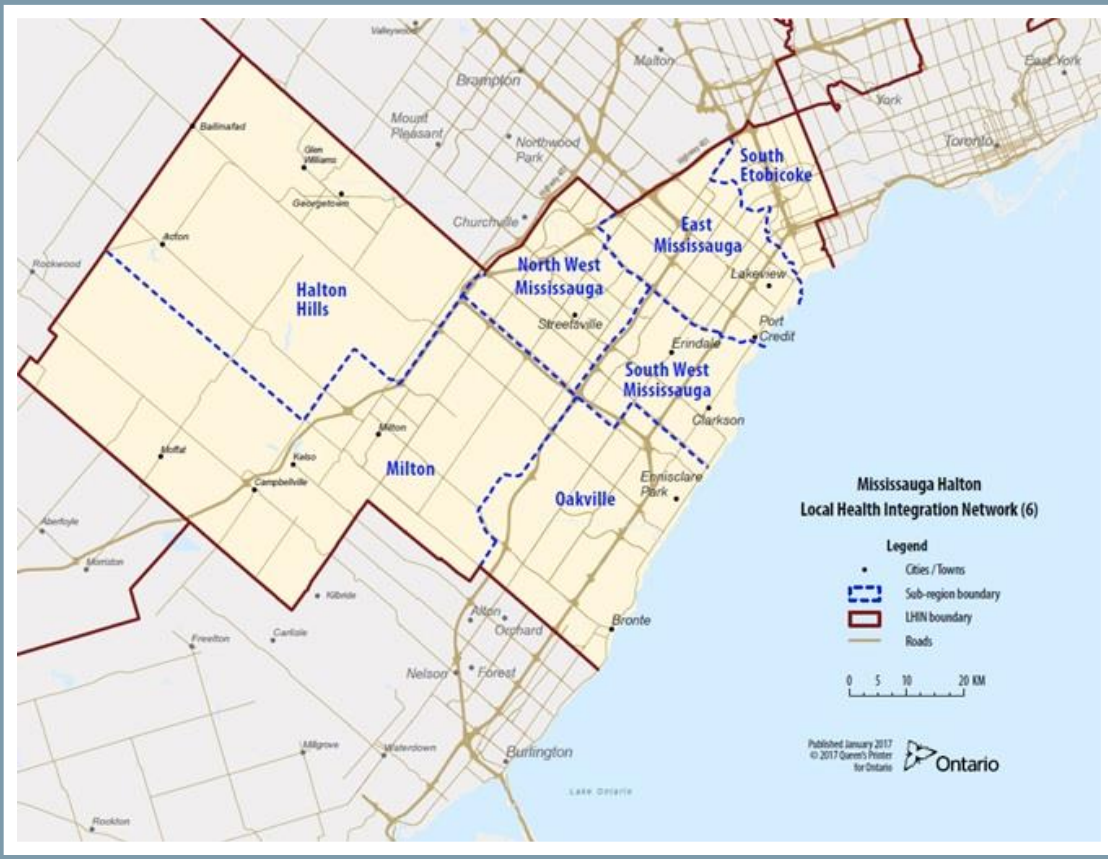
MOVING FORWARD TOGETHER

Mississauga Halton Local Health Integration Network
Annual Report 2017-2018

Ontario
Local Health Integration Network

Table of Contents

Cover: PSW Emelia, of CarePartners, makes sure all is well with patient Janet, as her daughter and caregiver, Paula, looks on.
Above: Kenneth and Mario piece together a puzzle during the "Wednesday Wellness" program at The Dorothy Ley Hospice, a volunteer-based palliative care centre.



The Mississauga Halton LHIN is divided into sub-regions including:

Halton Hills
Milton
Oakville
North West Mississauga
South West Mississauga
East Mississauga
South Etobicoke

These sub-regions are local planning regions that serve as the focal point for improved health system planning, performance and service integration.

They are the avenue for local improvement and innovation with the common objective of improving the patient experience.

MISSION

To lead health system integration for our communities.

VISION

A seamless health system for our communities – promoting optimal health and delivering high quality care when and where needed.

VALUES

The vision of a person-centred health system is built on the foundation of our values.
Quality is the framework from which we measure our success.

Respect through Compassion - We honour people
Innovative - We think forward
Collaboration - We nurture partnerships
Accountable - We take responsibility

Moving Forward Together:

A Message from the (Acting) Board Chair and Chief Executive Officer

Our region is home to more than 1.2 million residents, covers over 1,000 square kilometres, and continues to be one of the fastest growing LHINs in the province. In addition to our mandate to plan, fund and integrate our local health system, through the Patients First Act, we are now a direct provider of home and community care. As of May 31, 2017, the Mississauga Halton LHIN transitioned our organization with the Mississauga Halton CCAC to become one high-performing organization. Our Mississauga Halton LHIN care coordinators and patient-facing teams are a tremendous strength to our organization. With a continuous focus on delivering quality care to patients when and where they need it, the transition was seamless for our residents.

Additionally, transition saw the expansion of our board of governors from nine members to twelve, including two current vacancies, in order to guide the organization to work innovatively and collaboratively at a governance-to-governance level, which reinforces support from all of our partners as we move forward together.

2017-2018 marks the completion of the second year of our three-year Integrated Health Service Plan (IHSP) – which focuses on three key priorities: access, capacity and quality. Showing steadfast commitment to our priorities, we are making real progress.

In the fall of 2017, a Patient and Family Advisory Committee formed. The committee is representative of the diversity of our patients and worked alongside partner organizations and the Board to develop a roadmap for patient engagement. This roadmap will serve as a guide in all activities as we strive to improve the patient experience and embed the patient and caregiver voice in all that we do.

The Mississauga Halton Palliative Care Network is steadily improving patient and family conversations around goals of care and has established working groups with a focus on engagement, education, long-term care, patient experience and evaluation. In January 2018, an IDEAS (Improving and Driving Excellence Across Sectors) project to reduce emergency visits was accepted for implementation by the Health Quality Ontario team and is ongoing.

The Mississauga Halton LHIN is strategically focused on enhancing capacity within the long-term care sector. There are currently 10 long-term care homes and 1,344 beds that are identified for redevelopment, representing 32 per cent of the long-term bed capacity in our region. In addition, a collaborative plan was developed, and then approved by the Ministry of Health and Long-Term Care, that standardizes the regional behavioural supports Ontario program across our seven sub-regions.

As the LHIN mandate expands to a population health focus, our work on sub-region planning is concentrated on identifying and responding to each of the unique community needs. Sub-region planning has produced the foundation for more coordinated and consistent home and community care and primary care, while also serving to reduce wait times. This year the framework of how we work in partnership with our health service providers was defined and is leading our directives toward a renewed commitment to a shared culture and collaborative leadership. To support our seven sub-regions, Directors of Integrated Care are in place and working together with physician Clinical Leads to plan and optimize care coordination, and integrate home and community care with primary care. A key strategy is the alignment of staff working in service provider organizations to sub-regions, in order to localize care.

Across the organization, the 2017-2018 year saw several modernizations that are improving all priorities in our communities, including:

- ✓ Recognizing the important role peers play in both addiction and mental health treatment and recovery, the Mississauga Halton LHIN has increased peer support capacity, and invested to

support service coordination, training and development of peer support workers and supervisors. Enhancing peer support is an essential component of a more coordinated and integrated mental health and addiction system that delivers high quality care for positive person experiences and outcomes to people in our communities.

- ✓ Collaborations between Trillium Health Partners, Halton Healthcare and the Mississauga Halton LHIN are making the future of health care more viable. Working together, these key partnerships are responsible for evolving patients from hospitals to transitional spaces and to home. A three-pronged approach to the management of alternative levels of care; prevention, early identification and transition has been identified, and is proving positive as we work closely together. This year, the Bridges to Care project successfully moved 219 patients from acute care to transitional space, while 933 patients were discharged home before going to long-term care.

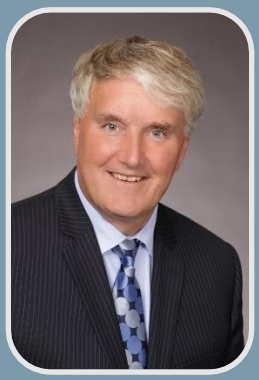
- ✓ On Sunday, October 1, 2017, Halton Healthcare opened its new three-storey building at the Milton District Hospital site, which offers a full range of clinical services including an expanded Emergency and Maternal Newborn departments.

While admittedly we were not able to achieve all objectives as suggested by ministry and LHIN accountability metrics, we have developed a Quality Improvement Plan that will ensure we continue to see steady progress even as our region faces some key demographic challenges to capacity.

The Mississauga Halton LHIN remains committed to a seamless health system for our communities. The last several months of this year have focused on the collaborative development of a renewed mission, vision and core values. While work continues on the mission and vision, our values: respect through compassion, innovative, collaboration and accountable, and the supporting behaviours that will surround them are enablers of the culture we are creating within the Mississauga Halton LHIN and that we will share with our communities. We are better equipped to identify and respond to the needs of our communities, as well as our health system leaders, primary care providers, nurse practitioners, home care coordinators and Health Service Providers as well as Service Provider Organizations. In the fall of 2017, we embarked on a collaborative strategic planning process to develop a six-year strategic plan that will serve as a roadmap for our system and our organization. The strategic plan will inform two successive IHSPs for the periods of 2019-2022 and 2022-2025.

As we continue moving forward together, our steadfast focus and dedication will result in high quality health care services to patients, families and residents in the region. We are building a system that allows for seamless transitions, for care that is more connected and one that always puts the patients and people of the Mississauga Halton LHIN at the forefront.

Mary Davies
Acting Board Chair



Bill MacLeod
Chief Executive Officer

Board of Directors

A Board of Directors who are selected by the Lieutenant Governor in Council and appointed through Order in Council governs the Mississauga Halton LHIN. The Board is skills-based, with a variety of experiences and expertise, and all are residents of the region.

Louis Girard

Role: Board Member
Resident of Mississauga
Date of first appointment: June 17, 2016
End of current term of appointment: June 16, 2019

Patrick Hop Hing

Role: Board Member
Resident of Mississauga
Date of first appointment: February 12, 2016
End of current term of appointment: February 11, 2019

Rick Johnson

Role: Board Member
Resident of Georgetown
Date of first appointment: June 17, 2016
End of current term of appointment: June 16, 2019

Kimbalin Kelly

Role: Board Member
Resident of Oakville
Date of first appointment: November 19, 2014
End of current term of appointment: November 17, 2020

Gulzar Ladhani

Role: Board Member
Resident of Oakville
Date of first appointment: November 19, 2014
End of current term of appointment: November 17, 2020

Mary Davies

Role: Acting Chair, Vice-Chair
Resident of Milton
Date of first appointment: April 30, 2014
End of current term of appointment: April 29, 2020

Rhonda Lawson

Role: Board Member
Resident of Oakville
Date of first appointment: March 22, 2017
End of current term of appointment: March 21, 2020

Joanne Rogers

Role: Board Member
Resident of Mississauga
Date of first appointment: July 11, 2017
End of current term of appointment: July 10, 2020

Sadaf Parvaiz

Role: Board Member
Resident of Oakville
Date of first appointment: August 31, 2017
End of current term of appointment: August 30, 2020

Dieter Pagani

Role: Board Member
Resident of Georgetown
Date of first appointment: January 8, 2018
End of current term of appointment: January 7, 2021

Biographies available at www.mississaugahaltonlhin.on.ca/boardandgovernance

Welcome to the Mississauga Halton LHIN

The Mississauga Halton LHIN guides ongoing and future initiatives in the development and implementation of a seamless health system for our communities.

As one of Ontario's 14 LHINs, the Mississauga Halton LHIN manages the planning and performance of the health care system, and brings greater accountability and leadership as it changes and evolves.

LHINs are the only organizations in Ontario that bring together health care partners from the following sectors — hospitals, community care, community support services, community mental health and addiction, community health centres, long-term care and primary care — to develop innovative, collaborative solutions leading to more timely access to high-quality services for the residents of Ontario, and through the Mississauga Halton LHIN for our local communities.

Through the combined effort of health service providers and agencies, the LHIN continues to innovate and support hundreds of change initiatives to improve the delivery of care, helping find better ways to provide services in the LHIN's communities.

Provincial Health Priorities

The Patients First Act, 2016, is part of the Government of Ontario's Patients First: Action Plan for Health Care to create a more patient-centred health care system in Ontario. Four key objectives are noted in Patients First: Action Plan for Health Care:

Access – provide faster access to the right care

Connect – deliver better coordinated and integrated care in the community closer to home

Inform – provide the education, information and transparency that people and patients need to make the right decisions about their health

Protect – make decisions based on value and quality, to sustain the system for generations to come

Ontario's Patients First Act includes some structural changes to the health care system that will help patients and their families access the health care they need more quickly and closer to home. The system changes will lead to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. Home and community care services are now provided through Ontario's 14 Local Health Integration Networks, while LHINs continue to plan, integrate and fund local health care.

On May 31, 2017, home and community care services and staff transferred from the Mississauga Halton Community Care Access Centre (CCAC) to the Mississauga Halton Local Health Integration Network (LHIN).

As part of the Government of Ontario's Patients First: Action Plan for Health Care, this health system change was seamless in order to ensure uninterrupted care and support for patients and home care clients.

Local Health Care Services

Mississauga Halton LHIN's funded health service providers include:

- Two hospital corporations, spanning six sites
- 32 community support service providers
- 28 long-term care homes
- 10 mental health and addiction service providers
- 1 Community Health Centre
- 14 Service Provider Organizations

Note that some health service providers deliver care and services in multiple sectors.

Sub-regions in the Mississauga Halton LHIN

The Mississauga Halton LHIN covers approximately 900 square kilometres and is divided into sub-regions including Halton Hills, Milton, Oakville, North West Mississauga, South West Mississauga, East Mississauga and South Etobicoke. A sub-region is a smaller geographic planning region within the Mississauga Halton LHIN.

Our Community

The municipalities of Halton Hills, Milton, Oakville, Mississauga (excluding Malton) and South Etobicoke (part of the City of Toronto) make up the Mississauga Halton LHIN geography. The Mississauga Halton LHIN is home to over 1.2 million residents, and continues to be one of the fastest-growing LHINs in the province, with the population growing by approximately 20,000 people each year.[1] The Mississauga Halton LHIN is projected to have one of the highest rates of population growth in Ontario over the next five to 10 years. From 2017 to 2027, the Mississauga Halton LHIN is projected to have the second-highest population growth in Ontario, increasing by 18.6 per cent in comparison to the provincial growth rate of 12.4 per cent. Over 97 per cent of the population is either within a large urban or medium population centre.[2] Aging of the population will continue to be a major theme in the Mississauga Halton LHIN in the coming years.

The Mississauga Halton LHIN has a wealth of culture due to its dynamic, diverse population demographic. Immigrants account for 45.4 per cent of residents. Nearly 45.2 per cent of residents are visible minorities, compared to 29.3 per cent for Ontario. The top five visible minorities are South Asian (including India and Pakistan), Chinese, Filipino and Arabic. Not including English, the top three languages spoken at home are Urdu, Mandarin and Arabic. Approximately 57.7 per cent of the residents in the Mississauga Halton LHIN identify English as their mother tongue, while 1.8 per cent of the population identify French as their mother tongue; 0.7 per cent of residents self-identify as Aboriginal.[3]

The proportion of residents in the Mississauga Halton LHIN living in low income is better compared to the provincial average (12.4 per cent compared to 14.4 per cent), as is the unemployment rate for both adults and youth. However, within the Mississauga Halton LHIN, there are areas that are more economically disadvantaged. For example, East Mississauga (18.0 per cent) has a larger portion of the population living below the low-income cut-off than Ontario (14.4 per cent) overall.

Our Health

From a health status perspective, the residents of Mississauga Halton LHIN are doing well, with 62 per cent reporting very good or excellent health. Compared to other LHINs across the province, Mississauga Halton LHIN residents are comparable or better in the areas of life expectancy, infant mortality, self-rated health and self-reported mental health.[4]

Mississauga Halton LHIN residents had the lowest emergency department (ED) visit rate in the province in 2016.[5] Mississauga Halton LHIN residents had 30.8 ED visits per 100 population, compared to the provincial rate of 45.6.

Although our ED visit rate is low, the number of ED visits at our hospitals has been growing steadily over the past several years (as rounded to the nearest 1,000):

- 2011–2012 = 364,000
- 2012–2013 = 373,000
- 2013–2014 = 382,000
- 2014–2015 = 392,000
- 2015–2016 = 406,000
- 2016–2017 = 418,000

The leading causes of death for Mississauga Halton LHIN residents were ischemic heart disease, dementia and Alzheimer's disease, lung cancer and cerebrovascular diseases (stroke). The leading causes of potential years of life lost for Ontario residents in 2011 were ischemic heart disease, cancer of lung and bronchus, perinatal conditions and intentional self-harm. The Mississauga Halton LHIN potential years of life lost rate is second lowest in the province and has decreased by 9 per cent since 2007.[6]

[1] 2011 Census-based Ministry of Finance Population Estimates (2011–2013) and Projections (2014–2041) for Local Health Integration Networks.

[2] Socio-Demographic Profile, by LHIN and sub-LHIN areas, Health Analytics Branch, March 2018.

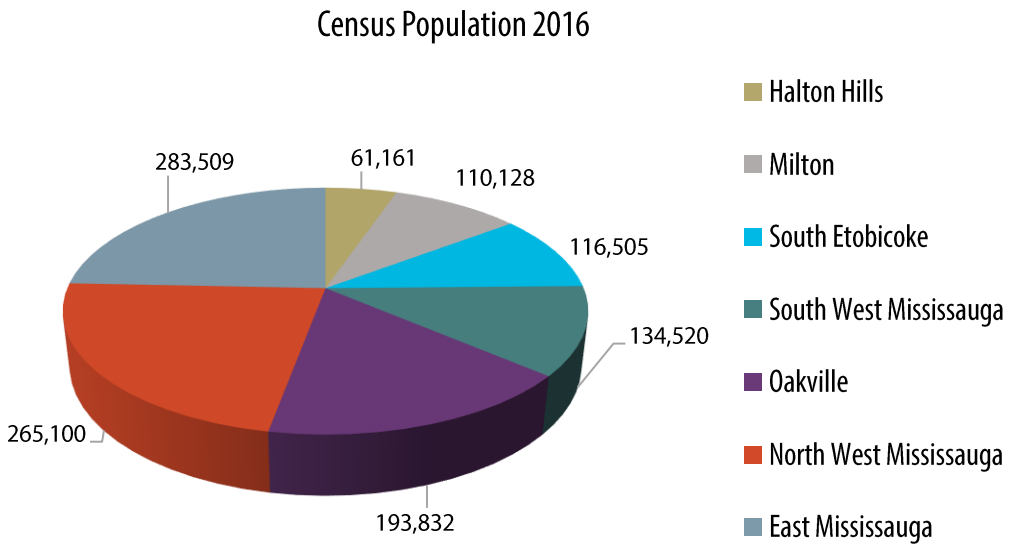
[3] Socio-Demographic Profile, by LHIN and sub-LHIN areas, Health Analytics Branch, March 2018.

[4] Statistics Canada. 2013. Mississauga Halton (Health Region), Ontario and Ontario (table). Health Profile. Statistics Canada Catalogue no. 82-228-XWE. Ottawa. Released December 12, 2013.

[5] Ambulatory Visit All Tables (NACRS, CIHI), MOHLTC, IntelliHEALTH ONTARIO.

[6] Births and mortality (2015) final, Health Analytics Branch (July 2015).

Mississauga Halton LHIN Population



Source:
Statistics Canada. Canada, Provinces, Territories, Census divisions, Census Subdivisions and Dissemination Areas tables.
Census Profile, 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Prepared by Health Analytics Branch, Ministry of Health and Long-Term Care

Funding and Operations

The Mississauga Halton LHIN received total funding of $1.618 billion in 2017–2018, mainly from the Ministry of Health and Long-Term Care (MOHLTC), to fund local health service providers as well as to fund LHIN operations. As a result of the Patients First Act, 2016, where the assets, liabilities, rights and obligations of the Mississauga Halton Community Care Access Centre were transferred to the LHIN effective May 31, 2017, including the transfer of all employees, the LHIN assumed a more comprehensive role in providing health and related services to patients.

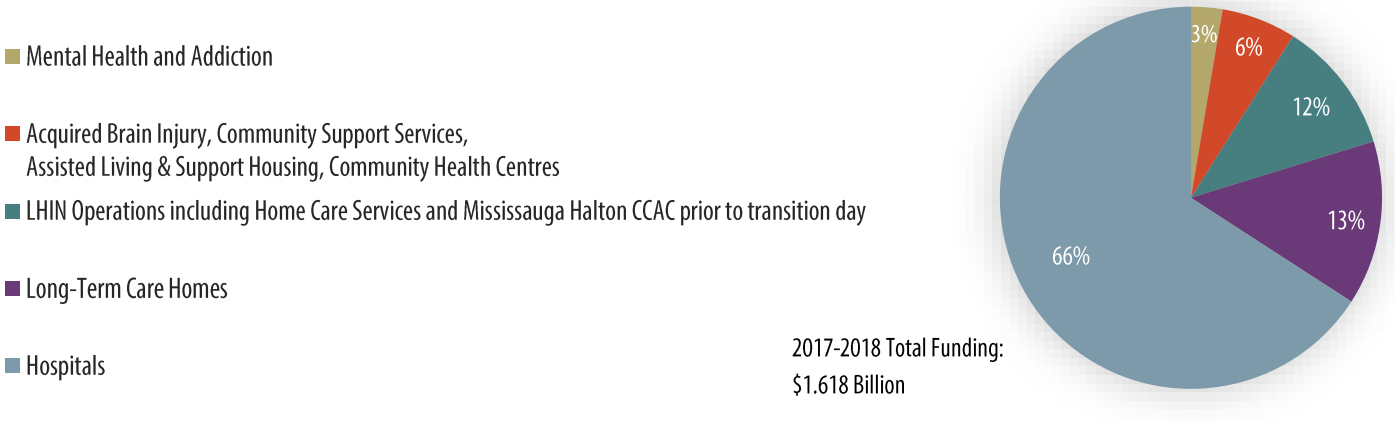
The LHIN has several operational functions, including: supporting and administering the direct provision of home care services, coordinating care for home care patients, oversight of the local health system, monitoring and managing the performance of the local health system, and planning, funding and improving the local health system as per the LHIN's mandate under the Local Health System Integration Act, 2006 (LHSIA). Through care coordination, the LHIN arranges the care that best supports the needs of each patient, including children with medically complex care needs, adults recovering from surgeries and treatments, seniors hoping to remain at home with some independence and people with life-limiting illnesses. In 2017–2018, the LHIN invested $168.7 million in home care, care coordination and medical supplies to provide care for over 54,000 patients.

Through the LHIN's service provider organizations, the LHIN delivered over three million units of services including personal support, nursing and rehabilitation.

The LHIN, as a funder, also provides leadership, accountability and performance management for the allocation of $1.447 billion of provincial health care funding to local health service providers through 70 Service Accountability Agreements. With this allocation, the LHIN ensures that the provision of health care services across the wide range of care sectors are aligned to create an integrated, sustainable system of care in the region and to advance the MOHLTC and LHIN's strategic priorities, including access, capacity and quality.

Total distribution of the funding received by the LHIN in fiscal 2017–2018, including LHIN operations and other sectors, can be broken down as follows:

2017-2018 Funding Distribution



Engaging Our Community

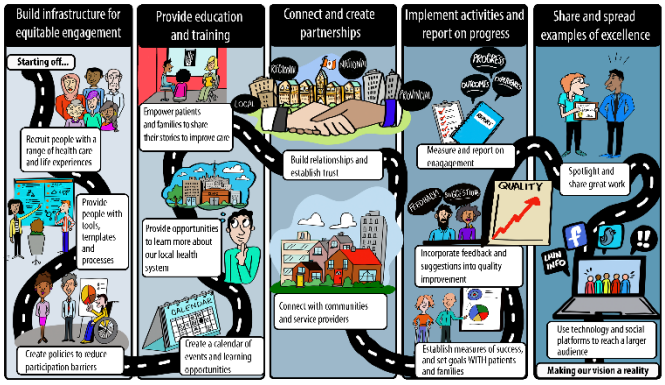
Community engagement is an integral part of the LHIN model and central to supporting LHIN decision-making. Meaningful engagement enables health system development in the Mississauga Halton LHIN to be informed by the experiences and stories of those who provide and receive care in our communities.

As a priority of the organization, the Mississauga Halton LHIN engages the community along its journey, building innovative collaborations with health care partners, stakeholders outside of health care and, importantly, patients, caregivers and their families. Over the 2017–2018 fiscal year, the Mississauga Halton LHIN held a number of engagements with all of its broader community of patients, caregivers and their family members, in addition to engagements with health service providers, service provider organizations and partners. Building on strong patient and family engagement, foundational within the LHIN, engagement efforts focused on embedding the patient voice within new and existing tables and collaborating with patients to co-design and evaluate initiatives.

In 2017, planning focused on the development of a LHIN-wide patient and family engagement strategy that would serve as a roadmap by which the LHIN will engage individuals with lived experience and its residents in the health system. A planning day was held to understand existing patient and family engagement efforts, and identify new opportunities. Several planning sessions were held with patients and family participation to understand how individuals wish to be engaged. The inaugural Mississauga Halton LHIN Patient and Family Advisory Committee (PFAC) launched in October 2017. The PFAC consists of 14 members that represent diversity in their health care journeys and residential geographies. The first task undertaken by the PFAC was the co-design of a Patient, Family and Community Engagement Roadmap. Individuals with lived experience from acute care settings, the mental health and addictions sector, Cancer Care Ontario, home care and system committees came together to develop the roadmap, and to commit to an exciting journey together.

Patient and Family Engagement Event, January 16, 2018

Empowering Agents of Change: A Roadmap for Patient, Family and Community Engagement in the Mississauga Halton LHIN



PFAC members planned the roadmap launch to coincide with National Caregiver Day, April 3, 2018. Over 110 people attended this Third Annual Patient and Caregiver Event to celebrate and acknowledge the important contributions of informal caregivers within our community. Mississauga Halton LHIN board members, patient and family engagement champions, as well as many patients, family members and individuals with lived experience participated. An increased number of patients, caregivers and individuals with lived experience participated in committees, tables and forums this year, including patient representation on our strategic planning project team, musculoskeletal central intake strategy, and primary care inter-professional care team expansion applications.

Indigenous Engagement

The Mississauga Halton LHIN is committed to working in collaboration with our urban First Nations, Inuit and Métis communities, organizations and leaders to improve access to culturally appropriate care by supporting local cultural competency training, engagement and partnership development.

The Indigenous Holistic Wellness Project: Enabling Culturally Safe and Responsive Care for First Nations, Métis and Inuit is a two-year partnership and cost-sharing initiative between the Ministry of Health and Long-Term Care (MOHLTC) and the Mississauga Halton and Central West LHINs. This innovative project is led collaboratively by Canadian Mental Health Association-Halton Region Branch, Reach Out Centre for Kids, Peel Aboriginal Network and the Métis Nation of Ontario Credit River Métis Council, and aims to improve access to culturally appropriate programming and services for Indigenous communities. Indigenous Elders, Spiritual and Traditional Healers provide culturally appropriate services such as Talking and Healing Circles and Sweat Lodges, as well as additional services offered in collaboration with the Indigenous Diabetes Health Circle. As part of this project, the Indigenous culturally sensitive training workshop "Creating Transformation in Service Settings: Getting to the Roots of Tolerance" was offered to Indigenous and non-Indigenous participants. Attendees explored models of cultural safety, and heard from Indigenous patients with lived experience about the Indigenous-specific colonial narratives that often inform dominant attitudes in Canada and continue to affect their health and well-being.

Health Service Providers (HSP) across the LHIN continue to participate in interactive, facilitated online Indigenous Cultural Safety training through ministry-funded training seats. Due to the popularity of this program, the Mississauga Halton LHIN purchased additional seats to offer the opportunity to more participants throughout the year. Working closely with an Indigenous Elder, Indigenous Cultural Competency trainings are provided at a variety of LHIN-sponsored events so that ongoing learning opportunities about Indigenous practices and knowledge continue to be shared and treaty maps of the province have been installed permanently in all Mississauga Halton LHIN offices.

Indigenous Holistic Health and Wellness project, Diabetes Clinic

Francophone Engagement

In order to improve Francophones' equitable access to health care in a minority situation, the Mississauga Halton LHIN works with community members, partners and health service providers to break down linguistic and cultural barriers. The LHIN and its partners explore potential pathways to build capacity by developing implementation strategies for the active offer of French language services (FLS).

In partnership with Reach Out Centre for Kids (ROCK), the Mississauga Halton LHIN French Language Services (FLS) Community of Practice (CoP) has grown to over 20 enthusiastic members from multidisciplinary and cross-sectoral groups across the LHIN. In collaboration with our French Language Health Planning Entity, Reflet Salvéo, and the bilingual Credit Valley Family Health Team (FHT), the CoP creates a supportive network for members. The network encourages regular connection to discuss strategies to close the identified gaps in the provision of FLS, promote FLS best practices, enhance FLS capacity of service providers, and improve equitable access to health and social services for Francophones in a minority situation. A Halton FLS Mapping Project was completed, and FLS capacity continues to evolve with two newly-created permanent positions: a bilingual health promoter at the East Mississauga Community Health Centre and a bilingual nurse practitioner at the Credit Valley FHT. These additional services will enhance an active offer of FLS to Francophones in the region.

Francophone community dinner, Trillium Health Partners, March 23, 2018

In collaboration with system partners, a very successful Francophone dinner was held in the spring when more than 70 Francophone patients, families and caregivers participated in an evening of lively discussion on FLS in the region. Comedic theatrical sketches highlighted some of the common challenges that Francophone residents experience when trying to access linguistically and culturally appropriate health care services. The LHIN continues to work in partnership to understand the experience of care through the eyes of patients in order to serve our diverse and vibrant Francophone community.

Governance-to- Governance Engagement

The Mississauga Halton LHIN Board meets on a quarterly basis with the governors and executive leaders of our health service providers (HSPs) and service provider organizations (SPOs) for Governance-to-Governance (G2G) sessions. These G2G sessions are an opportunity to engage and foster connection between the LHIN and HSPs/SPOS as well as organization to organization. The LHIN has also established a Community Governance Consultation Group (CGCG) consisting of Board Chairs and Board members from our community HSPs and two Mississauga Halton LHIN Board members. The Mississauga Halton LHIN CGCG was established to provide advice in the area of collaborative governance to advance the improvement of health system integration and coordination across the LHIN.

A highly skilled and dedicated Board of Directors that provides strong leadership to LHIN activities governs the Mississauga Halton LHIN. Passage of Ontario's Patients First Act was a milestone that laid the foundation for a significant transformation of provincial and local health care systems. The Mississauga Halton LHIN's G2G sessions this year focused on the Patients First vision, and set in motion collaborative planning and discussions with the governors and executive leaders of health service providers. In that collaborative spirit, sessions were strengthened by including the LHIN's contracted service provider organizations this year.

G2G engagement opportunities enabled partner input on the development of our six-year strategic plan. Discussions were held on topics such as identifying key success factors that would ensure the strategic plan serves as a roadmap for both the LHIN as an organization and the broader health system, opportunities for governance partnerships under Patients First and emerging LHIN values.

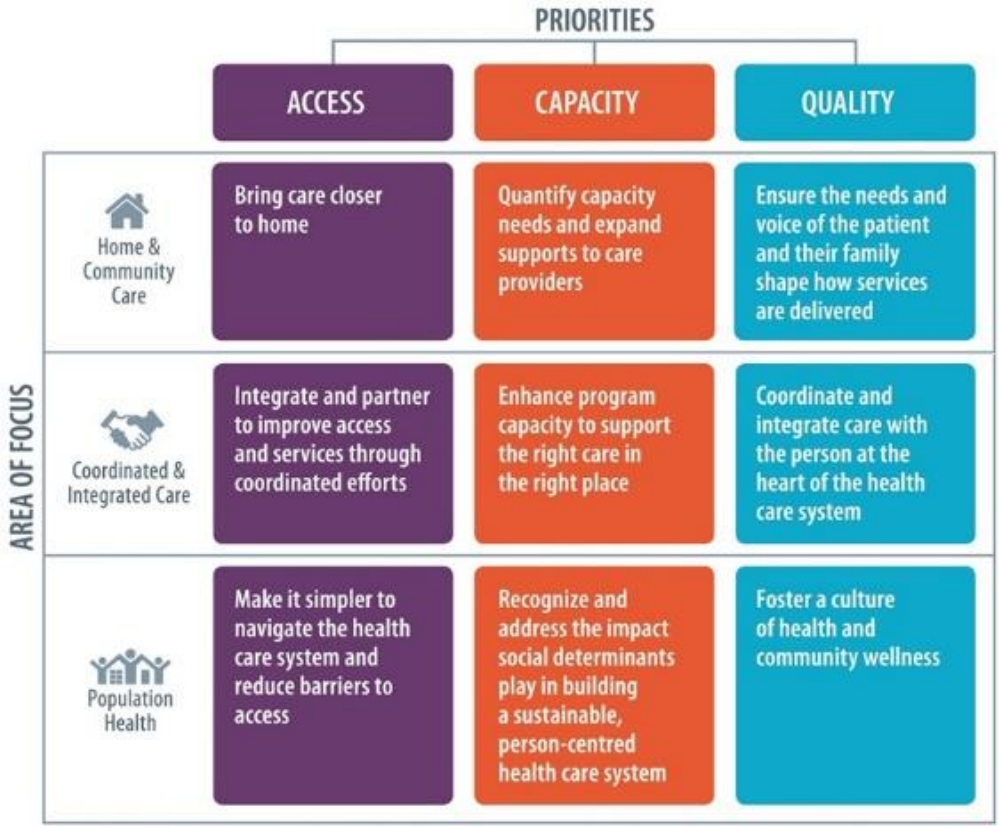
A Mississauga Halton LHIN Governance Strategic Planning Task Force was convened to serve as an advisory task force to guide the development of the 2019–2025 strategic plan. Board of Directors' guiding principles were introduced that reflect a shared vision for our local health system. The Mississauga Halton LHIN undertook a system partner survey in the fall of 2017 providing an opportunity for partners to reflect on the role of the LHIN, relationships between the LHIN and HSPs, and the opportunities for strengthened collaborations and shared system leadership. The high response rate was a clear reflection of the level of engagement and commitment of health service providers, service provider organizations, and our health system partners. Through the six-year strategic plan, and a focus on governance opportunities, the Mississauga Halton LHIN looks forward to working with health system providers, service provider organizations and partners to create a shared vision for integrated health system leadership, and collective ownership for improved patient outcomes and experience.

Key Strategic Priorities

The Mississauga Halton Local Health Integration Network 2016–2019 Integrated Health Service Plan (IHSP) is the fourth strategic plan developed by the Mississauga Halton LHIN. It builds off the successes and lessons learned over the past 10 years and leverages the strengths of local collaborative, innovative leaders and partners.

The plan represents the voices of our residents and what is needed to build a stronger system of care that focuses on the needs of the diverse people living in our community, including our Francophone and Indigenous residents.

In alignment with the provincial and pan-LHIN direction, the 2016–2019 IHSP identifies three areas of focus, with specific goals and strategies for the defined priorities in each of the three areas: Access, Capacity and Quality.



Access

Bring Care Closer to Home

Integrate and Partner to Improve Access and Services Through Coordinated Efforts

Make It Simpler to Navigate the Health Care System and Reduce Barriers to Access

José, Kenneth and Mario tend to their herb garden at The Dorothy Ley Hospice, a volunteer-based palliative care centre.

Life or Limb Repatriation Policy Evaluation

The provincial Life or Limb Policy is a "no refusal" policy for patients with life or limb threatening conditions. The guiding principles of the policy are triggered when a patient is life or limb threatened and therapeutic options exist, which are needed within four hours.

The annual Critical Care Services Ontario (CCSO) Town Hall meeting was held on October 5, 2017. It included patients and families to help inform and identify key areas of focus for critical care in our LHIN and Ontario for the 2018–2021 provincial plan. The session focused on:

- Improving patient and family experiences
- The provincial Life or Limb Policy

Improving Patient and Family Experiences

A key component in the provincial critical care plan is to strengthen the experience of patients and families in the critical care system. The framework includes the commitment to patient and family centred care for critical care users, engaging patients and families in care and monitoring patient-reported metrics. The Mississauga Halton LHIN had the privilege of interviewing and presenting a patient's journey to help inform the needs of patients and families and strengthen the system process in the transitions of long-term ventilated (LTV) patients.

The Provincial Life or Limb Policy

A review was done on the policy directions and the potential opportunities for 2017 onward. Targeted areas for focus include: ensuring that policy is informed by the Provincial Life or Limb Advisory Committee; strengthening accountability for repatriation and the One-Number-To-Call initiatives; and continuing to follow the patient journey.

The CCSO's Life or Limb Performance Management for Improving System Performance identified four key areas of focus:

1. Communications revitalization
2. Revitalizing the Life or Limb Implementation Guide
3. Renewing education for Life or Limb
4. Putting focus on issues arising from collected data

Comparing Mississauga Halton LHIN life or limb data (Q3 2016–2017 to Q3 2017–2018) reveals that the number of requests for consults increased 20.3 per cent. Further, there was a noted decrease of 15.6 per cent in Q3 2017–2018 for the number of confirmed life or limb cases, along with a 5.6 per cent decrease in the number of cases referred.

Multi-Sector Planning for Chronically Ventilated Patients

The Mississauga Halton LHIN Critical Care Network (multi-disciplinary) has developed a long-term ventilated sub-working group to advance the transition from the critical care environment directly into the community.

Chronic Disease Prevention and Management

The Mississauga Halton LHIN continues to build upon its strong collaborative relationships with provincial and regional partners to ensure LHIN residents at risk for or living with a chronic condition, have equitable access to programs and services that promote healthy lifestyles and assist with the management of chronic conditions to live with optimal health and wellness across the continuum of care.

Community Paramedicine

In the spring of 2017, the MOHLTC provided the Mississauga Halton LHIN with $312,500 in additional base funding to provide better access and support for Community Paramedicine initiatives across the Mississauga Halton LHIN.

Halton Paramedic Services, an early adopter of community paramedicine, had established a CP@Clinic model in partnership with McMasterUniversity. The CP@Clinic is a voluntary drop-in community-based health promotion program with a focus on the prevention of cardiovascular disease, diabetes and falls to empower seniors living in subsidized buildings to take action in addressing their health care needs. With funding from the Mississauga Halton LHIN, the Halton Paramedic Services was able to expand its CP@Clinic, adding two additional subsidized senior housing buildings in Oakville.

Patient and Paramedic, CP@Clinic, Oakville

In January 2018, the Mississauga Halton Community Paramedicine Advisory Committee was established to develop a plan and champion community paramedicine. Two paramedics who conducted an extensive environmental scan, literature review and current state review of community paramedicine support the advisory committee. The final report was presented to the Advisory Committee in March 2018, and included key findings and next steps for successfully integrating community paramedicine within the Mississauga Halton LHIN.

Diabetes

In June 2017, the Mississauga Halton Diabetes Alliance celebrated its first anniversary. In that year the alliance met regularly to discuss diabetes care within the Mississauga Halton LHIN and how to ensure patients at risk for, or with diabetes, receive timely access to standardized care. The Type 2 Diabetes education manual, My Diabetes Journey, was finalized and adopted by the Diabetes Education Programs across the region. The manual supports harmonized care and an education plan for Type 2 diabetes patients in the LHIN. The working group who led the development of the My Diabetes Journey underwent a one-year review in March 2018, and revisions to the educational resource based on provider and patient feedback are underway.

In the fall of 2017, the Mississauga Halton LHIN participated in the World Economic Forum Value-Based Health Care Type 2 Diabetes Management (T2DM) Pilot Project. The pilot project comprises two phases: developing a customized roadmap for transitioning to value-based health care in the Type 2 Diabetes population and the Implementation Phase. The Mississauga Halton LHIN will participate in this project over five years, focusing on the implementation of short- and long-term initiatives in order to improve health outcomes and lower costs.

Central Intake for Diabetes Education Programs

Since 2013, the Mississauga Halton LHIN central intake program has triaged over 20,000 diabetes patients and referred them to diabetes education programs (DEPs). In 2017–2018 more than 5,100 referrals were triaged to DEPs in the LHIN. The number of clients referred to education programs has increased, with over 75 per cent of all new diabetes clients referred to a diabetes education program in the LHIN.

Wound Care – Offloading Devices

In the Mississauga Halton LHIN, the prevalence rate of Diabetic Foot Ulcers (DFU) is 9.5 per cent, with an estimated 121,733 cases in 2017. To improve patient healing and access to care, Total Contact Casts (TCC) were made available to patients across the region within the six nurse-led Home and Community Care wound clinics. The program has been very successful healing wounds within six weeks, which have been open for some patients for more than three years. In response to his treatment, a patient said, "…imagine this wound has been open since May 2017, I've had I.V. treatment and wound care, but now it's healed after five weeks of TCC treatment."

Regional Meals in Home

Mississauga Halton LHIN's Meals in Home Program goal is to provide equitable access for meals in home to the most vulnerable residents. Eligibility will be determined by income and ability to move about in relation to other medical/health needs.

All Meals on Wheels health service providers' (HSP) clients have been assessed by the LHIN's central intake process hosted at central registry and led by Nucleus Independent Living. Nucleus Independent Living, the Mississauga Halton LHIN and interRAI have worked to create a first of its kind in Canada socio-economic assessment. The assessment focuses on food security to enable a standardized client-focused approach to determine eligibility, as well as other socio-economic contextual factors. The *Meals In Home*

Screener Tool will continue to assess based on its ability to determine the socio-economic needs of clients.

As a result, many existing Meals on Wheels clients did not meet the eligibility criteria for the new LHIN Meals in Home program, as they were able to afford the cost. As of April 9, 2017, identified clients, representing 4.5 per cent of previous Meals on Wheels clients, were transitioned to the Meals in Home program and are receiving meals at a new subsidized rate.

Telemedicine

The Mississauga Halton LHIN is working to champion and support a culture that uses telemedicine solutions to improve access and equity to health care services, to enhance health system capacity and to increase knowledge transfer and collaboration between health care providers in a way that will positively impact the overall patient and health care provider experience in the Mississauga Halton LHIN. Telemedicine allows providers to remotely diagnose, monitor and treat patients —and helps patients manage their illnesses through self-care and access to education and support systems. The Ontario Telemedicine Network (OTN) provides the platform and tools, programs and services that make this possible.

In partnership with OTN, the Mississauga Halton LHIN met with all LHIN CEOs to gain commitment to identify opportunities and work toward implementing OTN's solutions within the following categories:

- Video Visits
- Telehomecare
- eConsult
- Teleophthalmology
- Enhanced Access to Primary Care (EAPC) – eVisit

Throughout the 2017–2018 fiscal year, partners were consulted in order to identify gaps and issues that can be solved by applying existing OTN technology solutions. The result is a plan that will be pursued within fiscal 2018–2019.

Non-Urgent Accessible Transportation

The Mississauga Halton LHIN has developed a Non-Urgent Accessible Transportation Program, which will be implemented in a phased approach. The program will help improve access, optimize existing resources and focus improvement for complex, frail adults accessing adult day services.

In the fall of 2017, the Mississauga Halton LHIN was informed that the Canadian Red Cross Society (CRCS) will cease to offer transportation service in fiscal 2018–2019. At the same time, the Region of Peel will transition away from its existing Passenger Assist Program (PAP), also provided by CRCS. These notifications initiated the redevelopment and integration of the current transportation program to continue to serve over 2,338 clients in the Mississauga Halton LHIN. The integration will transfer up to $1,306,980 in existing LHIN funding to another health service provider to provide approximately 65,000 rides each year. The integration will transfer all the assets, existing transportation services and respective clients, including Region of Peel PAP clients served by Red Cross, to a health service provider of the LHIN, to be determined through the Mississauga Halton LHIN Accessible Transportation Program Request for Information (RFI). The RFI call specified that the new health service provider will work with the LHIN, regional and municipal transportation providers, as well as health service provider partners to modernize and integrate the existing transportation program through the development of a long-term strategy and vision for regional non-urgent transportation and passenger assist services in the region. It has been the intent, from the earliest stages of redesign, to build the foundational aspects of integration, access, partnership and simplicity into the program design.

During this period of development, the Mississauga Halton LHIN intends to ensure the best system possible for residents through a collaborative modernization. A phased timeline will be taken to support the continuity of service, while evolving to meet emerging system needs and the provision of future medical transportation services.

Health System Funding Reform

This regional group of health service providers convene bi-monthly at the Health System Funding Reform (HSFR) Local Partnership Committee to discuss local impacts and risks associated with the implementation. The work plan includes ongoing performance evaluation of quality-based procedures, opportunities for regional collaboration in areas such as case costing and health-based allocation methodology analyses, and volume planning and management.

Pilot Hip and Knee Bundled QBP

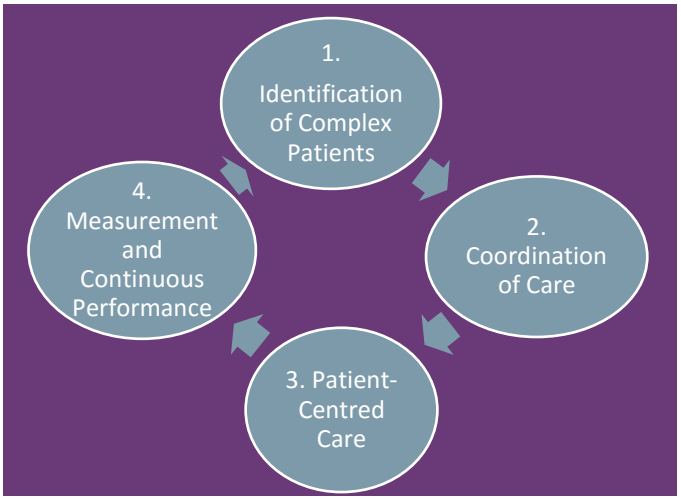
Building upon the successes of the Cardiac Care Seamless Transition bundled care project, Trillium Health Partners and Halton Healthcare are voluntarily participating in the provincial spread and scale of bundle care for patients undergoing hip and knee replacement surgery to support improved patient continuity through the care continuum. Bundled models provide a single payment for an episode of care across multiple settings and providers and incent high-quality outcomes while monitoring costs. Planning is in the early stages with full implementation expected in 2018-2019.

Health Links

The provincial mandate for Health Links is to move from a project-type initiative to an approach to care for all patients with complex needs. Therefore, these patients will get the care they need, when they need it, irrespective of the organization considered the most responsible for their care. The expectation is that Health Links will fully evolve into the sub-region planning approach within the next two years. As the Mississauga Halton LHIN works together to spread and scale the Health Links collaborative philosophy, like all LHINs across the province the organization will use the Health Links Maturity Domains —a model to gauge progress/maturity, which includes deliverables and outcomes that fall within four domains as set out by Health Quality Ontario. The Health Links approach will continue to guide community partnerships at the point of care, even as the LHIN integrates and evolves the Health Links' governance structure with sub-region planning.

Health Links Maturity Domains

The Health Links Maturity Domains are a model to gauge progress/maturity on the Health Links approach, which includes deliverables and outcomes that fall within four domains as set out by Health Quality Ontario.



1. Identification of Complex Patients

Embedding the Health Links approach for patients with complex needs within the Mississauga Halton LHIN, Home and Community Care

Moving from a Health Links program to an approach reflects the realities of the improvement in care coordinators working as a team alongside patients and their families to provide a holistic view to care, taking into account patients' clinical needs and social determinants of health. All new referrals to home and community care are assessed for complexity regardless of the referral source. Once the complex population has been established, these patients receive an intensive care management approach that involves having a coordinated care plan initiated and completed within 30 days of the initial visit along with a care conference involving more than one health professional. The care coordination guidelines of care (GOCs) were also revised to reflect the changes needed to implement the Health Links approach.

Implementing a Business Intelligence Tool within Mississauga Halton LHIN, Home and Community Care

This tool identifies high users of the emergency department (ED) at the point of intake. Home and community care team assistants and care coordinators use this tool to determine how many ED visits a patient has had and if they are a high user of the system (five+ ED visits per year). This information enables community care coordinators to prioritize these patients when delivering care.

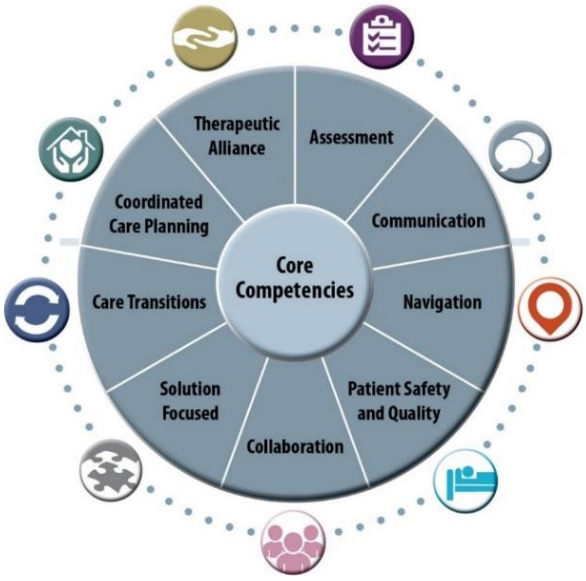
Over the past year, the Mississauga Halton LHIN home and community care has worked with all Health Links Co-Leads to establish and embed a patient identification process within each respective organization.

Inmate Community Health (INKH) Pilot Project: South Etobicoke Health Link partners worked together to improve the linkages to primary care and to care coordination for complex patients in a local detention centre.

2. Coordination of Care

Care Coordination Capacity Project

In order to provide the best quality care for patients, building community capacity for care coordination is identified as an important goal both provincially and regionally. Recognizing that many organizations are at various levels of providing care coordination to individuals, the Health Link partners asked for support in developing a Regional Learning Solution in order to provide a baseline understanding, standardization and consistency of care coordination functions across the region.



The Care Coordination Capacity Project involved the following:

1. A comprehensive review of the current state of care coordination functions across all health service providers.
2. Development of a Regional Core Competency and Practice Evaluation Framework.
3. Development of a Regional Learning Solution to support frontline staff for enhanced care coordination practice.

3. Patient-Centred Care

The patient engagement and community outreach team has recruited members of the Patient Family Advisory Committee and developed a roadmap to guide how the Mississauga Halton LHIN engages patients and caregivers. See *Engaging our Community* on page 11 to learn more.

4. Measurement and Continuous Performance

Data on current indicators (number of coordinated care plans (CCPs) and attachment to primary care plans (PCP)) continues to be collected and reported to Health Quality Ontario via Quality Improvement Reporting and Analysis Platform (QI RAP) on a quarterly basis.

Health Partner Gateway (HPG) Pilot Project

Seven organizations have volunteered to pilot use of the Health Partner Gateway (HPG) for adding, editing and sharing Coordinated Care Plans (CCPs) for patients with complex needs as part of the Mississauga Halton LHIN's Care Coordination Capacity Project. Partner access to HPG will encourage greater use of the CCP, reduce manual processes, ensure accuracy and facilitate timely sharing of CCP information among the circle of care. Learnings from this pilot will be used to inform the spread of the CCP via HPG on a broad system level throughout the LHIN.

Launch of the Mississauga Halton LHIN Health Links Dashboard 3.0

In the spring of 2018, this operational dashboard for internal use was launched. It tracks health link patient volumes and demographic as well as some process metrics at the sub-region level.

Care Coordination Optimization Project

The Care Coordination Optimization project is a continuous quality improvement initiative linked to the Care Coordination Program of Work (CCPW). The objectives are to identify further opportunities for improvement after the implementation and evaluation of the CCPW.

The Care Coordination Program of Work entailed a re-design of the care coordination approach to enable the delivery of better integrated, more consistent, patient-centred care at the neighbourhood level. In addition to an evaluation, staff identified that there were some issues and inequities within and across teams, in terms of perceived workload and associated activities. To improve access for patients, emphasis is on strengthening effective care coordination practices and improving efficiencies to enable the full value of care coordination as outlined in the Patients First transformation agenda. This project was a collaborative process, which involved regional representation from home and community care, community support services, service provider organizations, primary care, as well as patients and caregivers from the region. This project successfully enhances care coordination and is improving access by:

- Identifying waste
- Implementing quality improvement initiatives
- Improving operational processes and efficiencies within care coordination practice
- Improving care coordinator engagement with primary care and community support service providers in line with Patients First mandate

During this project many initiatives and efficiencies were identified, the topics were categorized and validated with each of the participating organizations to ensure collaborative understandings and consensus of recommendations.

Neighbourhood Forums

Seven inter-agency, cross-sector neighbourhood forums (one in each sub-region) were established to strengthen relationships among providers and serve as service resolution tables to discuss and resolve issues for specific patients to improve their outcomes and experience.

At bi-monthly forums, health and social service providers come together to share patient stories, address gaps in care plans and consider "out of box" solutions. Neighborhood Forums aim to achieve the following objectives:

- Improve the experience and health outcomes of complex patients and system performance
- Improve engagement and collaboration among the members of the circle of care
- Improve shared accountability and decision-making among providers in the circle of care
- Improve local capacity through engagement of community partners
- Identify professional development needs for all partners to enhance complexity capacity

Since March 2017, 638 participants from 37 care providers and community partners (representing both health and social service sectors) participated in 38 Forums. In total, 87 patient stories were reviewed and 116 issues addressed in support of patients with complex needs.

Regional Care Coordination Capacity Project

In order to provide the best quality care for patients, building community capacity for care coordination is identified as an important goal both provincially and regionally.

The care coordination capacity project is a collaborative initiative that was spearheaded by Mississauga Halton LHIN home and community care and health service provider partners. It involved:

1. **A comprehensive review** of the current state of care coordination functions across all health service providers. A survey was sent to 81 organizations, with an 85 per cent response rate. Findings revealed that:
   - There is significant variation in care coordination execution across the region
   - 1131 individuals provide care coordination as a function
   - There are 107 different titles and job descriptions
   - 62 per cent are regulated health professionals

   Information gathered from the survey has supported the development of the Core Competency Framework and the Regional Learning Solution, and will guide overall planning for care coordination in the future.

2. **Development of a Regional Core Competency and Practice Evaluation Framework**, which builds on the Mississauga Halton LHIN's Home and Community Care Core Competency Framework. **See *Care Coordination Optimization Project* on Page 21 to learn more**.

3. **Development of a Regional Learning Solution** that supports frontline staff to enhance care coordination practice and to support embedding the Health links approach to care within community partner agencies. **See *Coordination of Care* on Page 20 to learn more.**

Care Navigator Pilot

This Pilot Project is an initiative currently underway in Milton and Halton Hills sub-regions, which have the highest number of rural areas within the Mississauga Halton LHIN. The project aims to promote the self-efficacy of clients to navigate the health system, enhance client ability to self-manage care needs and build service system capacity to address complex needs through an integrated approach to achieving client-identified care plan goals.

Between April 1, 2017, and January 31, 2018, 61 patients participated in the care navigator pilot program. At the conclusion of patients' involvement, the majority of patients reported a significant and positive impact on their level of connection to supports indicating enhanced access to services, which will enable the achievement of care goals. Prior to their involvement with the program, patients reported feeling connected to an average of seven supports; by the end of their involvement in the program, the average number of connections to supports was 16, representing a 119 per cent increase.

Survey results following the care navigator-care coordinator partnership were very positive. Patients reported feeling:

- ✓ More connected to their support system (38 per cent increase)
- ✓ A better understanding of where to get help in the community (49 per cent increase)
- ✓ Less stress regarding their illness/issues (35 per cent decrease)
- ✓ More hopeful about meeting their future care goals (41 per cent increase)
- ✓ Less isolated (40 per cent decrease)
- ✓ More able to voice their health concerns (37 per cent increase)

Primary Care Integration

Primary Care Integration, designed to improve access to primary care and increase linkages between primary care and other health care providers, is working towards initiatives that will build awareness of health care system resources and capacity within the primary care sector.

Developing our Clinical Leaders

In June 2017, seven sub-region clinical leads joined the LHIN as part of the Patients First mandate. These roles enhance the LHIN's planning by providing first-hand knowledge of both the patient and provider experience on the front lines of primary care. Their active involvement in the co-design of the transformative model for primary care enables the LHIN to understand the local needs and be targeted in resource planning. Equipping these new leaders with the skills and knowledge to effectively engage with peers and partners in the system was a critical first step. Over the first three months, the clinical leads participated in an extensive orientation covering a wide range of topics from informational, such as the Patients First Act, 2016 and sub-region data, to tactical, such as resolving conflicts and delivering effective presentations. This investment in their growth will allow them to meaningfully contribute to system planning and develop a high-functioning team, ready for the next phase of their work.

Primary Care Advisors

Primary Care Advisors (PCAs) have now been out in the field for over three years. Having visited every primary care office in the LHIN, there is a clearer picture of the clinical interests, practice styles and preferences of primary care physicians in our LHIN. With this understanding, physicians are invited to contribute to the system in ways that align with their interests and expertise. This has included providing care to a specific patient population such as refugees and participating in committees designing changes to the palliative care system.

As PCAs continue to support primary care providers to stay current on the latest resources, they are now

embarking on sharing information in greater depth — focused on sharing the evidence, best practice and, most importantly, exploring with physicians how to individualize this information to the physician's practice in an effort to ensure the information is translated into their practice. This approach is yielding better uptake of resources.

The team is also working in partnership with the Centre for Effective Practice (CEP) as they launch an academic detailing program initially focusing on non-cancer-related pain. The team is supporting CEP by making warm connections with physicians, leveraging the PCAs' existing relationships with physicians. The team is also coordinating the content delivered so that any local resources or supporting tools related to the topic are shared concurrently.

Primary Care Network

Primary Care Network
MISSISSAUGA HALTON

The Primary Care Network (PCN) — which aims to build collegiality and integration amongst primary care providers, — recognized the significant impact the transformation efforts targeted at primary care would have on the sector. As such, network members felt it was critical to focus energies on maintaining the joy of practice. The network began exploring opportunities to offer mentorship for new physicians and to enhance physician wellness. Updating resources on the PCN website was also a focus to ensure easy access to needed resources on a single site.

Doctor's Lounge

Since many primary care physicians no longer hold active privileges at hospitals, the connection between primary and specialty care is deteriorating. To address this gap the Primary Care Network hosted the "Doctor's Lounge." This event was designed to bring primary and specialty care providers together, akin to the days when they interacted regularly in the hospital's doctor's lounge. The event provided an opportunity for 40 specialists and primary care physicians to network and collaboratively discuss solutions to improve both access to specialty care and the integration between primary and specialty care. The Primary Care Network has now hosted two Doctor's Lounge events, with the second highlighting the specialty services available to physicians at the Oakville Trafalgar Memorial Hospital.

Primary Care Clinic Day

The Mississauga Halton LHIN hosted its fifth Primary Care Clinic Day on February 28, 2018, with over 200 registrants. This year the program focused less on clinical capacity and more on physician wellness with a practical session on mindfulness and fostering office efficiencies by highlighting how to optimize electronic medical records and use apps to organize medical resources. Primary care providers always welcome the opportunity to connect directly with their colleagues and learn more about the services available in the region.

Primary Care Clinic Day, February 28, 2018

Mississauga Integrated Care Centre

The 2017 Ontario budget included a commitment of $15.5 million base funding in 2017–2018 and an additional $27.8 million base funding in 2018–2019 to support the expansion of interprofessional care teams so that all 76 sub-regions across the province have a team. The intent of the funding is to improve access to team-based primary care through broader geographic coverage commensurate with need. The interprofessional primary care teams will be the local platforms to support primary care-based innovation and engagement to further Patients First priorities.

Funding for 2017–2018 targeted those sub-regions across the province with the lowest rates of team-based primary care. In the Mississauga Halton LHIN, three sub-regions were successful in securing funding: East Mississauga, North West Mississauga and South West Mississauga. South West Mississauga was successful in securing additional funding for 2018–19. In total, the Mississauga Halton LHIN secured a total of $6.2 million through this funding process.
The Credit Valley Family Health Team will be providing leadership for the development of the expansion of the interprofessional primary care team in North West Mississauga. In South West Mississauga, no team-based primary care currently exists. This necessitated the development of the Mississauga Integrated Care Centre, a new health service provider, which will provide leadership for the development of two sites containing interprofessional primary care teams: one in South West Mississauga, the other in East Mississauga. All new funding will provide supports and services to physicians and patients who do not currently have access to team-based care.

The development of these new or expanded teams affords the Mississauga Halton LHIN the opportunity to truly be innovative, turn to best practices and shape a new model to achieve the goals of primary care transformation. These teams will foster teamwork between the allied health team and physicians across the sub-region from a variety of payment models. Services will be designed to meet the needs of the local community using a population health approach. Best practice scans and literature reviews are being used along with co-design to inform the planning of the physical spaces. The Mississauga Integrated Care Centres envisions being the prototype for optimal delivery of team-based care primary care.

Addiction and Mental Health

one-Link

Mississauga Halton LHIN's one-Link enables equitable access and coordinated care to make it possible for people to receive the right addiction and mental health care, at the right time and in the right place. Development and implementation of one-Link is ongoing.

One-link has seen a 13 per cent increase in referrals from 2016–2017. To ensure better access to care, the program now includes a pre-screening question of preferred language to ensure the choice is reflected and an interpreter and cultural broker can be scheduled for a patient's one-Link screening. one-Link introduced an active offer of screening via the Ontario Telemedicine Network (OTN) for all clients to provide the choice of phone, OTN or in-person appointments. Working with partners at Links2Care to expand access to service in North Halton, 10 weekly appointment slots with service coordination are now offered in the Georgetown space. In addition, one-Link has expanded to offer service on Saturdays along with appointment booking, service coordination and peer mentoring. In order to build equitable access, client preference for these appointment slots are being monitored and may be scaled up as demand and feedback is reviewed. Family members/supports of individuals screened by one-Link are successfully completing the Safe Talk three-hour training for providing suicide safe talk. These groups run two sessions per month and were completed by 125 individuals. As well, 34 people participated in the cognitive behavioural therapy skills group, which is offered weekly to teach self-management while waiting for case management and/or psychiatric consultation.

The total number of new individuals screened by the one-Link service coordinators has been the focus for continuous quality improvement through daily team huddles addressing wait time to screening as well as scaling standard operating processes targeting zero waste in available clinician time. Between October 1, 2017, and March 31, 2018, this system eliminated 208 hours of potentially wasted clinician time, allowing this time to be filled as appointments with people awaiting service.

One-Link mentors launched the Ask a Peer e-mail on the one-Link website to encourage individuals who are interested in seeking peer support as a first step to reach out. The peer mentor team at one-Link offers individual support along with group sessions that focus on community connections and supporting people in overcoming barriers to accessing the many mental health and addiction-based supports that exist in the community. Further to this, and grounded in client feedback, is the start of a community connections group that runs twice weekly and is facilitated by peers to further remove barriers to following up with recommended services and supports provided during one-Link service coordination.

Sustaining Peer Supports

Peer Support plays an important role in both addiction and mental health recovery. In 2015, Mississauga Halton LHIN increased peer support capacity by adding services to 11 mental health and addiction HSPs. The Mississauga Halton LHIN has also invested in supports to maintain the effectiveness of new and existing peer support in our region through coordination of services, best practices support for HSPs hiring peer support workers, and providing ongoing training and development of the peer support workers and their supervisors.

The Sustaining Peer Supports Team developed an instrument designed to collect information to evaluate the integrity, quality and outcomes associated with values-based peer support as perceived by people receiving peer support service. Taking a rigorous approach, the team has consulted with several academics and researchers for guidance, resources and support. Using the experience and best practices of this input, the LHIN is developing further research protocols and advancing peer support practices in order to improve access for residents of the region.

The Mississauga Halton LHIN is also working to move forward together with our provincial partners. The substance use and provincial systems lead continues extensive engagement and alignment with initiatives currently influencing system change such as the Ministry of Health and Long-Term Care Leadership Advisory Council's Lived Experience Reference Panel, Health Quality Ontario's Opioid Disorder Quality Standards Advisory and co-chair of the HQO Patient/Caregiver Resource Development Advisory.

Partners and organizations recognized several Mississauga Halton LHIN supported projects for their advancement of practices in peer support. They include:

- Sustaining Peer Supports Initiative
- The Enhancing and Sustaining Peer Support Initiative (led by Support and Housing-Halton)
- TEACH (led by Support and Housing-Halton)

2017 Ontario Peer Development Initiative, Lighthouse Innovators Award recipients. Support and Housing Halton's Enhancing & Sustaining Peer Support Initiative Staff, Betty-Lou Kristy and Christina Jabalee

Peer Support Strategic Re-alignment & Rebranding

The Enhancing and Sustaining Peer Support Initiative has now re-branded to the Centre for Innovation in Peer Support. TEACH will continue to offer the same tremendous programming across the Mississauga Halton region. The centre will also continue to do the excellent work it has been doing with all regional, provincial, national and international partners. The centre and TEACH (both embedded in Support and Housing Halton) will continue to work closely together. The leadership team was restructured to support the future direction and growth of the centre.

Centre for Innovation in Peer Support Team

The team recognized the need to emerge with a more comprehensive footprint and to continue to lead transitional change in the areas of Training, Implementation, Evaluation and Research, Capacity Building, Knowledge Brokerage and Quality Improvement. The work is focused in seven areas of

critical reflection: Person-Directed Services; Developing a New Role in a System, Emergence, Governance, Service Integrity, Communities of Practice and the marrying of all these areas. These will be embedded through six identified areas of influence and impact: Persons Engaging Services, Peer Support Workers, Peer Support Supervisors, Health Service Providers Providing Peer Support, Mississauga Halton LHIN Addiction and Mental Health system and overall healthcare system transformation. This will create strategic opportunities to influence the regional, provincial and national landscapes, and represent the innovative, well-researched and evidence-informed work to date.

Peer Position Supervisor Network

All staff-supervising peers in our region and several outside of the region continue to meet regularly. The network is working on developing additional guidelines to support the consistency in peer work roles across the region. Their current work involves the development of guidelines for internal and external promotional material content regarding peer support workers and guidelines for peer worker documentation.

Peer Supervisor Training

Peer position supervisors took part in four training sessions. All current supervisors in the Mississauga Halton LHIN are trained, including staff from outside of our LHIN region.

Peer Position Network

All peer positions continue to meet on a monthly basis in both the Halton and Mississauga locations. The agendas are set based on a collaborative priority setting from participants. The most recent workshop was on Mindfulness. The networks are working towards shared leadership and responsibilities amongst group members toward hosting, facilitating and setting the agendas.

Peer Staff Core Skills Training

Trainings continue to take place throughout the year for newly hired peer workers and to help provide a refresh to workers who have been in the field for two or more years.

Community Addiction Liaison to the Emergency Department (CALED)

The Community Addiction Liaison to the Emergency Department (CALED) initiative involves identification of individuals and family in the emergency department (ED) by the crisis teams and community addiction personnel being called into the ED to provide warm transfers to community addictions and mental health support services and programs.

Community Addictions Liaisons to the Emergency Department (CALED) Program continues to evolve at Halton Healthcare. CALED community staff are working closely with other hospital staff in a shared space in the emergency department (ED) to build bridges and increase awareness and referrals to the CALED Program. Opportunities to better align the CALED Program with other available Crisis Services Programs are being examined to best support patients. Anonymous data collection from all clients seen by the CALED Program continues. The purpose of this data collection is to better understand the population that is being seen at the emergency department for addictions. This online questionnaire is focused on the need for Residential Withdrawal Management Services and the barriers and opportunities in the system. Monthly reports are generated and sent to all participants of the Addiction Services Expert Panel (ASEP) for review, discussion and identification of quality improvement opportunities. The CALED Collaborative Agreement between the three community CALED service providers (ADAPT, PAARC and PCHS) and Trillium Health Partners (THP) was launched this spring at THP's Mississauga Site. CALED staff have been oriented to THP M-Site ED and completed all documentation required to access the facilities for the purpose of this program. The Addiction Services Expert Panel will be able to better understand and plan to support addiction clients presenting in the EDs once CALED is operational at THP, and will collect and combine data from Halton Healthcare with data from THP.

"Every Door is the Right Door" Service System

Through the No Wrong Door philosophy of care, providers are embracing a shared commitment to work collaboratively to help people with mental health and addiction challenges access the right service at the right time, adopt common values and objectives, and provide exceptional customer service.

No Wrong Door – Best Transfer Protocol Initiative

Under Peel Addiction Assessment and Referral Centre's (PAARC) leadership, partner agencies participated in the Advanced Quality Improvement Program with IDEAS (Improving and Driving Excellence Across Sectors) to test some of the innovations that were proposed in the No Wrong Door – Best Transfer Protocol. The Peer Program at Canadian Mental Health Association's Halton Region Branch (CMHA-HRB) was used for this applied learning. The aim was to reduce the "Did not attend" rate by 30 per cent from the baseline, by March 31, 2018, and saw the rate at an absolute zero during January 2018. CMHA-HRB will attempt to sustain these gains through continued monitoring and course correction in the Peer Support Program. The team graduated from the IDEAS advanced learning program and will assist others working on quality improvement initiatives. A technical change employed in this applied learning was the implementation of 72-hour reminder calls to clients before their scheduled appointments. When providing feedback on an experience with this change, a client with complex needs stated, "When my worker started to call a few days before my appointment, I stopped missing my times with her. Often I feel so scattered and anxious that I would miss my appointment. Now I meet my worker regularly and as a result I am able to meet my goals."

No Wrong Door – Building Bridges Initiative

During this phase of the work, called Building Bridges, the No Wrong Door initiative focused on improving continuity of care across the system. This is the first time the initiative has worked across sectors (hospital and community) with Halton Healthcare and CMHA Halton Region Brach (HRB) as co-leads. In this phase, the continuity of care model was employed with a focus on informational and relational continuity across sectors focusing on improving communication amongst the service providers so that where possible and agreed to by the client, all service providers are aware of the client's current needs. In addition, work focused on educating clients and families to equip them with the tools necessary to access the right service providers in their journey. The Canadian Foundation for Healthcare Improvement was used to guide this work.

Some gains made during this phase of the work include but are not limited to:

- Collecting health card numbers for clients at CMHA-HRB
- Sharing waitlist for the Case Management program at CMHA-HRB with the hospital
- Educating the clients and families to inform the hospital they are connected with a case manager in the community and provide contact details, if they wish
- Asking clients about any hospital visits since their last visit to better understand clients' needs and how they can best be met in the appropriate level of care
- Defining a process at CMHA-HRB Intake and Referral to respond to the hospital in a timely manner for any queries related to existing case management clients
- Providing the hospital all CMHA-HRB case managers' contact information
- Minimizing use of acronyms wherever possible to maximize clarity and communication

Regional Practical Clinic

The Mississauga Halton LHIN's Regional Practical Clinic offers three levels of psychotherapeutic intervention, matched to patient need, adapted from Cognitive-Behavioural and Mindfulness-Based approaches to treat symptoms of depression, anxiety and high stress.

Individuals referred to the practical clinic through one-Link begin with a structured assessment, which includes completion of standardized scales to establish a baseline of symptoms. A treatment plan is developed and referral to a nurse practitioner for medication consultation is available.

Regional Practical Clinic Services

1. Structured Psychotherapy
2. Group-Based Medical Visits

Regional Practical Clinic Data

Between October 2017 and March 31, 2018, 695 clients were assessed in the practical clinic, filling 241 group sessions with 1,537 visits.

Opioid Strategy

Mississauga Halton LHIN's strategy to prevent opioid addiction and overdose enables an urgent response to the opioid crisis by building equitable and accessible service capacity for addictions treatment and supports across the region.

The ministry has provided base funding to all LHINs in fiscal 2017–2018 to respond urgently to the opioid crisis by building service capacity for addictions treatment and supports across the province. After a jurisdictional review, consultations with HSPs, persons with lived experience and Pan-LHIN colleagues, the recommendation was to expand the capacity of selected existing addiction services. This is based on priority of need that will support additional psychosocial treatment capacity, community withdrawal management services, mobile outreach of addiction supports into the community and enhanced trauma-informed, recovery-oriented, harm-reduction before-and-after care to prevent overdose deaths and promote prevention of relapse. The Mississauga Halton LHIN's Board of Directors approved opioid funding on October 5, 2017. HSPs that were approved for funds were engaged individually to discuss role types, functional centres and ministry reporting requirements. Persons with lived experience were also engaged to discuss the implementation plan, rollout and innovative models of care.

Alongside this work, Mississauga Halton LHIN has been involved in provincial ministry-led opioid health system coordination emergency management teleconferences, public health consultations, LHIN home and community care professional practice supports for opioid use (prescription and non-prescription) and consultations with Health Quality Ontario for the quality standards for opioid prescribing for primary care.

Mississauga Halton LHIN Opioid Capacity Project

This project focused on capacity building of LHIN-funded addiction and mental health agencies to provide appropriate treatment services to individuals and their families who are affected by opioid use. Agencies were engaged with the LHIN to review and design a coordinated model of care for opioid addiction. Regional partnerships and coordination mechanisms were enhanced to the point that the project gains can be handed off to the coordinating body to sustain a regional system of care for individuals and their families and supports impacted by opioid use. Several deliverables were identified for the project including:

1. Reporting Support, Set Up and Data Collection
2. Service Alignment and Coordination of Care (ADAPT Lead Agency)
3. Opioid-Use Staff Training
4. Family member and significant other outreach education and training
5. Health Equity Impact Assessments
6. Human Centred Experience-Based Design

Improving Access and Flow Across Continuum of Care

Patient Access and Flow Steering Committee

Capacity is the single most important issue facing our LHIN when it comes to the provision of hospital and home and community care. Unprecedented numbers of Alternate Level of Care (ALC) patients being cared for in hospitals is among the top issues that must be urgently addressed. ALC avoidance and management strategies must be optimized and coordinated from across all hospital and home and community care partners. The strategies identified for this project were developed in collaboration between Mississauga Halton LHIN, Trillium Health Partners and Halton Healthcare who are working closely together for the success of this project.

ALC Management Team, Halton Healthcare

ALC Management was identified as a top priority for the Mississauga Halton LHIN; a three work stream approach was identified:

1. Prevention: Focus on community interventions to sustain patients in the community longer and avoid unnecessary visits to our Emergency Departments.
2. Early Identification: Focus on early identification of patients at risk for becoming ALC in acute care.
3. Transition: Focus on the transition of patients from acute care to their discharge destination.

Bridges to Care

Bridges to Care provides overnight accommodation in either a retirement community or community support service for patients no longer requiring medical intervention and are waiting to return home or transition to Long-Term Care. Mississauga Halton LHIN service providers and community support services deliver individualized supports.

The focus of Bridges to Care is to provide short-term enhanced supports in the community to support safer and smoother patient transitions from hospital to home, where "home" could be a long-term care home, retirement home, assisted living facility or a personal dwelling. This program was implemented in February 2017, with additional beds being added in December 2017. In total 219 patients were transitioned from acute care to transitional space.

Capacity 99

As part of Bridges to Care, the Capacity 99 initiative saw the transition of patients to post-acute spaces, including Bridges to Care as well as 2 North Milton. This project was a collaborative effort including the Mississauga Halton LHIN, Trillium Health Partners and Halton Healthcare.

My Way Home

Also part of the Bridges to Care program, the My Way Home initiative resulted in an increased volume of patients being discharged. In total, 933 patients were discharged home over the course of the year, with an average of 78 patients per month. This program provides in-home and community health care services for our patients who:

1. Are undecided about where they want to live in the future (e.g. retirement home, long-term care home, at home with supports) and wish to remain at home while they take some time to decide.
2. Have applied to long-term care home, and require additional support while they wait at home for placement.

Capacity

Quantify Capacity Needs and Expand Supports to Care Providers

Enhance Program Capacity to Support the Right Care in the Right Place

Recognize and Address the Impact Social Determinants Play in Building a Sustainable, Person-Centred Health Care System

A friendly visit between Walwe Villa Seniors Centre resident Anne-Marie and Mississauga Halton LHIN Care Coordinator Cornelia.

Regional Integrated Seniors Care

Mississauga Halton LHIN's Regional Integrated Seniors Care Model aims to enhance seniors' health and quality of life by supporting seniors to stay healthy and at home longer through a person-focused integrated accessible and sustainable system of care. The work aligns with provincial priorities, regional Older Adult Plans and the Mississauga Halton LHIN's Integrated Health Service Plan. The Seniors' Strategy Steering Committee works closely with existing committees and working groups associated with the delivery of seniors' care.

An integrated senior's care model has been developed and it is hoped to be co-located with the Mississauga Integrated Care Centre. The model was developed with the key elements of PACE - Program for the All-Inclusive Care for the Elderly. The model:

- Is a community-based day program with all necessary medical services to frail elderly persons to enable them to remain living at home instead of in an institution for as long as possible
- Coordinates and provides a "one-stop shop" for all necessary medical, restorative and social services

This integrated senior's care model provides:

- Active living environment in an adult day program setting
- Interdisciplinary team of professionals to provide holistic (medical/psycho-social), highly coordinated integrated community-based care and services
- Coordinated care, including clinical and resource integrations with the primary care team. This will minimize linkages and improve access for clients, patients and healthcare providers
- Close monitoring with multiple and consistent touch points
- Real-time information sharing
- Shared health record information
- Proactive, preventative care
- Caregiver Support

Mississauga Halton Palliative Care Network

Established in July 2015, the Ontario Palliative Care Network (OPCN) is a formalized provincial network tasked with implementing the provincial strategy for palliative care outlined in the Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action. To support the evolution of palliative care in Ontario, and to align with the Ontario Palliative Care Network's provincial strategy, the Mississauga Halton Palliative Care Network was formed. With reporting accountability to both the CEO of the Mississauga Halton LHIN, Bill MacLeod and the Regional Vice-President of the Mississauga Halton Central West Regional Cancer Program, Leslie Starr, the Mississauga Halton Palliative Care Network has executive-level representation from stakeholders across our region. The Mississauga Halton Palliative Care Network (MHPCN) builds on existing structures to create capacity and improve the quality of palliative care across our community.

In May 2017, the Mississauga Halton Palliative Care Network (MHPCN) launched three key working groups: the Primary Care Engagement, Education, and Long-Term Care (LTC) working groups. More recently, two additional working groups, the Metrics and Evaluation and the Caregiver Voices Survey working groups were developed. The MHPCN worked closely with the Ontario Palliative Care Network (OPCN) and set three-year local targets for three of OPCN big-dot metrics. In addition, in May to September 2017, the network developed its three-year Strategic Work Plan and Clinical Leadership Work Plans. The MHPCN completed the Innovative Models of Community Palliative Care for Vulnerable and Underserved Populations Project, which examined the need for palliative services for the homeless population in the Mississauga Halton LHIN. As part of the project, three workshops were held between November 2017 and February 2018 with over 30 community partners and relevant stakeholders at each session to assist in identifying the needs of this population. In January 2018, an IDEAS (Improving and Driving Excellence Across Sectors) project to reduce ED visits by October 2018 from 38.6 per cent to the provincial average of 23.8 per cent at the Mississauga Extendicare Long-Term Care (LTC) Home was successfully accepted for implementation

by the Health Quality Ontario team and is currently underway. Multiple education and training sessions were provided over the past year including LEAP (Learning Essential Approaches to Palliative and End-of-Life Care) for 108 primary care providers nurses in the community and LTC sectors. Three physician palliative care and end-of-life seminars were hosted and were attended by 75 primary care providers from across the region.

Mississauga Halton Palliative Care Network Staff

Networking, educational and relationship-building activities with community partners have been ongoing throughout the year. Primary care providers, working groups, quality tables, steering committees and other partners attend these many sessions to further our knowledge exchanges and continue to build upon our already strong collaborative efforts. In order to engage with our Indigenous partners, the palliative care network attended a First Nation Palliative Knowledge Exchange in March 2018. All of these efforts help provide an understanding where we can work together on common interests and priorities to benefit patients and families with palliative needs including those with multicultural and diverse beliefs and practices.

This past year a Primary Care Capacity Survey was conducted. The results will help the network to understand the needs of primary care physicians and how to best support them in providing palliative care and connecting them to specialty palliative providers. An agreement for 24/7 specialist support for primary care across the LHIN was established and specialty teams have enrolled for e-consults on the available platforms including Champlain Base e-Consult.

Medical Assistance in Dying

In June 2016, the Canadian government passed Bill C-14, which gives dying patients, who are suffering intolerably from a serious medical condition, the choice of medical assistance in dying (MAID). As a publicly funded health organization, the Mississauga Halton LHIN has been ensuring access and compassionate care for individuals who may request MAID since then. The Mississauga Halton LHIN MAID working group has developed an internal MAID process to ensure that patients, caregivers and staff are supported and educated regarding MAID.

As many residents in the Mississauga Halton LHIN interface with the hospital, community, long-term care (LTC) and hospice sectors, the LHIN is in the process of establishing a regional coordinated approach to MAID. This will ensure that the residents of the region have access to MAID information and education, when and where they need it. This project involves working with our partners in hospital, community, long-term care, retirement homes and hospices, to better understand the pathways for supporting patients to access MAID information and care. The collaborative group is developing a regional algorithm and will identify opportunities to improve coordination among partners to ensure patients who wish to receive MAID are supported. This collaborative will develop an approach to MAID that is safe, timely, equitable and respectful of the wishes of patients and families in the Mississauga Halton LHIN region.

Regional Rehabilitative Care Program

The Regional Rehabilitative Care Strategy is working to standardize and streamline rehabilitative care services across the Mississauga Halton LHIN. The Mississauga Halton LHIN is working with the Rehabilitative Care Alliance of Ontario and local stakeholders to implement initiatives across our hospitals, Long-Term Care (LTC), home and community providers to ensure that eligibility, service standards and access to care can be standardized irrespective of where the patient accesses the system.

Patient Participating in Halton-Peel Community Aphasia Program, with Support Staff

In alignment with the recommendations of the Rehabilitative Care Alliance, the Mississauga Halton LHIN hospital and community stakeholders have identified two key opportunities to improve the models and care planning for rehab services offered across the continuum of care:

1. Transfer of knowledge and accountability among providers
2. The development of an online resource for provider and patient navigation for rehab services.

The Patients First Act indicates the importance of patients being a part of their care planning. The Transfer of Accountability initiative supports using one standard referral/transfer of care document between providers as the patient moves through the rehabilitative continuum of care.

The Mississauga Halton LHIN Community Rehabilitative Care Planning Committee is supporting the Rehabilitative Care Alliance and the Healthline.ca team to develop an online resource "The Rehab Portal" to assist with the navigation of rehab services.

In 2017–2018, the Mississauga Halton LHIN provided one-time funding to the Halton-Peel Community Aphasia Program (H-PCAP) to support patients in their speech and language needs, after they have had a stroke. This communication supports program is operated as a group therapy model, supported by a speech language pathologist and communication disorders assistant. The H-PCAP program is offered across the region, making it easier for patients to access communication supports closer to home.

In 2017–2018, 92 clients and caregivers benefited from the introduction program and 114 benefited from the conversation program held concurrently in Milton, Oakville and Mississauga. The program is expected to serve up to 35 per cent of stroke patients. In the Mississauga Halton LHIN, this means that approximately 460 out of 1,315 patients will need to access the program. The program currently manages a waitlist, and is being redeveloped to enable more timely and expanded access to clients and caregivers.

"If we didn't do aphasia support group, we would be completely lost." ***(Client)***

"*What do you like the most about the aphasia program? It allows my spouse to see she is not alone and that stroke recovery is a long-term goal for all.*" (***Caregiver***)

The Mississauga Halton LHIN continues to provide one-time funding to the ministry-based Assess and Restore initiatives, where the goal is to provide timely interventions within an integrated multidisciplinary team approach to restore recent functional decline in seniors. This initiative is targeted to reduce the likelihood of further functional decline and related hospitalizations, decrease caregiver burden and reduce long-term care placement.

Within the LHIN, three unique initiatives serve this goal:

1. **Assess and Restore Clinic, Halton Healthcare**
   This program uses a multidisciplinary team of health care professionals, including an Occupational Therapist, Physical Therapist and Speech Language Pathologist. The program has been very effective in taking patients straight

from hospital inpatient units, improving their functional goals and reducing hospital length of stays, including serving community clients.

2. **Step-Up Community Program,** offered by Life Mark.
   This program uses a multidisciplinary team that is mobile and provides services at three different locations across the Mississauga Halton LHIN: Mississauga, South Etobicoke and Milton. The program has been instrumental in its mobile outreach to provide care close to patients' homes. It has seen immediate functional improvements in patients' activities of daily living, mobility and independence, and re-integration back into the community safely.
3. **SMART Enhanced, by Victorian Order of Nurses.**
   This is a home-based exercise program. The aim is to provide a series of 15 home-based exercises. Immediate improvements were observed in patients' mobility, independence, balance and risk of falls.

Education and Development Collective

The Education and Development Collective is targeting Mississauga Halton LHIN health service providers and informal caregivers/family to enhance, focus and strengthen the capacity of direct care providers (informal and formal caregivers) to acquire new skills and to transfer new knowledge and best practice understanding.

The primary focus of the Education and Development collective was to provide direction to the Mississauga Halton LHIN Regional Learning Centre in the five broad themes: Personal Support Worker (PSW) Practice Standards; Formal and Informal Caregiver Education; Health Equity; Addiction and Mental Health; LHIN and Provincial Priorities.

The 2017–2018 goals of the collective were to:

1. Standardize the methodology for the development and dissemination of evidence-informed leading practice.
2. Align standards with continuous quality improvement initiatives that advance the skills and knowledge of health service providers, and informal caregivers/family within the Mississauga Halton LHIN community.
3. Build relationships between communities' primary care, hospitals informal caregivers and families to avoid ED visits, hospitalizations and facilitate timely discharges.
4. Develop and implement a performance dashboard and trend outcomes.
5. While the formal Education and Development Collective was sunset in September 2017, a small subgroup continues the work in partnership with the Regional Learning Centre. The centre has successfully addressed the first three goals through its sourcing and designing materials in support of the identified themes. A dashboard was designed and implemented in the last quarter of the fiscal year and allows for consistent insight into the reach and scope of all offerings.

Mississauga Halton LHIN Regional Learning Centre

The Mississauga Halton LHIN Regional Learning Centre is an innovative community educational resource for health service providers, inclusive of both staff and management, as well as caregivers in the Mississauga Halton LHIN. The Regional Learning Centre's community educators, in partnership with the Education and Development Collective, inform diverse educational curricula that reflects a broad spectrum of community needs and supports using flexible learning opportunities to meet the needs of the participants.

Over the past year, the Regional Learning Centre (RLC) team responded to feedback from health service providers and others, which resulted in increased off-site education offerings and focused communications including the launch of a quarterly newsletter.

The comprehensive calendar consists of offerings for personal support workers, community workers, caregivers and supervisors. Examples for caregivers include Long-Term Care and Stress Busters (a four-session dementia overview). Learning offered to other stakeholders includes, among others: Health Equity Impact Assessment Socio-Demographic Data Collection, 3Ds – Dementia, Delirium and Depression, Introduction to Diabetes, Medication Management and Conflict Management.

In 2017–2018, the RLC filled 1,135 seats consisting of both RLC-based and mobile sessions — 150 unique sessions, 52 of these mobile. Caregiver participation was a primary focus and resulted in 358 filled seats in the fiscal year.

Caregiver Respite Program

The Caregiver Respite Program provides caregivers with five respite services customized to meet the unique needs of caregivers whose loved ones have high needs. Accessed through a central registry, respite advisors navigate caregivers to services including emergency/crisis respite care, short stay and long-stay respite, adult day, in-home respite care and education/skills training, helping caregivers in their journey. The purpose of the Caregiver Respite Collaborative is to identify opportunities to enhance respite services in the Mississauga Halton LHIN.

Caregiver Respite Program

The Caregiver Respite Collaborative identified the next area for development, specifically to create a community-based, non-medical emergency respite resource, which would complete the original vision for the Respite Strategy.
The project has identified the following deliverables:

- Respite continuum capacity analysis
- Operationalization of Emergency Respite Hub, including a pathway from emergency department to urgent to planned, using health service providers
- A fully integrated response to an emergency respite admission, including a transition within 24–48 hours to alternative respite
- A plan for increased short-stay respite capacity to support system flexibility and responsiveness, with an ability to meet both urgent and ongoing regular caregiver and care recipient respite needs
- Development of a real-time bed inventory board

Caregiver participation and co-design continues to drive the urgency of this model's development.

Continence

The Regional Continence Program Collaborative enriches, optimizes and maintains the health and wellness of Mississauga Halton LHIN residents through enhanced awareness, access, assessment and support by promoting bladder and bowel management.

The Mississauga Halton LHIN, in collaboration with both Trillium Health Partners and the Regional Continence Program Committee, identified system access, education and service delivery as key priorities for continence care to ensure the following:

1. Individuals with continence needs have improved quality of life.

2. Individuals have improved access to continence support that is barrier free and needs driven.

3. The system has realized efficiencies.

To work towards achieving the described outcomes, health service providers (community and hospitals), primary care physicians and caregivers were engaged to inform this initiative. Preliminary evidence from the engagement sessions indicate "the program works and has positive health outcomes for patients." Further information revealed "that scale and spread is needed."

The Mississauga Halton LHIN Regional Continence Program, in partnership with Trillium Health Partners, has developed two brochures: Regional Continence Program and Continence Clinics, as well as a website to help inform and support continence care in our region.

Supportive Housing, Assisted Living, Attendant Care and Acquired Brain Injury

The Supportive Housing, Assisted Living, Attendant Care and Acquired Brain Injury (SHALACABI) Collaborative was created to provide a forum for collaboration and shared communication. Strategic areas of focus include knowledge exchange, collaboration, capacity building, system coordination and service delivery.

The Supports for Daily Living (SDL) mobile program was integral to supporting home and community care during the hospital surge, with up to 50 spaces added to support hospital discharge to the community. The SDL hub and spokes also assisted with personal support resources. Ongoing opportunities for collaboration and integration continue to be identified to enable seamless client care.

As part of the SDL Collaborative, key integration strategies were identified to better support clients to age in place. To support this improvement stream, a project manager was put in place to provide support to the SDL Leadership Committee and its membership agencies. This year a series of deliverables have been designed to enable the SDL model to effectively adapt and respond to the increasing complexity of their clients.

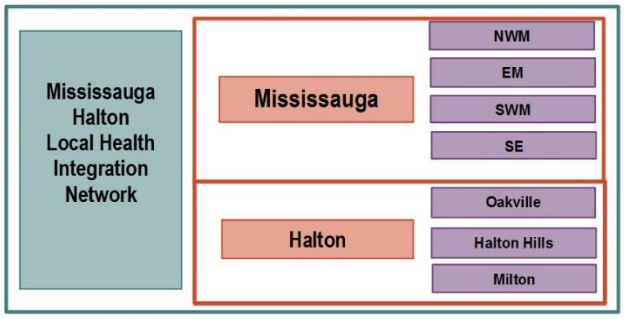
- Investigate opportunities to partner and integrate with home care and community services and primary care to more effectively support heavier-needs clients
- Develop and enhance standardized processes for seamless transitions
- Incorporate coordinated care planning for complex clients into the standardized protocols
- Facilitate data collection and analysis between SDL providers to quantify outcomes and demonstrate benefits
- Develop opportunities to use technology to share information and care plans in the circle of care
- Compare assisted living services for high-risk seniors service models across the province and develop recommendations to enhance the frequency model of service delivery
- Evolve the SDL standard manual to align with Levels of Care Framework and provincial initiative of Patients First to maintain clients on SDL services longer, with the intent of delaying or deferring alternate levels of care

Sub-Region Planning and Care Communities

Sub-regions were formalized as part of the Patients First Act, 2016 and reflect a smaller geographic planning region within the Mississauga Halton LHIN. By looking at care patterns through a smaller, local lens, the Mississauga Halton LHIN will be able to better identify and respond to community needs and ensure that patients across the entire LHIN have access to the care they need, when and where they need it. The end goal of sub-region planning efforts is the development of care closer to home, inclusive of partnerships with health and social service providers encompassing prevention, promotion and care for best possible population health outcomes, patient experience and optimized resources.

The Mississauga Halton LHIN is responsible for sub-region planning, which involves actively working with care communities to identify and respond to unique community needs. As the LHIN expands to a population health focus, providing high-quality, integrated care coordination for individuals with complex needs and Health Link maturity domains will continue to be a focus of sub-region work. Health Link partners came together in November 2017 for a consultation on sub-region planning framework and the elements of high-performing integrated systems of care. Care communities and sub-region geographies will be based on health link boundaries, and care communities will build on existing Health Link partnerships.

The Mississauga Halton LHIN framework describes how the organization will work with health service providers (HSPs) and other system partners, within a 1-2-7 approach. The “one” level includes the strategic direction for the Mississauga Halton LHIN and planning mechanisms that are LHIN-wide. At this level, HSPs and system partners will provide input to strategic planning and priorities consistent with our strategic plan and integrated health service plan. The “two” level focuses on implementation of plans appropriate to each region, while ensuring alignment to provincial and LHIN planning, consistency in best practice implementation. The “seven” level focuses on integrated care delivery and service resolution at the patient level, and a dedicated focus on sub-region profiles to understand the unique strengths, needs and considerations of each care community.



The focus on sub-regions is to achieve the following:

- Shared culture and collaborative leadership – breaking down the silos between health care sectors and providers to ensure seamless transitions for patients
- A focus on improving population health and equity – addressing the root causes of health inequities and the social determinants of health and investing in prevention and health promotion
- A commitment to community engagement and continuous quality improvement – partnering with patients in health care planning, and delivering care that reflects the patient voice and needs, values and preferences
- Integrated health care delivery – improving access to primary care, mental health and addiction services, home and community care, acute care, and specialized services when they need it
- Transparent care planning in partnership with patients and connectivity across all providers – supporting innovation and digital solutions to make accessing information and care easier for patients and more efficient for health care providers

MSK Rapid Access Clinics

A provincially driven initiative to implement timely assessments using a central intake model for musculoskeletal (MSK) patients to increase access to specialist care, increase patient satisfaction and experience and enable a shared care model linking primary care, specialists, allied health and patients.

The provincial vision of implementing the MSK Rapid Access Clinics (RAC) is to ensure timely and equitable access to MSK specialists care in a high-quality care continuum. The Mississauga Halton LHIN will be implementing RACs to provide timely assessments with a wait time target of four weeks by an advanced practice clinician for patients with hip and knee osteoarthritis and low-back pain.

Through the collaboration of an interprofessional team, the most appropriate pathway to best support the patient is recommended including surgical consultation and self-management techniques. Surgical candidates will have the choice of preferred hospital, preferred surgeon or next available appointment.

In the Mississauga Halton LHIN, there is currently one low-back pain assessor that was part of the provincial pilot and the program has engaged approximately 100 primary care providers in referring through this pathway.

The Mississauga Halton LHIN has developed a multi-disciplinary steering committee and four working groups to plan and implement the models of care. With perspectives from persons with lived experience, primary care physicians, surgeons, allied health, hospital leadership and Mississauga Halton LHIN leadership, the planning and implementation team are working collaboratively to implement these models. On February 22, 2018, the Mississauga Halton LHIN held an engagement session with over 40 participants representing each stakeholder group to gain feedback to inform the program's implementation.

System Capacity Planning

The aging population continues to be a major theme in the Mississauga Halton LHIN. In the next 10 years, the percentage of people aged 75 and older will grow by approximately 55 per cent. This growth creates increasing demands on the health care system. To ensure the Mississauga Halton LHIN is prepared to meet the needs of the region's growing and aging population now and into the future, capacity planning continues to be an area of focus, including assessment of current and future capacity in various sectors, including acute and community care capacity and appropriate sustainable solutions.

Acute and Capital Capacity Needs

The Mississauga Halton LHIN supports the planning for the provision of health care services in communities across the region. In conjunction with the MOHLTC, the LHIN works with HSPs to build capacity within the local system that can respond to growing population needs.

Milton District Hospital Expansion

On October 1, 2017, Halton Healthcare opened its new three-storey building at the Milton District Hospital (MDH) site, offering a full range of clinical services including an expanded emergency and maternal newborn departments. The new building has added 330,000 square feet to MDH and is providing patients with access to 66 new inpatient beds, an expanded diagnostic imaging department and a special-care nursery, which will offer extra care and closer monitoring for babies in the maternal newborn unit. This is a huge step in fulfilling the Mississauga Halton LHIN commitment to increasing capacity and providing patients with health care services closer to home.

Milton District Hospital

Trillium Health Partners Hospital Redevelopment Project

The Mississauga Halton LHIN continues to work with the Ministry of Health and Long-Term Care and Trillium Health Partners on the redevelopment and expansion projects at the Mississauga Hospital and the Queensway Health Centre. These projects will add over 500 new hospital beds and replace over 500 beds. The redevelopment plan includes a new acute care tower at the Mississauga Hospital and new post-acute complexes at the Queensway Health Centre creating much-needed capacity within the Mississauga Halton LHIN.

Dementia Strategy

The Patients First: Action Plan for Health Care was launched with a vision for health care system transformation including increased access and a commitment to improved dementia supports. Improvements in the supports for dementia are expected through the implementation of the dementia strategy that was released in 2016.

Additional investment for the Behavioural Supports Ontario (BSO) initiative was announced in August 2017 as the first investment towards the implementation of the dementia strategy. Given that it has been more than five years since the original direction and implementation of BSO, the Mississauga Halton LHIN's Regional Programs portfolio is using this as an opportunity to not only establish how the LHIN can appropriately invest the new $688,000, but also develop an implementation plan for BSO 2.0 in the region. This will provide the LHIN with the opportunity to refocus and realign the services, and restructure existing BSO services to ensure alignment and improve the ability to meet the needs of this special population. The project is on track given the assigned timelines.

In December 2017, the ministry issued a second funding letter as part of the dementia strategy. The ministry provided the LHIN with one-time funding as follows:

- $165,400 for community dementia programs including expanding day, evening and weekend/holiday programming
- $111,000 for behavioural supports at home and in the community to provide central coordination of these services within the region (implementation plan required for funds to flow)

Currently, the ministry is supporting LHINs in developing logic models that enables monitoring and evaluation in dementia capacity planning.
The ministry is also working with LHINs to co-develop guidance on requirements and expectations of 2018–2019 dementia capacity plans, including:

1. Objectives and expected outcomes of dementia capacity planning.
2. Planning horizon (i.e., how far into the future are we planning?).
3. Core elements (i.e., required components in all plans), including, characteristics of the dementia population, existing and planned capacity for dementia programs and services, capacity gaps, proposed enhancements and reporting standards for comparability over time and across LHINs.
4. Performance indicators and evaluation timelines for monitoring progress.

Enhance Capacity in Long-Term Care Sector

The Mississauga Halton LHIN is strategically focused on enhancing the capacity within the long-term care sector by enhancing behavioural supports, palliative care and the coordination of transitions between the sectors with the primary goal of improving the resident experience.

Long-Term Care Redevelopment

On October 28, 2014, the Associate Minister of Health and Long-Term Care announced the Enhanced Long-Term Care Home Renewal Strategy that will help bring all Long-Term Care (LTC) homes in the province up to the highest design standards.

The role of the LHIN is to help coordinate and prioritize the redevelopment of the beds within its region, while the ministry oversees the approval process and monitoring of the redevelopment.
The Mississauga Halton LHIN currently has 10 homes and 1,344 beds that are identified for redevelopment, representing 32 per cent of the long-term bed capacity.

Mississauga Halton LHIN, along with Central LHIN, have the lowest number of LTC beds per 1,000 people aged 75+, which is a major challenge given the growing rate of our population over the age of 65.
The homes for redevelopment are: Bennett Health Care Centre (66 beds), Cooksville Care Centre (192 beds), Dom Lipa (30 beds), Eatonville Care Centre (247 beds), Erin Mills Lodge (86 beds), Streetsville Care Centre (118 beds), Camilla Care Centre (237 beds), Mississauga Long Term Care Home (55 beds), Tyndall Seniors Village (151 beds) and Trillium Health Partners (220 beds).

Nurse Practitioner in Long-Term Care

In the fall of 2015, the Ministry of Health and Long-Term Care announced it would provide funding across the province for up to 75 new attending nurse practitioners in long-term care homes over three years as part of the Patients First: Action Plan for Health Care. The attending nurse practitioners are the on-site primary care providers for patients and work as part of a team of health professionals to strengthen the care that residents receive in long-term care homes.

Responsive Behaviours

The Responsive Behaviours Collaborative focuses on ensuring that every individual impacted by a responsive behaviour has access to coordinated, quality care and services. Strategic areas include knowledge exchange and capacity building; system coordination; and service delivery.

In August 2017, the ministry announced $10 million in additional base funding to support enhancements to Behavioural Supports Ontario (BSO) as part of the Ontario Dementia Strategy. As part of that announcement, the LHIN was required to ensure that all of the BSO community services and/or hospital services that are funded through the BSO ministry investment are cross-sectoral and aligned directly to the long-term care home sector. This was an opportunity to refocus and realign the services offered as a part of the BSO initiative.

Following the announcement, the Mississauga Halton LHIN led the process of redefining our BSO approach for the region and engaged with stakeholders from all sectors, including:

- Mississauga Halton LHIN Behaviours Collaborative
- The Alzheimer Society of Peel (BSO lead agency)
- Long-Term Care (LTC) homes: administrators, directors of care and existing BSO staff (including people with lived experience)

- Acute care hospitals (Trillium Health Partners and Halton Healthcare)

As an outcome of the engagement, a plan was developed and subsequently approved by the ministry that will regionalize the BSO program to support the seven sub-regions in a standardized, consistent and sustainable manner. This plan and new way of working has been coined as BSO 2.0. Each care community will have a dedicated BSO team to support the residents within that care community across the care continuum, regardless of the sector they are in.

At the end of 2017 the LHIN received additional investment from the ministry for behavioural supports at home and in the community as part of the Ontario Dementia Strategy. This funding was mandated to provide central coordination of BSO services. The Mississauga Halton LHIN allocated the funding to Alzheimer Society of Peel to enhance their existing First Link referral program to become the central intake, triage and coordination of services for BSO within our region. This enhancement has helped to move the LHIN closer to realizing the vision of regionalizing the BSO program.

Key accomplishments of 2017–2018

- Increased number of full-time employees in all 28 LTC homes
- Enhancement of Alzheimer Society Peel First Link referral program to enable central intake, triage and coordination of service for BSO
- Increase in full time employees to the BSO Community team – both hospital organizations in the LHIN now have a dedicated BSO team consisting of a BSO System Navigator and a BSO Intensive Support Community Support Worker

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Goal: BSO 2.0

A regionalized BSO program with a dedicated team to support each of the seven care communities within the Mississauga Halton LHIN.

Guiding Principles:

- Can be accessed by long-term care, acute care, or community sector
- Works to ensure consistency, continuity
- Works in concert with existing supports
- Aligned with the Home and Community Care team within the care communities
- Provide person and caregiver–centered care

Quality

Ensure the Needs and Voice of the Patient and Their Family Shape How Services are Delivered

Coordinate and Integrate Care with the Person at the Heart of the Health Care System

Foster a Culture of Health and Community Wellness

Joan shares a smile at The Dorothy Ley Hospice during social time.

Health Equity

A key focus for Health Equity is on initiatives aimed at collecting sociodemographic data to apply an equity lens to better inform program development and organizational outreach to marginalized groups for improved client outcomes.

Health equity capacity in the Mississauga Halton LHIN has been enhanced through evidence-based decision-making that is inclusive, transparent and that leverages collaborative partnerships. Over the past five years, the LHIN has continuously worked on evolving its sociodemographic data collection project. Through this project, the LHIN has engaged 25 organizations to become Focused Implementation Sites (FIS) to incorporate the eight core sociodemographic questions in one of their high-volume programs. FIS organizations have attended workshops and training opportunities where they shared some of their learnings, experiences and challenges. Each organization was offered individual consultation time with the consultants hired to coordinate the project, and one-hour bi-weekly Community of Practice teleconferences were held. The Mississauga Halton LHIN, in partnership with Summit Housing and Outreach Programs, held its Fifth Annual Health Equity Symposium "Transforming Health Care through Equity-Informed Data" in the spring. The event brought together partners and stakeholders throughout the region in important discussions on leadership, data collection and equity.

Healthy Equity Symposium, March 2018

A key focus for Health Equity in the Mississauga Halton LHIN is to continue to collect, measure, apply and evaluate sociodemographic data to improve connections between the social determinants of health and health care provision. This will allow health service providers to identify health disparities, determine who is most affected by health inequities and inform best practices that will enhance quality of care and improve health outcomes. We continue to phase in the FIS with the use of the Health Equity Impact Assessment Tool to enhance, build capacity and incorporate an equity lens that will better inform program development and organizational outreach to marginalized groups. Access to sociodemographic data is a resource for developing practices and operations that improve quality of health care for patients, clients, families and communities.

Mississauga Halton LHIN Regional Quality Table

The Regional Quality Table (RQT) is a partnership between the Mississauga Halton LHIN and Health Quality Ontario (HQO), and provides a mechanism to advance the foundations for clinical quality improvement in support of the LHIN's Integrated Health Service Plan. The RQT will align the quality agenda across the LHIN to build on existing efforts and promote a culture of quality to enable improved patient outcomes, experience of care and value for money.

The RQT completed its first annual Integrated Regional Quality Improvement Plan, endorsed by the LHIN Board on March 1, 2018. Its focus is on seamless transitions of care, particular from hospital to home, and on building capabilities for quality improvement. The RQT will now focus on measuring, monitoring and acting upon the identified system level indicators related to:

- Increasing the number of discharge summaries communicated to primary care within 48 hours of discharge
- Decreasing the rate of unscheduled emergency department (ED) visits for patients with mental health or substance abuse issues
- Increasing the number of patients seen in primary care within seven days of discharge from acute care
- Decreasing the number of palliative care patients who go to the ED, two or more times in the last month of life

- Increasing the number of complex care patients with coordinated care plans completed within 30 days of admission to home and community care
- Decreasing the rate LTC patients go to the ED for avoidable causes
- Improving the patient experience related to care transitions

High Intensity Community Services Review

The High Intensity Community Services Review (HICSR) is focused on achieving improvement in system outcomes including access to services, increased capacity in the system and improved quality and consistency as it relates to addiction and mental health services for clients requiring high-intensity community services (e.g., LOCUS level 3 services). The high number of individuals screened at one-Link requiring LOCUS Level 3 services identified the need.

Upon the completion of the Mississauga Halton LHIN Mental Health and Addiction High Intensity Community Services Review, the members of the one-Link Steering Committee and System Integration Group for Mental Health & Addictions (SIGMHA) reviewed and prioritized system enhancement opportunities identified post-review. It was determined that the top two priorities of focus would be:

1. Developing a minimum data set, for which all LHIN-funded agencies will be accountable.
2. Defining case management models, to which all LHIN-funded community mental health and addiction agencies will adhere.

Minimum Data Set Working Group

A Minimum Data Set (MDS) Working Group was formed as one of the priority system enhancement opportunities identified through the HICSR project. The HICSR work identified significant data quality limitations and gaps across LHIN-funded mental health and addictions agencies. A working group representing key stakeholders with lived experience formed to develop a minimum data set that would enable a better understanding of key gaps and challenges within high-intensity services across the LHIN, leading to enhanced system planning and decision-making. The prioritized 14 indicators that will comprise the MDS each anchored in the domains of capacity, access or quality. Another focus of the MDS work involved a Feasibility Analysis focused on whether existing data collection and analysis platforms in the province could be leveraged to assist with the MDS developed in the Mississauga Halton LHIN. There was a review of the Community Business Intelligence (CBI) platform to determine its alignment with the MDS project and provide a scenario of options for the LHIN to consider with respect to potential next steps.

Defining Case Management Working Group

This year a case management redesign was completed and a new model that includes 11 standards for service delivery was finalized. The implementation process began in February 2018 with the development of a reference implementation plan. Individual consultations with key stakeholder organizations were held to develop organization-specific implementation plans. Each organization-specific plan was validated and submitted to the Mississauga Halton LHIN, along with a summary report. The LHIN also worked closely with key stakeholders within the care coordination capacity project to ensure messaging and communication is developed to highlight how these two initiatives are aligned. The effort also clarified the roles and responsibilities of mental health and addiction case managers as both of these initiatives roll out.

Special Needs Strategy for Children: Transition of School-based Rehabilitation Services from LHINs to Children's Treatment Centres

Existing Mississauga Halton LHIN School Support Services contracts for speech-language pathology, occupational therapy and physiotherapy services in publicly funded schools will transition to our Children's Treatment Centre, ErinoakKids. The goal is to make it easier for families to access services, while ensuring seamless care from birth through the school years.

A key initiative of the Special Needs Strategy is the integrated delivery of rehabilitation services. As part of this initiative, existing Mississauga Halton LHIN School Support Services contracts for speech-language pathology, occupational therapy and physiotherapy services in publicly funded schools will transition to our Children's Treatment Centre (CTC), ErinoakKids, on July 17, 2018.

LHIN staff have been working to prepare for the smooth and safe transfer of 4,000 children and 2,000 plus on the waiting list.

On February 27, 2018, all LHINs received a joint update from the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services regarding the transition of contracts for physiotherapy, occupational therapy and speech-language pathology in publicly funded schools from LHINs to CTCs. The LHIN is proceeding with the transfer of contact management from LHINs to CTCs during the period April to August 2018. It is the expectation of the province that all communities will have transitioned school-based rehabilitation services in time for the 2018–2019 school year to ensure seamless continuity for children and families.

Ombudsperson, Privacy and Ethics

As a result of the integration of the Mississauga Halton LHIN and the Mississauga CCAC, the LHIN combined its responsibilities with respect to patient relations, patient privacy, freedom of information and ethics into the Ombudsperson, Privacy & Ethics Office.

The Ombudsperson, Privacy and Ethics (OPE) Office is responsible for:

- Oversight of the organization's complaints and appeals processes, including feedback related to health service providers
- Investigation and mediation of escalated complaints
- Acting as Privacy Officer for the organization as required under the *Personal Health Information Protection Act*
- Being the Freedom of Information and Protection of Privacy Coordinator under the *Freedom of Information and Protection of Privacy Act*
- Serving as the Ethics Officer and Liaison with the Regional Ethics Program
- Educating staff in areas falling under the responsibility of the office

Under its expanded scope, the OPE helps patients, caregivers and advocates address and resolve home and community care complaints, and works to ensure that health service providers within the region are responsive and accountable when addressing patient concerns that may arise.

With respect to freedom of information and privacy, the OPE works to both ensure transparency through responding to freedom of information requests; and to safeguard patient privacy by ensuring that patient information is protected in accordance with legislated requirements.

Enabling Technologies for Integration

Mississauga Halton LHIN and Trillium Health Partners staff collaborating at Trillium Health Partners, Credit Valley Hospital.

Information technology and information management are key elements that enable patients to be empowered and connected to their continuum of care.

Information technology and information management eliminate the need to capture the same information from Mississauga Halton LHIN residents multiple times, and support patients, their caregivers and their health service providers to share information and coordinate services quickly and efficiently as they transition from one care provider to another.

Leveraging information management and information technology investments made at the local, regional, and provincial levels will drive health care transformation and enable informed system planning decisions.

Electronic Medical Record Implementation

An Electronic Medical Record (EMR) is a digital version of the traditional paper-based medical record for a patient. The EMR typically represents a medical record within a single facility, such as a doctor's office or a clinic. OntarioMD managed the program put in place to help physicians and specialists fund the implementation of a specification-compliant EMR system.

A key deliverable related to gathering critical insight from the physician community was a direct result of the implementation of the Provider Relationship Management (PRM) solution. This solution was developed by Novari Health Inc. and is fully integrated with our Novari Referral Management Solution. Based on the in-house developed proof-of-concept, this customer-relationship-management-type solution allows primary care advisors to capture extensive physician profile information as well as record outcomes of engagement sessions. The solution launched in December 2017 and is ready to move into the analysis phase.

From this new digital health asset the LHIN can pinpoint gaps within our community where our physicians are not utilizing an EMR. Analysis of the Mississauga Halton LHIN physician community is used in the digital health strategy for primary care.

Primary Care Database Launch, December 11, 2017

Health Report Manager Implementation

OntarioMD's Health Report Manager (HRM) enables physicians using electronic medical records to receive direct electronic hospital reports into their patients' medical records within 30 minutes of transcription.

Entering fiscal 2017–2018, both Halton Healthcare and Trillium Health Partners (THP) completed the implementation of Health Report Manager (HRM). The balance of the work tracked over the year related to the registration of physicians to allow their certified Electronic Medical Records (EMR) to begin receiving hospital reports from any hospital within the province that has implemented HRM. In the first quarter, OntarioMD reported 503 physicians registered to receive hospital reports from HRM directly into their certified EMRs, and in the final quarter of the fiscal, there were 556, an increase of approximately 10.5%.

ConnectingOntario

Connecting Ontario is a regional solution that supports the delivery of provincial electronic health records by linking and integrating electronic patient information from across the care continuum and making it available at point-of-care to improve the patient and clinician experience. There are currently over 41,000 enrolled users who will gain access to their patient's records through ConnectingOntario.

The "Last Mile" performance assessment project was initiated by eHealth Ontario in the first quarter of fiscal 2017-2018. The purpose was to assess the user experience and to determine performance issues at any of the sites using ConnectingOntario clinical viewer. THP completed both phases of the ConnectingOntario project: phase one – data contribution, and phase two – data viewing before the beginning of the fiscal. Throughout the year, THP worked with various adoption groups identified within its hospital locations to promote and spread the adoption of this clinical viewer.
Also at the beginning of the fiscal year, Halton Healthcare completed phase one – data contribution, and plans to complete phase two in fiscal 2018-2019 followed by adoption initiatives within its hospital units. In addition to the acute care sector data contribution and viewing elements of

ConnectingOntario, a separate initiative was launched called “eConnect”. This will achieve the integration between PointClickCare, which is used within 86 per cent of all long-term care homes in Ontario, with the two regional viewers:

- ClinicalConnect (in the southwest region of Ontario)
- ConnectingOntario within the remainder of the province.

The integration between PointClickCare and ClinicalConnect is complete and ConnectingOntario will continue to spread beyond the two initial pilot sites. Long-term care homes can now view hospital patient data upon their return post discharge and remove the dependency on paper documentation to travel with the patient.

CHRIS 3.0

Client Health & Related Information System (CHRIS) is a web-based technology platform that holds the patient health records for each of the 14 LHINS. CHRIS provides LHINs with detailed client records, case-management tracking and support, while enabling health system integration to/from the community. It allows intake staff to assess patients, refer patients to community services and initiate care plans.

To better address patient care needs, CHRIS 3.0 was introduced. A series of significant enhancements were made to the application and the environment where it is hosted; specifically, the standardization of data (i.e., patient risk, client codes), the consolidation of core patient data (i.e., name, address, phone number) and the technology infrastructure modernization. The outcome has been “one electronic patient record shareable across the 14 LHINs.” This contributes to higher quality, more consistent and better integrated home and community care.

Creating an Integrated Health Care System

Mississauga Halton LHIN Patient and Family Advisory Committee members, Lynn, Mike and Jan discuss options during a brainstorming session.

Integration in the Mississauga Halton LHIN is the process of effectively aligning multiple systems of independent (and interdependent) organizations to achieve improved health system access, capacity and quality.

Integrations aim to deliver the following system improvements:

- Remove barriers to understanding and navigating the system
- Develop and implement system-wide best practices to improve health outcomes and take advantage of local innovations
- Deliver consistent health services through standardization of practices promoting good health outcomes and eliminating duplication and inefficiencies
- Develop centres of excellence to maximize available human resources expertise and specialized equipment and facilities
- Improve access to quality care and provide better value for money
- Enable the reinvestment of savings to address priority health needs

In the past year, the Mississauga Halton LHIN has begun, continued or completed 16 integrations. Many of the integration projects continue over a number of years because of the complexities of change management and coordination over multiple organizations across all sectors of the care continuum.

The Patients First Act, 2016

On December 7, 2016, Ontario passed Bill 41, Patients First Act, 2016, an important step forward in the Patients First: Action Plan for Health Care, which provides patients with faster access to the right care, better home and community care, the information they need to live healthy, and a health care system that is sustainable for generations to come.

On May 31, 2017, Mississauga Halton Community Care Access Centre (CCAC) staff and services were welcomed into the Mississauga Halton LHIN. Home and community care services transferred seamlessly, without any interruption to patient care. In accordance with the *Patients First Act*, the Mississauga Halton LHIN is better equipped to identify and respond to community needs and work with local health system leaders, including family doctors, nurse practitioners, home care coordinators and home and community care service providers to build more seamless local health service delivery and to continue our work to:

- Improve access to primary care for people in Ontario
- Improve local connections between primary care providers, inter-professional health care teams, hospitals, public health and home and community care to ensure a smoother patient experience and transitions
- Streamline and reduce administration of the health care system and direct savings into patient care
- Strengthen the voices of patients and families in their own health care planning
- Increase the focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French-speaking people in Ontario

Local Update

The Mississauga Halton LHIN and Mississauga Halton CCAC integration was accomplished through a strategic project management approach and the development of Functional Integration Teams to ensure seamless transition on transition day. Teams from both organizations worked diligently to identify and implement critical integration tasks prior to transition, and work has continued throughout this first year to ensure the ongoing development of one high-performing organization under the expanded LHIN mandate.

On May 31, 2017, the LHIN and CCAC successfully and seamlessly became one organization. On transition day, a welcome webcast introduced the Board Chair, Chief Executive Officer and executive team to over 400 staff. The webcast was followed by site visits to each location where the executive team greeted staff. These visits allowed for introductions, question-and-answer sessions and welcomed employees to the new organization.

The LHIN has developed an integrated work plan and strategic priorities, which are the focus of each portfolio in the new organization. The organizational design is complete among all portfolios and all staffing levels.

The key components of then Minister of Health and Long-Term Care Dr. Eric Hoskins' mandate letter to the Mississauga Halton LHIN are driving transformation. Transformation is now at the forefront of all initiatives, with the opportunity for embedding the "one team" culture throughout.

The Mississauga Halton LHIN continues to engage with partners and stakeholders, focusing on opportunities to transform the health care sector and to focus on transforming health care in the region, while continuing to maintain a patients first focus.

Voluntary Integrations

North Halton Mental Health Clinic Transfer

The transfer of North Halton Mental Health Clinic (NHMHC) to Halton Healthcare is an opportunity to re-focus the Halton Region Health Department on its core business and strategic priorities, and to align the NHMHC services in an organization that includes a mission and strategic priorities to advance the efficiency and quality of mental health and addiction services available to residents. The transfer aligns with Halton Healthcare's strategic priorities related to empowerment, collaboration and innovation in the delivery of health care services. Similarly, the transfer aligns with the strategic priorities of access, capacity and quality identified in the Mississauga Halton LHIN's Integrated Health Service Plan. Access to hospital and acute mental health services will improve for North Halton residents, with better communication and coordinated efforts leading to better overall care when and where it is needed
Note: With funding transfer associated, and one-time funding to assist with integration.

Regional Non-Urgent Transportation Project

The LHIN's current provider gave notice of a change in its corporate strategic directions and, subsequently, will no longer provide transportation services. The LHIN conducted a call for proposal, of which CANES Community Services was the successful candidate. The program will encompass Adult Day Services (ADS) and medical rides (dialysis & appointments). New technology will be used for scheduling and is integrated with Peel Region as well as other providers outside of the region. **See *Regional Non-Urgent Transportation* on page 18 to learn more.**

Regional Food Table Strategy – Phase One: Meals in Home

This voluntary funding integration supports the delivery of the Meals on Wheels (MOW) program in the Mississauga Halton LHIN and the LHIN's Welcome to Our Food Table Strategy. This is a regional approach to modernizing the food program with the goal to improve access and equity to the most vulnerable residents in the region through a coordinated lead agency. Ongoing MOW program expansion and enhancement will occur through the Meals in Home program, when fully implemented. This integration involved the transfer of clients and services to another health service provider where a new award was provided to Victorian Order of Nurses. **See *Meals in Home* on page 17 to learn more.**

Primary Care Physicians and Advanced Practice PT/Chiropractors and Orthopedic Surgeons

As a result of collaboration, an inter-professional Spine Assessment and Education Clinic (ISAEC) care pathway is now available for patient referral by primary care providers. ISAEC will enable evidence-based treatment of low back pain and ensure that patients receive the appropriate level of care.

Primary Care Providers

The Mississauga Halton LHIN partnerships with primary care are reducing barriers and strengthening access to care. This year seven Clinical Leads were recruited to support primary care transformation. These individuals will engage in co-design of the future model for primary care, and engage with their peers and colleagues to bring them to the tables to participate in the new model.

Funded Integrations

Regional Food Table Strategy – Phase One: Meals in Home, Central Intake

The Mississauga Halton LHIN is pursuing a new program seeking to serve individuals with high health needs and economic vulnerability. Funding currently used to support traditional Meals on Wheels service will be moved to the new program offering, including centralized intake and standardized assessment (inter-Rai). The successful health service provider to lead the agency is Nucleus Independent Living. A request for proposals awarded service transfer from Canadian Red Cross Society to Victorian Order of Nurses (VON), with VON meals business centralized at intake at Nucleus.

See *Meals in Home* on page 17 to learn more.

High Intensity Community Services Review

The Mississauga Halton LHIN is coordinating a review of all level of care utilization system (LOCUS) level 3 High Intensity Community Support Services in the Canadian Mental Health Association (CMHA) due to a high need identified by one-Link volumes and wait times for services. This review will identify and optimize existing capacity within the system. An initial review identified data quality challenges that prevented system-wide comparisons and decision-making, but suggests some capacity exists. Phase two of the work is identifying a minimum data set for system planning, implementing data collection and re-analysis. Phase two also includes a review of mental health and addiction case management services and standardization of roles, competencies and services included across the system including LHIN-funded and non-LHIN funded participants.

Transitional Aged Youth (TAY)

Integration through collaboration with the Mississauga Halton LHIN and its mental health & addiction health service providers is aimed at improving the patient experience by implementing a Transitional Aged Youth Protocol to provide service resolution for complex cases. This will ensure transitional aged youth 16–24 years receive seamless care when evolving from the youth health care system to adult care. There are 22 health service providers participating over two sites, one in Mississauga and one in Halton. This cross-ministerial integration also includes coordinated efforts with the Ministry of Child and Youth Services and Ministry of Community and Social Services.

Trillium Health Partners / Halton Healthcare

The Mississauga Halton LHIN is synchronising two new Pediatric Nurse Practitioners for Eating Disorders. This will further enhance the regional eating disorder program and provide more equitable access to care.

Early Psychosis Intervention Program

In 2017–2018 the LHIN coordinated two Registered Nurses for the Mississauga Halton LHIN Community Mental Health Early Psychosis Intervention (EPI) program. The program reduces the duration of untreated illness for children less than 14 years of age, which improves health outcomes and minimizes disruption to the lives of young people to maintain their educational, vocational, social and other roles and to minimize the societal impact of psychosis. The EPI program keeps children and youth out of hospital and in their communities connected to their families and friends.

Mental Health Integration Advisory Committee – System Access Model and Service Resolution – one-Link

One-Link provides improved coordinated service access and support through a single point of contact for clients and service providers. The Mississauga Halton LHIN is working in collaboration with the two co-lead organizations Halton Healthcare and Trillium Health Partners along with key stakeholders to develop a System Access Model and aligned Service Resolution Table. Change management includes utilizing standardized screening tools that determine the level of care. Currently all referrals from primary care and between health service providers are moving through one-Link.

Regional Approach to Opioid Addiction Treatment

In order to provide equitable access across the region, integration is ongoing for an opioid addiction treatment with the development of an Opioid Addiction Treatment System. The Mississauga Halton LHIN is working with additional partners that are both funded and non-funded health service providers. The focus is on increased capacity and improving transition through the system to provide holistic supports for those with opioid addiction and pregnant and parenting women with opioid addiction. The approach is moving to engage non-funded partners to help improve access and capacity.

Sustaining Peer Supports

The Mississauga Halton LHIN provided regional infrastructure to support investment in mental health and addiction peer supports across 10 different providers. The effort developed common basic job descriptions while also providing training support and the development and implementation of a network of peers and network of peer supervisors from all funded HSPs. This work is an important step to ensuring better access and capacity for the region.

See *Sustaining Peer Supports* on page 25 to learn more.

Community Addiction Liaison to the Emergency Department

In 2017–2018, the Mississauga Halton LHIN funded community addiction liaisons to regional emergency departments to assist with warm transfers for those with substance abuse challenges. These liaisons provide access to the appropriate community resources that includes wait list support for clients and families in order to help deliver care when and where it is needed most.

See Community Addiction Liaison to the Emergency Department (CALED) on page 26 to learn more.

Defining and Developing Addiction Services

This integration is core to providing access as a review of the current state of addiction services. The review involves looking into the impact of a general shortage of residential withdrawal management services. The Mississauga Halton LHIN is developing a plan that explores the current state of addiction services and the impact of a lack of residential withdrawal management services in the region. Ultimately, a current state value stream map will be developed to identify gaps or barriers that can be addressed with current resources and plans will be made for additional services that are required.

Mississauga Halton LHIN Regional Learning Centre

The Mississauga Halton LHIN Regional Learning Centre (RLC) is an innovative educational resource for health service providers, caregivers and families to build community knowledge, educate, train and support an evidence-informed practice, using flexible learning modalities through the centrally located RLC, Skills Lab and the RLC Mobile Program.

The stratified integration included in the LHIN-funded Regional Learning Centre are four regional community educators, which fall under the umbrella of the Advancement of Community Practice (ACP) initiative, governed by the Advancement of Community Practice Steering Committee. The infrastructure of the ACP and the RLC have evolved through extensive consultation with and participation

of community and health service providers. The integration infrastructure enables the Regional Learning Centre to be the single lead in providing and managing training to ensure consistency and quality across the entire Mississauga Halton LHIN, informed and in partnership with the Education and Development Collective. This collective is focused on LHIN health service providers, informal caregivers and families to enhance, focus and strengthen the capacity of direct care providers (informal and formal) to acquire new skills and to transfer new knowledge and best practice understanding. The collective formulates an annual work plan that is modified to the needs of the community, the LHIN and Ministry of Health and Long-Term Care priorities. The goals of the Education Master Plan include:

1. Incorporating standard methodology for the development and dissemination of evidenced-informed leading practice.

2. Aligning standards with continuous quality improvement initiatives that advance the skills and knowledge of health service providers, and informal caregivers and families within the Mississauga Halton LHIN community.

3. Building relationships between communities, primary care, hospitals, informal caregivers and families to avoid emergency department visits, hospitalizations and facilitate timely discharges.

4. Developing and implementing a performance dashboard and trend outcomes.

Health System Performance and Accountability

Ministry LHIN Accountability Agreement (MLAA)

The MLAA establishes a mutual understanding between the Ministry and the LHIN, and outlines respective targets focused on system performance and financial accountabilities within a pre-defined period. The following table outlines Mississauga Halton LHIN performance against targets for 2017–2018.

Indicator	Provincial target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Result (Year to Date)
Performance Indicators									
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	88.50%	92.07%	91.48%	92.63%	90.57%
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.21%	95.22%	95.58%	96.69%	96.59%
90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	27.00	28.00	34.00	27.00 (20% improvement from 2016/17)
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	6.00	7.00	11.00	9.00 (20% improvement from 2016/17)
90th Percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	9.15	9.62	10.47	10.82
90th Percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	3.58	3.70	3.72	3.82
Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	89.36%	69.10%	57.02%	49.42%
Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	76.51%	53.48%	46.16%	42.06%

Indicator	Provincial target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Result (Year to Date)
Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.18%	12.62%	14.05%	15.18%	16.66%
ALC rate	12.70%	13.70%	13.98%	15.19%	15.49%	9.60%	11.35%	14.05%	14.62%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	20.97%	17.23%	17.30%	16.69%	16.87%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.25%	25.50%	25.48%	27.21%	26.55%
Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.41%	16.09%	15.52%	15.80%	15.41%
Monitoring Indicators									
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	95.74%	77.31%	73.06%	64.05%
Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	77.31%	73.57%	79.68%	83.44%
Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18%	82.11%	84.73%	74.46%	78.41%	79.58%	81.01%
Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	14.00	20.00	15.00	12.00	10.00
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	17.00	11.00	12.00	15.00
Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	12.06	6.36	6.00	5.17	3.91
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	243.31	205.67	192.44	199.39	148.56
Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.43%	47.31%	52.99%	53.46%	54.28%	55.01%

*FY 2017-2018 is based on the available data from the fiscal year (Q1-Q3, 2017-2018)

**FY 2017-2018 is based on the available data from the fiscal year (Q1-Q2, 2017-2018)

Red/Green: 2017-2018 provincial year-to date results compared with 2017-2018 LHIN year-to date results – target met within performance corridor of =+/-10%

Performance Indicators

In consideration of twenty-one (21) MLAA performance, monitoring and developmental indicators, the Mississauga Halton LHIN's relative performance with peers *or* within 10 per cent corridor of established targets was thirteen (13) indicators were above expected targets and eight (8) were below. However, while two (2) indicators within home and community care were below the provincial average, the LHIN illustrated 20 per cent improvement in comparison with the previous year's results, a remarkable accomplishment with the capacity pressures that commenced, September 2017.

90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management) and 90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*

An exciting provincial initiative undertaken in 2017–2018 was to update the Client Health and Related Information System (CHRIS) to version 3.0, to help support the transformation expectations of the *Patients First Act*. This implementation required significant education, and impacted the ability of care coordination to complete patient assessments within the previously established timelines, as system upgrades and downtime took a substantial amount of time.

While the provincial target is five days to receive nursing care, this LHIN's 90th percentile performance is two days, continuing to meet the needs of this complex and growing population. Further, 98 per cent of the LHIN's patients received care within 10 days or less, for other services such as personal support, occupational therapy, nutrition, speech language pathology and physiotherapy, key services to help complex patients remain safely in their home.

Acute Care Access

90th percentile emergency department (ED) length of stay for complex patients

The LHIN experienced an increase in high complex patients of 2.5 per cent in 2017–2018, or 6,627 patients, and an overall ED visit rate increase of 2.2 per cent or about 10,000 visits. Further, the LHIN continues to experience higher-than-normal alternate-level-of-care rates, where the appropriate post-acute care location is not immediately available to the patient. This situation creates a challenge for the ED to transfer patients to inpatient units. While the overall number of admissions, as a proportion of total ED volume, has remained relatively stable at 10 per cent, the LHIN has experienced an overall increase in ED visits of 3 per cent. In turn, an additional 1,267 residents were admitted to LHIN-area hospitals.

Noteworthy in 2017–2018: Halton Healthcare received provincial recognition for their improvement in ED wait times for a large community hospital as part of the Pay for Results Program.

Percent of priority 2, 3 and 4 cases completed within access target for MRI & CT scans

The LHIN continues to prioritize the most urgent cases first, resulting in priority 1 and 2 cases achieving the target nearly 100 per cent of the time. Less urgent cases, priority 3 and 4, are served in priority order from receipt of referral.

Percent of priority 2, 3 and 4 cases completed within access target for hip & knee replacement

The LHIN continues to prioritize the most urgent cases first; 2017–2018 identified three key areas for improvement and action:

1. The provincial vision of implementing the Musculoskeletal (MSK) Rapid Access Clinics(RACs) is to ensure timely and equitable access to MSK specialists care in a high-quality care continuum. The Mississauga Halton LHIN will be implementing RACs to provide timely assessments with a wait time target of four weeks by an advanced practice clinician for patients with hip and knee osteoarthritis and low-back pain. This implementation is expected to increase consistency of provincial definitions associated with prioritizing elective surgical cases.
2. Building upon the successes of the Cardiac Care Seamless Transition bundled care project, Trillium Health Partners and Halton Healthcare

Services Corporation are voluntarily participating in the provincial spread and scale of bundle care for patients undergoing hip and knee replacement surgery to support improved patient continuity and choice through the care continuum. Bundled models provide a single payment for an episode of care across multiple settings and providers, and incent high-quality outcomes while monitoring costs. Planning is in the early stages with full implementation expected in 2018–2019.

3. While both hospitals received additional funding to complete more surgical cases in 2017–2018, due to extraordinary surge and system-strained capacity, this volume was not realized. The LHIN is in a better position leading into 2018–2019 to optimize all surgical volumes related to hips and knees.

System Level Access

Percentage of Alternate Level of Care (ALC) Days and ALC Rate

ALC is a designation assigned to a hospitalized patient who no longer requires acute medical services but remains in hospital awaiting care in a more appropriate setting.

The Mississauga Halton LHIN is home to one of the fastest-growing senior populations in Ontario. There are fewer long-term care home beds than the provincial average and a growing number of patients with complex needs. These factors have contributed to a high percentage of patients designated ALC in Mississauga Halton LHIN hospitals. A high ALC percentage signals system conditions that impact health service use, quality of care delivery and increase costs to the overall health care system.

THEN

Fewer options for post-acute care transitional bed spaces existed in the community. In March 2018, the Mississauga Halton LHIN's ALC rate was 16.6 per cent, compared to the provincial ALC rate of 15.2 per cent.

NOW

The ALC Management Project created an active call to action between the Mississauga Halton LHIN, Trillium Health Partners and Halton Healthcare with a singular focus to enable highly effective transitions for patients to better-suited and innovative locations where their needs could be met, rather than in a hospital.

In May 2018, the Mississauga Halton LHIN ALC rate was reduced to 11 per cent because of the creation of short- and long-term transitional bed spaces in the community through a variety of new programs, services and partnerships:

- *Long-term care homes*: notionally, over 600 beds have been announced for this LHIN, to be developed over the next two to three years.
- *Home and Community Care* includes expansion of innovative LHIN-delivered services, such as Bridges to Care and My Way Home as well as community-based programming, Supports for Daily Living: these Mississauga Halton LHIN programs provide enhanced short-term care in the community to support safer and smoother patient transitions from hospital to home
- *Capacity 99*: In partnership with Trillium Health Partners, the Mississauga Halton LHIN established the Capacity 99 Project to operationalize 99 beds for immediate short-term transitional care in the community for patients with specialized needs. Some key partnerships the project established include:
    - Halton Healthcare for 35 beds at Milton District Hospital, West Park Healthcare Centre for five beds; Bridges to Care program in retirement homes for 24 beds; in community locations, 20 beds; and the University Health Network for five beds
- *Intensive care unit patients*: The Mississauga Halton LHIN and Trillium Health Partners worked collaboratively to safely transition seven patients from the intensive care unit to post-acute spaces with an overall better quality of life and living, outside of the hospital
- *Runnymede Healthcare Centre*: with the success of an existing partnership that transitions complex patients to a centre of excellence for their health improvement journey, Trillium Health Partners expanded their relationship with Runnymede to plan for the transition of patients with rehabilitation-based needs to also create more acute hospital bed capacity in the LHIN.
- *Community Addiction Liaisons to the Emergency Department (CALED)*: with the goal to improve transitions and continuity from crisis to stable care from EDs to community services and further

planning to better define and develop a plan for integrated local services helped over 360 people to connect with peer supports and avoided hospitalization

Did you know?

- Since February 2017, 219 patients from Trillium Health Partners and Halton Healthcare were transitioned to post-acute spaces
- Bridges to Care community and retirement home beds enabled residents to experience the right level of care in settings that were best suited to their needs, along the entire continuum of care, ranging from acute to transitional care, with overall equivalent capacity created in the hospital of about 11 beds
- The My Way Home program helped transition 933 patients from hospital to post-acute spaces in the 2017–2018 fiscal year

As of April 30, 2018, the overall Mississauga Halton LHIN ALC Rate was 11 per cent, with Trillium Health Partners ALC rate at 11 per cent and Halton Healthcare at 10 per cent. At the same time last year, Mississauga Halton LHIN's rate was 14 per cent, with an all-time high rate of 16 per cent experienced in August 2017.

Readmission within 30 days for selected HIG conditions

The LHIN continues to outperform other regions for this particular metric. Some newer initiatives credited to this sustained performance include navigation roles for specific conditions and Trillium Health Partners' integrated funding model for cardiac surgery patients. The LHIN invested in an optimization exercise for ambulatory clinics at Halton Healthcare, expected to contribute to decreasing targeted population readmissions in 2018–2019.

Addiction and Mental Health Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions and Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions

The Mississauga Halton LHIN performed better in both indicators compared to provincial performance, as local solutions have focused on improving access to the right service at the right time, and increasing capacity in priority services as determined by data from the LHIN's centralized intake system, one-Link. Other quality improvement work has focused on improving transitions from the ED to community services to reduce repeat visits, and data, to understand the needs of these complex populations.

Monitoring Indicators

Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery

The LHIN continues to work within existing funding models associated with cataract surgery. Some innovative research is unfolding at the Institute for Better Health, including ascertaining the appropriateness of referrals for cataract surgery.

Wait times from application to eligibility determination for long-term care home placements: from acute setting

As the region with the lowest bedded number of long-term care home beds, this metric is challenging to meet and is further exacerbated by the redevelopment required for 30 per cent of the long-term care homes. Patients have limited choices when it comes to selecting a home with a reasonable wait time, and one that is acceptable to their choice. The 90th percentile wait time for a long-term care home bed is over 500 days. The LHIN continues to explore other opportunities such as using retirement homes for bridging care between the hospital and home.

Mississauga Halton LHIN Health Service Providers

Health service providers play an integral role in ensuring seamless, timely and effective service provision in a manner that is consistent with Mississauga Halton LHIN goals. The Mississauga Halton LHIN plans, coordinates, integrates, funds and monitors local health service providers, including hospitals, community support services, long-term care homes, mental health and addictions services, and a community health centre.

Community Health Centres

- Lakeshore Area Multi-Services Project Inc. (LAMP)

Community Support Services

- Acclaim Health and Community Care Services
- Alzheimer Society Peel
- The Arthritis Society
- The Canadian Hearing Society
- Canadian National Institute for the Blind - CNIB - Ontario Division (Halton/Peel)
- The Canadian Red Cross Society - Peel Branch
- City of Mississauga - Next Step to Active Living Program
- The Corporation of the Town of Halton Hills
- Dixie Bloor Neighbourhood Drop-In Centre
- The Dorothy Ley Hospice Inc.
- Halton Healthcare - Supportive Housing
- Heart House Hospice Inc.
- Indus Community Services
- Ivan Franko Homes
- Joyce Scott Non-Profit Homes Inc.
- Links2Care
- March of Dimes Canada - Peel
- MICBA Forum Italia Community Services
- Milton Meals on Wheels
- Nucleus Independent Living
- Oakville Kiwanis Meals on Wheels
- Oakville Senior Citizens Residence
- Peel Cheshire Homes Inc.
- Peel Halton Dufferin Acquired Brain Injury Services (PHD ABIS)
- Peel Senior Link
- Regional Municipality of Halton - Supportive Housing
- S.E.N.A.C.A. Seniors Day Program Halton Inc.
- Seniors Life Enhancement Centres
- Trillium Health Partners - CSS
- Victorian Order of Nurses for Canada - Ontario Branch - Peel Site
- Yee Hong Centre for Geriatric Care
- Wesburn Manor - City of Toronto

Hospitals

- Trillium Health Partners
- Halton Healthcare

Long-Term Care Homes

- Allendale Village
- Bennett Village
- Camilla Care Community
- Cawthra Gardens
- Chartwell Waterford Long Term Care Residence
- Chartwell Wenleigh Long Term Care Residence
- Chartwell Westbury Long Term Care Residence
- Cooksville Care Centre
- Dom Lipa
- Eatonville Care Centre
- Erin Mills Lodge Long Term Care
- Extendicare Halton Hills
- Extendicare Mississauga
- Labdara Lithuanian Nursing Home
- McCall Centre Long Term Care
- Mississauga Long Term Care Facility
- Northridge Long Term Care Facility
- Post Inn Village
- Sheridan Villa Long Term Care Centre
- Silverthorn Care Community
- Streetsville Care Community
- Tyndall Seniors Village
- Villa Forum Long Term Care Residence
- The Village of Erin Meadows
- Wesburn Manor - City of Toronto
- West Oak Village Long Term Care Centre
- Wyndham Manor Long Term Care
- Yee Hong Centre for Geriatric Care

Mental Health & Addiction

- Canadian Mental Health Association - Halton Region Branch
- Halton Alcohol, Drug & Gambling Assessment, Prevention and Treatment Services (ADAPT)
- Halton Healthcare - Community Mental Health
- Hope Place Centres
- North Halton Mental Health Clinic
- Summit Housing & Outreach Programs
- Support & Housing – Halton
- Supported Training and Rehabilitation in Diverse Environments (STRIDE)
- The Peel Addiction Assessment and Referral Centre (PAARC)
- Trillium Health Partners - Community Mental Health

Mississauga Halton LHIN Service Provider Organizations

Service Provider Organizations deliver care in the home, when and where needed. Health providers who have successfully completed a rigorous quality review are under contract to provide services to patients on behalf of the Mississauga Halton LHIN through Home and Community Care.

Acclaim Health & Community Care Services
Bayshore HealthCare Ltd.
CarePartners
CBI Ltd.
Closing the Gap Healthcare Group Inc.
Praxair Canada Inc.
ParaMed Inc.
Saint Elizabeth Health Care
Spectrum Health Care LLP
SRT Med-Staff
Storefront Humber Inc.
VHA Home HealthCare
Victorian Order of Nurses
We Care Health Services LP

Financial Statements of the Mississauga Halton Local Health Integration

March 31, 2018

Table of Contents

Deloitte LLP
400 Applewood Crescent
Suite 500
Vaughan, ON L4K 0C3
Canada

Phone: 416-601-6150
Fax: 416-601-6151

Independent Auditor's Report

To the Members of the Board of Directors of the
Mississauga Halton Local Health Integration Network

We have audited the accompanying financial statements of the Mississauga Halton Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2018, and the statements of operations and changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
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 comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2018, and the results of its operations, changes in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 7, 2018

MISSISSAUGA HALTON LOCAL HEALTH INTEGRATION NETWORK

Statement of financial position

As at March 31, 2018

	Notes	2018	2017
		$	$
Assets			
Current assets			
Cash		**9,020,076**	605,714
Due from Ministry of Health and Long-Term Care ("MOHLTC")		**1,279,900**	—
MOHLTC transfer payments to Health Service Providers ("HSPs")	14	**1,424,224**	534,600
Due from other LHIN's - enabling technology		**39,160**	124,948
Accounts receivable		**1,059,694**	49,536
Prepaid expenses		**1,466,461**	81,951
		14,289,515	1,396,749
Capital assets	7	**11,193**	26,190
		14,300,708	1,422,939
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**12,586,137**	740,719
Due to Health Service Providers ("HSPs")	14	**1,424,224**	534,600
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**279,154**	121,430
		14,289,515	1,396,749
Deferred capital contributions	8	**11,193**	26,190
		14,300,708	1,422,939
Commitments	9		
Net assets		**—**	—
		14,300,708	1,422,939

Approved by the Board

Mary Davies
Acting Chair, Board of Directors

Joanne Rogers, CPA, CA
Acting Chair, Audit and Finance Committee

The accompanying notes are an integral part of the financial statements.

MISSISSAUGA HALTON LOCAL HEALTH INTEGRATION NETWORK

Statement of operations and changes in net assets

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Revenue			
MOHLTC funding - transfer payments	14	**1,446,667,755**	1,530,939,575
MOHLTC funding - Operations and Initiatives		**171,102,998**	6,388,505
Interest income		**97,269**	—
Amortization of deferred capital contributions		**227,287**	38,258
Other revenue		**463,685**	—
Less:			—
Funding repayable to MOHLTC		**(279,154)**	(106,574)
		171,612,085	6,320,189
Total Revenue		**1,618,279,840**	1,537,259,764
Expenses			
HSP transfer payments	14	**1,446,667,755**	1,530,939,575
Operations and Initiatives			
Contracted out			
In-home/clinic services		**104,773,717**	—
School services		**4,871,043**	—
Hospice services		**1,424,433**	—
Salaries and benefits		**45,682,487**	4,662,840
Medical professional services		**828,719**	361,897
Medical supplies		**5,084,558**	—
Medical equipment rental		**2,120,338**	—
Supplies and sundry		**1,992,049**	892,984
Building and ground		**2,029,778**	227,990
Amortization		**227,287**	38,258
Equipment repairs and maintenance		**742,950**	—
Board costs	15	**73,301**	136,220
		169,850,660	6,320,189
Total Expenses		**1,616,518,415**	1,537,259,764
Excess of revenue over expenses before the undernoted		**1,761,425**	—
Net liabilities assumed on transition	12	**(1,761,425)**	—
		—	—
Net assets, beginning of year		**—**	—
Net assets, end of year		**—**	—

The accompanying notes are an integral part of the financial statements.

MISSISSAUGA HALTON LOCAL HEALTH INTEGRATION NETWORK

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		—	—
Cash assumed on transition	12	7,424,939	—
Net liabilities assumed on transition	12	1,761,425	—
Less: amounts not affecting cash			
Amortization of capital assets		284,322	38,258
Amortization of deferred capital contributions		(284,322)	(38,258)
		9,186,364	—
Changes in non-cash working capital items	11	(772,002)	(31,968)
		8,414,362	(31,968)
Investing activities			
Purchase of capital assets		—	(6,983)
Financing activities			
Increase in deferred capital contributions		—	6,983
Net increase (decrease) in cash		8,414,362	(31,968)
Cash, beginning of year		605,714	637,682
Cash, end of year		9,020,076	605,714

The accompanying notes are an integral part of the financial statements.

1. Description of Business

The Mississauga Halton 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 Mississauga Halton 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 mandate of the LHIN is as follows:

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 a south-west portion of the City of Toronto, the south part of Peel Region and all of Halton Region except for Burlington. The LHIN enters into service accountability agreements with service providers.

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.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

Effective May 31, 2017, the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOHLTC represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOHLTC are set up as repayable to the MOHLTC at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOHLTC.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account. Funding allocations for transfer payment from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2018.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer and communications equipment	3 years
Leasehold improvements	Over the remaining lease term

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

Adoption of PSAS 3430 – Restructuring Transactions

The LHIN has implemented Public sector Accounting Board ("PSAB") section 3430 Restructuring Transactions. Section 3430 requires that the assets and liabilities assumed in a restructuring agreement be recorded at the carrying value and that the increase in net assets or net liabilities received from the transferor be recognized as revenue or expense. Restructuring is an event that changes the economics of the recipient from the restructuring date onward. It does not change their history or accountability in the past, and therefore retroactive application with restatement of prior periods is permitted only in certain circumstances. The impact of this policy on the current year is detailed in note 12.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in accounting policy

As a result of the transition of responsibility for the delivery of certain services related to home care as described above, there has been a significant change in the operations of the LHIN over prior year. As a result of these changes, the LHIN has determined that the adoption of Canadian public sector accounting standards for Government not-for-profit organizations is appropriate. Previously the LHIN followed Canadian public sector accounting standards. The adoption of this policy has no impact on numbers previously reported. The impact of the change is limited to presentation only, and as a result the prior year figures presented for comparative purposes have been reclassified to conform with the current year's presentation.

4. Funding repayable to the MOHLTC

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

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

	2018	2017
	$	$
Due to MOHLTC, beginning of year	**121,430**	181,681
Funding repaid to MOHLTC	**(121,430)**	(166,825)
Funding repayable to the MOHLTC related to current year activities	**279,154**	106,574
Due to MOHLTC, end of year	**279,154**	121,430

5. Enabling Technologies for Integration Project Management Office

Effective February 1, 2012 the LHIN entered into an agreement with Central West, Central, Central East, Toronto Central, and North Simcoe Muskoka (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received one-time funding from Central West LHIN of $336,969 ($327,277 in 2017).

6. Related party transactions

Health Shared Services Ontario (HSSO)

HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under the *Local Health System Integration Act, 2006* with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long-Term Care.

During the year, the LHIN received Business Technology Infrastructure (BTI) funding from HSSO of $275,260 (Nil in 2017).

7. Capital assets

			2018	2017
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Computer equipment	**1,360,742**	**1,360,742**	**—**	—
Leasehold improvements	**6,422,929**	**6,422,929**	**—**	1,436
Furniture and equipment	**1,278,304**	**1,267,111**	**11,193**	24,754
	9,061,975	**9,050,782**	**11,193**	26,190

8. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**26,190**	57,465
Capital contributions acquired (Note 12)	**212,290**	—
Capital contributions received during the year	**—**	6,983
Amortization for the year	**(227,287)**	(38,258)
Balance, end of year	**11,193**	26,190

9. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due in each of the next five fiscal years are as follows:

2019	2,723,236
2020	2,596,951
2021	2,198,382
2022	1,167,965
2023	1,166,565

10. Contingencies

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

The LHIN potential liability due to claims arising in the ordinary course of business would be adequately covered by existing liability insurance. As confirmed by HIROC, as at close of March 31, 2018, there were no claims reported by the LHIN to HIROC.

11. Net change in Non-cash working capital

	2018	2017
	$	$
Due from MOHLTC	**(1,279,900)**	—
Accounts receivable – Includes due from LHINs	**456,885**	(133,461)
Accounts receivable MOHLTC transfer payments to Health Service Providers (HSPs)	**(889,624)**	6,331,504
Prepaid expenses	**(155,429)**	(48,267)
Accounts payable and accrued liabilities	**48,718**	215,179
Due to HSPs transfer payments	**889,624**	(6,331,504)
Due to MOHLTC	**157,724**	(60,251)
Due to Health Shared Services Ontario	**—**	(5,168)
	772,002	(31,968)

12. Community Care Access Centre transition

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Mississauga Halton Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employees of the MH CCAC. This transition took place on May 31, 2017.

The LHIN assumed the following assets and liabilities, which were recorded at the carrying value of the CCAC.

12. Community Care Access Centre transition (continued)

	$
Cash	7,424,939
Accounts receivable	1,381,255
Prepaid expenses	1,229,081
Tangible capital assets	212,290
	10,247,565
Accounts payable and accrued liabilties	11,796,700
Deferred capital contributions	212,290
	12,008,990
Net liabilities assumed	(1,761,425)

13. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 600 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 2018 was $3,250,558 ($376,251 in 2017). The last actuarial valuation was completed for the plan as of December 31, 2017. At that time, the plan was fully funded.

14. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $1,446,667,755 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**1,065,404,135**	1,013,011,981
Grants to compensate for municipal taxation – public hospitals	**163,200**	163,200
Long-term care homes	**207,941,836**	202,724,637
Community care access centres	**28,465,081**	176,279,459
Community support services	**49,358,359**	47,743,303
Assisted living services in supportive housing	**40,811,937**	39,962,439
Community mental health	**36,106,179**	34,777,191
Addictions program	**8,992,401**	7,735,785
Acquired brain injury	**6,303,432**	6,102,724
Community health centres	**3,121,195**	2,438,856
	1,446,667,755	1,530,939,575

14. Transfer payment to HSPs (continued)

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $1,424,224 ($534,600 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and changes in net assets and are included in the table above.

Pursuant to note 12, effective May 31, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the Mississauga Halton CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC up to the date of transfer.

15. Board costs

The following provides the details of Board expenses:

	2018	2017
	$	$
Board Chair per diem expenses	**13,150**	38,850
Other Board members' per diem expenses	**48,350**	72,800
Other governance and travel	**11,801**	24,570
	73,301	136,220

16. Financial risk

The LHIN through its exposure to financial assets and liabilities has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

17. 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 favor 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.

Mississauga Halton **LHIN**

Mississauga Halton Local Health Integration Network
700 Dorval Drive, Suite 500
Oakville, ON L6K 3V3
Tel: 905 337-7131 • Fax: 905 337-8330
Toll Free: 1 866 371-5446
Email : mississaugahalton@lhins.on.ca
www.mississaugahaltonlhin.on.ca

ISSN 1911-2971 (Print)
ISSN 1911-298X (Online)

Ontario
Local Health Integration Network