Mississauga Halton **LHIN**

REPORT TO THE COMMUNITY 2011

Your local health care leader, bringing health care innovations to Mississauga Halton communities.

Integration in Action

This past year was characterized by an ongoing commitment to improve integration through community engagement.

Since their inception, the LHINs have been working closely with communities and local health service providers to identify and plan for local health needs by implementing services and programs. Mississauga Halton LHIN residents and health service providers have been engaged in a variety of ways. They have helped to identify local needs and challenges, suggested solutions, and developed the priorities for our local health system. Consultations have been held on a variety of health system issues, such as the health care needs of growing communities, multicultural communities, Francophone and Aboriginal communities.

The Mississauga Halton LHIN works with, monitors, and funds 77 Health Service Providers (HSPs) that deliver services to more than one million people throughout our region. We are proud of our responsibility and never forget that the people best able to set priorities for health care in any community are the people who deliver, and the people who receive, that care. Our responsibility, always, is to listen to them.

This Report highlights the successes and the challenges that we have had over this past year.

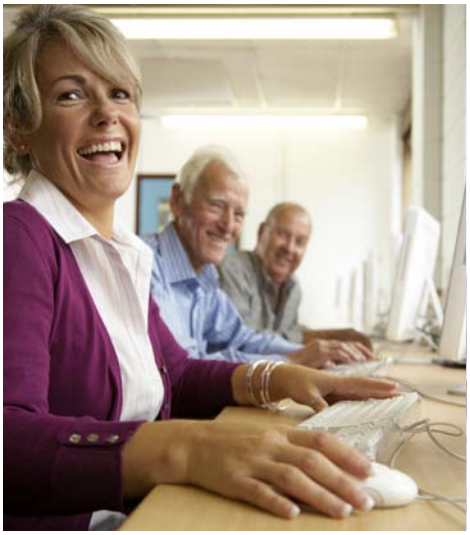
Overall, we are transforming healthcare to provide the right care, at the right time, in the right place for people in our communities. Programs such as Supports for Daily Living and Home First are showing measurable success in reducing the number of Alternate Level of Care patients in the LHIN. We are spearheading integration opportunities to improve access to diabetes services, as well as increasing community-level mental health and addictions services.

CONTACT US

Mississauga Halton LHIN
700 Dorval Drive, Suite 500
Oakville, ON L6K 3V3

Tel: (905) 337-7131 (local) or
1-866-371-5446 (toll-free)
Fax: (905) 337-8330
Email: mississaugahalton@lhins.on.ca

Ontario
Mississauga Halton Local Health Integration Network
Réseau local d'intégration des services de santé de Mississauga Halton



Engaged the Mississauga Halton LHIN Community

Community engagement helps ensure that residents in the Mississauga Halton LHIN are informed about health system decisions, and learn more about the experiences of those who provide and receive care in the Mississauga Halton LHIN.

Engagement, based on data and evidence, is central to fostering a collaborative experience and increasing accountability — all essential for health system integration and transformation. The Mississauga Halton LHIN respects the unique roles of providers, consumers and community partners. The foundations for transformative change are these mutually respectful relationships.

Reduced Emergency Departments Wait Times and Alternate Level of Care Days

"The Emergency Department Wait Time Initiative is the latest wait time strategy designed to improve access to care, and in my opinion most important."

Dr. Eric Letovsky, Emergency Department Lead, Mississauga Halton LHIN

A goal of the Mississauga Halton LHIN is to reduce **Emergency Department Wait Times and Alternate Level of Care (ALC) Days**.

While the average wait times in our emergency departments have been reduced dramatically, each day, some patients visiting emergency departments wait longer than recommended to be treated or admitted into hospital. While there are many complex reasons for delays, one key reason is that the hospital beds needed by emergency department patients are occupied by patients who are waiting to be transferred to a more appropriate place of care.

Under the pressures from a rapidly growing population in the Mississauga Halton LHIN, the hospitals are committed to working with community partners to explore new and innovative ways to provide better and faster care to the residents of this LHIN. The Emergency Department Wait Time Initiative is a critical component of that strategy.

A patient is identified as requiring **Alternate Level of Care (ALC)** when the patient occupies a bed in a hospital, but no longer requires the intensity of resources and services provided in that care setting. In Ontario hospitals, high volumes of ALC patients and ALC days are impacting timely access for patients who need to be admitted into hospital beds from the emergency department. More importantly, long ALC stays in hospital have negative impacts on a patient's quality of life.

At the forefront of LHIN activities this year has been a dedicated focus on ALC activities, and improved emergency department wait times. Successful community investments have led to more appropriate post-hospital discharges of ALC patients to home care and community programs.

Many of these investments made in ALC initiatives are contributing to more appropriate use of emergency departments, by enhancing and increasing the capacity of community-based services, such as through the Aging at Home Strategy.

Innovative Programs Developed in Mississauga Halton LHIN to Enable "Home First" Care	# of Clients Served (Over 2 Years)	# of Hospital Referrals (Over 2 Years)	Return on Investment (Annually)
Supports for Daily Living	2,905	741	$6.3 M
Assess and Restore Program	428	428	$0.6 M
Enhanced Home Care	574	574	$12.5 M

Created Regional Centres of Excellence Programs

In order to improve quality and access to care, the Mississauga Halton LHIN ensures programs are consistent across the LHIN. We are working with Health Service Provider (HSP) partners to develop Regional Centres of Excellence programs among hospitals and community agencies in the LHIN. Integration of programs and services between sectors will result in better outcomes, and will provide more services in a more efficient manner.

Regional service delivery models are important in the community sectors, hospitals and long-term care homes. This year, the LHIN developed regional programs in vascular surgery, thoracic surgery and neurosurgery. We are moving forward with implementing specialized geriatric care, palliative care, diabetes and complex continuing care services.

HIGHLIGHTS

Provided funding to Sheridan Villa Long-Term Care Home to support Ontario's first Specialized Behavioural Support Unit in a long-term care home.

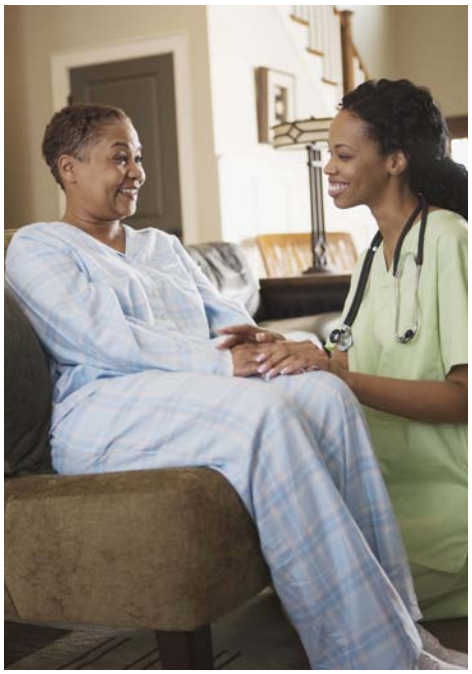
Partnered with Trillium Health Centre and The Credit Valley Hospital to successfully integrate several clinical programs to improve health outcomes for people in our region.

Centralized highly-specialized surgeries in one location in the Regional Thoracic Oncology Program, so that each hospital can make the best use of health care dollars and professional expertise within their surgical programs.

Enhanced the In-Home Palliative Care Program as a patient-focused model of care, that reduces hospitalizations, creates a LHIN-wide process for responding to palliative care needs, and reduces unnecessary emergency department visits and ALC days for palliative patients.

"By providing enhanced home care services to people with palliative care needs, we are improving the quality of their lives in their own homes, supporting their families and preventing unnecessary visits and admissions to emergency departments and hospitals. This is a good example where improving the quality of care also improves the efficient use of our health care resources."

Dr. Robert Sauls, Medical Lead for Palliative Care at the Carlo Fidani Peel Regional Cancer Centre and Medical Director of the in-patient Palliative Care Unit at Credit Valley Hospital



"The Specialized Behavioural Unit at Sheridan Villa is the first of its kind in Ontario to provide residents struggling with dementia the care they need and deserve. We are very fortunate that this important initiative is happening right here in our communities."

Mississauga South MPP, Charles Sousa

HIGHLIGHTS

Mobile Diabetes Team (MDT) in the Mississauga Halton LHIN community helps fight against the increasing prevalence of diabetes. Teams provide multi-lingual services, including those in support of the LHIN's South Asian communities (Urdu, Hindi, Punjabi and Tamil).

Chronic Disease Self Management Program is an opportunity for Mississauga Halton residents to learn more about managing chronic illnesses, and begin to think and act more positively, as well as learning coping skills.

Prevention and Management of Chronic Conditions

Effective management of chronic diseases can help to prevent the onset of other complications in the future, and is important for Mississauga Halton residents, and also for the health care system. As our population ages, there will be more people with chronic conditions such as diabetes, asthma, heart disease, arthritis and hypertension. This will place significant amounts of pressure on local resources. By better managing chronic conditions, we can reduce hospital stays, reduce health care costs, decrease mortalities and decrease hospital readmission rates in the Mississauga Halton LHIN.

*Diabetes is on the rise. In 2007-2008, approximately 969,000 Ontarians had diabetes. In 2010, that number reached **1.2 million.** - ontario.ca*

*According to the Arthritis Society's Ontario Division, **arthritis** and other **rheumatic conditions** affect **1.4 million** men, women and children in the province.*

***Hypertension** (high blood pressure) is the most prevalent chronic disease in Canada, affecting **1 in 5** adult Ontarians.*

"People with chronic conditions can work together in the Program and see that they are not alone. They can offer support and solutions to others with the same health problems."

Megan Suddergaard, Manager of Health Promotion at Halton Healthcare Services

"Clients have told us that the Mobile Diabetes Team Program is great and the location is convenient because they already see their physician. Physicians have expressed praise for the Program too."

Stacey Horodezny, Diabetes Management Centre at Trillium Health Centre

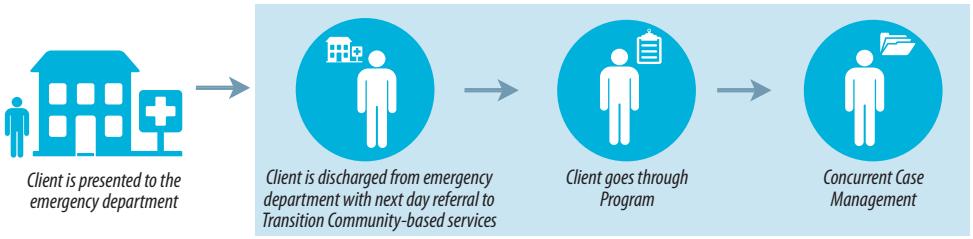
Integrated Mental Health and Addiction Services

Mental illness and substance abuse have a significant impact on Ontarians by reducing their quality of life, impacting overall health, relationships, finances and self-confidence. In the Mississauga Halton LHIN, the need for mental health and addiction services is on the rise. We know there are an increasing number of people with mental health and addiction issues returning to our hospital emergency departments on a regular basis.

Addressing service gaps in the community can help reduce the number of avoidable emergency department visits. Mississauga Halton LHIN is committed to improving access to services and improving the quality of care throughout the LHIN.

Strengthening Community Support for Concurrent Disorders

Clients pass through a "service continuum" where they are fully supported. They experience shorter wait times which result in reduced relapse rates and/or repeat visits to emergency departments



Client Progresses through the Continuum of Addiction/Concurrent Disorders Services

Increasing Community Capacity to Support People with Addictions or Concurrent Disorders

- ***80%** reduction in early return emergency department visits*
- *Overall **10%** reduction in emergency department visits*
- *Reduced length of stay in emergency department*
- *Reduced average length of stay in hospital*
- *Seamless service for those most in need – case complexity*
- *Compliance with common practices – improved access*
- *Compliance with Ministry of Health and Long-Term Care (MOHLTC) standards*

HIGHLIGHTS

The Community Concurrent Disorders Program (CCDP) was implemented with the collaboration of community mental health and addiction agencies, and is being used to support clients with concurrent mental health and addiction issues, when they present in the emergency department.

Geriatric Mental Health Outreach (GMHO) supports seniors with mental health issues and reduces the need for hospitalization or Long-Term Care placement. The GMHO Program is collaborating with partners to better support people in the community.

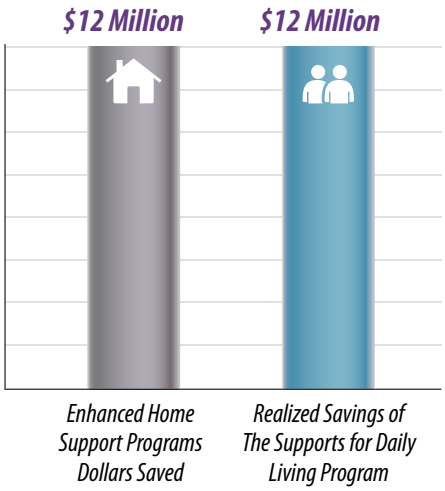
The Hope Place Women's Treatment Centre is a 24-hour therapeutic treatment program that addresses the physical, mental, emotional, social and spiritual aspects of addiction to alcohol and drug addiction, in a rural setting. The program includes a comprehensive holistic addiction treatment that incorporates the 12-Step philosophy, and is open to women 18 years of age or older.

"The Community Concurrent Disorders Program is a demonstration of how coordinating the services available in our community can make a difference to with mental health and addiction issues. It is a true example of collaboration making a difference to the people in our Mississauga Halton community."

Radhika Subramanyan, Canadian Mental Health Association (CMHA) Halton Region

Return on Investment

Aging at Home initiatives in Mississauga Halton LHIN have helped thousands of seniors and have saved millions of dollars.



HIGHLIGHTS

Leveraged the resources in community care services for **The Homes First Program,** which creates operational processes to enable access to community care services and helps promote a commitment to care for seniors in our community outside of the hospital.

Supports for Daily Living (SDL) provides high needs seniors with services in their own home, through 24/7 access to supports with on-site personal support workers and mobile patrol. Services include personal care, homemaking and attendant care, in order to assist with the essential activities of daily living.

Mississauga Halton LHIN's highly successful **Supports for Daily Living (SDL)** received the national 3M Quality Award in June 2011.

Helped Seniors Age at Home

Designed to expand seniors' access to care options at home and in the community, the Aging at Home Strategy is a three-year initiative to create locally-driven solutions to enhance seniors' independence and health. The programs help support high-needs seniors, as they transition to a level of care that better meets their needs, and – where appropriate – divert them from avoidable emergency department visits.

We continue to listen to people in our communities. Over and over again, seniors in Mississauga Halton LHIN have told us that they prefer to stay in their own homes with support. The Mississauga Halton LHIN has invested in supporting seniors to live healthy, independent lives in their own homes. Thanks to programs like **Supports for Daily Living (SDL)**, more seniors are happily receiving care in their own homes and communities.

Enhanced Seniors' Health, Wellness and Quality of Life

Over the past years, the Mississauga Halton LHIN has invested significantly in expanding community support services for seniors. These services help seniors to live at home for as long as possible, and improve their quality of life. This has created efficiencies in the health care system, has fostered many collaborations, and reduced emergency department wait times and the number of ALC days in the LHIN.

The LHIN has focused on expanding community living options for seniors with a wide range of community support services, enabling our seniors to continue to lead healthy and independent lives in their own homes.

Enhanced Home Care: The Perianayagm's Story:

Josephine is the primary support for her parents, Mary and Soospaipillai Perianayagm, who are both in their late 70's. Mary has a bipolar disorder and Soospaipillai has diabetes. Both partners require extra care and from time-to-time have spent time in hospital critical care units.

After one long stay in critical care and then a rehabilitation hospital, Soospaipillai was told that he would be sent to a long-term care home.

The Mississauga Halton CCAC provided daily support from a personal support worker to help with bathing, feeding and daily care at home, as well as the services of a physiotherapist. With the support from the CCAC, Josephine worked with a physician and the CCAC to help review her father's medication to help him feel more alert. Along with the support of case managers, physiotherapists and other caregivers, Soospaipillai's speech improved and he can now even walk for short distances with the help of a walker.

"My father cried at the thought of going to a long-term care home. He wanted to be at home with his family. The CCAC arranged many supports and services to make this possible and that was a big help for me.My father is doing great now. He is alert and he is more functional. Most importantly, he enjoys spending his days at home with his grandchildren."

Josephine

Adela's Mother's Story

Adela's mother is unable to walk due to a spinal problem. She receives three visits a day through the Supports for Daily Living Program, and has access to that care, even after hours if needed. Staff help her maintain safe, independent living in familiar surroundings. Now, she is out of bed when Adela comes home from work and they can enjoy their time together.

Enhanced Home Care Net Annual Savings, 2010

Savings Sector	Net Savings
Hospital Days	$4,378,012
Long-Term Care Days	$8,165,780
Total Net Savings	**$12,543,792**

Supports for Daily Living (SDL) 2009 - 2011 Savings

Program	SDL
Number of clients taken from Long-Term Care (LTC) wait list or Long-Term Care Hospital (LTCH)	371
LTC cost per diem	$94
Net Savings	**$5,826,082**

Although the total number of clients that were taken off the LTC wait list, or removed from a LTCH and put on the SDL Program is being shown, calculations have been adjusted to address those clients that have been discharged from the Program and to account for the amount of time they would have spent in the Program over the two year period.

The LTCH cost per diem is taken as the system cost which is minus the co-pay amount.

In Praise of The ReCharge Program

I would like to share with you what a difference The ReCharge Program has made to my life. In June of 2009, I retired from teaching and was looking forward to a lazy summer. A couple of weeks into the summer, my mother had a condition that made her unable to move her right arm. I brought her to my house so that I could care for her. She did recover, but not long after, my wonderful, independent mother suffered a severe stroke. Shortly after that, my mother-in-law started to need more care.

So basically, from the summer of 2009 until the fall of 2010, I was the main caregiver to both my mother and mother-in-law in our home. During that time, I rarely went out because my mother needed total care. She was in a wheelchair and her right side was paralyzed. She also lost her speech, so her communication was limited. In the meantime, my mother-in-law fell and broke her hip and her Alzheimer's became worse and she needed a lot more care. The CCAC did give hours for basic care. I chose not to have anyone come on the weekend from the CCAC, so that I could have two hours of respite time during the week.

My family tried to help, but my husband still needed to work and my adult children don't live locally. My sister lives in China and came to help out, but could not stay forever.

It was a privilege to care for both our mothers. I was glad that I could have them at home with us, rather than put them in long-term care homes. But I was stressed, rarely went out and quickly felt trapped. In the fall of 2010, I heard about The ReCharge Program. When I called, the people were so understanding and helpful. When I was accepted into the Program, I sat down and cried. Having 168 hours available meant I could spend time with my grandchildren, go out with friends, attend functions during the day, and my husband and I could actually go out together and not worry about leaving our mothers. Sadly, in April 2011 my mother passed away. She died here at home surrounded by her family. For the next few days, we were very busy with the visitation and the funeral arrangements. Once again The ReCharge Program came to the rescue. My mother-in-law could not be left alone, but I was not worried. I called my friends at The ReCharge Program and we knew she would be in great hands. The fact that I can count on The ReCharge Program is so assuring and uplifting.

Carmela Picci

HIGHLIGHTS

The ReCharge Program can provide up to one week of available, worry-free, in-home relief when caregivers need a scheduled break or have a last minute emergency. The ReCharge Program is an integrated community service and is collaboratively provided by Nucleus Independent Living and AbleLiving, in consultation with the Alzheimer Society of Peel.

The ReCharge Program can help caregivers sleep at night, knowing a qualified person is there should a loved one become restless.