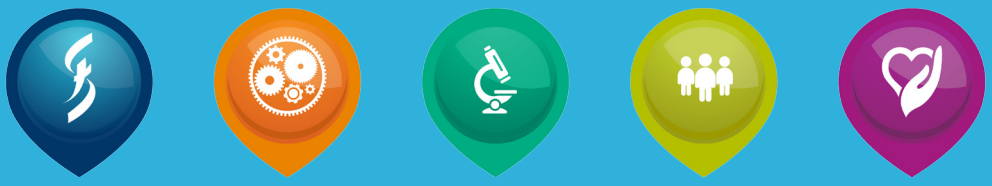
Mapping our future

ST. JOSEPH'S HOME CARE'S STRATEGIC PLAN 2012-2017



FINAL REPORT

MAY 2018

MISSION
VISION
VALUES

Our Mission is simple:

Living the Legacy: Compassionate Care. Faith. Discovery.

Every day the people who work at St. Joseph's Home Care live this mission in pursuit of our vision.

Our Vision:

"On behalf of those we are privileged to serve, we will deliver an integrated, high-quality care experience, pursue and share knowledge, and respect our rich diversity, always remaining faithful to our Roman Catholic values and traditions."

We commit ourselves to demonstrate in all that we undertake - the values instilled in our organization by the Sisters of St. Joseph of Hamilton.

Our Values:

Dignity. Respect. Service. Justice. Responsibility. Enquiry.

St. Joseph's
HEALTH SYSTEM

INTRODUCTION

Welcome to St. Joseph's Home Care's Mapping our Future 2012-2017 Final Report.

When we first embarked on this journey, we wanted our direction's theme to build on the progress of our previous strategic priorities and propel us into the future together with our St. Joseph's in Hamilton partners. The theme was also motivated by the way our organization's mission is embodied within our dedicated staff – the true spirit of St. Joseph's.

To that end, we adopted the 5 strategic pillars to embody our way forward:

Find **QUALITY** here – Our Commitment to Quality and Safety

Find **CHANGE** here – Transforming How We Work

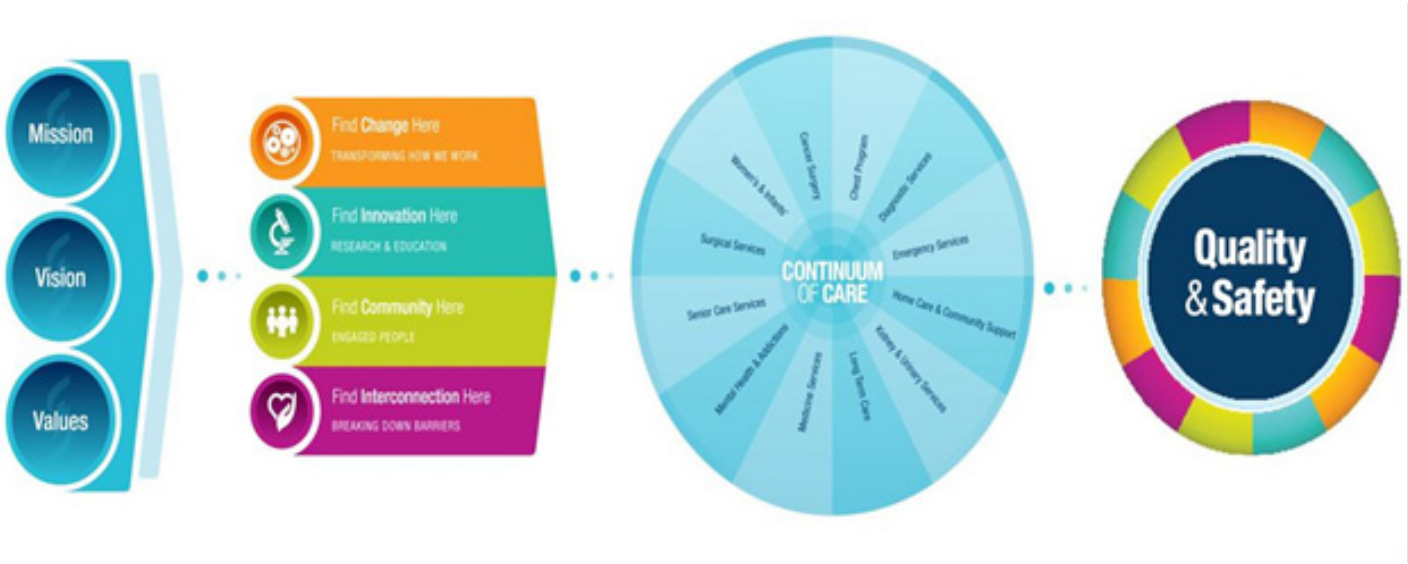
Find **INNOVATION** here – Research and Innovation

Find **COMMUNITY** here – Engaged People

Find **INTERCONNECTION** here – Breaking Down Barriers

In addition to strategic initiatives in the joint St. Joseph's in Hamilton plan that crossed sectors, St. Joseph's Home Care translated the strategic pillars into a local plan with organization-specific initiatives.

We are pleased to highlight some of these initiatives here.



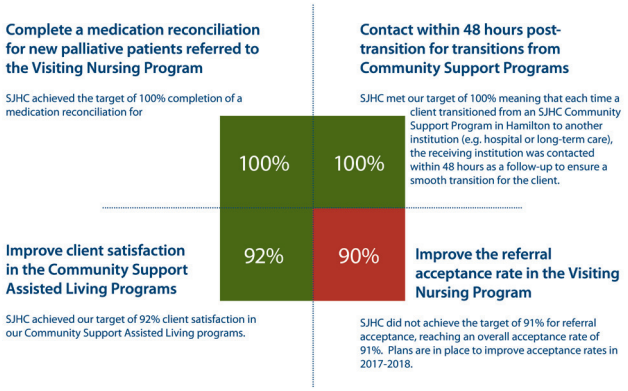
Commitment to Quality & Safety

Quality is the foundation of our Strategic Plan. It drives everything we do.

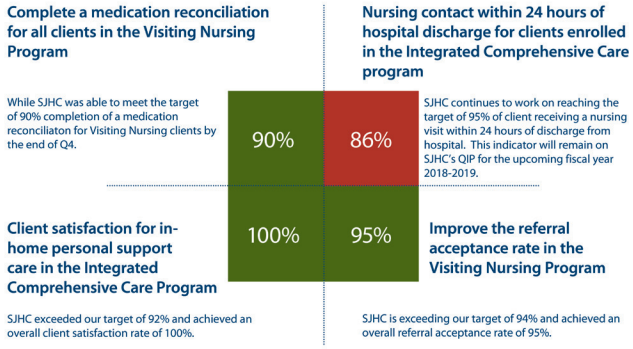
Quality Improvement Plans

St. Joseph's Home Care has been in voluntary compliance with the Excellent Care for All Act (ECFAA) requirement of annual Quality Improvement Plans since 2012. While home care and community support agencies are exempted from the requirement to develop and implement annual Quality Improvement Plans, St. Joseph's Home Care was one of the first home and community care agencies to adopt this important initiative.

St. Joseph's Home Care's direction for the Quality Improvement Plan has been two-fold: adopt indicators for new quality initiatives aligned with the quality priorities for the St. Joseph's organizations in Hamilton (St. Joseph's Home Care, St. Joseph's Healthcare Hamilton and St. Joseph's Villa) and continue the quality improvement work on indicators where the target was not achieved.



2016-2017 Quality Improvement Plan



2017-2018 Quality Improvement Plan

Patient Safety Initiatives & Reporting

St. Joseph's Home Care is dedicated to providing the best quality of care to our clients. Along with St. Joseph's Healthcare Hamilton and St. Joseph's Villa Dundas, we have adopted key patient safety initiatives with a focus on transitions, infection prevention, improving access, medication safety, and continuing employee education and training.

We are always tracking and measuring our performance using recognized evidence-based patient safety indicators. Our core belief in transparency and accountability means that we voluntarily report our performance widely: to all St. Joseph's Home Care staff, to our Joint Boards of Governors and to the broader public.

Partnering with Clients & Families

A cornerstone of our performance monitoring at SJHC is the client satisfaction surveys that are in place across all our programs. Results of client satisfaction surveys are tabulated and reported internally at team meetings and externally on our website. In addition to specific questions about the service, each survey has a space where clients can write their own comments on the service; these comments are used to provide qualitative input to help direct SJHC programs and inform changes to improve the client experience.

SJHC has client and family representatives on our internal Quality and Client Safety (QCS) Committee, along with representation from employees in all functional areas. The committee meets monthly and is accountable to Senior Management for proactively monitoring, measuring and providing analysis of quality and safety improvements within our services across all programs.

In the ICC Program, the voice of patients and caregivers is incorporated through the patient advisor role, which is involved in program Governance through the ICC Executive Steering Committee and ICC Operations and Clinical Committee. The patient advisor is involved in program events, like the recent Innovation Sprint, and acts as a Program advocate in the community.

Preparing for the 2018 Accreditation Survey

St. Joseph's Home Care received **Accreditation with Exemplary Standing**.

Accreditation is the on-going process of assessing our quality improvement initiatives and processes against established standards of excellence to identify successes and areas for improvement. This process allows us to identify how to enhance quality and safety, and reduce risk, for both clients and employees; make better use of resources; and, increase efficiency.

Accreditation with Exemplary Standing means that SJHC has surpassed the requirements outlined in the standards for the second consecutive cycle.

During the on-site survey, surveyors met with teams and individuals across the organization, from the Board of Directors to frontline staff, as well as members of the community like clients and families, and community partners.

Commitment to Quality & Safety

Transforming How We Work

Transforming how we work is helping us create a new norm by removing frustrating obstacles to care and releasing wasted energy to better serve our patients and clients.

Seniors Transitions Enhancement Program (STEP)

SJHC participated in the development of the Standard of Practice for Transitions as part of the Seniors Transitions Enhancement Program (STEP), which aims to improve transitions for vulnerable populations, especially elderly patients, between St. Joseph's Healthcare Hamilton, St. Joseph's Villa and SJHC. One of the project goals was to enhance communication across sectors to bring about better understanding of each client's unique circumstances.

A key element of the program is the warm hand-off – a phone call within 48-hours of a transition to the receiving organization that allows the teams to share important information about the client, like the supports the client might have in place at home to support discharge planning. SJHC has implemented this warm hand-off in all its CSS programs.

Improvements in Emergency Plans

SJHC has made some significant improvements in our Emergency Management and Continuity Plans. The Emergency and Continuity Plan is reviewed and updated regularly through monthly emergency management committee meetings.

We test the plan through drills and real-time situations and hold debrief sessions following each situation to determine how well the plan is working and whether any revisions are necessary. For example, following a particularly bad winter storm, SJHC adopted hospital protocols for calling and reporting into work during inclement weather episodes. This ensures that we can continue to provide service to clients even during an emergency situation.

New Patient Welcome Process in Visiting Nursing

Once an offer for service is accepted by the Visiting Nursing team, a Program Assistant will call the client to verify information about the client, like home address and telephone number. This process gives SJHC staff an opportunity to greet new clients even before service starts and helps improve each client's connection to our organization and improve how supported each client feels on initial transition into our Visiting Nursing program.

More importantly, this call allows SJHC to share relevant information with the client even before service starts, such as information about the first nursing visit, the name of the primary nurse, and contact information for the Program Assistant who will be the point of contact for scheduling.

I.T. Upgrade Project

SJHC undertook a technology upgrade in the Visiting Nursing and ICC programs starting in June 2015 based on feedback from frontline nurses about cumbersome, paper-based processes,. The original plan was to adopt new modules in the existing client database in three interdependent phases to reduce paper-based patient health documentation, reduce the amount of time nurses spent on administrative tasks like visit verification, and create efficiencies in travel and mileage calculations and reimbursement.

Each of the phases addressed a different series of issues and, together, were expected to drastically increase efficiencies and open nurses' time for direct client care with access to real-time information for front line nurses, right in the palm of their hands.

Through the project, the Visiting Nursing program adopted Clinical Day View, a module in our client database that allows nurses to conveniently see their patient assignment list on one page.

Plans are in place to revisit the project and continue building the I.T. tools to help open more time for direct care and reduce the amount of time frontline nurses spend on paperwork and other administrative processes.

Transforming How We Work

Strategic Review and Partnership with Bayshore

In late 2014, SJHC started a strategic review to identify opportunities and determine strategic directions for the organization. The results of the review and recommendations for sustainability and growth were shared with staff at a townhall meeting in spring 2015.

The recommended strategic directions included expanding and strengthening ICC and pursuing a strategic partnership with another organization in the home and community care sector.

Compatible organizations were identified and approached to submit an expression of interest in a strategic partnership with St. Joseph's Home Care. Bayshore Health Care was identified as the partner and both organizations engaged in an extensive due diligence process to seek opportunities for growth for each organization and define goals and objectives for the partnership.

Process Improvements in Visiting Nursing

Important process improvements have been implemented to support operation in the Visiting Nursing Program:

A Supervisor role has been added to the Program Assistant team to provide additional support to the team and solve operational issues as they arise.

Reports of critical quality indicators are reviewed daily. Missed care incidents are reviewed to confirm that the episode meets the criteria for missed care and determine causes. To improve the referral acceptance rate, the team aims to accept every referral made and must have management approval before refusing any referrals.

Research and Innovation

Research and innovation is a fundamental pillar of our organization. We are committed to supporting our academic capacity and developing and sustaining successful areas of innovation.

Designing new service areas that meet the needs of the community

Ensuring that individuals receive the right level of care, in the right place and at the right time, is a key priority for the Ministry of Health and Long-Term Care (MOHLTC). SJHC has been deeply involved in designing programs that meet the needs of our broader community. This work has taken on a variety of shapes – from partnering with different sectors and organizations; to seeking funding from new sources; to rethinking the client populations who need service and broadening age or other criteria for acceptance into our programs.

For example:

The HNHB LHIN identified a patient population that is pursuing long-term care prematurely because of a lack of alternative affordable community housing and care options. Affordability, not need for the level of care needed, was the driving factor in choosing to go into long-term care. SJHC partnered with the HNHB LHIN and CityHousing Hamilton to submit a proposal to the MOHLTC for funding for a rental supplement to resolve affordability issues and help clients receive the right level of care in an environment suited to their needs.

Another service area that came about from new thinking was the Community Connector role. SJHC worked closely with other community agencies to develop the Hamilton Seniors Isolation Reduction Impact Plan. The project has a three-step approach to reduce isolation in seniors: a city-wide plan to tackle the issue driven by focus groups and interviews with local seniors and service providers, an interactive referral service to link seniors with the services available in the community, and implementing a Community Connector program to help seniors transition back into the community following a hospitalization. SJHC's Community Connector works in collaboration with St. Joseph's Healthcare Hamilton, HNHB LHIN Home and Community, and community support services, to ensure seniors at high risk for becoming isolated receive support to return to the community following a hospitalization.

HQO Standard on Dementia Care for People Living in the Community

Health Quality Ontario is responsible for defining the meaning of quality in health care and publishes a number of quality standards that provide a guideline for clinicians and patients.

Quality standards clearly outline, through a set of concise easy-to-understand statements, what quality care looks like for a condition or topic based on the evidence. Health Quality Ontario collaborates with clinical experts, patients, residents, and caregivers across the province to develop these standards, which are designed to help health care professionals easily and quickly know what care to provide, based on the best evidence, and to help patients, residents, their families and informal caregivers know what to discuss about their care with their health care professionals.

Work to define what quality dementia care looks like in a community setting began in May 2016 and St. Joseph's Home Care was invited to participate in the development of this standard that addresses care for people living with dementia or mild cognitive impairment in the community (residing outside of long-term care homes and hospitals). Specifically, this standard focuses on care provided by primary care, specialist care, hospital outpatient, home care, and community support services.

The invitation to participate in developing the guideline for caring for individuals with dementia and mild cognitive impairment living in the community recognizes St. Joseph's Home Care's expertise in home and community care.

Research and Innovation

Integrated Comprehensive Care (ICC) Program

Since 2012, the ICC model has been connecting patients in specific medicine streams (hip and knee replacement surgery, thoracic surgery, and congestive heart failure and chronic obstructive pulmonary disease) with one Integrated Care Coordinator before, during and after their hospital stay. The ICC navigator is the link between hospital specialists and necessary services in the community that can include a variety of professionals including nurses, therapists, and personal support workers.

The program started as a pilot project within the St. Joseph's Health System and leveraged member organizations St. Joseph's Healthcare Hamilton and St. Joseph's Home Care.

The program is structured on 8 elements:

Client Centered Care: empowering clients with knowledge, participation and self-care

Integrated Care Coordinators that follow clients across the continuum of care – from pre-hospital admission, through the hospital experience, and onto home care.

Integrated team committed to standardization and interdisciplinary care pathways spanning hospital and community.

A **shared electronic health record** which also serves as a hub for communication

Simple, available technology that provides flexibility in communication

Ready access to medical care and community-based 24/7 contact number for patients

Flexibility in the delivery of care with a continual process of improvement that responds immediately to patient needs.

Bundled funding which we leverage to do this work.

In September 2015, the Ministry of Health announced the approval of six bundled funding programs in the province, one of which was the extension of the ICC model across the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) for patients with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). St. Joseph's Healthcare Hamilton was named to lead this expansion and St. Joseph's Home Care became the project's leading Home Care Agency for the HNHB LHIN. We called this extension ICC 2.0.

Provincial roll-out of QBP for hip and knee

St. Joseph's Home Care has been the home care voice at the table with the Ministry of Health and Long-Term Care in the development Quality–Based Procedures (QBPs) in Hip and Knee Replacement surgeries, which is our opportunity to share best practices that will allow the system as a whole achieve even better quality and system efficiencies.

Roll-out of 3.0 – adding new patient streams

The St. Joseph's Health System continues to build on the success of ICC with the addition of new streams into the growing program – we are now in ICC 3.0.

The focus of ICC 3.0 is to expand the program to other patient groups. Starting in January 2018, SJHC became the lead home care agency in the HNHB LHIN for in-home peritoneal dialysis.

Another area for expansion is to apply the ICC model to all scheduled surgeries at St. Joseph's Healthcare Hamilton, starting with esophagectomies and laryngectomies. These patient populations have more complex needs and would benefit from the interdisciplinary approach to care that is intrinsic to the ICC model, especially when a larger part of this care can be received in the patient's own home.

Strategic Review and Partnership with Bayshore

In late 2014, St. Joseph's Home Care embarked on a comprehensive strategic assessment to develop our strategic direction for the next 3-5 years.

The resulting recommendations provided a roadmap to strengthen the organization and establish a vision for our future that built on our strengths by expanding the Integrated Comprehensive Care program and embarking on a strategic partnership with another home and community care organizations.

In June 2016, senior leadership announced that St. Joseph's Home Care would be exploring a strategic partnership with Bayshore Health Care. Phase one involved the completion of an operational plan and a more in-depth understanding of the opportunities for each organization. The specifics of the relationship have evolved over time as Bayshore and SJHC continue to identify opportunities for collaboration and leveraging each organization's strengths.

Research and Innovation

Engaged People

People are the power behind our achievements. As a community of engaged people, we will better serve our patients, clients and community and take greater joy and satisfaction from our work.

Improvements to New Employee Orientation and Onboarding

Corporate

SJHC has made significant improvements to its orientation and onboarding processes for new employees. At the heart of the changes is an understanding that engagement with new employees is a crucial element in successful onboarding, which begins on day one.

Once a candidate accepts the offer letter, a welcome package is prepared and picked up ahead of time. This package contains important reading material that new employees can review at their convenience. Through a series of pre-employment communication opportunities, a dedicated HR Team Member reaches out to new staff, and begins to establish solid team-based relationships. This encourages new employees to connect with existing staff members and to begin to connect with their internal support networks.

Another continuous improvement initiative is our revamped new employee orientation presentation utilized during the Corporate Orientation Session that occurs at our Head Office location on the first day of employment. This presentation builds on the information shared in the welcome package and focuses on providing new employees with a general overview of the organization, our culture of safety, internal resources, and behavior expectations. The session is interactive and encourages new employees to ask questions and encourages new employees to gain an understanding of SJHC's programs, services, team mates and work culture.

A second package is given to new employees at the Orientation session. This package includes practical information such as an organizational chart and phone contact list, as well as some required reading materials

and hand hygiene take away cards. Immediately following the sessions, new employees have a tour of the head office and are introduced to head office colleagues.

Program-Specific Orientation

After the 4-hour corporate orientation, new employees then spend time with either the Clinical Nurse Educator or their Program Manager where they receive further on-boarding education specific to their role and/or work area. Site specific or job specific on-boarding can take as few as 4 additional hours or as many as 37.5 additional hours depending on the need, and includes education on various items such as safety, client care, equipment use, emergency response, etc.

Clinical: ICC/Visiting

The goal of clinical orientation for employees new to the organization is to provide a total of 37.5 hrs of mandatory hands-on education and training for all new nurses. The time is divided into a full-day in-office training that includes the corporate orientation and four days in the field with a preceptor. This co-operative approach is tailored to the needs of the individual based on their general experience in the nursing field and their particular experience in the home care sector. An inventory of clinical skills helps management put a customized plan in place for supporting the orientation and onboarding of each new employee.

Enhanced Management Supports for Front-Line Nurses

The management team in the Visiting Nursing program has implemented monthly group practice meetings to provide the team a forum to engage in clinical and operational problem-solving and provide the opportunity for touch-points and relationship building. In addition, the Manager of Education and Clinical Support provides supplementary support to front-line nurses by joining nurses on client visits when needed to help nurses gain confidence in their independent practice that is intrinsic to caring for patients right in the patient's own home.

Employee Engagement Survey

In 2015 SJHC moved from measuring employee satisfaction to assessing engagement, which is a more effective measure of employee commitment and connection to their day-to-day work and the organization's mission.

Results from the 2016 survey show staff have an emotional connection with the Mission, Vision and Values of St. Joseph's Home Care.

Survey Question	*% Favourable Responses*
I am determined to give my best effort at work each day	*94%*
I am often so involved in my work that the day goes by very quickly.	*90%*
St. Joseph's Home Care provides training and information to me so that I am informed about health and safety risks in the workplace.	*91.5%*
Our values of Dignity, Respect, Service, Justice, Responsibility and Enquiry are part of our everyday work.	*95%*
My organization is dedicated to diversity and inclusiveness.	*92%*
I am familiar with St. Joseph's Home Care's Mission, Vision and Values.	*94%*
St. Joseph's Home Care provides essential home care services to individuals living in the community.	*97%*
The staff at St. Joseph's Home Care always work to provide quality of care.	*93%*
I feel good about the work that I do and the quality of care that we provide.	*96%*
Reporting errors or incidents leads to improved client safety and opportunities for learning.	*93%*

Chronic Disease Management Training for PSWs

SJHC hosted a number of specialized training sessions for PSWs to assist clients with chronic diseases. As the number of clients presenting with chronic illnesses increases, there is a need for greater knowledge of chronic disease management for PSW staff providing care to these client populations in the community.

In total 24 PSWs completed the education that focused on day-to-day management of congestive heart failure, chronic obstructive pulmonary disease and diabetes. Education was provided by a representative from ProResp, a partner in the ICC program, with funding provided through the PSW Collaborative of the HNHB LHIN.

Engaged People

Improved Communications

Team Huddles

SJHC has embraced regular team huddles at all levels of the organization. The frequency of the huddles varies depending on the needs of the team, but the purpose is consistent: to reinforce our culture of collaboration and align the team.

Huddles reinforce the importance of the team and allow individual team members to adjust their priorities and schedules to focus on current events and changing needs. Even the senior team meets weekly in a huddle to share information, review issues and brainstorm solutions.

Emails for all staff

SJHC rolled out emails for all employees. Employees who use email in their day-to-day work communication have had this tool for years, but in 2015 SJHC rolled out email to employees who did not use email in their day-to-day work. Email has become an essential tool in communication and the purpose of this spread of email was to facilitate communication across the organization.

SJHC Corner

SJHC continues to publish SJHC Corner, a quarterly employee newsletter to highlight the breadth of our programs and the work being done by various teams across the organization.

Gentle Persuasive Approaches Training to Reduce Responsive Behaviours

Gentle Persuasive Approach (GPA) training for staff is a key strategy in providing client-centred care to support individuals living with dementia who exhibit responsive behaviours.

GPA is an evidence-based training program that helps care providers deliver person-centred, compassionate care to individuals with dementia. The GPA material focuses on four key areas: personhood, brain and behaviour, the interpersonal environment, and gentle persuasive techniques. A variety of educational tools are used and include videos, white board animations, interactive exercises, and sharing personal experiences in working with individuals with dementia.

Important teachings in this curriculum are:

- Individuals with dementia are persons first, with a unique history and a capacity for interpersonal relationships.
- All behaviour has meaning and to understand the behaviour, we must know the person behind the illness
- The onus is on caregivers to try and understand patterns and triggers and respond respectfully and confidently to the individual with dementia.
- Reframe behaviour as a response attempt to protect/defend oneself.
- Despite our best efforts, sometimes protective behaviours occur and caregivers need to learn ways to protect themselves and the persons with dementia to reduce injury

In 2017 SJHC enhanced its training capacity and now has four employees who have become Certified GPA Coaches and are leading training sessions for their colleagues. Our trainers are able to train new employees and offer refreshers for staff who have completed their GPA training.

Engaged People

Recognizing Excellence

Each year we celebrate the dedicated, mission-driven people who work at St. Joseph's Home Care and the remarkable contributions made to the organization by our employees.

The Award of Excellence recognizes the work of employees who exemplify the values of our organization and is presented to four individuals, each representing a different service area within the organization including Home Care Services, Community Support Services, Corporate Services, and Leadership.

The Years of Service recognition honours long-serving staff. We present awards to employees that have been with the organization for 5, 10, 15, 20, 25 and 30+ years - each receiving a different gift to thank them for their dedication and service.

The community of St. Joseph's Home Care shares a deep connection to the values of the Sisters of St. Joseph of Hamilton: that it is an honour to serve – and in particular to ensure that those most vulnerable have access to compassionate, high-quality care. Held every three years, the Mission Legacy Awards celebrates individuals who embody the legacy of the Sisters of St. Joseph in Hamilton.

We are a very fortunate organization to have staff who live out the mission, vision, and values of our organization daily to help improve the lives of our clients.

Breaking Down Barriers

We will integrate our services internally and, with our partners, externally so that transitions of care become safer, more reliable and invisible to our clients. We will place particular emphasis on the poor and marginalized in our community

Building Capacity across the Continuum: Working to Improve Client Flow

To help address patient flow issues in our community, St. Joseph's Home Care has introduced three innovative programs aligned with the MOHLTC's "home first" philosophy to provide care for an aging population with complex needs and support aging in place.

Transitional Beds

A part of the HNHB LHIN Transitional Wellness Capacity Project, SJHC's Transitional Beds program on the Assisted Living floor at First Place Hamilton launched in 2013 with 3 beds and quickly grew to 32 beds. The program supports seniors who are awaiting discharge from hospital once their acute care episode is complete, but who cannot be discharged home because of behavioural issues, because they do not have family to support care at home, are having housing issues or have unsuitable housing that poses a barrier for home supports, or require two-person assistance with transfers. The transitional beds programs provides short-term housing, usually 60-90 days, with enhanced supports while the individual awaits the next level of care destination.

First Place Supportive Housing Hub

SJHC, with the HNHB LHIN and CityHousing Hamilton, was successful in a proposal to the MOHLTC and HNHB LHIN for funding for rent supports and personal support services for seniors designated alternate level of care (ALC) in hospitals and/or health facilities who could continue living independently in the community with appropriate support services, but cannot be discharged from hospital because they are homeless or cannot afford to return to their pre-hospitalization home. Housing is an important social determinant of physical and mental health and well-being. For seniors, stable housing can serve as a platform for supportive services to improve the health and functional outcomes of vulnerable older adults.

SJHC launched a new 40-unit supportive housing program. This new program is a hub model where clients in the program will live in residential units at First Place Hamilton. The MOHLTC and HNHB LHIN funding is used to supplement rent as well as provide home and community care supports, so that clients receive the right care in an environment suited to their needs.

Community Connector

Since 2016, SJHC has been actively engaged in the Hamilton Seniors Isolation Reduction Impact Plan collaborative that aims to reduce social isolation for seniors in the Hamilton area. One of the critical components of the plan is the Community Connector program to help seniors transition back into the community after a hospitalization. The role of SJHC's Community Connector is to work in collaboration with the discharge team at St. Joseph's Healthcare Hamilton to ensure that community and housing services are available to support a senior's to return to their community.

The Community Connector tailors services to the needs of the client, which vary depending on the individual. These services can include connecting with seniors through home visits and attending appointments with clients to ensure initial transition, completing referral processes with the client for community support services, linking the client with community resources, and continuing to provide support to the client until they are anchored into community supports.

EXAMPLES OF COMMUNITY CONNECTOR IMPACT	
Referrals from St. Joseph's Healthcare Hamilton Discharge	23
Referrals from the community	18
# of Clients who agreed to services	36
# of Clients who received home visits	48
# of Hospital Visits	13
# of Home Visits	96
Advocacy type appointments attended with client (e.g. medical/housing/financial)	36
Care Connections suggested to clients	123

Working with the LHIN Home and Community Care

In early June 2016, Dr. Eric Hoskins, Minister of Health and Long-Term Care tabled the Patients First Act. Under this new legislation, the LHINs were granted additional responsibilities for advancing locally integrated patient-centred healthcare delivery. A significant change in this legislation was that the Community Care Access Centres (CCACs) were dismantled in 2017 and oversight for home and community care was transferred to the LHINs.

SJHC is working closely with the LHIN Home and Community (formerly CCAC) and we are actively involved in discussions and problem-solving improvements to services for clients. For example, SJHC participated in discussions with other service provider organizations to brainstorm solutions and build efficiency by reducing the amount of time nurses spent on travel by reorganizing referrals by geographic area. Discussions continue and we are proud to be at these tables advocating for clients in our community.

Leadership Restructure

In late 2016, SJHC announced a new leadership structure. Dr. Carolyn Gosse was appointed to the role of President at St. Joseph's Home Care and Vice President of Integrated Care at the St. Joseph's Health System.

Previously, Dr. Gosse held positions as Director of Clinical Programs, which included the Emergency Department, General Internal Medicine, and Urgent Care (2013-2017) and Director of Pharmacy Services (2003-2011) at St. Joseph's Healthcare Hamilton (SJHH).

From 2011-2013, she led the implementation of the Integrated Comprehensive Care (ICC) project for St. Joseph's Health System, funded by the Ministry of Health and Long-Term Care (MOHLTC) in Ontario and has been working closely with the MOHLTC since 2014 on the implementation of Integrated Funding Models across the province.

This appointment realigns our organization to continue charting our future in innovative service design.

Breaking Down Barriers

Collaborations to support vulnerable populations

SJHC works closely with Health Links in a number of our programs. A Health Link is a team of providers in a geographic area (primary care, hospital, home, community care, long-term care providers, community support agencies and other community partners) working together to provide coordinated health care to individuals, often seniors, with multiple complex conditions. Providers design a care plan for each patient and work together with patients and their families to ensure they receive the care they need.

Collaboration between sectors and service providers is at the heart of Health Links and SJHC works closely with the Hamilton West Health Links lead to support vulnerable seniors in the downtown core where food security and support for attending healthcare appointments are fundamental issues.

Key to a co-ordination of services is respect and valuing the role of each service provider in achieving positive client outcomes.

St. Joseph's Home Care

STAY CONNECTED

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