JUNE 2016

ANNUAL REPORT TO THE COMMUNITY

St. Joseph's Home Care

95 YEARS

ICC: from pilot to expansion

Since 2012, the Integrated Comprehensive Care (ICC) program has been connecting patients with one Integrated Care Coordinator before, during and after their hospital stay. The Integrated Care Coordinator is the link between hospital specialists, community service providers (nurses, personal support workers and therapists), primary care, and community programs.

This coordinated approach to care with a cohesive multidisciplinary team that wraps care around the patient has proven to be a better model to support patients in their homes, maintain independence and avoid return visits to the hospital. Mobile technology allows the teams to communicate easily with each other and with patients at home, and along with 24/7 telephone access to an SJHC nurse, have reduced unnecessary trips to hospital for ICC patients.

Patient outcomes and satisfaction have been excellent. According to the independent findings by the Programs for Assessment of Technology in Health (PATH) Research Institute published in July 2014, the ICC model resulted in shortened hospital stays, improved patient satisfaction and fewer readmissions to the emergency department. In fact, the model has been so successful that the Ministry of Health and Long-Term Care issued an Expression of Interest in February 2015 looking for proposals of similar integrated models from hospitals and home care agencies across the province.

Last September, Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care made a special announcement about expanding the Integrated Comprehensive Care (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). This was one of six "ICC-like" models that were approved for piloting by the Ministry.

We now refer to the original 3-stream project in Hamilton and in Waterloo Wellington as ICC 1.0. This program continues for patients who have undergone thoracic (lung and esophageal cancer) and joint (total hip and knee joint replacements) surgeries with St. Joseph's Healthcare Hamilton and patients who have undergone cardiovascular and thoracic surgery with St. Mary's General Hospital in Kitchener. COPD and CHF are part of the chronic patient stream, the third original ICC stream tested at St. Joseph's Healthcare Hamilton in the project pilot.

During the expansion announcement in September 2015, Minister Hoskins described the ICC project as a vision for the future of care delivery in the province of Ontario by providing a "bundled" approach to health care that aims to guide patients throughout their entire medical treatment, from hospital to home.

The goals of the project are:

- To establish a seamless patient centered care continuum from hospital to home, from both the patient and funder perspective
- To improve the patient experience by implementing the ICC Program HNHB LHIN-wide
- To improve quality outcomes and reduce unwanted or unwarranted variation in patient care pathways: reduce hospital length of stay, reduce emergency department visits and unplanned hospital

INTEGRATED COMPREHENSIVE CARE PROGRAM

readmissions, improve productivity of hospital and home care, and reduce overall cost

- To improve efficiency of the healthcare system by integrating resources across the continuum
- To inform policy by implementing ICC HNHB LHIN-wide.
- To fully engage key stakeholders (e.g. physicians) and patients/family in the HNHB LHIN ICC Model.

St. Joseph's Healthcare Hamilton was named to lead the expansion of St. Joseph's Health System's ICC model for COPD and CHF across all HNHB LHIN acute care hospitals, while St. Joseph's Home Care is the project's lead home care agency for the HNHB LHIN.

Identifying challenges and brainstorming solutions is embedded right into the structure of the program. The roll-out of ICC 2.0 is being staged in four separate phases to allow the teams to look at what is working and to problem solve issues as they come up, while applying the learnings as more patients are enrolled in the program. This collaborative approach builds the interdisciplinary and cross-organizational teams.

The expansion of the ICC model will transform patient care across the HNHB LHIN, providing an innovative, patient-centered, bundled approach to health care.

ICC 2.0 Roll-out Phases

Phase and Area	*Details*
Phase 1: Burlington	Joseph Brant Hospital enrolled its first patient in October2015.
Phase 2: Hamilton/West Lincoln	Enrollment started in January 2016 for patients from three hospital sites within the Hamilton Health Sciences corporation: Hamilton General Hospital, Juravinski Hospital and West Lincoln Memorial Hospital.
Phase 3: South Zone	Four hospitals in the Haldimand and Brant area started patient enrollment in February 2016. The hospital sites include Brant Community Hospital, Norfolk General Hospital in Simcoe, West Haldimand General Hospital in Hagersville and Haldimand War Memorial Hospital in Dunnville.
Phase 4: Niagara	Enrollment began in April 2016 for patients from three sites in the Niagara Health System: the Welland Site, Niagara General Hospital, and St. Catharines Site.

St. Joseph's Home Care has served Hamilton for 95 years

The year was 1921.

That year, Hamilton was in the depths of an influenza epidemic. Bishop Dowling of the Hamilton Diocese directed the Catholic Women's League to start a visiting nursing service to assist with the medical and social needs of the community.

The new service would be called the St. Elizabeth's Visiting Nurses' Association after Saint Elizabeth of Hungary, the thirteenth century saint venerated by Germans as the saint of the common people because of her efforts to help people right in their own environment, no matter how humble.

Nursing care was a focus, but public health education and charitable work were often part of the service these nurses offered patients.

St. Elizabeth Visiting Nurses' Association was incorporated in 1958 and became a member of St. Joseph's Health System in 1996. The name was changed in April of 2005 to St. Joseph's Home Care.

Our services have evolved over the last 95 years to meet the changing needs to our community, but our commitment to delivering compassionate, quality care to people of all creeds, races and economic backgrounds is unwavering. It is this philosophy that is still at the heart of our mission and is the true legacy of our founders.

Mission

Living the Legacy – Compassionate Care. Faith. Discovery.

Vision

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

Values

We commit ourselves to demonstrate in all that we undertake, the vision and values that inspired our Founders, the Sisters of St. Joseph. These are: **Dignity, Respect, Service, Justice, Responsibility** and **Enquiry.**

BOARD OF DIRECTORS

Chair	Peter Tice
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Access to technology translates to better client care

In June 2015, St. Joseph's Home Care embarked on a project to improve technology capabilities to support client care in our Visiting Nursing program. The goal of the project was to replace labour intensive, paper-based processes followed by our front line nursing staff with access to real-time information, and to put that information right in the palm of front-line nurses' hands.

Our nurses encountered challenges stemming from the reliance on paper charting on a daily basis.

A nurse in our Visiting Nursing program sees between 10 and 12 patients each day and, while the Care Coordinators who work at head office do their best to ensure that patients are seen by the same team of nurses each visit, with the number of clients seen by SJHC nurses ranging on average from 200 to 250 each day, there are days when it can be a challenge to provide the desired level of continuity. When the nurse arrives at a patient's home, he or she greets the patient and immediately looks for the patient's chart, a folder containing all the information the nurse will need in order to provide care that visit.

The nurse may or may not know the patient well, depending on whether the nurse is part of the patient's usual care team. Regardless of the nurse's familiarity with the patient, the nurse still needs to review the chart to be updated on critical information concerning the care the patient is receiving.

This is where having a paper record in the home can be problematic.

While the chart is meant to remain in the home, patients sometimes take the chart to a doctor's or specialist's appointment and inadvertently leave it behind, so it is missing when the nurse arrives for the visit. Even when the chart is in the patient's home, nurses have to rely on the hand-written information in the chart completed by colleagues, which means the nurse needs to be able to read his or her colleague's hand-writing, interpret any abbreviations or symbols, and review any additional documents in the chart, especially doctor's orders, before being able to start providing care.

If any information is difficult to interpret or missing altogether, the nurse would have to call head office for clarification; for example, if he or she can't interpret the hand-writing, if updated doctor's orders are not in the chart or if the chart is missing. At head office, the Care Coordinators will search for the information in the St. Joseph's Home Care patient database and call the nurse in the patient's home to relay the information. All this back and forth takes time, sometimes as long as 20 minutes – time that could and should be dedicated to providing direct care for the patient.

We knew there had to be a better way to ensure nurses could review a patient's complete chart each and every time they visit a patient's home; a way for our nurses to review the information in the chart quickly and effectively; one that gave nurses the critical patient information they needed in each patient's home so they could spend their time providing direct care for patients instead of chasing information.

After exploring a number of options, SJHC nursing management decided that the best way to solve the reliance on paper charts was to give nurses direct access to the information in the patient database; and, the best

way to provide this level of access would be to deploy tablets to each and every nurse in the field.

Not only would nurses be able to decrease the amount of time they spent on administrative processes, they would have access to immediate and up-to-date information, including changes in scheduling (such as canceled visits) and in each patient's record (like updated doctor's instructions or other changes in a patient's information).

With the use of mobile technology, nurses would also be able to enter updates in a patient's own record themselves by completing their charting electronically.

We were excited to be undertaking a project of this scope to make paper-based practices a thing of the past.

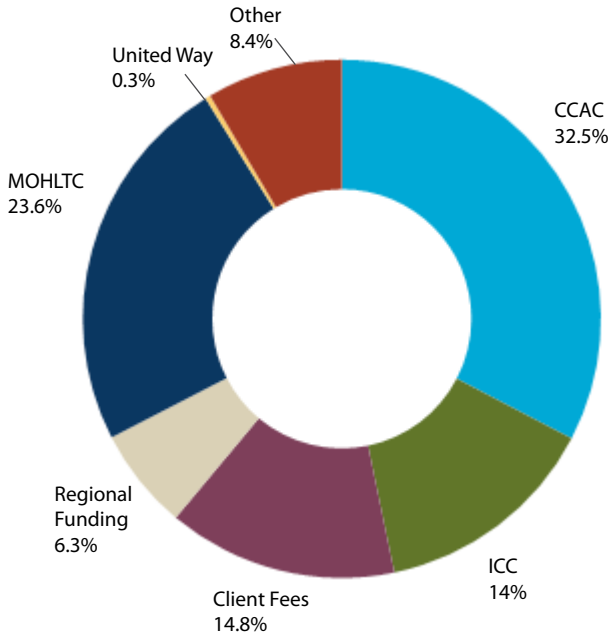
Deployment of the tablets started in September 2015 with very positive feedback from nurses, who generally felt the tablets were tremendously helpful in completing the necessary documentation and easily accessing crucial patient information.

Another significant benefit we are experiencing from using the enhanced capabilities of mobile technology is a decrease in the amount of time our nurses spend on the road. Because, the less time a nurses spends on the road getting from one patient's home to another patient's home means that more time the nurse can spend providing direct care for patients.

SJHC continues to look at how we can extend the use of our new technological capabilities through the adoption of broader electronic documentation.

ST. JOSEPH'S HOME CARE BY THE NUMBERS

Funding Sources
(year ended March 31, 2016)



Our staff

Long-serving staff	
5-9 years	87
10-14 years	33
15-19 years	18
20+ years	23

TOTAL STAFF	323
Front-line staff	291
Corporate support	32

Community Wellness Funding

St. Joseph's Home Care continues the tradition of designating funds to benefit the most vulnerable in our community. Each year since 2009, SJHC has specifically designated funds to be able to provide vulnerable seniors in the community access to a range of services, enabling them to remain living at home safely and independently while preserving the individuals' dignity and respect.

Formerly known as the Poor and Marginalized Program, St. Joseph's Home Care changed the name of the program to the Community Wellness Funding in early 2016 so the program name is better aligned with the goals of the funding and the services provided to people living in our community.

In 2015-2016, the specific areas supported under the Community Wellness Funding were:

Bi-Weekly Home Cleaning

St. Joseph's Home Care offered 700 hours of cleaning to 10 clients who cannot access services due to socio-economic challenges.

A service like regular home cleaning can mean the difference between living independently at home and having to enter long-term care. In fact, lack of assistance with homemaking is often a key factor for the premature placement of seniors in long-term care who, because of their frailty and chronic conditions, are unable to complete activities of daily living. Home cleaning may even help a senior remain social; if a senior's home is unclean, they may be unwilling to allow people to visit, resulting in social withdrawal and isolation.

Falls Prevention

St. Joseph's Home Care subsidized the purchases of 200 grab bars that assisted in reducing the risk of falls for 100 clients.

Injuries resulting from falls can have a tremendous impact on an individual's quality of life and improving safety for seniors living independently by reducing the risk of falling at home is key to St. Joseph's Home Care's falls prevention strategy.

Foot care

The goal of the foot care component of the Community Wellness Funding is to provide access to foot care services to men, women and families in need who are homeless or at risk of being homeless. Specialized nurses provided 57 free foot care visits clients at the Hamilton Out of the Cold program. In addition, St. Joseph's Home Care subsidized 35 home foot care visits to low-income seniors.

Good Food Box

St. Joseph's Home Care subsidized $10 toward the $15 cost of monthly Good Food Box distributions and subsidized 1,000 Good Food Boxes over the course of the year.

Between September and May residents at four different buildings in the Hamilton core, who may not otherwise have been able to purchase nutritious food, were able to receive affordable seasonal fruits and vegetables.

Home First philosophy: supports for seniors at home

The Home First philosophy takes into account that many people prefer to receive care in their homes. For seniors who have been hospitalized, but whose acute care episode is over and are being discharged from hospital, home is the first option and is considered before any other discharge options. Care plans are developed in consultation with the client – it is a person-centred, evidence-based approach that is an integral part of providing the right type of care, in the right place, and at the right time.

Supports are provided for people to return home or to be discharged to an alternate setting, like a transitional bed program, and can include assistance with activities of daily living and instrumental activities of daily living that include: personal care like bathing, feeding, dressing, toileting; lifting, transferring and/or repositioning; light housekeeping; medication reminders; menu planning, shopping, and meal preparation; accompanying clients to appointments; and educational and recreational assistance. Long-term care is considered only when it is the best option because a person's needs cannot be met at home or through an alternate setting.

The Home First philosophy is helping people live independently at home for as long as possible Appropriate services and supports at home reduce the need for emergency department visits, unnecessary re-admission to hospital, as well as premature admission to long-term care.

St. Joseph's home Care has a number of initiatives that are aligned with the Home First philosophy aimed at helping seniors live independently at home.

The Collaborative Care Model (CCM) Program

One of the St. Joseph's Home Care programs that aligns with the Home First philosophy is the Collaborative Care Model program.

The reasoning behind the program is to have a "one sector" approach between the home and community care sectors that reduces CCAC waitlists by utilizing existing capacity for service within the community sector. Care for clients with low to moderate needs who are waitlisted for CCAC service is transferred to a participating community support services (CSS) agency.

The CCM program at St. Joseph's Home Care was launched in February 2015 as a "hub" based model of home care service delivery with the capacity to serve 90 clients living in the defined geographic hubs of downtown Hamilton or the Dundas area. Clients in this program require personal support for safety and independence to prevent deterioration of functional status. The target population is older adults with light or moderate care needs who are frail or have long-term chronic conditions and require one or more home and community services. Care is provided right in the client's own home and can include: personal care like bathing, feeding, dressing, toileting; lifting, transferring and/or repositioning; light housekeeping; menu planning and meal preparation; and medication reminders.

Consistent with the Ministry of Health and Long-Term Care guideline that there is no wrong door for clients to receive information or to access home and community services, the program is funded through the Hamilton

Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) and fosters a self-management approach while providing linkages to other community resources to promote independence and prevent escalation of care needs.

Referrals are made through the Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC), with a Care Coordinator conducting an initial screening for each referral using a standardized assessment protocol to determine eligibility, identify the level of care needed, create a care plan and confirm the client's consent to personal support services. These steps are completed within 5 business days in alignment with the wait time target for PSW care, a priority set by both Health Quality Ontario & the CCACs.

Reducing the Risk of Falls

Older people have the highest risk of serious injury or premature death arising from a fall and the risk increases with age. The reasons seniors are at higher risk of injury from falls are numerous and complex and each older person may face a unique combination of risk factors depending on their individual circumstances, health status and behaviours, economic situation, social supports and environment.

The majority of falls result in broken or fractured bones, and over one third of fall-related hospitalizations among seniors were associated with a hip fracture. Fortunately, programs and strategies that focus on falls prevention and improving home safety work and have demonstrated a significant reduction in falls among seniors. Some preventative steps include good nutrition, staying active,

being aware of side-effects from prescriptions and over-the-counter medications, and using personal assistive devices and personal aides.

Since 2010, Falls Prevention has been a major area of focus for all the LHINs across the province and is an important part of the Home First philosophy.

A multi-sector provincial working group co-led by the LHINs and Public Health Departments developed a framework for falls prevention at the local and provincial levels to ensure a consistent approach to preventing falls across the province. SJHC used this framework to develop its own Falls Prevention Strategy, which focuses on seven categories of intervention: changing behavior, education, equipment, changing the environment, activity, clothing and footwear, and health management.

The Safety at Home Program is a part of the St. Joseph's Home Care Fall Prevention Strategy, which sets out to:

1. Identify and connect with all SJHC clients including at risk seniors;
2. Assess how to reduce risk by conducting a Safety at Home Assessment;
3. Provide services to help reduce risk. These services will aim to change behavior, provide equipment, change the environment, encourage activity and

support health management;

4. Help connect seniors (in the Hamilton and Burlington community at large) with other programs within the HNHB LHIN Falls Prevention Collaborative;
5. Provide education, recommendations and referrals to clients and caregivers; and,
6. Monitor success of services in reducing risk of falls.

The Program promotes independence and mobility among older adults, allowing them to stay healthy, safe, and strong at home.

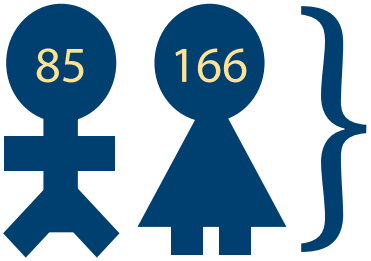
Funding is provided by the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) with four service providers working in collaboration across the region. Referrals for the program can come from CCAC, doctor's offices, OTs, other CSS agencies, family members, self-assessments, Hamilton Paramedics Department (Ambulance Services), and internally from SJHC staff.

When a referral is received, an in-person assessment in the client's home is scheduled. Once the in-home assessment is completed, the client receives a copy of the assessment, which includes recommendations to help reduce risks of falls and information about other community-based programs available.

The entire process is directed by the client; clients can choose to stop the process at any time and make the ultimate decision whether to implement some recommendations, all of them, or none at all. If the client chooses to implement some or all of the recommendations, they are connected to support services that can help implement the recommendations.

Safety at Home Program at a glance

251 new assessments in 2015-16



77% had a fall prior to assessment

33% had not fallen, but were concerned about falling

Recommendations:
grab bars | improved lighting and night lights | referrals
remove mats | install ramp | regular meals | assistive devices: hand-held shower, raised toilet seat, bath chairs/seat/transfer bench, walker, reacher, cane

2 grab bars & installation: $160
BUT **broken hip: $$$$$**

Client satisfaction – **100%**

Assessments funded through
Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network

40% – received subsidy through HNHB CCAC or SJHC's Community Wellness Funding for equipment or installation

ST. JOSEPH'S HOME CARE BY THE NUMBERS

Clients served *(year ended March 31, 2016)*

Program	Clients	Service Units
Visiting Nursing	2,468	73,602 visits
Shift Nursing	59	8,559 hours
ICC *Hamilton | Kitchener*	2,401	26,943 visits
Assisted Living *Gwen Lee | Wellington Terrace | Park Street Hub First Place*	303	54,975 resident days
Observational Care & ALC	169	55,454 hours
Other Community Services *Neighbourhood Model | TOPS | CCM | Safety at Home*	1,144	39,591 hours

PROGRAMS & SERVICES

Home Care

- Visiting nursing
- Shift nursing
- Private nursing
- Foot care
- Therapies
- ICC Program

Community Supports

- Personal care at home & companionship
- Caregiver relief & respite
- Home cleaning & maintenance
- Food services
- Assisted living programs: Gwen Lee, First Place, Wellington Terrace, Park Street
- Private personal support services
- Safety at Home falls prevention
- Transitional Beds – First Place

UPDATE FROM ST. JOSEPH'S HEALTH SYSTEM

Each day, the physicians, staff, researchers, learners, donors and volunteers of St. Joseph's Health System dedicate significant effort, expertise and time to the advancement of the Mission of the System in the spirit of the Sisters of St. Joseph. Without the support and the contributions of our member Foundations we would not be able to achieve our goal of improving care and inspiring discovery for the benefit of our patients, clients and residents.

This year, we acknowledge with pride and gratitude the following key initiatives which are taking shape within St. Joseph's Health System.

Strategic Planning/Integrated Comprehensive Care Initiatives (ICC)

The leadership of the SJHS Board inspired the SJHS strategic plan which focused on the integration of care with the expectation that our model of care would be centered on the resident, client and patient and less driven by organizational structures and silos. As we operationalize this strategic plan, our selection of priorities will be Mission sensitive. We are committed to delivering health care that is seamless and closes 'gaps in the system' that can, and do, lead to harm. This plan also places great emphasis on education and research, as well as training and support for our staff, physicians and volunteers. At the heart of this innovative care is the recognition that we all need to work toward a more holistic, effective and resource conscious health care system. As we embark upon this bold new vision we understand at the outset, that those we serve and our frontline leaders and staff will play a crucial role in the design and innovation of new models which reflect of our Mission and Values in action.

As a key component of SJHS strategic planning, the ICC initiatives continue to grow both within SJHS, neighbouring LHINS and across the province. 'ICC 2.0', is the project taking place within the HNHB LHIN and has spread to almost all LHIN hospitals. An iteration of the ICC initiative is also taking hold in the Waterloo Wellington (WW) LHIN where the program will support advances in St. Mary's General Hospital's minimally invasive Thoracic program. This support will be in the form of a pre-hospital service visit (which is unique) and a follow up service visit once the patient has had their surgery and has been discharged. In both LHINs, the transformation in care and experience for patients and families in the ICC programs continues to be reinforced. Provincially, SJHS continues to participate and support as a regional consultant in Integrated Funding Methodology.

End of Life Care

In April 2016 we saw the first draft of legislation to amend the Criminal Code of Canada and other relevant acts in response to the Supreme Court of Canada decision on Physician Assisted Death (PAD).

St. Joseph's
HEALTH SYSTEM

Of utmost importance is the need to emphasize that we are committed to compassion, holistic and excellent end of life care and palliative care for those we serve. Those in our care and their loved ones will be treated with the compassion, dignity and respect that our Mission, Vision and Values require.

SJHS continues to work with our partner organizations in local communities as well as the Centre for Clinical Ethics in Toronto, the Catholic Health Association of Ontario, the Catholic Health Alliance of Canada and others. We are also working closely with our internal PAD Task Group which is comprised of clinical and ethical experts from all of our member organizations.

The SJHS Foundations

As key members of the SJHS, it is important to recognize the critical contributions of the five Foundations of the St. Joseph's Health System, which include St. Joseph's Lifecare Foundation Brantford, St. Joseph's Healthcare Foundation Hamilton, St. Joseph's Health Centre Foundation Guelph, St. Joseph's Villa Foundation Dundas, and St. Mary's General Hospital Foundation Kitchener

In the 2015/16 fiscal year the charitable Foundations of the SJHS collectively secured $22.1 million (excluding investment income) and cumulatively granted $19.8 million to partner healthcare organizations. It is important to note that all funding commitments to partner healthcare organizations were met.

We remain indebted and grateful to the SJHS Foundations and donors for their unwavering support and contribution to the Mission of SJHS and ultimately to the patients, clients, residents and families that we are privileged to serve.

Partnerships

SJHS would also like to recognize the positive progress achieved with partners in local regions and Local Health integration Networks (LHINs). Of note is our ongoing partnership with the Niagara Health System (NHS) and agreement to appoint a common Chief of Staff, Dr. Tom Stewart, for St. Joseph's Healthcare Hamilton and the NHS.

As interest continues to grow in the St. Joseph's Health System and our work to integrate care, we are connecting with new potential partners who share our philosophy of care.

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St. Joseph's Home Care

95 YEARS