St. Joseph's Home Care

Annual Report 2018

SERVE
INNOVATE
PARTNER

MISSION & VISION

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:

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.

VALUES

DIGNITY

We emphasize the worth and value of the individual by focusing on the needs of the person and respecting their choices.

JUSTICE

For us justice is synonymous with fairness; in order to be just, we must be able to care for individuals free from personal bias or prejudice.

RESPECT

We value each person's uniqueness and recognize the importance of responding to the needs of the whole person – body, mind and spirit.

RESPONSIBILITY

We are committed to being a supportive and positive example for others and to meeting a high standard.

SERVICE

We strive to serve with integrity to meet the needs of our clients with the highest level of quality.

ENQUIRY

We are constantly seeking knowledge and understanding through a blend of tested practices and innovation.

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2017-2018 YEAR IN REVIEW – A MESSAGE FROM DR. CAROLYN GOSSE

If we had to summarize the last year for our organization, we would describe it as a time of expanding partnerships, developing innovative programs, and on-going service to our community. We continue to collaborate with partners – funders, housing providers, local hospitals, etc. to lead innovation within our sector and across the healthcare continuum, while remaining deeply committed to excellence in person-centred service.

To highlight some of our achievements in 2017-2018:

- We continue to grow our Integrated Comprehensive Care to expand the patient populations served through this ground-breaking model of care – both in our region and across our province.
- We informed the new quality standard in Dementia Care for People Living in the Community from Health Quality Ontario.
- We provided 112,328 visits, 46,490 resident days, and 98,307 hours of service to our clients.
- We achieved Accreditation with Exemplary Standing, the highest recognition level from Accreditation Canada for the second consecutive cycle, recognizing SJHC's commitment to quality and our culture of safety.
- We continue to develop programs to meet the needs of the community. We launched a new program aimed at facilitating discharge from hospital for clients who need personal and rental supports to live independently in the community.
- We have applied our core principle of person-centredness to important process changes that have improved our ability to accept referrals and those crucial initial contacts with our clients.
- We restructured our leadership team to reflect our priority service areas with senior leadership in Community Supports, Visiting Nursing and Integrated Comprehensive Care. This leadership structure allows us to continue expanding programs and services working collaboratively with partners.

- We continued to partner with St. Joseph's Healthcare Hamilton to help seniors discharged from hospital become anchored into community services, which helps clients live independently in the community for as long as possible.

We are proud of our achievements over this past year and look forward to continuing to work collaboratively with all our partners to develop programs that solve complex issues and transform our healthcare system for the benefit of the broader community.

Accreditation with Exemplary Standing – Again!

We achieved Accreditation with Exemplary Standing from Accreditation Canada in May 2018 for the second consecutive cycle.

This certification status means that St. Joseph's Home Care has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program. It is a nod to the excellent work SJHC employees do each and every day and our management team's commitment to quality and safety.

Quality improvement is a constant process of examining all aspects of our services to identify what we do well and find areas where we can do better. The continual improvement process is integral to St. Joseph's Home Care's ability to deliver consistent high quality, client-centred care.

Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed the organization's leadership, governance, clinical and non-clinical programs and services against national standards of excellence. SJHC met 468 of 470 requirements in the standards including the successful implementation of all applicable Required Organizational Practices (ROPs).

The Accreditation Report noted that St. Joseph's Home Care has a strong legacy of care and compassion, and is recognized by partners and funders as living its mission through innovation, collaboration, willingness to care for complex clients, responsiveness, flexibility, and client-centredness. Successes highlighted in the Accreditation Report include our leadership in the Integrated Comprehensive Care program, the development of quality improvement plans and voluntary compliance with the Excellent Care For All Act since 2012, and a strong culture of, and commitment to, safety and quality.

ICC 3.0: EXPANDING THE MODEL TO NEW PATIENT POPULATIONS

Since 2012, the Integrated Comprehensive Care (ICC) model has been connecting patients in specific medicine streams – hip and knee replacement surgery, thoracic surgery, and congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). One Integrated Care Coordinator follows the patient before, during and after their hospital stay and serves as a link between hospital specialists and necessary services in the community that can include a variety of professionals like nurses, therapists, and personal support workers.

The model is structured on 8 elements:

1. Client Centered Care that empowers clients with knowledge, participation and self-care
2. Integrated Care Coordinators who follow clients across the continuum of care – from pre-hospital admission, through the hospital experience, and onto home care.
3. Integrated team committed to standardization and interdisciplinary care pathways spanning hospital and community.
4. A shared electronic health record which also serves as a hub for communication
5. Simple, available technology that provides flexibility in communication

ICC TIMELINE

2011

St. Joseph's Health System submits a proposal to the Ministry of Health and Long-Term Care for an innovative pilot program: ICC

2012

ICC launches pilot program for 3 surgical patient streams at St. Joseph's Healthcare Hamilton: thoracics, hip and knee replacements, and COPD/CHF

2013

ICC expands to St. Mary's General Hospital in Kitchener, ON. Patient streams are thoracic, cardiovascular surgery and COPD/CHF

2014

PATH publishes program results, confirming better patient outcomes: shorter hospital stays, fewer readmissions and ED visits, and high satisfaction

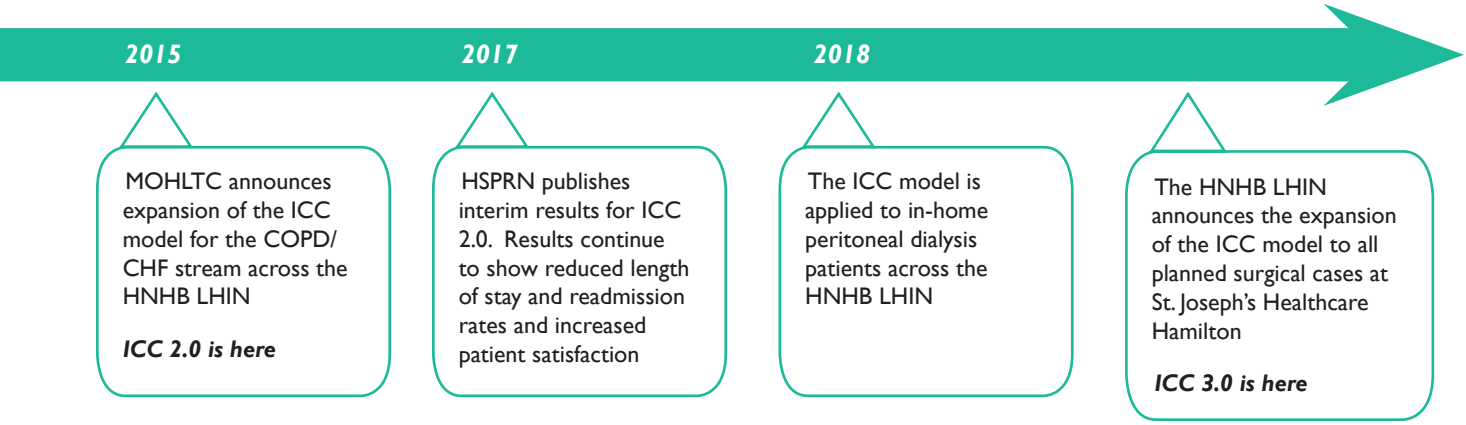
6. Ready access to medical care and community-based 24/7 contact number for patients
7. Flexibility in the delivery of care with a continual process of improvement that responds immediately to patient needs.
8. Bundled funding which we leverage to do this work.

The ICC model 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. Independent data review has shown that the program is successful in reducing the length of time patients remain in hospital following their surgery, while reducing visits to the emergency department and hospital readmissions following discharge – all indicators of positive patient outcomes.

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. In early 2018, SJHC received notice of approval for a proposal to expand the ICC program to all planned surgical cases at St. Joseph's Healthcare Hamilton.

Building on the learnings from ICC 1.0 and 2.0 (the original 3 patient steams in Hamilton and the expansion of the chronic stream to patients with COPD and CHF across the HNHB LHIN), SJHC is working with hospital colleagues at St. Joseph's Healthcare Hamilton to develop carepaths for esophagectomies and laryngectomies while staying true to the 8 core elements of the program.

We are starting with esophagectomies and laryngectomies because these patients have complex needs even after discharge from hospital and would benefit from the interdisciplinary approach to care and enhanced communication between teams that is intrinsic to the ICC model, especially when a larger part of this care can be received in the patient's own home.



Caring for Peritoneal Dialysis Patients at Home

Until now, Peritoneal Dialysis (PD) patients in the HNHB LHIN received service from one of several providers, but starting in January 2018, St. Joseph's Home Care became the lead home care agency for all patients of the Peritoneal Dialysis Program at St. Joseph's Healthcare Hamilton for in-home peritoneal dialysis. This has given us the opportunity to develop an expertise in this particular area and build therapeutic relationships with PD patients across the region.

We have applied key elements of the ICC model to this patient stream, like fostering collegial relationships with staff at the Peritoneal Dialysis Clinic at St. Joseph's Healthcare Hamilton. SJHC nurses and management meet with nurses from the Peritoneal Dialysis Clinic regularly through virtual rounds that include brainstorming solutions to common issues in in-home peritoneal dialysis.

The most significant benefit of this approach is being able to designate nurses to the in-home peritoneal dialysis stream and provide these employees with enhanced education specific to peritoneal dialysis that allows them to spot potential problems, like infections, and adopt interventions early.

Peritonitis, an infection of the internal abdominal lining (peritoneum), is a fairly common problem for patients who receive peritoneal dialysis and peritonitis rates are used as quality indicators for in-home peritoneal dialysis. To prevent infection, anyone assisting with the procedure must strictly follow infection prevention protocols like hand washing, wearing personal protective equipment (like gloves and masks), cleaning the incision site, keeping the catheter dry and disinfecting equipment.

Our approach is working. Over these first six months of the program, there have been no incidences of peritonitis or exit site infections in program patients.

OUR TEAM

TOTAL EMPLOYEES: 333

- Front-line employees: 284
- Program management & corporate support: 52

LONG-SERVING STAFF

- 5-9 years: 70
- 10-14 years: 31
- 15-19 years: 16
- 20+ years:: 26

A CLIENT'S PERSPECTIVE: ICC Peritoneal Dialysis

Mrs. T is a deeply religious person who relies on her faith in times of difficulty. She has attended prayers every day for years and her peritoneal dialysis treatment needed to accommodate her prayer meetings, which are a crucially important part of her daily life.

One of the key benefits for eligible patients of peritoneal dialysis over hemodialysis is the flexibility it provides patients as it frees them to go about their daily activities – allowing patients greater lifestyle choices and independence.

A key goal in the Peritoneal Dialysis stream of the Integrated Comprehensive Care program is to promote independence and the patient's participation in their own care, involving their caregivers and family members when appropriate.

In order to attend the early morning prayer meetings, Mrs. T would need to be disconnected from the dialysis machine (or PD cycler), a procedure often done by a home care nurse. Fortunately, Mrs. T has a close-knit family and a relative volunteered to help disconnect the cycler each morning.

Working with Mrs. T and the Peritoneal Dialysis Clinic at St. Joseph's Healthcare Hamilton, SJHC's home care nurses and program management we were able to come up with a plan that would permit Mrs. T to attend prayers while ensuring she would have optimal health outcomes. The Peritoneal Dialysis Clinic provided specialized training for Mrs. T's relative, with additional supervision and support at home from SJHC nurses.

Proper training is important to prevent infections like peritonitis or exit site infections, which can be serious. Following procedures and ensuring that the proper disinfection and hand hygiene is in place are essential.

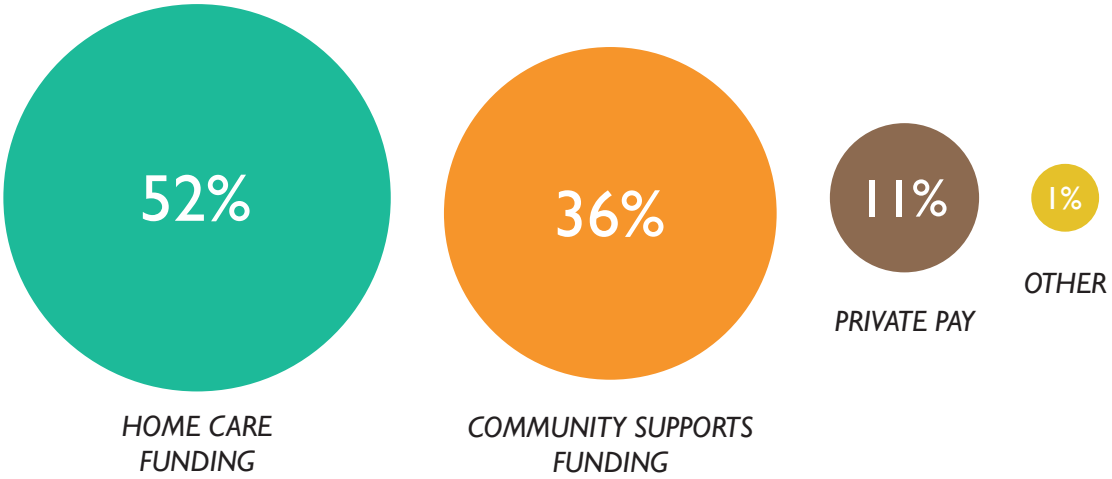
Mrs. T's relative now has the flexibility to disconnect the peritoneal dialysis cycler as needed.

The ICC model's virtual rounds facilitated the planning process by allowing SJHC to connect directly with hospital colleagues at the Peritoneal Dialysis Clinic to brainstorm solutions that meet the patient's wishes. Working together, we were able to provide the training needed so Mrs. T could attend to her spiritual needs.

**Client's initial is used to protect privacy*

FUNDING

Total Funding for 2017/2018: $16.1 million



CLIENTS SERVED

PROGRAM	CLIENTS SERVED	SERVICE UNITS
Visiting Nursing	2,467	76,726 visits
Shift Nursing	38	15,100 hours
ICC	2,619	35,602 visits
Supportive Housing	272	46,490 resident days
Community Supports	1,225	83,207 hours

PROGRAMS AND SERVICES

COMMUNITY SUPPORT SERVICES

- Personal care & companionship
- Caregiver relief & respite care
- Assisted living in supportive housing: Gwen Lee, First Place, Wellington Terrace, Park Street, Neighbourhood Model
- Home cleaning & maintenance
- Safety at home: falls prevention
- Food services & catering
- Transitional beds at First Place

HOME CARE SERVICES

- Visiting nursing
- Shift nursing
- Private nursing
- Advanced foot care
- Therapies
- ICC Program

PROCESS CHANGES FOR MORE PERSON-CENTRED NURSING CARE

Important process improvements have been implemented to support operations in the Visiting Nursing program that have a real impact in how we deliver on our promise of person-centred care.

We have changed the way we confirm our initial visits. Once an offer for service is accepted by the Visiting Nursing team, a Program Assistant calls the client to verify important information, like home address and telephone number. By making contact with the client before the initial nursing visit, we have an opportunity to greet new clients even before service starts. It helps us begin the therapeutic relationship earlier and each new client's connection to our organization.

It 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. More importantly, this call improves how supported each client feels on initial transition into our Visiting Nursing program.

We are keeping a close eye on our quality metrics and review reports of critical indicators daily.

Our frontline nurses are receiving enhanced supports from management too. Community nursing can feel lonely and overwhelming, even for veteran nurses. To foster teambuilding, the management team in the Visiting Nursing program has implemented monthly group practice meetings to provide nurses a forum to engage in clinical and operational problem-solving and provide the opportunity for touch-points and relationship building. In addition, we provide supplementary support to front-line nurses by joining nurses on client visits as needed; this helps nurses gain confidence in their independent practice, a quality that is intrinsic to caring for patients right in their own home.

Enhanced Technology to Improve Patient Care

In 2015 SJHC started a technology upgrade in the Visiting Nursing and ICC programs to adopt new modules in our existing client database that would ultimately reduce paper-based patient health documentation, decrease the amount of time nurses spent on administrative tasks, and create efficiencies in travel and mileage calculations and reimbursement.

Through the project, the Visiting Nursing program rolled out tablets to all our nurses and adopted a module in our client database that allows nurses to conveniently see their patient assignment list on one page.

We need to continue the journey of improving our technological capabilities to support client care in the Visiting Nursing program as we invest in tools that open up time for direct care for our front-line staff. Ultimately, our goal is to use as much of each nurse's time providing direct care for clients rather than to complete paperwork.

Technology that reduces the burden of administrative processes on our nurses and the manual work done by our office staff is a much needed investment and having these technological supports is an expectation of our funders and is a standard within our sector.

Working with the LHIN Home and Community Care

The Patients First Act tabled in 2016 granted additional responsibilities to the province's 14 Local Health Integration Networks for advancing locally-integrated patient-centred healthcare delivery. A significant change in this legislation was that the Community Care Access Centres (CCACs) were dissolved in May 2017 and oversight for home and community care was transferred to the LHINs.

As a long-standing service provider organization in the greater Hamilton community, SJHC continues to collaborate closely with the LHIN Home and Community (formerly CCAC) and we are actively involved in discussions and problem-solving improvements to services for clients across our region including brainstorming solutions and building efficiencies in home care delivery, such as reorganizing referrals by geographic area so service provider organizations can focus staff in a particular area of the city and reduce the amount of time nurses spend on the road. Discussions continue and we are proud to be at these tables continuing to advocate for clients in our community.

BUILDING CAPACITY TO IMPROVE PATIENT FLOW

Ensuring that clients receive the care they need in the most appropriate setting is an enormous concern for all healthcare organizations and we are very proud of the work we are doing to improve access to supportive housing and ease patient flow issues.

LHINs across the province were mandated to make it their focus for 2017-2018 to improve patient flow through hospitals, avoid unnecessary hospital stays, and reduce the time people spend in hospital waiting for the right level of care.

In October 2017, SJHC launched a new 40-unit supportive housing hub at First Place Hamilton thanks to combined funding from the HNHB LHIN and the MOHLTC. Funding was for personal supports and assistance with activities of daily living, as well as a rent subsidy.

The program aimed to serve a population that was identified by the HNHB LHIN as pursuing long-term care prematurely because of a lack of alternative affordable community housing and care options (retirement homes are prohibitively expensive and there are few supportive housing options). Affordability, not care needs, was the driving factor in choosing to go into long-term care.

SJHC staff and dignitaries at the funding announcement by the MOHLTC on October 25, 2017.

This funding was targeted to assist seniors designated alternate level of care (ALC) in hospitals and/or health facilities who are able to live independently with appropriate supports, but cannot return to their previous home because they are homeless or need affordability assistance to secure an appropriate home.

Housing is an important social determinant of physical and mental health and well-being. The ability to access suitable stable housing, coupled with the appropriate care, has supported individuals in

retaining greater independence and control of their own care needs over an extended period of time.

It improves quality of life for individuals who, with the combination of housing assistance and supports, could live independently in the community for a longer period of time by providing care for an aging population with complex needs and supporting aging in place. It improves the ability of individuals to manage their own care and care decisions and would also prevent individuals from being prematurely admitted to long-term care.

Images of the residences in the First Place Supportive Housing program.

This program is an example of how we can work together to provide community-based solutions to alternate level of care challenges by working together with partners from our Hamilton-based hospitals, St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, the LHIN's Home and Community Care, and CityHousing Hamilton.

HQO Standard on Dementia Care for People Living in the Community

Health Quality Ontario (HQO) is responsible for defining the meaning of quality in health care and publishes a number of standards to serve as a quality guideline for clinicians and patients. The HQO 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.

HQO 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.

Lori Lawson, Director of Community Support Services at St. Joseph's Home Care was a member of the Community Quality Standard Advisory Committee for Health Quality Ontario. The purpose of Committee was to provide advice to HQO to support the development of a Quality Standard for the delivery of community-based dementia care.

Continued on page 17

A CLIENT'S PERSPECTIVE: First Place Supportive Housing

For Mr. S, Hamilton has always been home. Born and raised here, he has always been drawn back to his birthplace, even after a promising career in the Navy where he got to travel the world. Back in Hamilton, he worked odd jobs for years until he eventually settled into a driving a taxi. He enjoyed driving, even when that meant regular12-hour shifts.

Sadly, he had to stop driving for a living after suffering a heart attack while behind the wheel of his taxi. For the next 14 years, Mr. S was unable to work, surviving on income from the Ontario Disability Support Program.

Four years ago, Mr. S noticed that his left foot had turned black. The black continued to spread up his leg, resulting in the amputation of his leg. He would need a total of 6 surgeries and spend a lot of time in hospital. In fact, he was hospitalized over Christmas and two New Year's over the last four years.

After a two-month hospitalization, Mr. S was referred to the First Place Supportive Housing program. Mr. S credits the program for his health now; he says he wouldn't be doing as well as he is without the help. He loves the PSWs helping him and says they have made a huge impact on his life. For instance, Mr. S cannot cook for himself anymore but the PSWs happily help him with this and other things.

Personal supports are only a part of why Mr. S is doing better now. He has found a home in the community at First Place Hamilton. When he first moved to First Place, he didn't know anyone – that soon changed. Mr. S is outgoing and loves talking to people and this has helped him make friends in the building and beyond. He often goes out of his way to help others feel less lonely and says his favourite thing to do is to sit outside on a nice day with the new friends he has made and just talk with anyone and everyone.

**Client's initial is used to protect privacy*

Mr. S enjoys a rest at home

The Community Quality Standard Advisory Committee was tasked with determining the priority areas for the development of quality statements that had the highest potential to improve the care of individuals with dementia living in the community.

Over the course of a year, quality statements were developed that focused on these core principles: people living with dementia need a comprehensive assessment; involvement of an inter-professional care team to support them; individualized care plan that family and service providers can follow; education and training for people living with dementia and their caregivers; service provider training and education; a named point of contact to assist with communication and planning; timely access to services; caregiver assessment and support; appropriate housing; and, access to primary care.

Through public consultation people across the province had the opportunity to provide feedback on these principles that would come to form the basis for the Quality Standard that was released in March 2018.

QUALITY IMPROVEMENT METRICS

We have been in voluntary compliance with the Excellent Care for All Act requirement that healthcare organizations establish yearly quality improvement plans since 2012. Each year we identify areas for improvement and establish quality goals. For 2017-18, our quality improvement plan results are:

Complete a medication reconciliation for all clients in the Visiting Nursing Program

Target: 90%
RESULT: 90%

Client satisfaction for in-home personal support care in the Integrated Comprehensive Care Program

Target: 92%
RESULT: 100%

Nursing contact within 24 hours of hospital discharge for clients enrolled in the Integrated Comprehensive Care program

Target: 95%
RESULT: 86%*

Improve the referral acceptance rate in the Visiting Nursing Program

Target: 94%
RESULT: 95%

* Since we did not meet our target for this indicator, we will keep the metric on our Quality Improvement Plan for 2018-2019 so we can continue to closely monitor progress.

A MESSAGE FROM THE ST. JOSEPH'S HEALTH SYSTEM

Each day, the physicians, staff, researchers, learners, donors and volunteers of St. Joseph's Health System (SJHS) dedicate remarkable effort, expertise and time to advance the Mission of SJHS in the spirit and charism of the Sisters of St. Joseph. Without the support, leadership and the contributions of our member Organizations and Foundations we simply could not achieve our goal of improving care and inspiring discovery. This year, we acknowledge with pride and gratitude, just a few examples of the many successful projects developed with, and for, our patients, clients, residents and their families.

Compassionate Care and Innovation

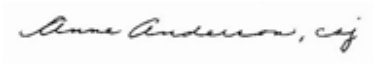
The driving strategic focus of SJHS is to better integrate the care experience. Much important work in recent years has been led by St. Joseph's Villa in Dundas, St. Joseph's Lifecare in Brantford, and St. Joseph's Health Centre in Guelph.

- Plans for a new hospice in Dundas and record breaking fundraising to build it
- Expansion of hospice beds in Brantford in a state of the art and 'home like' environment
- Continued success in Hospice Outreach, which greatly increases access to hospice care
- An expert review of selected emergency departments in Hamilton and the Niagara Region, to provide recommendations on how to make them more 'Senior Friendly'
- Coordinated end of life care to remove the stress of navigating the health care system
- Integrated specialized geriatric health care services with Navigators to support families

Other highlights this year include:

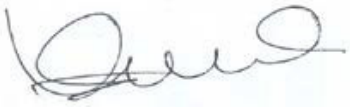
- St. Joseph's Healthcare Hamilton live-streamed a kidney transplant operation to raise awareness about kidney disease and the importance of organ donation. This award winning live-stream and associated social media received 30 million hits worldwide.
- St. Mary's General Hospital in Kitchener was ranked among the top three Cardiac Centres in Canada, and also the safest hospital in Canada two out of the last five years.
- St. Joseph's Home Care continues to be the Canadian leader for the integration of home care and hospital services and has now coached or advised more than 50 health care organizations across Canada.
- St. Joseph's Healthcare Hamilton implemented a new electronic medical record (EMR), and is expected to receive the highest EMR ranking possible within twelve months.
- In close partnership with McMaster University and the Diocese of Hamilton, our International Outreach Program continues to support teaching hospitals in Haiti, Guyana and Uganda, by providing training and ongoing support to physicians and nurses in those countries in clinical specialties, education and research.

With Gratitude and Best Wishes,



Sister Anne Anderson

Chair, St. Joseph's Health System



Dr. Kevin Smith

President & CEO, St. Joseph's Health System

St. Joseph's Home Care

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