moving forward

Annual Report 2019

Dr. Carolyn Gosse,
President of
St. Joseph's Home Care

In February 2019, the Ministry of Health and Long-Term Care announced profound changes to the healthcare system. In particular, the launch of Ontario Health Teams and Ontario Health will have a signficant impact on how care is coordinated and delivered in Ontario.

Ontario Health Teams will be built with an emphasis on deep patient engagement and co-design, and a coordinated continuum of care for a population within a geographic region. Ontario Health Teams will be exepected to offer patients 24/7 access to coordination of care, system navigation services and seamless transitions throughout their care journey

As we prepare our Annual Report to the community, we reflect on our accomplishments over the previous year. In light of the changes to our healthcare system, it is also very timely to reflect on the future of our healthcare system, and the ways in which SJHC can contribute to the new vision of healthcare in Ontario.

We have a unique opportunity to contribute to integrated care, building on our extensive experience in the Integrated Comprehensive Care Program, and expertise in community support programs and visiting nursing programs.

We are very optimistic about the future of integrated healthcare,and the enormous potential that technology has to improve how we deliver care in the community. As we launch our strategic plan in the fall of 2019, in partnership with St. Joseph's Healthcare Hamilton and St. Joseph's Villa, we will be building on the strengths of our teams and experience to date.

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THE CHANGING HEALTHCARE SYSTEM

The Minister of Health and Long-Term Care announced significant changes to the healthcare system in February 2019. One key change was the consolidation of 14 different health care oversight agencies into one "super-agency" called Ontario Health. Another important change was the development of provider-driven local Ontario Health Teams (OHTs) to integrate health and social services across sectors locally– from hospital, to community care, to home care, to primary care, to long-term care.

Over the last few months, partners from across the different healthcare sectors in Hamilton have come together to design a new way to provide services for Hamilton residents. Partners includes primary care, home care, community mental health, the City of Hamilton, McMaster University, local hospitals and more.

As the population ages, the number of seniors with multiple chronic conditions will increase over the next decades, which will put additional pressure on the healthcare system to provide the appropriate level of care and in the most suitable environment for patients and caregivers.

As leaders in integrated care, St. Joseph's Home Care has built an expertise and first-hand experience in working across sectors to provide patients a seamless transition from hospital to home; we have managed the home care portion of a bundled funding model; and, have extensive experience in providing community support services for seniors.

The Hamilton Health Team has taken initial steps by forming the Hamilton Health Team and working collaboratively with organizations across all sectors to submit the self-assessment to the Ministry of Health and Long-Term Care. We are now waiting for the Ministry's response and look forward to the next phase of developing the Hamilton Health Team.

The Hon. Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care and the Hon. Donna Skelly MPP for Flamborough—Glanbrook pose with senior leaders from the St. Joseph's Health System and Niagara Health. at the annual System Day. This year's theme was integration, innovation and inspiration.

DEVELOPING A STRATEGY FOR OUR FUTURE

Last fall, St. Joseph's Home Care embarked on a journey to determine our strategic direction for the next five years. Strategic planning provides a shared direction that helps guide day-to-day decisions and focuses the energy, resources, and time of everyone in the organization.

This 5 year plan for our organization is being developed in conjunction with our system partners, St. Joseph's Hospital and St. Joseph's Villa, Dundas. Working together, under the direction or our one board of directors, will result in a synergized strategic plan with a focus on providing integrated care where ever possible to meet the needs of our community.

Our direction for the future has been informed through an open and creative exchange of ideas and included input from staff, community partners, and our clients and caregivers. We looked outside of our organization to our government, LHIN's, Health systems and other care provider organizations for input into the plan. We wanted to understand they envision the future delivery of integrated, technology enabled care, as our patient population grows and their care needs become more complex.

All this information was consolidated, key themes were distilled, and the leadership team analyzed the results and identified areas of focus. Across the system, we have most recently focused on the government of Ontario's new vision for the healthcare and are in the process of reflecting these different elements in our directions, goals and initiatives.

The St. Joseph's Home Care's strategic plan is nearing completion. Together with SJH and the Villa, we are targeting the fall 2019 to launch the final plan which will outline how we will work together with our patients, caregivers, staff, the St. Joseph's health system, our service provider partners and the government of Ontario to deliver the high quality care our patients have told us they want.

A LEAD AGENCY

Since 2012, St. Joseph's Home Care has been the lead home care agency in an integrated care model. As leaders in integrated care in the province of Ontario, St. Joseph's Home Care is developing a Lead Home Care Agency framework that will support the expansion of integrated care for patients across the province.

One of the challenges of integrated care is the collaboration between sectors to ensure patients have a seamless transition from one sector to another. SJHC has a significant advantage in our expertise as a lead home care agency in the Integrated Comprehensive Care program, a program we pioneered with St. Joseph's Healthcare Hamilton. This expertise puts SJHC in a position to support hospital organizations across the province to launch integrated care models.

Leveraging our proficiency in integrated care provides an opportunity to expand a model of care that has been proven to have better health outcomes with higher patient satisfaction.

LEADERSHIP CHANGES

Dr. Carolyn Gosse, President

In October, Dr. Carolyn Gosse, President of St. Joseph's Home Care, was appointed President of St. Joseph's Villa. Carolyn is also Vice-President of Integrated Care at the St. Joseph's Health System, a position she has held since 2016.

The President roles at St. Joseph's Home Care and St. Joseph's Villa were reorganized to advance the strategic goals of St. Joseph's Health System of integrating services for patients and residents across the continuum of care, from home to hospital to long term care.

Ms. Lori Lawson, Senior Director

In alignment with these added responsibilities, Ms. Lori Lawson was appointed Senior Director at St. Joseph's Home Care with oversight for all day-to-day operations at SJHC. Her responsibilities include the direction of all management staff, budget development and compliance, strategic direction of programs within the Community Support Services and Visiting Nursing divisions, legislative compliance, and general business.

Lori has been in the role of Director of Community Support Services at St. Joseph's Home Care since July 2015.

ICC SHOWS GREAT RESULTS IN INDEPENDENT STUDY

In 2015, the Ministry of Health and Long-Term Care (MOHLTC) issued a call for proposals to participate in an Integrated Funding Model (IFM) initiative to test integrated care and funding. In total six projects were selected for this pilot; one of these projects was the expansion of the ICC model to patients with congestive heart failure and chronic obstructive pulmonary disease to the entire HNHB LHIN (ICC 2.0). The goal of the project was to improve efficiency and value for money as well as patient, caregiver and provider experience.

The MOHLTC commissioned an independent evaluation of all 6 programs that was completed by the Health System Performance Research Network at the University of Toronto. The evaluation focused on identifying success factors and potential barriers to implementation of integrated care models; measuring patients' health outcomes; measuring and reporting on costs and healthcare resource utilization, as well as patient, caregiver and provider experience; and informing policy and potential provincial spread of integrated models of care.

In a report published in June 2019, the HSPRN researchers concluded that the IFM program had positive patient outcomes and reduced health care cost and attributed much of the success of the initiative to the two largest, ICC 2.0 being one of these two. The report went further to recommend expansion bundled care to all surgical care and to explore improvements needed for successful roll-out to all patients with chronic medical conditions.

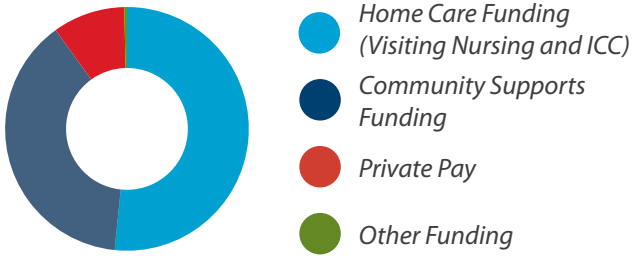
St. Joseph›s Home Care was the lead home care agency for the spread of ICC for patients with congestive heart failure and chronic obstructive pulmonary disease across the HNHB LHIN. We worked with nine partner hospitals across the region to integrate care for this patient population for better health outcomes and collaborated closely with allied health professionals from St. Elizabeth Health Care, ProResp and VitalAire who provided various therapeutic services.

One of the keys to a successful integration of care across sectors is the transition of patients and the information that is provided to patients, caregivers and the care teams. We can attribute much of the success of ICC 2.0 in improving health outcomes and patient satisfaction to the education and support patients and caregivers received from the home care team, a dedicated group of nurses, PSWs and allied health professionals who ensure patient healthcare needs were being met in their own homes.

2018-19 YEAR IN REVIEW

FUNDING

Total funding for fiscal 2018-2019: $16.7 million



OUR EMPLOYEES

329 *Total number of employees*

280 *Front-line employees – RNs, RPNs and PSWs*

84 *Employees who have been with St. Joseph's Home Care* ***10+ years***

COMMUNITY SUPPORTS FOR THE FUTURE

St. Joseph's Home Care PSWs Michelle, Yolanda and Felicia help clients in the Neighbourhood Model program with various activities of daily living.

With 17 programs spanning supportive housing, personal supports in the home, falls prevention, home maintenance, to reduction of social isolation for seniors, St. Joseph's Home Care has a recognized expertise in caring for seniors and a deep knowledge of issues related to aging and the complexities of providing personal supports for older adults in their own homes.

Our philosophy of care is to provide services to meet the needs of each individual client, understanding and respecting each individual's needs and wants. We tailor services around the person to meet their physical, mental, social and spiritual needs and support seniors to live independently for as long as possible and improve their quality of life.

In Hamilton seniors make up 17.9% of the population (according to the 2016 census) and the number is projected to almost double by 2031. Older adults, and their families and caregivers, are best served in a community setting where services are coordinated for the individual to meet their unique needs.

Providing care in the community can be complex, with a combination of intricate factors that can include the impact of social determinants of health, housing stability and affordability, mental health and addictions, multiple chronic disease diagnoses, reduced mobility and cognitive impairment.

St. Joseph's Home Care has an invaluable expertise in providing supports for individuals in a community setting. We are well positioned to continue developing programs that meet the needs of seniors in a community setting and leverages an interdisciplinary team and specialty services to manage chronic conditions and support seniors to remain independent in the community for as long as possible.

CONNECTIONS & PARTNERSHIPS

When you consider how many partners are involved in providing services in a community setting, the list is quite extensive.

As a member of St. Joseph's Health System, St. Joseph's Home Care works very closely with Hamilton partners St. Joseph's Healthcare Hamilton, an academic acute care hospital, and St. Joseph's Villa, one of the largest not-for-profit long-term care facilities in Ontario.

We also work with regional and provincial partners that include the provincial government, the Hamilton Niagara Haldimand Brant Local Health Integration Network, for-profit and not-for-profit home and community care service providers, hospitals, long-term care facilities and other organizations that specialize in seniors' services, the Hamilton Council on Aging, the City of Hamilton and CityHousing Hamilton, etc.

We have a recognized expertise in seniors' care and integrated care, and a reputation for being a reliable and engaged partner. We are often approached to share our expertise and participate within our broader community as members of a number of working groups, tables and committees that inform seniors' care and integrated care.

SPECIALTY CARE UNIT AT FIRST PLACE HAMILTON

In April 2019, St. Joseph's Home Care launched the Specialty Care Unit, a 12-unit transitional bed program tailored to clients with a dementia diagnosis who have exhibited responsive behaviours .

The program operates within the retirement residence floor at First Place Hamilton with support from the HNHB LHIN.

St. Joseph's Home Care has partnered with the Behavioural Supports (BSO) Program at St. Joseph's Villa to ensure supports are in place for program residents. In particular, BSO will support the development of care plans for resident that incorporate strategies for reducing responsive behaviours.

The goal of the Specialty Care Unit is to help residents transition to their next destination.

PREVENTING EMERGENCY DEPARTMENT VISITS AND UNNECESSARY ADMISSIONS TO HOSPITAL

St. Joseph's Healthcare Hamilton (SJHH) received funding from the Ministry of Health and Long-Term Care in March 2018 to develop an integrated care framework for Admission Avoidance and ALC reduction. Focus was on discharge plans for general internal medicine patients, particularly the frail elderly, who presented to the emergency department but did not need admission to hospital.

We believed this patient population would benefit from the philosophy of one team, one number to call, one medical record to support patients in their own homes and prevent unnecessary hospital admissions.

The ICC support was in place for the 72-hours post-discharge from the emergency department until home care could be scheduled through the HNHB LHIN Home and Community Care.

During this pilot phase, we identified new opportunities to support these patients in the community and collected key data on the outcomes for patients enrolled in this pilot. The initial trial was extended for an additional 3 months so more feedback and outcome data could be collected.

The innovative approach with the patient at the centre was a key enabler of success. Stakeholders highlighted improved processes, and both patients and providers had a positive experience during the pilot.

This pilot program reinforced the importance of timely, informed communication between hospital and home care teams to ensure supports are in place for patients as soon as they arrive home from hospital. Access to a shared medical record with input from all team members created a safety network surrounding the patient and allowed smoother transitions in care from hospital to home.

DATA HIGHLIGHTS

Number of patients supported with ICC: 20

Average age of patients who received ICC support: 81.3 years old

Patients with ICC supports receiving a nursing visit within 24 hours of discharge: 95%

Discharge phone calls made: >120 patients

Readmissions for Patients receiving ICC supports: 0

ED Revisits for Patients receiving ICC supports: 1

EXPANDING INTEGRATED CARE

St. Joseph's Home Care Registered Practical Nurse Dayna speaking with a patient in the ICC program.

The Integrated Comprehensive Care (ICC) program has been successfully operating within the St. Joseph's Health System (SJHS) and Niagara Health (NH) since 2012 for patients who have thoracic surgery, cardiovascular surgery, hip or knee replacement surgery, and patients with Chronic Obstructive Pulmonary Disease or Congestive Heart Failure.

This innovative model provides seamless patient-centered care by fully integrating the hospital and home care teams, providing the patient and caregiver with one point of contact, and enabling both hospital and home care staff to access a single electronic health record.

The ICC program has experienced positive results to date by enabling a seamless transition from hospital to home for patients in the program. Notable improvements include better provider and patient experiences, along with reductions in the length of hospital stays, post-discharge visits to the emergency department, and lower readmissions to hospital.

With support from the Ministry of Health and Long Term Care our ICC program is expanding to new patient populations and will be rolled out to patients who live in the community who are having a planned (elective) surgery at St. Joseph's Healthcare Hamilton that require home care on discharge from hospital. This expansion of the program translates to an additional 700 patients each year that will be enrolled into the ICC program.

Surgery streams are being rolled out progressively in close collaboration with our hospital partners and started in March 2019 with patients undergoing an esophagectomy or laryngectomy. The next patient stream will be patients undergoing a prostatectomy and transurethral resection of the prostate (TURPS).

Other elective surgical procedures will follow, including cardiovascular surgery, general surgery, neurosurgery, obstetrics and gynecology, orthopedic surgery, otolaryngology, plastic surgery, and vascular surgery.

LEVERAGING TECHNOLOGY FOR BETTER PATIENT CARE

LEADING VIRTUAL CARE

Since January 2019, St. Joseph's Home Care has partnered with St. Joseph's Healthcare Hamilton and the Ontario Telemedicine Network (OTN) to leverage OTNs two-way videoconferencing and provide virtual nursing visits to patients in the Integrated Comprehensive Care program.

Telephone visits (nursing assessments completed by telephone) were introduced in 2012 as part of the carepath in the original pilot for the ICC program. Adoption of virtual visits allows St. Joseph's Home Care nurses to replace telephone assessments with a face-to-face virtual visit.

Virtual visits give patients flexibility, as they can connect from their home using their smartphone, tablet or computer with a webcam. The conversation over video feels more natural and allows both the nurse and patient the full range of verbal and non-verbal communication. Nurses have better insight into the patient's progress and can provide more in-depth and timely assessments.

ADOPTING MOBILE TOOLS

We continue to adopt technological solutions to improve patient care.

We have made a significant investment to adopt a mobile application that allows nurses to start, close and verify patient visits in their car on their smartphone.

Using this application reduced administrative processes that were onerous and took a nurse's time away from direct client care and clinical documentation.

The application was rolled out in fall 2018 and also provides frontline staff with accurate information on the best route between one patient's home and the next patient's home and ultimately helps nurses reduce the time spent on the road and away from patients.

2018-19 YEAR IN REVIEW

OUR CLIENTS

Program	No. of Clients Served	No. Units of Service
Visiting Nursing	2,055	77,689 *visits*
Shift Nursing	27	13,592 *hours*
ICC	2,713	44,077 *visits*
Supportive Housing	368	70,807 *resident days*
Community Connectors	158	752 *home visits*
Other Community Supports	1,431	126,051 *hours*

A MESSAGE FROM ST. JOSEPH'S HEALTH SYSTEM

When the Sisters of St. Joseph's arrived in Hamilton in 1852, they began their work in the freight sheds at the docks in Hamilton treating the victims of a cholera epidemic often putting their own lives at risk caring for the sick in a time when health care was a luxury for the few.

Today, the Sisters' mission shapes and informs our unique culture, which is the hallmark of our service. Their legacy lives through each one of our physicians, staff, researchers, learners, donors and volunteers of St. Joseph's Health System (SJHS). Our system encompasses five cities, with over fifteen thousand staff serving a population of over 2 million. SJHS is a sought after leader in the delivery of integrated care, which is transforming patient care and outcomes.

Congratulations to the St. Joseph's Home Care team, which, under the outstanding leadership of the Board Chair Sonny Monzavi and President Carolyn Gosse, through the support of our generous donors, continues to empower and support our vision. Home Care plays a critical role spreading our innovative Integrated Comprehensive Program (ICC). The nurses, PSW's and frontline staff have done an exceptional job providing seamless transition for patients from hospital to home and we're very proud of the entire team.

SJHC also launched a 40-unit supportive housing program for patients in hospital who are homeless or precariously housed and in need of personal support, where their housing and supports needs are a barrier to hospital discharge.

SJHC is a vital pillar in the health of our community delivering high-quality care. Without the support, leadership and the contributions of our member Organizations and Foundations, we could not achieve our goal of improving care and inspiring discovery through education and research.

We are proud to acknowledge just a few examples of the many initiatives developed with, and for, our patients, clients, residents and their families.

Integrated Comprehensive Care (ICC)

St. Joseph's Health System's Integrated Comprehensive Care program has received global, and national attention from health organizations as one of the sought after programs that seek to provide the highest quality of care, delivering a seamless health care journey for patients from the hospital to the community with a fully equipped health care team within reach 24/7. This year, SJHS launched a virtual care option

for our ICC patients that made headlines in Ontario. Patients and their families can connect with their care team virtually, anytime from anywhere during recovery.

Results show 98% patient satisfaction and up to 30% reduction in readmissions to hospitals and emergency departments. The numbers speak for themselves, and our member organizations are working on expanding the program to a wider net of patients, clients and residents.

Other highlights this year include:

- St. Joseph's Healthcare Hamilton under the leadership of Dr. Adili performed the first robotic knee replacement in Canada using the MAKO Rio Surgical Robotic System. The robot is currently being used to perform knee replacement surgeries as part of research into this new technology and will eventually expand to include research into hip replacement and other orthopedic surgical needs.
- St. Mary's General Hospital in Kitchener once again ranked among the top three Cardiac Centres in Canada. It is recognized as one of the safest hospitals in Canada, with the seventh lowest mortality rate in the country and readmission rates that are significantly lower than the national average.
- St. Joseph's Villa is on track to open Margaret's Place Hospice at St. Joseph's Villa in 2020. It will be a yet another significant step in the provision of palliative services both for residents and those at home. With over 140 years of dedicated service, we look forward to continued progress and innovation in the many programs offered not only to our residents but to the entire community through SJV.
- St. Joseph's Health Centre Guelph will begin construction of 28 affordable rental townhouses geared to seniors on its land this spring. The object is to provide housing for seniors in an accessible manner and to meet the housing needs in the County of Wellington and Guelph.
- Stedman Hospice at St. Joseph's Lifecare Centre in Brantford is providing end of life care outside hospice walls and into homes. The Community Outreach Program assesses, arranges and coordinates palliative care service for the patients and families in their residence to fulfill the last wishes.

It is our pleasure to express our thanks and gratitude to all those who contribute to the member Organizations and Foundations of the SJHS.

With Gratitude,

Sister Anne Anderson,
Chair
St. Joseph's Health System

Dr. Thomas Stewart,
President & CEO
St. Joseph's Health System

CONTACT US

PHONE 905.522.6887

MAILING ADDRESS
1550 Upper James Street, Suite 201
Hamilton, ON L9B 2L6

FAX 905.522.5579

CHARITABLE REGISTRATION NO. 108C1 4077 RR001

STAY CONNECTED

SJHCPresident@stjhc.ca

www.stjosephshomecare.ca