St. Joseph's Home Care

# Annual Report to the Community

June 2015

**Mr. Carl Santoni**
Board Chair
*St. Joseph's Home Care*

**Ms. Jane Loncke**
Interim President
*St. Joseph's Home Care*

We like to take time each year to reflect on the year that was and share some of our accomplishments in our community. This year, we have an over-arching theme that encompasses much of our efforts throughout the year: cementing our partnerships and collaborations to drive the client experience.

We continue to embrace the Government's plan for health care system reform and have demonstrated our willingness and ability to find innovative ways to collaborate with other healthcare organizations to develop partnerships that deliver better service for clients.

## WORKING IN ALIGNMENT WITH PROVINCIAL OBJECTIVES

Responding to recommendations in Bringing Care Home, a report from the expert group on home and community care, the government has released Patients First: A Roadmap to Strengthen Home and Community Care, which is in turn aligned with the next phase of the government's transformation of the health care system to meet the changing needs of Ontarians established in Patients First: Action Plan for Health Care released in February.

One project that has been highlighted time and again by the Minister of Health and Long-Term Care is the St. Joseph's Health System Integrated Comprehensive Care (ICC) initiative. We are immensely proud to have been the lead home and community care agency in the Hamilton Niagara Haldimand Brant and Waterloo Wellington areas.

We are very proud of the project results: a smoother transition from hospital to home that has resulted in a reduction in the length of hospital stay, and associated healthcare resource use, increased health care staff satisfaction and

engagement, and, most importantly, increased client satisfaction. The Minister of Health and Long-Term Care has already called this approach a "better and more integrated care for patients and their families."

In fact, the pilot has been so successful that the government has invited health care institutions and organizations across the province to submit expressions of interest to develop other innovative models which may be similar to the ICC "bundled care" approach.

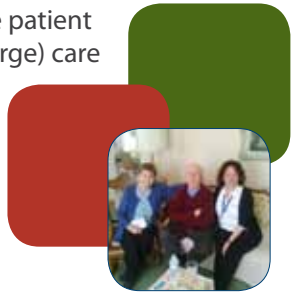
As the project moves from the pilot stage to a sustainable initiative, St. Joseph's Home Care will continue to seek out innovative opportunities to champion changes that will drive efficiencies while providing high quality client-centred care.

## IMPROVING TRANSITIONS FOR THE MOST VULNERABLE

St. Joseph's Home Care is collaborating with St. Joseph's Healthcare Hamilton and St. Joseph's Villa on an initiative that aims to improve transitions for vulnerable populations, especially elderly patients, between all three organizations: hospital, home and community care, and long-term care. Improving transitions for vulnerable populations is aligned with the principles of client-centred care. The program is called STEP – the Seniors Transitions Enhancement Program.

When transitions are not planned with all parties in mind, it is the clients who can suffer the consequences. An example that illustrates the challenges of transitions is the experience of Mr. J, a single 85 year-old with multiple chronic conditions and mild cognitive impairment who is supported in assisted living by St. Joseph's Home Care. Mr. J goes to the Emergency Department in the morning with complaints of back pain and inability to get up out of bed or walk, but is released from hospital in the afternoon the following day still unable to get out of bed. In the evening, he falls out of bed and is transported to the Emergency Department at a different area hospital, where he is admitted.

This situation illustrates a few of the most significant challenges related to safe patient care in the current transition (discharge) care planning. Hospital staff may not have been aware that Mr. J lives in Assisted Living and that St. Joseph's Home Care provides supports, and since they don't know about the patient's relationship with SJHC,



the discharge planner would not have known to contact SJHC to ensure the right supports are in place to care for Mr. J after he is discharged from hospital.

The project goal for STEP is to develop, implement and evaluate a program for safe, effective and efficient transitions in care for our most vulnerable seniors and their families and/or informal caregivers. The program seeks to implement a Standard of Practice for Transitions: a corporate standard within all programs, services, and departments at SJHC, SJHH, and SJVD to to enhance seamless transitions scros the healthcare continuum. This standard also sets out expectations for staff in the areas of communication and collaboration.

Using the example above, our vision for an improved client experience is that hospital discharge planners would know what community agencies already provide services to a particular patient and there would be communication between the hospital and the agency to plan for supports in the home post-discharge. Prior to discharge, the agency would be aware that the patient is being discharged from hospital and the hospital would know that the necessary supports are in place for the patient in the community. This is what is often referred to as the "warm hand-off".

St. Joseph's Home Care and our partners in Hamilton are acknowledged leaders in improving transitions for clients and providing client-centred care. While the program is being developed and tested within St. Joseph's in Hamilton, the program is being created with the intention of rolling it out more broadly. The aim is to create an approach that can be replicated throughout by balancing standardization for consistency and customization through individualization that focuses on partnerships with clients.

## DELIVERING ENHANCED TRAINING, LEVERAGING PARTNERSHIPS

As a member of St. Joseph's in Hamilton, SJHC had the opportunity to collaborate with partner St. Joseph's Healthcare Hamilton in boosting training available to staff. Training initiatives included hosting workshops for SJHC personal support workers on the Gentle Persuasive Approach led by staff from St. Joseph's Healthcare Hamilton.

Gentle Persuasive Approach is an evidence-based, practical, person-centred training program designed for people who care for older adults with dementia and their challenging responsive behaviours. It has proven to be an effective way to help persons with dementia when they are upset and frustrated, which focuses on treating people with dementia with compassion, respect and dignity. It helps promote the safety of both the patients and staff and improves the quality of care for elderly patients who have cognitive challenges. Approximately 60% of SJHC PSWs have been trained on the Gentle Persuasive Approach.

It is not just SJHC that benefits from this collaboration; the learning opportunity is mutual. The sessions were led by various health professionals (physiotherapists, nurses, occupational therapists, speech language pathologists, social workers, educators, and recreational therapists) from St. Joseph's Healthcare Hamilton, who in turn gained an increased awareness of the community and, ultimately, a better understanding about some patients they see in hospital.

*"It was definitely a different experience teaching PSWs... It became evident that PSWs are more exposed to responsive behaviours because of the personal care they provide."*

*"I found all topics that speakers discussed I can use in my work/job as a PSW," especially to "always see things from their [the client's] perspective"*

## 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.

In alignment with the Ontario government's priorities of providing the right level of care, in the right place and at the right time, St. Joseph's Home Care continues to be an enthusiastic participant in providing support for seniors to allow them to live independently as long as possible.

One of the three goals identified in the report is to "ensure that Ontario seniors are provided with the programs, services and supports that help them live safely, independently, and with dignity."

SJHC is a witness and an enthusiastic participant in the shift of resources to areas of greater need, especially to community care. In alignment with the province's goal of providing the right care, at the right time, in the right place, we have observed a continued trend of moving more care to the community. SJHC continues to expand its community support services and this past year has presented notable opportunities to collaborate with funders, the Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC) and other service organizations in providing supports in a community setting.

## TRANSITIONAL COMMUNITY WELLNESS PROGRAM

While the transitional beds program at First Place was launched in Fall 2013, the program underwent a thorough transformation in the last year.

Hamilton has been faced with an increase in the number of individuals waiting in hospital for an alternate level of care (ALC). While this situation has created a serious patient flow issue in acute care facilities, what is even more significant is that the patient flow challenge has a detrimental effect on patients; according to Dr. S. Sinha, older adults lose 5% of their function each day they are in hospital.

In October 2014, SJHC received funding for a substantial increase in the number of beds available through the program – from three to 32. The revised funding was accompanied by a broader focus.

Transformed into the Transitional Community Wellness Program, the program has evolved as

a collaborative initiative between the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN), the Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC), St. Joseph's Healthcare Hamilton, Hamilton Health Sciences, City of Hamilton, and colleagues in the retirement home sector to address the patient flow challenges faced by acute care hospitals in the city. The program leverages the potential for transitional accommodation in local retirement residence environments.

The Transitional Community Wellness Program provides personal support services for patients whose acute treatment phase is complete but who are unable to return to their pre-hospital living arrangement because they still require additional supports. Patients and their families receive the support of a clustered environment staffed by personal support workers on a 24/7 basis for personal hygiene, assistance with mobility, medication reminders, and just-in-time support for urgent personal care.

The First Place Transitional Beds Program is one of several programs under the Transitional Community Wellness Program. The program provides the supports necessary for clients to recover from their acute medical episode before returning to life in the community.

Outcomes reported by the program include reduced hospital lengths of stay and improved patient experience. SJHC staff has observed improved independence, cognition and mobility for clients in the program.

## COUNCIL ON AGING

Glenys Currie, Director of Community Support Services at SJHC is a member of the Board of Directors of the Hamilton Council on Aging. Glenys is the Chair of the Committee Against Abuse of Older Persons. The work that SJHC does on a daily basis to provide support services for seniors to promote independence is well aligned with the focus of the Council on Aging, which is to improve aging experiences for older adults.

Glenys chairs the Committee Against Abuse of Older Persons (CAAOP), of the Hamilton Council on

Aging. The Committee's mandate is to strengthen the community's ability to prevent, recognize and respond to the abuse of older persons through advocacy, education and linking individuals to services that assist older adults at risk of being abused.

With funding from the Government of Ontario, SJHC organized a series of Self-Defense for Seniors Information Sessions in collaboration with The Committee Against Abuse of Older Adults of the Council on Aging.

## COLLABORATIVE CARE MODEL

Over the past year, the HNHB LHIN has been working with community partners including SJHC and the HNHB CCAC to expand their shared capacity to support older adults living in the community. Older adults living in the community needing low level personal support at home are now receiving care through LHIN-funded community support service (CSS) agencies.

The goal is to standardize and integrate services to ensure that personal support services are available to people who need them and to have greater coordination between HNHB CCAC and CSS which will help ensure the right place of care for patients.

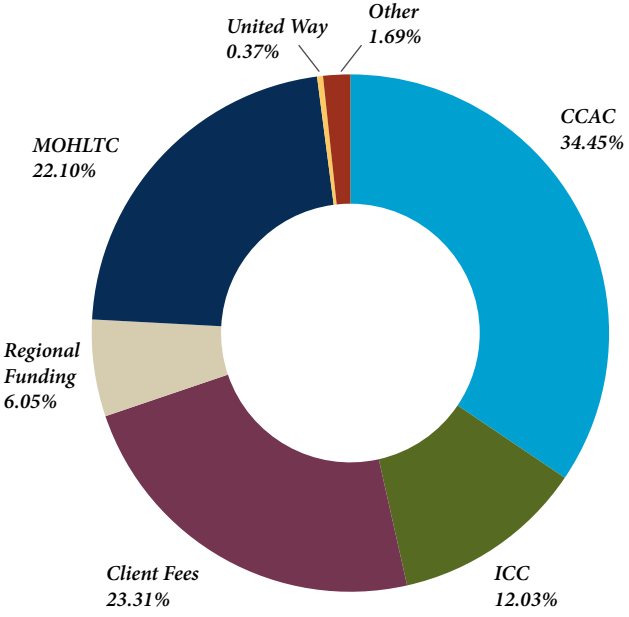
Launched in February 2015, the Collaborative Care Model (CCM) program is a "hub" based model of home care service delivery with the capacity to serve 60 clients with light to moderate needs living in downtown Hamilton and Dundas.

Clients in this program require personal support for safety and independence to prevent deterioration of functional status. It supports older adults, who are capable of living independently with appropriate supports and community linkages, and who are in need of or are currently receiving one or more home and community services as a result of their frailty or long-term chronic conditions with light or moderate care needs. Care can include assistance with showering or bathing, dressing and undressing, personal hygiene, toileting, feeding, transfers, and other routine activities of daily living.

With care provided right in the client's own home, the program fosters a self-management approach to prevent escalation of care needs and focuses on linkages to community resources for other programs to proactively promote independence in the home and prevent deterioration of function and allow functioning within the community.

# BY THE NUMBERS

## FUNDING SOURCES
year ended March 31, 2015




## STAFF

| | |
|---|---|
| TOTAL STAFF | 345 |
| Front-line staff | 305 |
| Corporate support | 40 |

## LONG-SERVING STAFF

| | |
|---|---|
| 5-9 YEARS | 81 |
| 10-14 YEARS | 29 |
| 15-19 YEARS | 19 |
| 20+ YEARS | 19 |

## EXCELLENCE IN END-OF-LIFE CARE

Most Canadians would rather die at home surrounded by their loved ones, than in hospitals. Being at home can often help patients remain involved with their families and live as normally as possible. Some feel that when they are at home they have more freedom to make choices about their care.

Palliative care, a specific approach to services focusing on the relief of pain and other symptoms for patients with advanced illnesses and on maximizing the quality of a patient's remaining life, received much attention recently with the release of the Health Quality Ontario (HQO) report, titled Health Care for People Approaching the End of Life: An Evidentiary Framework, and the 2014 Annual Report of the Office of the Auditor General of Ontario, both released in December 2014. The HQO report calls for fundamental changes to improve end-of-life care in Ontario; the Auditor General of Ontario report included a review of palliative care in the province that was critical of the inconsistent availability of high-quality end-of-life care.

St. Joseph's Home Care provides quality palliative care in a patient's own home through our visiting, shift and private pay nursing programs. Care for a palliative client can vary from one-hour to several hours of care per week, to shifts of 8 or 12-hours, depending on the health status of the patient and their care needs. The care is provided by both Registered Nurses (RNs) and Registered Practical Nurses (RPNs), usually working as a team.

Nurses regularly screen patients for distress and other needs using validated screening tools. The type of assessment used and the intervals for re-evaluation depend on the needs of the patient. Results of these screening tools are used to prompt further discussions with patients and their families, including critical conversations about a person's illness understanding, their values and beliefs, and their goals and wishes for current and future care. These conversations are on-going and revisited regularly.

An important objective of palliative care is to meet

the psychological, social, cultural, emotional and spiritual needs, as well as the physical needs of each person and family. For patients who are terminally ill and within their last few weeks or months of life, palliative care helps the patient live out their remaining time in comfort and dignity.

SJHC nurses have various levels of knowledge in palliative care; in fact, 79% of SJHC nurses have at least one type of formal training in palliative care, making palliative care an area of significant strength in our Home Care Services. Training ranges from having completed The Comprehensive Advanced Palliative Care Education (CAPCE) Program, Learning Essential Approaches to Palliative and End of Life Care (LEAP) or the Fundamentals of Palliative Care course to provincial certification in palliative care from Hospice Palliative Care Ontario.

According to the report published in December 2011 by the Local Health Integration Networks, the Quality Hospice Palliative Care Coalition of Ontario and the Government of Ontario titled Advancing High Quality, High Value Palliative Care in Ontario, A Declaration of Partnership and Commitment to Action, specialized palliative and advanced chronic disease resources need to be coordinated at a regional level through an organized program or network. Our expertise in direct palliative care continues to be recognized through our participation in local and regional efforts to improve the delivery of palliative care, specifically our membership in palliative-centric committees. Within the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN), Jane Loncke, President of St. Joseph's Home Care, is a member of the Regional Hospice Palliative Care Program Council; this group is tasked with developing a comprehensive integrated regional palliative care program. SJHC is also a member of the Palliative Care in Nursing Quality and Safety Committee at the Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC), a group that establishes best practice guidelines for palliative care at the local level.

## CARE & SERVICE DELIVERY PROJECT

One of the challenges of delivering nursing care in clients' homes each day is to ensure continuity of care for the clients so that the same nurse or team of nurses visits the client, scheduling visits

around each client's availability and scheduling preferences, while ensuring visits are scheduled in such a way that nurses have the opportunity to spend the majority of their time providing direct care to clients. At times, this can seem like a herculean task.

To drive client satisfaction through improvements in visit scheduling and continuity, SJHC launched the Care and Service Delivery Project in June 2014. The purpose of the project is to improve continuity of care.

For us this meant re-evaluating staffing needs, including examining competencies, continuing education needs for staff, the RN and RPN scope of practice. Part of this work included reorganizing SJHC's catchment area into sectors and assigning teams to each sector to reduce nurses' time spent on the road. We also adopted LEAN principles and improved communication internally, engaging staff in driving quality improvements that impact the client experience.

Since the program launched, we have experienced a notable improvement in client satisfaction, and the work continues.

# BY THE NUMBERS

## CLIENTS SERVED

| Program | Clients | Service Units |
|---|---|---|
| Visiting Nursing | 2,819 | 74,968 visits |
| Shift Nursing | 31 | 9,633 hours |
| ICC *Hamilton \| Kitchener* | 1,927 | 22,940 visits |
| Assisted Living Gwen Lee \| Wellington Terrace \| Neighbourhood Model \| Park Street Hub \| First Place | 367 | 102,884 resident days |
| Observational Care & ALC | 138 | 60,066 hours |
| Transfer of Personal Support (TOPS) | 26 | 1,984 hours |
| Community Services | 557 | 12,298 hours |

**Sister Anne Anderson**
Board Chair
*St. Joseph's Health System*

**Dr. Kevin Smith**
President & CEO
*St. Joseph's Health System*

This year has been rich in innovation and initiatives that improve care for those we are privileged to serve. We would like to highlight three of those remarkable initiatives.

## INTEGRATED COMPREHENSIVE CARE INITIATIVE

Since the Integrated Comprehensive Care Initiative (ICI) launch in March of 2012, this model has developed into a successful bundled care program that coordinates acute and home care services to improve the patient experience and outcomes while also providing value to the healthcare system. The ICI and bundled care model is in place in Hamilton and Waterloo and we are now in the process of having this model adopted by other sites across Ontario, with the SJHS taking a lead role in this expansion.

Advantages of the ICI bundled care program include:

- Better experience and better outcomes for patients
- Empowering patients to thrive at home while still receiving appropriate medical care
- Providing patients continuous access to clinical care including, surgeons, nurses, physiotherapists, and personal support workers
- Focus placed on fast, timely, and responsive care
- ICC care coordinator ensures an inclusive model of care from referral until rehabilitation is complete
- 24/7 access to ICC care coordinator
- Value for healthcare services

During his February 2, 2015 address at the Empire Club of Canada, Dr. Hoskins stated, "We believe that we will see similar results if we expand this model to other clinical streams, such as mental health, head and neck surgery and other chronic diseases." In carrying out Dr. Hoskins' vision, patients can depend on having a wider range of clinical services available to them through comprehensive integrated care.

## ST. JOSEPH'S HEALTH SYSTEM PARTNERSHIP WITH NIAGARA HEALTH SYSTEM

SJHS would also like to recognize the positive partnership and progress achieved with the Niagara Health System (NHS), and particularly our joint collaboration to enhance the care of patients who experience chronic renal disease. Dr. Kevin Smith, President and CEO, SJHS and CEO, NHS, affirms that having both organizations work closely together ensures the highest quality patient experience for residents in the Hamilton Niagara Haldimand Brant (HNHB) LHIN. The program currently stands as Ontario's largest renal care partnership and looks forward to additional alliances which will serve the best interest of our patients and communities.

## ST. JOSEPH'S HEALTH SYSTEM: ELDER CARE INITIATIVE

Another highlight of the past year is the SJHS Elder Care initiative which includes the leadership teams at St. Joseph's Villa Dundas, St. Joseph's Lifecare Brantford and St. Joseph's Health Centre Guelph. The goal of this model is to mobilize our combined talent, expertise, and resources to advance elder care in order to: provide leadership in the standardization of clinical best practices, the measurement of outcomes, and the achievement of benchmarks across a network of elder care sites; advise and partner with LHINs, hospitals, and other service providers for the delivery of effective senior-friendly services; be looked to as a provincial resource and pilot site for innovation in service delivery and transitions in elder care.

The ICC bundled care model, our partnerships with NHS, and our progress in Elder Care, are a reflection of our continued commitment to living our Mission, Vision and Values. Through our ongoing commitment to providing high quality, compassionate care and continuously striving to enhance the patient experience, we are advancing as an academic health system, with the ultimate goal of improving patient care and patient experience for those we serve.

Our success reflects the generous contribution of all Board members, management, staff, volunteers and physicians for the unwavering support that they provide to improving care to our patients and residents. Without their support and the contributions of our member Foundations and donors we would not be able to achieve this extraordinary level of patient focused care.

# CONTACT US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