Hamilton Board Committee

Thursday, March 29, 2012
15:30 pm
Dofasco Boardroom – Juravinski Innovation Tower

Open Session

ST. JOSEPH'S VILLA
Over 125 Years of Love and Care for Seniors

St. Joseph's Healthcare Hamilton

St. Joseph's Home Care

St. Joseph's Healthcare Hamilton

St. Joseph's Villa — Over 125 Years of Love and Care for Seniors

St. Joseph's Home Care

HAMILTON BOARD COMMITTEE (HBC)

*March 29, 2012 – Juravinski Innovation Tower –**1530** hours*

OPEN SESSION

	Page(s)	Time
1. PROTOCOL 1.1 Call to Order – Mr. B. Gould 1.2 Opening Prayer - Mr. P. Tice 1.3 Introduction of Guests 1.4 Declaration of Conflict of Interest		3:30-3:35
2. APPROVAL OF AGENDA – Mr. B. Gould		3:35-3:40
3. ADDITIONS TO THE AGENDA – Mr. B. Gould		
4. APPROVAL OF THE HAMILTON BOARD COMMITTEE MINUTES OF FEBRUARY 23, 2012 (OPEN) Motions for Approval: Hamilton Board Committee 4.1 ***That the minutes of the February 23, 2012 Hamilton Board Committee be approved***	1-3	
5. REPORTS 5.1 Chair's Report – Mr. B. Gould 5.2 President's Report – Dr. D. Higgins/Mr. S. Gadsby/Mrs. K. Ciavarella 5.3 President of the Medical Staff – Dr. T. Packer 5.4 St. Joseph's Healthcare Foundation and St. Joseph's Villa Foundation – Ms. S. Filice-Armenio/Ms. M. Ellis	4-23	3:40-3:45 3:45-3:50 3:50-3:55 3:55-4:00
6. OTHER BUSINESS		4:00-4:05
7. INFORMATION ITEMS		
8. MOTION TO MOVE INTO THE CLOSED SESSION		

Note: Trustees who wish to have items moved from the Consent Agenda to the Closed/Open Agenda should contact the President's Office prior to the Board Meeting. Trustees also have an opportunity to make this request when the agenda is presented at the Board Meeting.

St. Joseph's Healthcare Hamilton

St. Joseph's Villa — Over 125 Years of Love and Care for Seniors

St. Joseph's Home Care

Committee:	**Hamilton Board Committee – OPEN SESSION**	Date: February 23, 2012
Called to order at:	1530 hours	Adjourned: 1610 hours
Location:	Dofasco Boardroom – 2nd Floor Juravinski Innovation Tower	
Present:	Mr. B. Gould, Chair, Mr. C. Santoni, Mr. T. Thoma, Mr. J. LoPresti, Mr. R. Rocci, Mrs. M. Taylor, Mr. S. Monzavi, Dr. M. Guise, Ms. W. Doyle, Dr. T. Packer, Mrs. I. Schachler, , Dr. H. Fuller.	
Regrets:	Mrs. M. Dow, Mr. T. Valeri, Dr. J. Kelton, Mr. P. Tice.	
Resource Staff:	Dr. D. Higgins, Mr. S. Gadsby, Ms. F. Ros, Ms. V. Dodds, Mrs. K. Ciavarella, Ms. M.Ellis.	
Guests:	Dr. A. Bellissimo, Ms. S. Hollis, Ms. D. Elder, Ms. K. MacKinnon, Mr. R. Cercone, Mr. J. Woods, Mr. J. Nashid.	
NEXT MEETING	March 29, 2012	

Subject	Discussion
1. PROTOCOL	
1.1 CALL TO ORDER	The meeting was called to order at 1500 hours by B. Gould.
1.2 OPENING PRAYER	J. LoPresti opened the meeting with a prayer.
1.3 GUESTS	All guests in attendance were introduced.
1.4 DECLARATION OF CONFLICT OF INTEREST	There was no declaration of conflict of interest.
2. APPROVAL OF AGENDA	It was MOVED by C. Santoni, SECONDED by R. Rocci, VOTED AND CARRIED: **THAT THE HAMILTON BOARD COMMITTEE AGENDA BE APPROVED AS CIRCULATED**
3. ADDITIONS TO THE AGENDA	There were no additions to the open agenda.
4. APPROVAL OF THE MINUTES	It was noted that K. Smith was also present at the meeting. With this correction, it was MOVED by J. LoPresti, SECONDED by M. Taylor, VOTED AND CARRIED **THAT THE MINUTES OF THE HAMILTON BOARD COMMITTEE (OPEN) OF JANUARY 26, 2012 BE APPROVED**
5. REPORTS	
5.1 Chair's Report	B. Gould reported the following: • The Drummond Report was released last week featuring recommendations to address Ontario's current economic challenges. The HBC was provided a document summary from the OHA. It is important to note that at the present time

Subject	Discussion
	coming months it will be determined which will be implemented and which will potentially become legislation. In 2010-11 it was noted that the Province of Ontario spent 40.3% of its program funding on health care; as such, 105 of the report's recommendations pertain to health care. Further updates will be provided as information and decisions become available. • The Around the Bay Road Race will be held on March 25th. Great support from the community has been realized as all categories of the race are sold out. • Two patient safety walkabouts are scheduled for March 2012 – one in the Pre-Anesthetic Assessment Unit and one in the SPD Department.
5.2 President's Report	**D. Higgins – President – St. Joseph's Healthcare** • Accreditation Canada has implemented new accreditation decision levels. SJHH has received the standing - Accredited with Exemplary Standing, which is the highest level of standing an organization can achieve. SJHH underwent accreditation in 2011. **K. Ciavarella – President and CEO – St. Joseph's Home Care** • It was noted that with respect to the LHIN Assisted Living Services/Supportive Housing Stakeholder Working Group, the meeting between the LHIN and the stakeholders did not occur and will be rescheduled in the near future. • With respect to the ProHome Acquisition, it was noted that the amalgamation of these two entities will provide a "one stop shop" for clients. • The Government of Ontario's action plan under the umbrella of a new Senior Care Strategy, the MOHLTC outlines proposals to provide 3 million new hours of personal support to seniors in their homes. Depending on how those hours are allocated SJHC may or may not see increased service levels, when more information is known about the plan we will have a better sense of how it will impact the organization. **S. Gadsby – President, St. Joseph's Villa Dundas** • In response to a question, it was clarified that the position of Medical Director at the Villa is a physician who supervises medical care provided at the Villa. The role of the Medical Director, a physician, is to supervise care provided at the Villa. • It was noted that the recommendations from the Office of the Chief Coroner – Geriatric and Long Term Care Review Board are not legally binding. The intent of the recommendations are to provide a guideline and build awareness and recognition of issues to LTC providers. Providers are encouraged to review these recommendations carefully.
5.3 President of the Medical Staff	The following was reported: • It was noted that physicians do not have access to hospital Employee Assistance Programs (EAP). Several physicians have offered to provide EAP services on a voluntary basis to physicians who feel the need or require the use of these services. • The issue of wait times for the new Tim Horton's in the Lobby of the JIT was discussed. Solutions to enhance staff and visitor wait times will be explored with the service provider.
5.4 St. Joseph's Healthcare Foundation and St. Joseph's Villa Foundation	**St. Joseph's Healthcare Foundation** • There was no further report.

Subject	Discussion
	St. Joseph's Villa Foundation • The AVIVA Fund renovations are scheduled to begin on April 16th with a target completion date in June. • The 11th Annual St. Joseph's Villa Gala will be held on April 20th at Liuna Station. Please contact the Foundation Offices at SJV should you wish to order tickets for this event. • A donation of computers for resident use in 15 Resident Home areas has been made. SJV has 13 on site and are expecting two more in the first quarter of 2012. • The Foundation is launching a $2M Capital Campaign for SJV to renovate and construct 12 additional long term care beds. A first gift of $400K has been secured.
6. OTHER BUSINESS	There was no further business.
7. INFORMATION ITEMS	There were no information items.
8. MOTION TO MOVE INTO THE CLOSED SESSION	There was no further business and the meeting adjourned at 1610 hours. It was MOVED by J. LoPresti, SECONDED by T. Thoma, VOTED AND CARRIED **THAT THE HBC MOVE INTO THE CLOSED SESSION OF THE FEBRUARY 23, 2012 HBC** Ben Gould, Chair David Higgins, Secretary Fadia Ros, Recorder

OPEN SESSION REPORT TO THE HAMILTON BOARD COMMITTEE – MARCH 2012

SECTION 1: HBC REPORTING

1.0 Environmental Scan (Legislative, Health Care Industry and Government Update)

1.1 SJVD: Long-Term Care Task Force on Resident Care and Safety to Develop Action Plan to Protect Residents: *Consultations to Address Abuse and Neglect in Long-Term Care Homes*
A task force was established to address incidents of abuse and neglect in long-term care homes, as well as the potential underreporting of these incidents. All long term care homes were provided with numerous materials as well as a questionnaire to have available to complete by families, visitors, volunteers and staff. The Villa posted the information and made questionnaires accessible. Both the Family Council and Residents' Council were made aware of the information. There is a deadline of March 19th to have the questionnaire completed.
The task force is independent of government and is chaired by Dr. Gail Donner, Dean and Professor Emeriti, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. She has extensive experience and expertise in education, research, and health policy and has held a number of government and community appointments.

1.2 SJVD: One-Time Funding Request Approval
The HNHB LHIN identified the availability of funds in the community sectors that would not be spent this fiscal year. There was an extremely compressed timeline and there were over 100 applications for this one-time funding. The HNHB LHIN announced that the Villa would receive funding in the amount of $24,130 for the following:

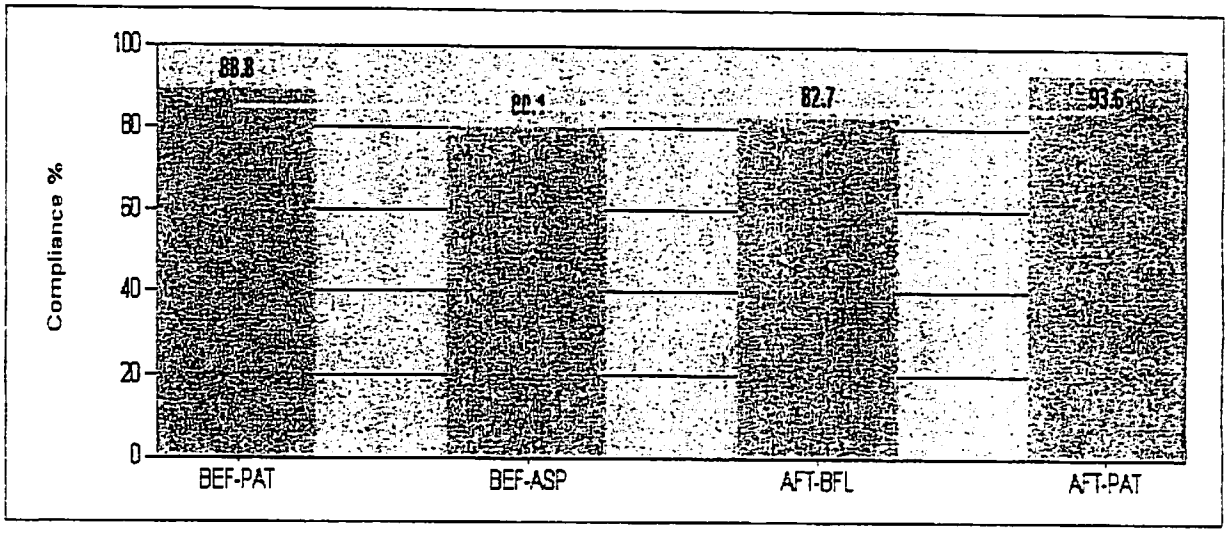
- Dishwasher/installation (Adult Day Program)
- Bathroom Renovation (Community Outreach Services)
- Self Operated Life (Swimming Pool)
- Shower Chairs/Wet Vests (Swimming Pool)

The funds had to be spent by March 31, 2012.

1.3 SJHC: Government Update
Susan Thorning, CEO of Ontario Community Support Association (OSCA) submitted a summary report of budget recommendations to Minister of Finance for 2012 / 2013 which aligned well with the Drummond Report recommendations in regards to the investment in home and community support services. The summary report has been included as an appendix to this President's Report.

1.4 SJHH: Hand Hygiene
The following graph illustrates the "Four Moments of Hand Hygiene" data for all SJHH Campuses. The corporate hand hygiene goal is 85%. The "Four Moments of Hand Hygiene" represented in the graph below are:

- before initial patient / patient environment contact
- before aseptic procedure
- after body fluid exposure risk
- after patient / patient environment contact



2.0 Mission, Vision and Values Update (Strategic Planning, Quality, Patient Safety, Partnerships and Community Engagement, SJHS Mission Integration)

2.1 SJVD: Community Outreach Program

After lengthy deliberation, the decision was made to close the Villa's Community Bathing Program. The impact of the closure will be to nine clients, two of which are Villa residents and others are clients of the Villa's Day Program. The Villa has had to subsidize the program for the last several years, and the funds can be better used to provide care to the residents.

The Community Outreach Clinics do continue to expand. Dr. Anthony Kerigan, Geriatrician will be providing assessments to the Villa's residents on a physician referral basis starting April 4, 2012.

Dr. Flett will be continuing some of his wound care hours after his retirement.

2.2 SJVD: Partnerships with St. Joseph's Home Care: Frozen Entrees

St. Joseph's Estates held an Open House which was hosted by St. Joseph's Home Care. There was a positive response to the meal 'taste testing'. St. Joseph's Home Care has prepared a package offered to Estates Advisory Committee members which explains a bi-monthly frozen meal delivery service to residents who are interested in purchasing meals.

Information will also be distributed to Estates residents to see whether there is enough interest in housekeeping and foot care services. If there is, then a designated person would provide services to several residents during the day. This would lower the cost of the service.

2.3 SJHC: Accreditation Update

On February 15, 2012 SJHC was informed by Accreditation Canada that we had been Accredited with Commendation.

2.4 SJHC: Nursing Subcontracting Agreement

On February 6th, 2012 SJHC begun to coordinate shift care referrals with Pro Home to address unmet CCAC performance indicators in the shift care program. Since the implementation, SJHC has been able to accept referrals improving the contractual obligations under our CCAC agreement.

2.5 SJHC: Home Care Sector: Client Outcome indicators

SJHC has been invited to sit on two working group committees at the Ontario Association of Community Care Access Centres (OACCAC) and Health Quality Ontario (HQO). The objective of these working groups is to come up with a set of outcome-focused indicators that will inform HQO in the development of home and community care quality improvement plans (QIPs).

2.6 SJHC: OHCA symposium

SJHC will be presenting at the Ontario Home Care Association (OHCA) Symposium on May 24, 2012. The focus of the convention this year was quality improvement initiatives. The main focus of SJHC's presentation will be on the results of our 2009 – 2012 strategic plan which was appropriately titled "Operationalizing Strategy: Quality where you need it most – at home!"

2.7 SJHC: Transferring of Personal Support

With the additional funding received from the HNHB LHIN and added to our M-SAA agreement, SJHC has started to receive referrals from the HNHB CCAC for low need clients that are on the CCAC's waitlist. This is a new project and five Community Agencies across the LHIN are working with both the CCAC and LHIN to provide services to clients in the community and to assist them in remaining at home independently. The total funding is $69,603 for both 2011/ 2012 and for 2012/2013. We will be providing 3193 hours of service and will be collecting data, including # falls, # of trips to ER and how many remain at home after a year of service with us. We intend to use this data to extend this funding past 2013.

2.8 SJHC: Healthy Community Funding through the Ministry of Health Promotion and Sport: Hamilton Good Food Box Network

In 2011 SJHC partnered with Environment Hamilton and CityHousing Hamilton in a project that aimed to reduce the number of falls of seniors with low income by improving knowledge of healthy eating through workshops and provision of education material and a good food box. This funding was used to develop a local based Good Food Box that became an important component of SJHC's nutrition program and an integral part of our "Poor and Marginalized" program. This program is due to end March 31st and I am pleased to announce that this program exceeded its targets and we were able to link a reduction in falls among the target population with the provision of nutritional services.
A further application has been submitted to the Ministry of Health Promotion and Sport to expand this program for a further year until March 31st 2013.

2.9 SJHC: Trillium Funding

SJHC has submitted an application to The Trillium Foundation for $43,000 to fund a Volunteer Coordinator to assist in the recruitment and supervision of students and volunteers that work in our Nutrition Program. If successful we will be greatly expanding the role of volunteers to reach more clients.

2.10 SJHH: Diversity Training Project

The Diversity Training Project: "Facilitating Mental Health & Addictions Access and Inclusion" has begun in the Mental Health & Addictions Program. This project is funded through the Ministry of Health Promotion and Sport; Healthy Communities Fund grant. The lead agency, Hamilton Centre for Civic Inclusion (HCCI) has partnered with St. Joseph's Healthcare, Hamilton Mental Health &

Addictions Program, Good Shepherd Homes and the Hamilton Family Health Team. HCCI will conduct diversity assessments with the following two goals:
1. To help marginalized individuals from diverse ethno cultural and linguistic communities successfully gain access, navigate and feel comfortable in the mental health and addiction system.
2. To help organizations that provide service to individuals with mental health and addiction problems become more inclusive and thereby reduce barriers that persons from the diverse communities may experience.

2.11 SJHH: Wellness Program

The Wellenss Program recently launched a new calendar of wellness events that can be found on the SJHH website. Lunch time and after work programming has 180 new participants. The running club is so popular that an additional lunch time class has been added. Wellness Committee will be established in April and will aim to connect to more departments. One example of departmental participation is the Operating Room Team which has agreed to stay after work for a power fitness class.

2.12 SJHH: National Volunteer Week

National Volunteer Week will be celebrated from April 15th-21st with award ceremony on April 18th.

3.0 Planning and Development (Redevelopment, Integration and SJHS Integration Projects; Regional Partners (LHIN, CCAC, MOH, HHS, etc.)

3.1 SJVD: Centric Health Physiotherapy Services: Seniors Exercise Classes

Centric Health's Seniors Wellness division provides physiotherapy services to Villa residents. In discussions with them, they are extending this program to the Estates residents. If there is enough interest, they will provide physiotherapy services to Estates residents in the Social Room through Balance and Strengthening Group Classes and/or Individualized. There is no direct cost to the resident.

3.2 SJHC: SJHS Integrated Comprehensive Care Project

The go live date for the first patient group (Thoracics Department) was March 19, 2012. The home care service delivery will not occur until the week the March 26, 2012. All Integrated Care Coordinators (ICCs) and home care clinical staff have been hired. The PSW hiring process will be taking place in April for the third patient population group (COPD / CHF). Funding agreements are still being finalized with CCAC however we are not anticipating any issues.

3.3 SJHH: West 5th Campus Redevelopment

Project is on schedule and installations of various components such as window, roofing, penthouse siding, interior masonry, stud work, mechanical and electrical installations continue. In order to ensure staff is informed of the progress at the West 5th Campus, tours will be held monthly on Friday afternoons from 3:00 to 4:00 with max, 6 to 8 people. All tour participants will need to attend safety orientation. The intent is to initially have all managers and directors who have been involved in planning of the building through the site at this early stage. As the building nears completion and safety is less of a concern we will open up to larger groups.

SECTION 2 – OPERATIONAL INFORMATION (Changes to Clinical Programs and Services, Financial/Budget Status, Human Resources and Quality of Work Life)

1.0 SJVD

1.1 Compliance: Review Update

The last Villa compliance report that was provided to the HBC was in October 2011. The most recent information since that report is as follows:

Written Notifications (WN)	17
Voluntary Plan of Correction (VPC)	10
Compliance Order (CO)	5
Visits with no Unmet Standards	4

One of these incidents was considered a Never Event after the compliance inspection was issued. This was reported at the last HBC meeting in February and the March 2012 SJHS Mission and Quality Committee. A letter was sent to the Ministry of Health & Long Term Care indicating our concern of the timelines of the review and not indicating the staff response to the allegation.

1.2 Outbreaks

SJVD is currently experiencing three outbreaks:

Outbreak Type	Current # of cases	Declared
C. Difficile	2	February 28, 2012 - no new cases
Norovirus	5	March 1, 2012
Respiratory	2	March 13, 2012

1.3 Behavioural Supports Ontario (BSO)

The Villa has hired 40 staff with goal of "Going Live" April 2, 2012. Project Lead will be finished as of March 31, 2012. The Memorandum of Understanding has been sent to each Long Term Care Home.

2.0 SJHC

2.1 Sandoz Canada Drug Shortages

Sandoz Canada recently announced a reduction in their ability to produce some injectable drugs. The Ministry of Health and Long-Term Care is coordinating the Ontario health care system's response to the drug shortage.

The main impact for home care will be on our palliative clients who rely on some of these medications. To date we have not experienced any problems and the agency is working with our community partners, associations and CCAC to mitigate the risk associated with the shortages.

3.0 SJHH

3.1 Charlton Campus - Intensive Care Unit (ICU) Redevelopment Project

Phase One of the ICU redevelopment project was completed on March 8, 2012. The new rooms are patient centered; the décor is bright and fresh, showcasing bright greens, blue sky ceiling, laminate natural wood flooring and much natural light to encourage wellness, comfort and speed of recovery. New equipment promotes quality and patient safety with features such as state-of-the-art lights useful for line insertion, procedures and patient exams. Each new ICU patient room features a flat

screen LED TV, two procedure carts, a line insertion cart and a continuous renal replacement supply cart enabled by a generous gift from the HMECU. Wall-mounted documentation stations, with wireless access points are located outside each patient room which enables staff to complete patient documentation while being able to see and monitor the patient.
Over 510 staff members toured through the new ICU on the afternoon of Friday, March 2nd and over 100 staff and family members visited during the evening open house. This renewal and expansion project is another positive step in the development of the new SJHH Department of Critical Care Medicine.

3.2 Health System Funding Reform

On March 19th the Ministry of Health and Long Term Care announced changes to hospital funding methodology. The new Patient Based Funding Model will consider how many patients are seen in a particular hospital, services provided, quality of those services and specific community needs. This new model will be phased in over the next three years. This new approach is part of the *Ontario' Action Plan for Health Care*; this type of funding model has already been adopted with positive outcomes in Sweden, England, British Columbia and Alberta. SJHH is one of 91 Ontario hospitals that are transitioning to the new Patient Based Funding Model. The Ministry of Health and Long Term Care Backgrounder is provided below for additional information:

Patient-Based Funding For Hospitals *- March 19, 2012*
Hospitals currently receive one lump-sum payment called a global budget, which is based on a hospital's previous budget, instead of on a hospital's performance. There are significant disadvantages to this funding model, including differences in the quality of care, how much a procedure costs at each institution, patient outcomes and specific community needs such as population growth. The new patient-based funding model would fund patients instead of the institutions, meaning families get the right health care, at the right time, in the right place. The new model is also more cost effective. There are two main components to patient-based funding.

1. Health-Based Allocation Model
Health-Based Allocation Model is an evidence-based funding method that takes into consideration the population and clinical needs of the communities served by a hospital. Population information includes age, gender and growth projections, as well as socioeconomic status and geography. Clinical information measures how many complex patients are receiving care and the types of care being provided to the community. For example, hospitals that serve growing and more clinically complex communities will see an increase in their funding over time.

2. Quality-Based Procedures
Health care providers will receive funding for the number of patients they treat for select procedures, using standard rates that are adjusted for each procedure. Ontario will establish prices for hospital services based on efficiency and best practices.
Starting in April, Quality-Based Procedures will include:

- *Hip replacement*
- *Knee replacement*
- *Dialysis and other treatments for chronic kidney diseases*
- *Cataract surgery*

Other quality-based procedures will be added over time. Global budgets will still be in place for activities that cannot be modeled. Small hospitals and forensic mental health services will continue to be funded through global budgets.

Patient-based funding will be phased-in over the next three years as follows:

	April 2011	Phase 1 April 2012	Phase 2 April 2013	Phase 3 April 2014
Quality-Based Procedures	0%	6%	15%	30%
Health-based	1.5%	40%	40%	40%
Global	98.5%	54%	45%	30%

3.3 Critical Drug Shortage

Sandoz Canada, a key manufacturer of IV injectable drugs used primarily in hospitals, has significantly slowed production. Sandoz produces more than 110 drugs including antibiotics, anaesthesia drugs, pain management and anti-nausea medications. This is a national issue is being addressed at the SJHH level with collaboration between the medical and administrative leadership. The Incident Management System (IMS) has been put in place immediately after the shortage was announced. With patient care quality and safety as the main priority, processes have been developed to identify in advance the drugs that may be in critical supply. Daily IMS meetings have enabled the creation of new methods for tracking drug inventory and utilization as well as communication templates to ensure all staff are aware of modified drug dispensing practices. All staff have access to the new "Hot Button" on MyStJoes Intranet which consolidates all communications including Daily IMS Updates, Clinical Process Change Communications, and an updated Critical Drug List. Developments and communication from the LHIN, Ministry of Health and Long Term Care and Health Canada are actively being monitored.

3.4 Emergency Preparedness Exercise

On March 3rd a very successful provincial emergency exercise took place at SJHH in partnership with Ministry of Health Emergency Management Branch, the provincial Emergency Medical Assistance Team, Red Cross volunteers, students, Emergency Department nurses and physicians from across Hamilton. More than 300 people including professional actors simulating patients took part in an exercise that mimicked a disaster requiring urgent medical care. Recommendations and key learning's resulting from this exercise will be used to further enhance emergency preparedness across the province.

OCSA
Ontario Community Support Association

Ontario Community Support Association
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Recommendations to The Government of Ontario For the 2012-2013 Budget

Transforming Healthcare and Controlling Costs through Community-based Health Services

Our Vision:

As Ontario's population ages, it has become clear that our health care system must move beyond acute care services to fully embrace integrated community-based delivery models. Don Drummond, in his recently released report underscored the importance of this. Ontario's Action Plan for Health Care also recognizes the need for "care as close to home as possible." We agree with Minister Matthews that we "need to keep seniors and others with needs, living in their own homes."

We need to reduce avoidable visits to hospital and help seniors and people with disabilities return home quickly with supports after necessary hospitalizations. The delivery model must support timely and equitable access to care in the community regardless of location. As well as receiving value for money, it must ensure that Ontario's citizens receive the appropriate services, delivered by the most appropriate health service provider at the most appropriate location.

In our view, sustaining our health care system will require two things:

1. Investing in approaches which help people stay healthy and independent at home, and
2. Resourcing appropriately the most cost-effective delivery models in home and community support.

While we recognize the current fiscal pressures, we urge government to invest in the community in order to protect our acute and long-term care resources for those who really need them. When considered in relation to the entire health budget, these investments are minimal and will, over time, save the system money.

Below we have outlined our recommendations to the Government of Ontario on how to direct health care spending so that our health system might be changed in order to create a truly people centred health system and at the same time, responsibly control costs.

Integrated Services for Home and Community Support

For more than a decade there has been discussion and serious consideration of the benefits of integrated health care in Ontario. Recently Ontario's Ministry of Health and Long-Term Care (MOHLTC) released two more reports, "Enhancing the Continuum of Care"[1] and "Caring for Our Aging Population and Addressing Alternate Level of Care."[2] Both of these were calls to action on health system integration. The most recent report by Don Drummond recommends expanding the scope of the Local Health Integration Networks (LHINs) and including primary care and public health in a broader continuum.

Yet, in spite of all the discussion and consideration we are still a long way from a provincially supported approach to integrated care. We need to speed the transformation and not spend more time on pilots, trials and tests. We need to identify and replicate existing models which have demonstrated effectiveness; there are many such models across the province.

Some examples of these existing models or those in progress include:

- In the Champlain LHIN there are plans to develop "service hubs" for a range of services.
- In Bolton and Shelburne, Local Health and Care Centres have been initiated which will coordinate services across local providers including primary care, build on existing health services and help address unmet local needs.
- Organizations like CANES in the Central West LHIN and VON in Eastern Ontario have used their base of community support services to expand into Family Health Teams and Pharmacies to create integrated care services for seniors within their catchments.
- The collaborative model on which the Community Health Centres are based is providing an integrated approach which includes primary health care in many communities.
- Supportive housing, assisted living and in-home delivery models provide a natural foundation for integrated care for the elderly and those with physical disabilities. There are numerous creative models for supported living which can be expanded quickly and cost-effectively and which could act as models for new community living options.

These are all models which are built on the existing structures, many integrate primary care and all are worthy of replication. All are built on existing local

[1] Enhancing the Continuum of Care, Report of the Avoidable Hospitalization Advisory Panel, Submitted to the Ministry of Health and Long-Term Care, November 2011.
[2] Walker, Dr. David, Caring for our Aging Population and Addressing Alternate Level of Care, Report Submitted to the Minister of Health and Long-Term Care, June 30, 2011.

momentum; local providers planning, initiating and developing the integrated services.

Recommendations to support development of integrated models of care in the community:

- *Implement integrated systems of care by encouraging and resourcing existing local home and community providers to enhance connections with each other and other health providers. This includes Community Support Services (CSS), home care, community mental health and addictions and community health centres.*
  - *Integration activities must take place from the ground up.*
  - *The goal of integration should be increased access, better quality of services, greater efficiencies and improved customer service for clients*
  - *It is critical to link primary health care to the integrated community services.*

- *Implement provincial approaches for direct access to existing not-for-profit Home Care and Community Support Services providers that simplifies the referral process for family physicians and family health care, hospitals and the public. What the system needs is a robust referral system which allows referrers to connect their clients with existing not-for-profit home care and CSS providers quickly and directly. We are currently adding layers which slow the process, add expense and allow clients to slip between the cracks; all doors should lead directly to services. All providers should be responsible for assessing eligibility and intake to their own services, working closely with other parts of the system to connect clients and caregivers to the services they need while at the same time meeting accountability obligations.*
  - *Waterloo Wellington region has implemented a simple on-line directory and intake booking process which provides effective direct referral to Community Support Services by health care referrers such as family physicians and hospitals. The platform has demonstrated its effectiveness, is already built, and is scalable. It could be implemented province-wide quickly, and with minimal expense to allow direct access to all community support services, saving unnecessary steps for clients and referrers.*

- *Expand supported living options in the community to support a range of needs, from the frail elderly to the individual with more complex needs.*
  - *Investigate successful cohabitation models such as the Abbeyfield model, which can be developed as community alternatives for frail older adults by traditional and non-traditional community groups.*

- *Expand support to caregivers to prevent burnout. Investing in support for family caregivers, especially flexible respite care services would provide up-stream prevention. Respite is a crucial support for families to renew/sustain their energy so they can continue their role as caregiver by helping to avert caregiver exhaustion and burnout. Respite may be the difference that enables them to carry on.*

Health Human Resource: the Transformative Impact of Working to the Full Scope of Practice

The mantra "*right* service at the *right* time in the *right* place" is well accepted as a goal. However the fourth *right*, the *right* service provider, is not consistently considered. Don Drummond's report takes considerable time describing the need to optimize human resources capacity by shifting to the lowest cost, appropriately trained worker. This is also seen by Drummond as a method to address the concern that the current labour pool will not match the future demand for health care professionals.

In the community, nurse practitioners, nurses, and PSWs do not work to their full scope of practice. Allowing, or requiring, care to be provided by more extensively trained health care professionals than necessary results in inflated costs for services. In the home care sector in particular, shifting the care to the most appropriate provider has great potential for increasing the efficiency of service delivery.

Recommendations for Health Human Resources: the Transformative Impact of Working to the Full Scope of Practice:

- *Enable existing not-for-profit home care and community support service providers to accept direct referrals, conduct assessments, determine service plans and manage care plans with appropriate accountability and auditing activity in order to reduce administration costs and duplication of effort and redirect investment to increase hands-on care.*

- *Implement immediately the three million hours of PSW service which were promised by the Liberal party during the recent election and included in Ontario's Action Plan for Health Care.*

- *Implement the Community Health Coordinator concept described in the Liberal election platform. This concept was described in the Drummond Report as a "clerical system navigator." Base this on the successful WWLHIN Geriatric Service Worker program*

- *In the Waterloo Wellington LHIN this model has demonstrated its effectiveness in avoiding un-necessary readmissions to hospital, especially for individuals without robust caregiver support networks. The individuals who are hired as Geriatric Service Workers are unregulated workers which would free up nurses to provide nursing care that requires their level of training and skill.*

- *Use the model of direct referrals, assessments, and case management by providers to minimize administration costs and layers, and optimize the investment available for hands-on care.*

- *Review the home and community care service delivery models currently in place to ensure that the most appropriate health care practitioner is delivering the service with the leanest administrative structure possible.*
  - *Well trained and supported PSWs may be able to take on responsibility for complex but stable clients in the community. Like other health care providers, few PSWs are working to their maximum scope of practice.*
  - *Increase access to attendant services for adults with physical disabilities and assisted living services to support clients with complex needs. The clients of these services often have care needs which exceed what can be managed in long-term care, yet these clients are fully supported safely in their own homes in the community with this successful approach.*
  - *Shift resources from Community Care Access Centres (CCACs) to not-for-profit home care providers to take on the case management function for their clients, resulting in cost savings and better care.*
  - *Allow hospitals to work directly with existing not-for-profit home care and community support providers for the delivery of post-acute home care services.*

Data Analysis to Support Quality Improvement and Increased Accountability

Legislation, public reporting requirements and the M-SAAs make quality improvement activities an imperative for all community care providers. While the CSS and other community sectors are not required to meet all the requirements currently expected of hospitals, they will be required to do so in the future. It is critical that all community sectors build the capacity to be able to meet the requirements when they are applied.

The government has supported the implementation of MIS/OHRS reporting for Community Support Services and is in the process of rolling out a common

assessment instrument. Capacity for data analysis in the CSS sector is now a critical need. With analytics capacity in place, the result will be increased ability to identify and disseminate best practices, improved quality and heightened accountability.

The Drummond Report includes a number of recommendations focusing on electronic records, information sharing, the need for data analysis for planning, fiscal management etc. We agree that these are critical to effective planning and decision making. If we are to make evidence based decisions, we must have data and evidence.

Recommendations for Quality Improvement and Accountability:

- *Mandate and resource the Ontario Community Support Association to provide analysis of the MIS/OHRS and common assessment data to drive quality improvement and increase accountability in the Community Support Sector.*

- *Resource Community Support Service providers for sustained Information Management capacity, including the completion of client assessments on an ongoing basis.*

Addressing Inequities in the System

There has been much effort and focus in recent years on wait times in emergency rooms and addressing the Alternate Level of Care beds in hospitals. The approach has been to push more resources directly at the problem – getting people out of hospital and back home.

What we really need to do is prevent people from entering hospital in the first place. Policy makers agree with this, yet most new funding continues to go to acute care. Home care expenditures as a per cent of total health care expenditures have not risen above five per cent.

Wage restraint legislation has placed an unfair burden on community providers. Compensation in the community is approximately 30% less than other parts of the health system. Wage restraint legislation is increasing this wage differential as well as making it increasingly difficult to recruit and retain skilled and experienced staff in the community. This is particularly troublesome in some parts of the province for both Home Care and Community Support Services where there simply are not enough health care workers. In many parts of the province the community

cannot attract or retain PSWs because they are leaving the community for openings in LTC due to higher wages, guaranteed hours and better working conditions.

Enhancement funding for many services and from several ministries includes only wages and benefits, leaving the agencies to struggle with other necessary costs such as rent and computers for additional services. The cost savings to the total health budget from these measures are miniscule, yet the impact on the ability of the community to build the capacity to support the transformation of the health system is great. In addition, it would be helpful to the CSS sector to have a more global approach to budgets instead of the current line-by-line accountability.

Many of these inequities can be addressed by the LHINs if they are given greater flexibility to shift resources where the need is greatest, such as home care and community care. We agree with Minister Matthews on this point which is clearly articulated in Ontario's Action Plan for Health Care. We agree with Don Drummond in his articulation of this point in his report as well.

Recommendations to Address Inequities:

- *Shift resources from acute care – from hospitals – to home and community support and particularly to those services which provide early intervention to get up-stream of the health conditions and the crisis they create that are backing up Emergency Departments and acute hospital beds.*

- *Do not extend the wage restraint legislation or exempt home and community support providers from this legislation. This will allow home and community support providers to recruit and retain skilled staff.*

- *Recognize administrative and infrastructure costs in all funding to community support service providers. A more global budget approach would assist in the building of capacity in the CSS sector.*

- *Given increased CCAC requirements for service providers related to reporting, statutory employer costs, etc, direct CCACs to pass along the 1.5% budget increase to providers to cover some of these costs of doing business on existing volumes vs allowing CCACs to direct these funds to new and specialized volumes*

We thank you for the opportunity to present our ideas for the transformation of Ontario's health system. Please do not hesitate to contact us if you would like further information on any of these recommendations.

Patient-Based Funding

- information summary

Presentation to the Hamilton Board Committee

March 29, 2012

St. Joseph's Healthcare Hamilton

Health System Funding Reform (HSFR)

- Ontario's Action Plan for Health Care introduced January 2012
- Aim: "better value from health care dollars"

- **Current model**: global funding
- **New model**: Patient-Based Funding (PBF)
  - Compensation based on:
    - number of patients
    - services delivered
    - evidence-based quality of those services
    - specific needs of the broader population served

St. Joseph's Healthcare Hamilton

Why Patient-Based Funding (PBF)?

- Today, health care consumes 42 cents of every tax dollar; by 2024 it could account for 70 per cent of provincial budget
- Changing population structure
- Health care dollars distribution between hospitals, doctors, long-term care, drugs, home care and other services
- Need to shift spending to ensure best value, most appropriate care (ex. home care opportunities)
- Current state:
  - Current lump-sum payment (global budget) is based on hospital's previous budget, instead of on a hospital's performance.
  - Hospitals differ in: quality of care, procedure costs, patient outcomes and specific community needs.

St. Joseph's Healthcare Hamilton

Patient-Based Funding (PBF) Components

1. Health-Based Allocation Model

- Evidence-based method; accounts for community population and clinical needs
- Population information: age, gender, growth projections, socio-economic status, etc.
- Clinical information: how many complex patients are receiving care; types of care being provided to the community

2. Quality-Based Procedures

- Funding received for the number of patients treated for select procedures; using standard rates adjusted for each procedure
- Ontario to establish prices for hospital services based on efficiency and best practices

Starting in April, Quality-Based Procedures will include:

- Dialysis and other treatments for chronic kidney diseases
- Hip replacement
- Knee replacement
- Cataract surgery

St. Joseph's Healthcare Hamilton

Patient-Based Funding (PBF) Phasing

	April 2011	Phase 1 April 2012	Phase 2 April 2013	Phase 3 April 2014
Quality Based Procedures	0%	6%	15%	30%
Health-based	1.5%	40%	40%	40%
Global	98.5%	54%	45%	30%

- PBF will be phased-in over the next three years
- Other quality-based procedures to be added over time

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Patient-Based Funding (PBF) Closing Comments

- Increased funding over time for hospitals that serve growing and more clinically complex communities
- Global budgets still in place for activities that cannot be modeled
  - small hospitals and forensic mental health services global budgets funding to continue

- 91 hospitals transitioning to PBF model
- 55 small hospitals excluded from new model

- PBF used in other jurisdictions with benefits such as decreased wait times and higher number of procedures
  - Sweden (1992)
  - England (2003)
  - British Columbia (2010)
  - Alberta (2010)

St. Joseph's Healthcare Hamilton

Hamilton Board Committee (HBC) – Summary of January 26, 2012 Closed Meeting Session

Motions Summary

Recommending Subcommittee	Motion Summary
Resource & Audit Committee of the HBC	That the Resource & Audit Committee recommend to the HBC - SJHH voting members the following authorization levels to execute individual transactions pertaining to the cash allowances outlined in the signed project agreement for the West 5th facility: ▪ any two of the executive management group for the purchase of goods and services up to $1,000,000 ▪ President and VP or Chief Financial Officers (two signatures) on any value over $1,000,000-$2,000,000 ▪ Chair of the Board of Trustees and President of St. Joseph's Healthcare Hamilton for values greater than $2,000,000 be approved

Presentations and Reports to the HBC - Summary

- Congratulations were extended to SJHH on receipt of the *Leading Practice Designation for Restraints and Seclusions in the Mental Health Program* as reported through the Quality & Mission Committee of the HBC.
- Dr. M. Crowther, Vice President, Research, provided an overview of the research program at SJHH. Discussion took place on topic of enhancing Research at SJHH including the development of a mechanism for reporting research activity and metrics to the HBC.
- Dr. M. Crowther, Chief, Department of Laboratory Medicine provided the guest presentation from the Medical Advisory Committee (MAC). The MAC presentation featured a description of the Department of Laboratory Medicine and specifically the Department's quality management system.
- The preliminary draft of the new Strategic Plan was presented to the HBC; key items of focus are access and continuity of care, staff engagement and research.