



"We want you to stay connected".

COMMITTEE PROGRESS REPORTS

ALL COMMITTEES STILL WORKING HARD

Patient Flow Processes Subcommittee

- Development of a Patient Letter of Understanding
- Development of a Transfer of Accountability Tool
- Development of the CCAC and Hospital Waitlist Template
- Development of a Generic Workflow Diagram
- Approval from the ALC Steering Committee of Recommendations on 10 Challenging Patient Flow Scenarios

Human Resources Planning Subcommittee

- Survey of Current RN & RPN Clinical Skills and Future Recommendations

Finance Subcommittee

- Costing of Proposed Staffing Models
- Review of Current Copayment Practices



A Newsletter about the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Complex Care Implementation Project

Welcome to the third issue of "The Complex Care Connection". We hope this newsletter helps you stay informed and up-to-date on this exciting project. With successful implementation we will see the admission of complex care patients to one of 13 hospital sites. Complex Care patients have multiple medically complex conditions, behavioural health issues caused by dementia, or are at the end stage of life.



Ontario

Hamilton Niagara Haldimand Brant
Local Health Integration Network

The HNHB LHIN Complex Care Implementation Project is part of the LHIN's work toward advancing its Clinical Program Integration priority.

Community Care Access Centre (CCAC) Working Hard

The HNHB CCAC will expand their role with patient flow processes including the management of a centralized wait list, implementation of comprehensive patient assessments using the RAI-HC tool, defined below, and patient placement into the right hospital bed.

The expanded role has meant hours of education for CCAC staff. The CCAC staff from 15 hospital sites are receiving education about the Complex Care Project, and the new computer system. The Case Managers are also receiving extensive training and practice using the RAI tools, to ensure the collection of accurate patient information, to be shared with hospital staff.

Norfolk General Hospital

Norfolk's hospital staff have been preparing for the changes to complex care. Norfolk's Project Team, pictured here include (L to R): Joe Bitz, Social Worker, Leila Mair, Charge Nurse & Project Lead, Mary Ann MacDonald CCAC Client Services Mgr, Janice Macovik, Program Director & Brenda St. Amant, CC Project Mgr. Absent: Karen Keegan, Discharge Planner & Sonia Rogers, CCAC Client Services Mgr



RAI-HC (RESIDENT ASSESSMENT INSTRUMENT- HOME CARE)

All Complex Care patients will be assessed using the RAI-HC Tool, a standardized, comprehensive, multidimensional assessment tool. A CCAC Case Manager meets with the patient and family to complete the tool. The tool identifies a patient's values, function, strengths, abilities, preferences, health risks, resources, available supports and caregiver stresses and needs. The CCAC Case Manager shares the information with the patient's complex care team allowing them to prioritize the patient goals and plan individualized care. Some of the scales built into the RAI include the Cognitive Performance Scale, the Depression Rating Scale, the Activities of Daily Living (ADL), Self Performance Hierarchy and the Pain Scale.



Partnering Hospital Sites

Complex Care hospital sites across the Hamilton Niagara Haldimand Brant LHIN will have expertise in complex care and we want to transfer a patient as soon as that care is needed but, we also want to provide “care close to a patient’s home”. To help us achieve this, hospital sites will be partnered.

Group A

St. Peter’s Hospital, Hamilton; Hamilton Health Sciences, Hamilton; Joseph Brant Memorial Hospital, Burlington; and St. Joseph’s Healthcare, Hamilton.

Group B

Niagara Health System – Welland Hospital, Welland; Greater Niagara General, Niagara Falls; Niagara on the Lake, Niagara on the Lake; Douglas Memorial, Fort Erie; Port Colborne General, Port Colborne; and St. Catharines General, St. Catharines, a referring site.

Group C

Brant Community Healthcare System, Brantford; and Norfolk General Hospital, Simcoe.

Group D

Haldimand War Memorial, Dunnville – with Group A or B depending on patient’s address.

Group E

West Haldimand General Hospital, Hagersville – a referring site, partnering with Group C or D depending on a patient’s address.



Haldimand War Memorial Hospital, Dunnville was the first hospital to implement! Their hard working project team included (seated L to R) Sonia Rogers, CCAC Client Services Mgr, Sherry Reidy, Inpatient Unit Mgr & Project Lead, (standing L to R) Kathryn Stengel, Day Unit Leader, Mary Ann MacDonald, CCAC Client Services Mgr, Brenda St. Amant, CC Project Mgr, and Sharon Moore, VP and Chief Nursing Officer.

Project Planning

Each hospital’s project team will use Project Planning Guidelines to develop their project plan. They will:

- Define the project
- Identify the team who is responsible for developing the plan
- Identify the major activities and tasks
- Identify key stakeholders to review the plan
- Anticipate and plan to deal with issues
- Plan and develop communication strategies
- Develop evaluation strategies

Communication Links

Hospitals will share specific information with CCAC’s Placement Services, located at the CCAC Burlington Branch. Using new forms, hospitals will notify Placement Services when they have a vacant bed, when a new patient has arrived, and with any weekend admissions and discharges for the “End of Life” patient stream. Placement Services will send Complex Care units all patient assessment information. Establishing simple communication links is key to success.

SINGLE LOCAL HEALTH INTEGRATION NETWORK (LHIN) VISION

Accessibility
Quality
Sustainability

Improving the health of the population
Enhancing the individual’s experience of care
Reducing or at a minimum maintaining costs

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