LHINsight

Special Edition July 2008 ISSN 1913-1089

Hamilton Niagara Haldimand Brant Local Health Integration Network
(also serving the communities of Burlington and Norfolk County)

LHIN Urgent Priorities Fund (LUPF) Provincially Guided, Community Decided

Welcome to this special edition of LHINsight. The stories inside celebrate some of the initiatives funded by the Hamilton Niagara Haldimand Brant (HNHB) LHIN that make a difference for people served by our local health care system.

The Ministry of Health and Long-Term Care made resources available to help us address the priorities set out in our Integrated Health Service Plan as well as emerging pressure points. This LHIN Urgent Priorities Fund (LUPF) totalled $2.9 million for 2007-2008 and $5.6 million for 2008-2009.

Over the course of six months, (October 2007 to March 2008) health service providers submitted proposals to the HNHB LHIN which were assessed against three principle criteria: 'Is the proposed initiative of benefit to the community?' 'What are the risks involved?' and 'How feasible is the proposed initiative?'. Proposals were reviewed to ensure they advanced our priorities or emerging pressure points. Finally, each proposal was reviewed for the following specific criteria.

- **Sustainability** – Does it optimize the distribution and use of resources to achieve the best possible outcomes over the long term?
- **Access and Equity** – Does it ensure patients can obtain appropriate health care services at the right place and right time based on need?
- **Quality of Care** – Does it improve the quality and delivery of existing or new services?
- **System Performance** – Does it promote collaboration, coordination, and partnerships across providers, sectors, and/or LHINs?

The initiatives described in the following pages met all of these criteria, and we are excited to see how they improve our local health care system.

LUPF is only one of several funding envelopes that the LHIN has spent this year to help address the priorities of the community. Other funding envelopes include:

- **Emergency Department Action Plan** (EDAP) was a one-time fund used to help shorten some of our emergency room wait times. See page 11 for an overview. Details about EDAP are available in the LHINsight Issue 1, Volume 2 available on our website (www.hnhblhin.on.ca).
- **Internal Reallocation** refers to funds that were not used by our health service providers in the 2007-08 fiscal year, and could therefore be reallocated to meet other needs in our LHIN. See page 11 for an overview of organizations who received funding through internal reallocation.
- **Aging at Home (AAH) Strategy** is a three year strategy to support healthy independent living. You can read more about the AAH strategy through our AAH Bulletin, available online.

I am very proud of the work that we do, together with our providers and stakeholders, to help keep people healthy, and get them good care when they are sick. Celebrate with us!

from the desk of Alan Iskiw, Senior Director of Performance, Contract and Allocation

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Local Health Integration Network

An Overview of Funded Projects by Priority

The LUPF focused on four priorities:

- independent living,
- mental health,
- end of life care, and
- e-health.

LUPF also focused on two emerging pressure points:

- chronic disease and
- patient flow.

The following table shows the priorities/emerging pressure points and the initiatives funded to help address that priority.

Detailed descriptions of the priorities and the funded initiatives can be found in the pages that follow. The descriptions provide a short overview of the program, the funded initiative, and in some cases include quotes from the provider or clients (in shaded italics), and performance measures.

Note: In the chart below, we distinguish between one-time funding (funding that is provided only once in the year that it is granted, and not again in any other year) and base funding (funding that will be provided not only this year, but on an ongoing basis).

Title of Initiative	One Time ($)	Base ($)	Total ($)
Independent Living: Assist Persons to Live Independently in the Community			
A Refurbished Elevator at Heidehof Home for the Aged	85,000		85,000
An Additional Nurse Practitioner at Shalom Village		30,000	30,000
Expanded In-Home Respite through VON Hamilton	23,000	34,500	57,500
15 Rehabilitation Beds at Hotel Dieu Shaver Hospital	316,329		316,329
The Seniors in Motion Gym at St. Joseph's Villa	24,775	34,100	58,875
Increased Staffing for the *Maintaining Health through Community Alternatives* program at Participation House		11,250	11,250
Upgraded Bathrooms at Twenty Emerald North through the Rehabilitation Foundation for the Disabled	72,500		72,500
New Equipment for Carey House, Halton Chesire Homes	97,500		97,500
Enhanced Transportation for Haldimand Norfolk Community Senior Support Services	65,000	11,563	76,563
A Wheelchair Accessible Van for Burlington Home to Stay	85,000		85,000
Volunteer-Assisted Transportation from VON Hamilton		9,964	9,964
Support for the Adult Recreation Therapy Program in Brant County	50,000		50,000
Attendant Services for Young Adults with Multi-Disabilities at Jason House		25,000	25,000
Relocation of VON Adult Day Care, VON Hamilton	30,000		30,000
Supportive Housing through AIDS Niagara	57,165		57,165
Expansion of the Adult Recreation Therapy Program into Paris	2,000	22,000	24,000
Totals for this priority	**$908,269**	**$178,377**	**$1,086,646**

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An Overview of Funded Projects by Priority (continued)

Title of Initiative	One Time ($)	Base ($)	Total ($)
Mental Health: Support Persons with Mental Health and Addictions Issues			
Improved Access to Residential Addictions Treatment at Wayside House	19,720		19,720
A Concurrent Disorders Counselling Program at St. Leonard's Community Services	2,300	22,910	25,210
The Pulse Youth Health Centre at Transitions for Youth, Halton	41,182		41,182
Life Skills at Chatham Street Residence		48,440	48,440
A Special Care Unit at Claremont House	283,015		283,015
The *Taking Steps for Men* Program at Suntrac, Mission Services	8,900	3,700	12,600
Life Skills Coaching at Adult Mental Health Services	16,000		16,000
The *Setting Boundaries* Program at Adult Mental Health Services	14,000		14,000
Increased Operations for the Haldimand Norfolk Withdrawal Management and Rehab Services		28,000	28,000
PACT for Halton at Joseph Brant Hospital	28,495		28,495
Two Safe Beds at Erie North Shore's Rose of Sharon Location	60,000		60,000
The Installation of an Elevator at Barrett House	100,000		100,000
Totals for this priority	**$573,612**	**$103,050**	**$676,662**
Chronic Disease: Prevent and Manage Chronic Disease			
Additional Points of Service (Robert Land Renovation) at the North Hamilton Community Health Centre	83,000		83,000
A Pharmacy Integration Project at the North Hamilton Community Health Centre	35,000		35,000
The *Steps to Health* Wellness Program through Good Shephard HOMES	23,299		23,299
Totals for this priority	**$141,299**		**$141,299**
End-of-Life Care: Improve the Quality of Care at the End of Life			
A Palliative Care Team at Stedman Hospice	119,244		119,244
A Clinical Nurse Specialist through the Dr. Bob Kemp Hospice	33,000		33,000
Totals for this priority	**$152,244**		**$152,244**
Patient Flow: Enhance Patient Flow from Hospital to 'Home'			
A Slow Stream Rehab Coordinator	27,750		27,750
A Slow Stream Rehab Pilot Project at Brant Community Health Centre	255,236		255,236
A Slow Stream Rehab Pilot Project at Hotel Dieu Shaver Hospital	398,901		398,901
An Ambulatory Slow Stream Rehab Pilot Project at Shalom Village	201,104		201,104
A Transportation Plan for Passage Home, Niagara	6,000		6,000
Totals for this priority	**$888,991**		**$888,991**
E-Health: Improve Access to Health Care Information			
An Integrated Decision Support Strategy	40,000		40,000
Totals for this priority	**$40,000**		**$40,000**

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Independent Living

Assist Persons to Live Independently in the Community

The Challenge:

As our population ages, people need services and supports to help them maintain their level of independence in the community, to prevent their hospitalization, and to ease their recovery in the community. Patients leaving the hospital and their families may need support from community-based programs and services that can help them recover and "get back on their feet." Lack of access to these services may result in deteriorating health, increased disability, and earlier requirements for admission or re-admission to hospital or other facilities.

The Solution:

The following initiatives work to enhance the programs and services that support persons to "get back on their feet." In addition, as the HNHB LHIN works with the Aging at Home funds, it hopes to continue to build on the initiatives that are funded through LUPF.

A Refurbished Elevator at Heidehof Home for the Aged
$85,000

An existing elevator will be made barrier free to enable people who are frail and less ambulatory to get around their home.

"We are the people place and we put a high priority on the care of our seniors wherever they live."

"I'm excited! I will be able to use the elevator by myself again. It will help me remain independent."

Our success will be evident when all residents have full access to the building and are able to get to the doctor's office on their own.

An Additional Nurse Practitioner at Shalom Village $30,000

An additional nurse practitioner will help residents receive the complex care they need for their chronic illnesses within the walls of their 'home' and from staff who know them and are skilled at providing the care and services they need. The nurses' familiarity with the complex needs of these residents, will make a trip to hospital easier and more comfortable.

"For me, Shalom Village is a change of address - close to care but not distant from my life and who I am."

We will know we have succeeded when there are fewer hospital admissions due to pneumonia and congestive heart failure, among other things. These issues will be managed in-house by the nurse practitioners without use of hospital resources.

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Independent Living

Assist Persons to Live Independently in the Community

Expanded In-Home Respite through the VON Hamilton Site $57,500

35 people on the waitlist will receive 20 hours of in-home respite per month from a personal support worker. This means that caregivers will have a much needed break from their caregiving responsibilities while their family members enjoy company and support.

"Caregivers can use the hours of service that best suits what the family needs. This promotes a sense of control in a situation were there is often little control as the client's condition declines."

"We love it because Mom spends time with her wonderful worker while Dad gets a break so he can do his favourite thing – exercise"

We will know we have succeeded when we have helped reduce caregiver stress by providing increased support in the home.

15 Rehabilitation Beds at Hotel Dieu Shaver Hospital & Rehabilitation Centre $316,329

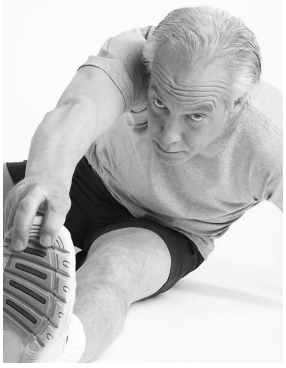
These funds will allow us to continue to provide 15 interim rehabilitation beds between January 1 and March 31, 2008.

The S.I.M Gym (Seniors in Motion Gym) at St. Joseph's Villa, Home for the Aged $58,875

The S.I.M Gym focuses on fun, friendship, and fitness. Under the direction of a personal trainer, individual programs for seniors are established in a safe, accessible, and supportive environment. Our vision is a healthier community. We help get there by enabling seniors to maintain a higher level of activity in a setting that is not intimidating.

"I love my personal trainer – she helps me know I'm doing it the right way."

"I have been an employee of St. Joseph's Villa for almost 18 years. It is the kind of organization where as a team member, you really are a family member."



"I have higher energy levels and feel more motivated."

We will know we have succeeded when our seniors are more active, have improved their physical abilities, and maintained or improved their agility. We also hope to develop stronger connections to other service organizations for seniors.

Increased Staffing for the *Maintaining Health through Community Alternatives* Program at Participation House $11,250

Participation House Brantford provides supportive housing for persons with physical disabilities at two locations in Brantford. These funds will allow us to hire one full-time equivalent staff person to support our clients' participation in community activities. We will target clients in the supportive housing program who are at risk of losing the skills and abilities necessary to continue to live independently.

Our success will be evident when our clients have retained or increased their ability to live independently.

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Independent Living

Assist Persons to Live Independently in the Community

11 Upgraded Bathrooms at Twenty Emerald North through the Rehabilitation Foundation for the Disabled (March of Dimes) $72,500

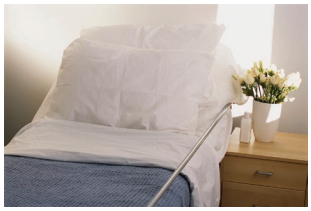
We will upgrade the bathrooms in 11 of the units occupied by March of Dimes consumers.

"I know that it's been hard on my caregivers to push me up the ramp leading to the shower stall. Nowadays builders know not to make ramps too steep."

We know we will have been successful when people are able to stay longer in their home because the homes are accessible and easy to live in.

New Equipment for Carey House, Halton Cheshire Homes $97,500

Carey House is a supportive housing program for older adults with physical disabilities. Critical to a safe environment is properly functioning equipment like a voice activated call system, tracking and lift systems, hospital beds, pressure reducing mattresses, and commode chairs. This funding will help us purchase this equipment.



We will know we are successful when quality care improves skin health and reduces staff and resident injuries.

Enhanced Transportation for H-N Community Senior Support Services $76,563

These funds will purchase a new van to help us provide enhanced transportation services. This program will provide improved access to health services, social and recreational opportunities, and food services through the provision of a specially equipped wheelchair accessible van for Haldimand-Norfolk area.

A Wheelchair Accessible Van for Burlington Home to Stay $85,000

The purchase of a wheelchair accessible van will increase access to transportation services for those clients who need a ride home from hospital or to get to medical appointments. This purchase will allow us to increase transportation services to eligible residents in Burlington.

Volunteer-Assisted Transportation from VON Hamilton $9,964

Our Volunteer-Assisted Transportation improves access for elderly seniors to health services. These seniors benefit from a drive to a medical appointment and friendly conversation and companionship with a caring volunteer. The volunteer driver provides door-to-door personal service and waits with the seniors for the duration of the appointment. The volunteer assists individuals with canes and walkers.

"Friendly conversation is key. Research in social isolation has demonstrated that social networks can protect health, act as a buffer against stress, and prevent physical and psychological deterioration."

"My volunteer driver really takes the time and makes me feel comfortable."

We will know we have succeeded when seniors tell us they were able to make all of their medical appointments because of our friendly door-to-door transportation.

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Independent Living

Assist Persons to Live Independently in the Community

Support for the Adult Recreation Therapy Program in Brant County $50,000

The Adult Recreation Therapy program works with individuals with stroke, Parkinson's disease, multiple sclerosis and frail elderly people. The funding will allow us to replace and expand our therapeutic equipment used to provide therapy services to clients and also allow us to provide an education series for family members and caregivers of people with aphasia.

Attendant Services for Young Adults with Multi-Disabilities at Jason House, through the Rehabilitation Foundation for the Disabled (March of Dimes) $25,000

Jason House is a congregate housing facility for young adults with multi-disabilities. Our current capacity is four clients, however, at present we are only funded to provide attendant services to three clients. The LUPF funding will allow us to provide attendant services to the fourth resident and to increase our services to 365 days per year.

Relocation of VON Adult Day Care, VON Hamilton. $30,000

VON Adult Day Care provides supportive programs for clients with dementia and other long term disabilities. We are expanding our services and need to relocate for six months while expansions are constructed. Our temporary facilities have been located at St. Elizabeth's place. This one time funding will support the costs of moving to our temporary location.

Supportive Housing through AIDS Niagara $57,165

The supportive housing program offered by AIDS Niagara takes a unique harm/risk reduction approach to support individuals affected by the HIV/AIDS virus. This funding will support five additional subsidized spaces in the community for persons with HIV/AIDs.

"Let me give you an example to describe what we do. Two years ago we had a client. He was in his thirties, used intravenous drugs, was homeless, had 'burned bridges' with his family and other community organizations, remained on a probation order, and had HIV. Two years later, this same man has a home, is stable, is monitored by his family doctor, has received counselling, and is involved in the community. We should be celebrating. He is!"

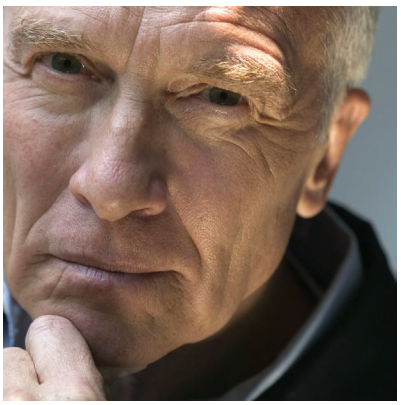
"What's it like to get your life back? Only a few of us know."

We will know we have succeeded when HIV/AIDS infection rates decrease due to prevention, and people with HIV/AIDS live are given the support to live in the community independently.

Expansion of the Adult Recreation Therapy Program into Paris $24,000

These funds will help us expand our adult recreation therapy program to a satellite location for three days a week. This satellite program will provide services to people who live in the Brant County area.

"'It's about time; I love attending the program closer to home."



"We get them to participate in activities they may not otherwise have had the opportunity to, improving the quality of their life and that of their caregivers."

We know we will have been successful when people in the Brant area have services that enable them to remain independent in their own homes longer.

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Mental Health

Support Persons with Mental Health and Addictions Issues

The Challenge

People with mental health and addictions issues often do not receive the services they need and they continue to cycle through the mental health and/or addictions system. The services are frequently fragmented and some have exclusionary admission criteria. As a result, some clients experience barriers to receiving services, making it difficult for them to maintain their long-term treatment. Alternatively, people may not receive any service at all. Other health and social service needs may remain unaddressed, increasing the likelihood of inappropriate and frequent use of hospital services.

The Solution

Providers are working together to address the identified challenges. The following initiatives work to reduce exclusionary admission criteria and other barriers to receiving services. They seek also to provide integrated services that support persons with mental health and addictions issues on multiple fronts, including health and social services to foster their long-term health and wellness.

Improved Access to Residential Addictions Treatment at Wayside House of Hamilton $19,720

Wayside House will expand services for clients with concurrent disorders and supportive housing concerns, improving our clients' access to residential addictions treatment. They will depend less on emergency psychiatric services and will be linked, through case management, with mental health supports. This will decrease wait times for other clients and will have a direct impact on relapse.

"Without this housing I would be lost. I was so depressed before. This is the longest that I have stayed clean and I really think that this time I can make it."

"By offering supported housing and continuing care, our clients will remain engaged in treatment and establish solid recovery plans."

"My room is great!"

We will know we have been successful when an increased number of men with concurrent disorders are maintaining their recovery goals.

A Concurrent Disorders Counsellor at St. Leonard's Community Services $25,210

With this funding, we will be able to provide a concurrent disorders counselling program. This program offers interventions that address both mental health and substance abuse concerns of our clients. This program enhances the continuum of care and increases the community's capacity to more effectively meet the needs of individuals struggling with both mental health and addictions issues.

We will know we have succeeded when people have increased access to appropriate services such as supportive housing, withdrawal management, and psychiatric services that help them reduce the risk of relapse and/or hospitalization.

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Mental Health

Support Persons with Mental Health and Addictions Issues

The Pulse Youth Health Centre at Transitions for Youth, Halton $41,182

This funding will enable the Pulse Youth Health Centre to maintain and expand their health services for children and youth from birth to 24 years of age, especially those at risk. Pulse provides a wide range of services including general health exams, nutrition counselling, pregnancy testing, drug and alcohol counselling and referral, sexually transmitted infections testing, treatment and prevention, counselling, and information on health & socially related topics.

"Pulse is phenomenal. Pulse has definitely changed the way I take care of my body, because for the first time in my life I am not totally embarrassed to go for a physical."

"We provide health services for children and youth in a non-judgemental, youth friendly, and accessible setting."

We will know we have succeeded when children and youth in our community have improved access to health care that meets their needs.

Life Skills at Chatham Street Residence $48,440

St. Leonard's Community Services will broaden its life skills program at the Chatham Street Residence. The residence provides safe, affordable, transitional housing, and supports young women who have experienced significant barriers to independent living due to addiction, mental illness, homelessness, lack of family support, limited education, and unemployment.

"I learned that I had the courage and ability to make it on my own."

"A place like the Chatham Street Residence is exactly what kids needed to get their lives together and make a new start."

"Helping our youth by providing stable and supportive housing is not just a caring thing to do, it is a wise investment in our community's future."

We will know we have succeeded when women move on to independent living with enhanced coping and life skills such as relationship building, shopping, menu planning, cooking, and money management.

A Special Care Unit at Claremont House $283,015

The Claremont House Special Care Unit is a 16 bed Managed Alcohol Program for people experiencing homelessness and living with serious health problems as a result of addiction to alcohol. It is a harm reduction program for those whom conventional abstinence-based programs have failed. This funding will sustain the program for three months while we explore options for sustainable long-term funding.

"I feel like I can trust the staff, I think the other guys do too, we wouldn't be here if we didn't. That is why the program works; trust and acceptance. The program allows people to take their time to regroup and be what they may have been".

We will know we have succeeded when our clients have reduced their use of emergency and hospital services, reduced their contact with police, and feel safe, affirmed, and valued.

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Mental Health

Support Persons with Mental Health and Addictions Issues

The *Taking Steps for Men* Program at Suntrac, Mission Services $12,600

The *Taking Steps for Men* program is designed for men with both mental health and addictions issues, also known as concurrent disorders. The program is specifically for the man who has not yet decided to enter treatment and would benefit from a program that can be accessed quickly. Weekly groups will deliver a variety of topics in order to promote self awareness of substance abuse.

We will know we have succeeded when clients have timely access to information regarding substance use and consequences, and become self aware of their substance abuse, and the options available for treatment.

Life Skills Coaching at Adult Mental Health Services $16,000

The project is a "train the trainer" model to provide life skills for consumers and survivors of the mental health system. Training of peer support providers in Life Skills Coaching will help peer support staff to work with persons with mental illness and/or concurrent disorders to provide problem solving skills that are needed to successfully manage all aspects of life including self, family, community, career and leisure.

"We help consumer/survivors develop a stronger sense of self-worth."

We will know we have been successful once our staff can work more effectively with our clients on goal setting.

The *Setting Boundaries* Program at Adult Mental Health Services $14,000

Safety of staff and clients is highly important and implementing *Setting Boundaries* is an opportunity for staff to be trained in non-violent crisis intervention. Staff certified in this non-violent crisis intervention will be able to service clients outside of the office as is often needed, providing better care closer to home.

We will know we have been successful when there is an increase in clients served closer to home.

Increased Operations for the Haldimand Norfolk Withdrawal Management and Rehab Services $28,000

This program provides withdrawal management and rehabilitation services to individuals with adaptation and mental health disorders. The increased funding will allow for the program to be operational for 52 weeks a year.

Success of this program is important because people who need treatment will receive it in the most appropriate setting and not in the hospital emergency room, which is often the only other option.

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Mental Health

Program for Assertive Community Treatment (PACT) for Halton, Joseph Brant Hospital $28,495

PACT provides services to individuals with serious mental illnesses who cannot be managed within traditional services. This funding will enhance our Peer Support Role - a critical part of the team approach - allowing us to expand our range of treatment strategies and accept 8 new clients.

2 Safe Beds at Erie North Shore's Rose of Sharon Location $60,000

With these funds, Erie North Shore will outfit two beds at their Rose of Sharon location to meet the requirements for safe beds.

The Installation of an Elevator at Barrett House $100,000

Barrett House is a multi-level dwelling that serves as a mental health respite program for persons not requiring hospitalization. The funding will help make Barrett House more accessible. The installation of an elevator will improve client and staff safety, eliminate barriers to the services for residents with mobility issues, improve coordination of care, and optimize existing resources.

EDAP and Internal Reallocation Funds

For initiatives that support our community priorities

Emergency Department Action Plan (EDAP)	$
Benevolent Society Heidehof for the Care of the Aged	201,800
HNHB Community Care Access Centre	59,250
Mennonite Brethren Senior Citizens Home (Tabor Manor)	74,387
Niagara Ina Grafton Gage Home of the United Church of Canada	70,000
Pleasant Manor Retirement Village - Heritage Place	221,938
Region of Niagara	675,825
United Mennonite Home for the Aged	23,100
Total Funding: $1,326,300	

Internal Reallocation	$
Alzheimer Society of Brant	42,000
Alzheimer Society of Haldimand-Norfolk	10,000
Alzheimer Society of Niagara Region	10,000
Joseph Brant Memorial Hospital	20,500
Meals on Wheels Thorold - St. Catharines	4,205
Niagara District Homes Committee for the Physically Disabled	42,200
St. Catharines Niagara Health System	50,000
Haldimand-Norfolk Work Group of Simcoe	7,500
ARID Group Homes (Niagara)	32,000
Brantford General Hospital (BCHS)	20,800
De dwa da dehs nye's Aboriginal Health Centre	43,268
Hamilton Health Science Centre	55,800
Joseph Brant Memorial Hospital	40,000
Mission Services of Hamilton	4,750
Niagara Health System (Addictions)	99,065
St. Leonard's Society of Brant (CMHA)	63,350
True Experience Supportive Housing And Community Work Program	61,477
Wayside House Of Hamilton	6,157
Participation House Brantford	62,048
Temporary Long-Term Care Over Bedding	115,046
Total Funding: $790,166	

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Chronic Disease

Prevent and Manage Chronic Disease

The Challenge:

In 2007, the Ontario Quality Council reported that the real story in modern health care is the rise in chronic diseases (conditions); the illnesses people live with for years. Chronic disease presents a particular challenge to modern health care systems, which have been designed to respond to acute illnesses and often fall short of meeting the needs of people living with chronic conditions. In order to meet the health needs of residents living with chronic health conditions, Ontario is moving from its existing `find it and cure it' approach for health care delivery, which was designed for acute illnesses, to one that aims to `prevent, find and manage' chronic conditions.

The Solution:

The following initiatives are aimed at prevention (*Steps to Health* Wellness Program) or improving access to access to health resources (Pharmacy Integration Project and Additional Points of Service). Many health service providers and stakeholders across the LHIN are working to improve the support for individuals living with chronic health conditions. The LHIN is exploring ways to work together with these providers and stakeholders. To this end the LHIN has engaged Dr. Akbar Panju and Dr. Nasima Mottiar. Their first target will be working with providers with expertise in diabetes to identify opportunities to improve prevention and management of diabetes within the LHIN. The LHIN is also linking chronic disease prevention and management with other LHIN initiatives such as the Aging at Home Strategy and LHIN Urgent Priority Funding.

Additional Points of Service (Robert Land Renovation), North Hamilton Community Health Centre $83,000

Renovations to the former Robert Land School will give residents in north central Hamilton increased access to medical staff. Residents in this area will have increased access to doctors, nurses, counsellors, and other medical staff.

We will know we have been successful when we are able to provide medical services in an area of Hamilton where we previously did not provide services such as primary care, birth control, prenatal and parenting care, mentoring programs, and teen support.

Pharmacy Integration Project, North Hamilton Community Health Centre $35, 000

People need good information about the drugs they are taking, how to effectively use them, and how the drugs interact with each other. This project provides this information through a pharmacist, reducing the amount of time physicians and nurse practitioners spend dealing with medications and increasing the time they have available for clinical priorities.

***Steps to Health* Wellness Program through Good Shepherd HOMES $23,299**

The *Steps to Health* program's goal is to achieve long-term life style changes for our clients; people with mental health and addictions issues who are also at risk of developing serious physical health issues. *Steps to Health* encourages positive lifestyle changes through group participation in physical, educational, and recreational activities.

"It's totally changed my life. It's been inspirational."

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End-of-Life Care

Improve the Quality of Care at the End of Life

The Challenge:

People who are dying are at risk for sub-optimal care when their caregivers and health professionals are not up-to-date with assessment, treatment and symptom management standards and practices.

People at the end of life are making choices as to where they want to die, whether at home, in a community setting or at a hospital. Health care professionals and volunteer caregivers require specialized education and training in palliative care to provide high quality care in all settings - consistent and effective care that respects values and promotes choice for the growing number of patients with end-of-life care needs.

The Solution:

The following initiatives work to improve the quality of care at the end of life by ensuring that staff who work in hospices have the best possible training and are knowledgeable about best practices.

Palliative Care Team at Stedman Hospice $119,244

Stedman Hospice will bring together a dedicated outreach team of professionals to provide physical, emotional, and spiritual support to those who are living with a progressive life-threatening illness.

"To have someone to stand in the fire with me, as I face my own death, is invaluable." "Companioning the dying has gifted me with a heightened appreciation of every moment of life."

We will know we have succeeded when we have helped to improve the quality of life of an individual and their family from the time of diagnosis through to death and bereavement.

A Clinical Nurse Specialist through the Dr. Bob Kemp Hospice $33,000

A Clinical Nurse Specialist will provide us with the means to better assess clients in the community, resulting in improved pain control and reduced ER visits as well as providing palliative patients the resources to help them remain in their home longer.

"It's a privilege to be find myself working side by side with the extraordinary volunteers and staff at the hospice, in the service of our clients, who, with their families, have allowed us to share in the final days of their life journey."

"I don't know how we would have managed without so many of "Bob's angels" to help us."

We will know we have succeeded when more palliative patients feel confident and supported in their homes.

Ontario
Hamilton Niagara Haldimand Brant
Local Health Integration Network

Patient Flow

Enhance Patient Flow from Hospital to 'Home'

The Challenge

Nearly one in four acute hospital beds in our LHIN are occupied by someone waiting for care in another setting (the majority for a bed in a long-term care home). Others are awaiting different types of hospital care (such as rehabilitation and complex continuing care) and some are awaiting services to support their return home. In the hospital environment, these patients are not receiving care appropriate to their needs, for example: group dining, social interaction, and recreation. Without these supports, and others, many of these patients risk losing some physical and cognitive function as a result of receiving interim care in the wrong type of setting. Further, access to acute care beds for new patients in the emergency room or those needing elective surgery is impeded.

The Solution

We are piloting a different approach where the patient is matched with a multidisciplinary team to help them address their rehabilitation goals. The patient may work with occupational therapists, physiotherapists, speech language pathologists, and registered nurses, depending on their needs. The goal is to maintain or improve their physical and cognitive abilities to enable them to return home, with external support if necessary, rather than admission to institutional care. This approach is called slow stream rehab.

Slow Stream Rehab at Brant Community Health Centre $255, 236

In partnership with the HNHB CCAC, Brant Community Health System has designated 15 beds as slow stream rehab beds. This program will help patients improve their functional ability and level of independence before being discharged from hospital.

Slow Stream Rehab at Hotel Dieu Shaver $398,901

In partnership with the Niagara Health System, 15 beds at Hotel Dieu Shaver have been designated as slow stream rehab beds. In these beds, people awaiting placement in a long-term care home will be involved in a 90-day daily rehabilitation program, aimed at increasing their functional abilities.

"Through this pilot, we are making a significant difference in these patients' lives - we help them become stronger, more independent and more confident in their ability to return home."

Ambulatory Slow Stream Rehab at Shalom Village $201,104

This project is an ambulatory slow stream rehab program that assists older adults living in home/community environments, enabling them to remain there.

Slow Stream Rehab Coordinator $27,750

This funding provides a coordinator to monitor and enable the slow stream rehabilitation pilot projects. The coordinator is involved with the LHIN-wide rehabilitation network and is working with the network to map the continuum of rehab services in our LHIN, and will assist in determine where slow stream rehab fits on the continuum of care. The coordinator will also complete a review of inpatient and outpatient rehabilitation services for the network and work with the network to enable implementation of network and LHIN priorities in rehabilitation services.

Passage Home, Canadian Red Cross, Niagara Branch $6,000

With this funding, we will work on the implementation of Passage Home, a program through which individuals who require a wheelchair can now return home via an accessible van after being discharged from hospital. Planning for this discharge service will actually begin when patients are admitted to hospital. The Integrated Managers of the Niagara Health System register the patients with Red Cross to speed up the discharge process and time it takes to return home.

We will know we have succeeded when patients are using this service which provides a cost effective alternative for both clients and the health care system in addition to what currently exists.

Ontario
Hamilton Niagara Haldimand Brant
Local Health Integration Network

E-Health

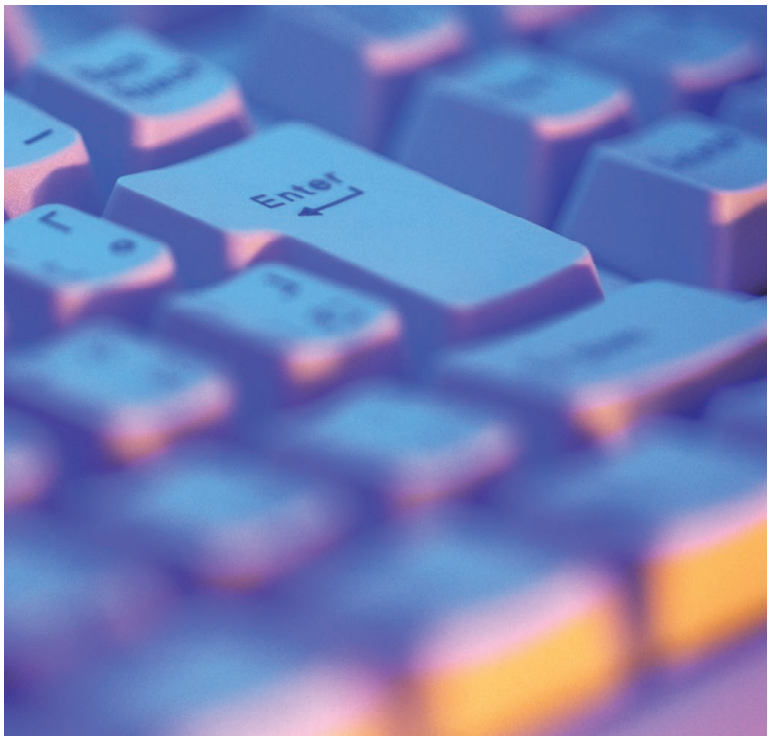
Improving and modernizing our health care system

The Challenge

Personal health information is not readily available to people when they need it, nor is it stored in a way that it can be analyzed by health service providers for trends. Patients and health providers do not have quick and easy access to information about health care choices and outcomes. A person's health data is stored in paper files or distributed through a patchwork of isolated computer systems. Clients and patients are asked to repeat their medical history each time they seek or receive care. People will often undergo the same test many times for different physicians or providers because it is easier to redo a test than retrieve the results or report. Physicians often do not receive their patients' hospital discharge summaries. Limited access to to best practice information reduces health outcomes. The inefficient access or transfer of patient information limits opportunities to make the right health system improvements.

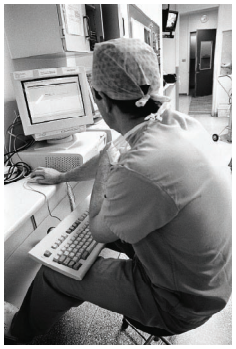
The Solution

As a community, we need sophisticated, quantitative models and tools to help us make important decisions about health care, improve the quality of care, and keep it cost effective. Many health service providers in the HNHB LHIN recognize this need and are beginning to develop information capabilities that allow them to view their region as an integrated system as opposed to a collective of individual players. At the LHIN, we are working towards right information for right care, at the right time and right place. The Integrated Decision Support initiative is one step towards that goal.



Integrated Decision Support, HNHB LHIN in partnership with Hamilton Health Sciences $40,000

Accurate, comprehensive and timely information is required to support collaborative planning for the purposes of identifying outstanding health care needs and enhancing the coordination and integration of health care services across the HNHB LHIN. An Integrated Decision Support function will build on existing decision support capacity at the HNHB CCAC, hospitals, and LHIN office, to provide LHIN-wide data, analyses, and reports in response to the planning and information needs of these organizations.



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About LHINsight

This publication aims to keep the community informed about the activities of the HNHB LHIN and its community members.

The LHINsight is being sent to any organization, group, or individual interested in the HNHB LHIN's activities. If you are, or you know of, an organization that would like to be included on our mailing list, please contact Kathy Gilchrist at kathy.gilchrist@lhins.on.ca.

The LHINsight is available on the HNHB LHIN website at www.hnhblhin.on.ca under the 'Be Informed, Get Involved' tab.

To submit or suggest a story idea for an upcoming edition of LHINsight, please contact Chandra Rice at chandra.rice@lhins.on.ca or 905.945.4930 x214.

Visit us on the Web

For more information on any of the stories you have read in the LHINsight, or any other LHIN initiatives, or to send us your comments, please visit our site at www.hnhblin.on.ca

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Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK

RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

LHINsight is produced by the Hamilton Niagara Haldimand Brant LHIN, one of 14 local health integration networks. The LHIN is responsible for planning, coordinating, and funding the local health system in this region which spans from Burlington to Fort Erie and from Burford to Cayuga and includes more than 1.3 million residents. The LHIN represents local decision-making; decisions about the organization, coordination and funding of health services are made closer to home by people who live and work in the LHIN. The health services include community support services, mental health and addictions services, community health centres, the Community Care Access Centre, long-term care homes, and hospital services.

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