www.hnhblhin.on.ca


# LHINsight

**LHINsight** is the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) electronic newsletter. Please share it with colleagues, clients, friends and family.

*Strategic Vision: Creating a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.*

*Strategic Aim: Dramatically improve the patient experience through quality, integration and value.*

---

## Donna's Blog - March 2014

**Check out an excerpt from Donna Cripps' latest blog post and be sure to catch her upcoming post on April 7, 2014.**

Happy March to everyone! I trust people are finding time to enjoy our traditional winter weather this year! For many people, March is a month where we celebrate the winter with a “March break”, time away from work and time with our families. For others March signals the last month of the fiscal year where we reflect on the year that has past and plan for the upcoming year.

At your LHIN, March is a busy month for us as we prepare and submit our 2014-15 draft Annual Business Plan to our Board of Directors and then the Ministry of Health and Long-Term Care. Our Annual Business Plan reflects both the progress we have made and what we still plan to achieve moving forward as it relates to providing the right care, in the right place and at the right time for all of our residents.

**Read the full Blog Post.**


**Sign up to receive Donna's Blog**

---

# Critical Care Nurse Training Fund Receiving Applications

The Critical Care Nurse Training Fund is in its eighth year and has provided hospitals across the province with financial support to train nurses new to critical care. The call for applications for the 2014-15 Critical Care Nurse Training Fund is now underway to continue to build the infrastructure and to support critical care services across Ontario.

The deadline for applications is March 28, 2014 at 5pm. **Late submissions will not be considered.**

To learn more, visit the **Ministry of Health and Long-Term Care's Critical Care Strategy website** (**French version**) where the **Critical Care Nurse Training Fund Application Guide** can be found which provides further details and eligibility requirements.

Completed applications (**English** and **French**) must be submitted electronically to **ccsadmin@uhn.ca** by **March 28, 2014 by 5:00 PM EST.**

If you should have any questions related to this application process, please contact Critical Care Services Ontario at **ccsadmin@uhn.ca** or Catherine Lundy, Project Manager by phone at 416-340-4800 ext. 8077.

---

# Moving to a New Home: *Smoothing Transitions into Long-Term Care*

Providing assistance with transitions – times when an individual moves from one living environment to another – is a key function of the HNHB Behavioural Supports Ontario (BSO) Long-Term Care (LTC) Mobile Team. Those working in the LTC homes have seen the positive impact a collaborative, well-planned move from the community or acute-care setting to a LTC home can have on an individual's journey, their caregivers and the staff of the LTC home.

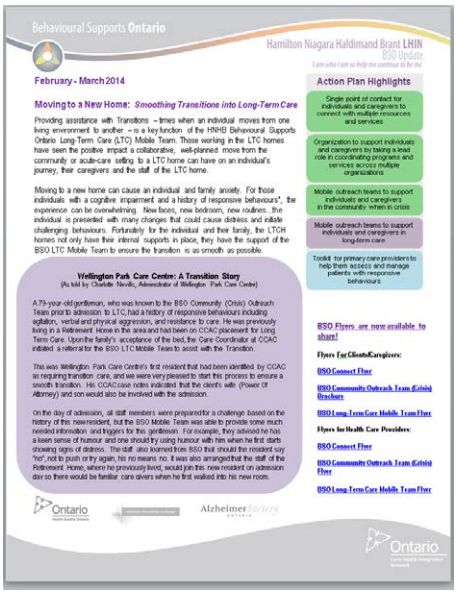
Moving to a new home can cause an individual and family anxiety. For those individuals with a cognitive impairment and a history of responsive behaviours, the experience can be overwhelming. New faces, new bedroom, new routines…the individual is presented with many changes that could cause distress and initiate challenging behaviours. Fortunately for the individual and their family, the LTC homes not only have their internal supports in place, they have the support of the BSO LTC Mobile Team to ensure the transition is as smooth as possible.

### Wellington Park Care Centre: A Transition Story

(As told by Charlotte Nevills, Administrator of Wellington Park Care Centre)

*A 79-year-old gentleman, who was known to the BSO Community (Crisis) Outreach Team prior to admission to LTC, had a history of responsive behaviours including agitation, verbal and physical aggression, and resistance to care. He was previously living in a retirement home in the area and had been on CCAC placement for long-term care. Upon the family's acceptance of the bed, the Care Coordinator at CCAC initiated a referral for the BSO LTC Mobile Team to assist with the transition.*

*This was Wellington Park Care Centre's first resident that had been identified by CCAC as requiring transition care, and we were very pleased to start this process to ensure a smooth transition. His CCAC case notes indicated that the client's wife (Power Of Attorney) and son would also be involved with the admission.*


Behavioural Supports Ontario

Hamilton Niagara Haldimand Brant LHIN

BSO Update

February - March 2014

**Moving to a New Home:** *Smoothing Transitions into Long-Term Care*

Providing assistance with Transitions – times when an individual moves from one living environment to another – is a key function of the HNHB Behavioural Supports Ontario Long-Term Care (LTC) Mobile Team. Those working in the LTC homes have seen the positive impact a collaborative, well-planned move from the community or acute-care setting to a LTC home can have on an individual's journey, their caregivers and the staff of the LTC home.

Moving to a new home can cause an individual and family anxiety. For those individuals with a cognitive impairment and a history of responsive behaviours*, the experience can be overwhelming. New faces, new bedroom, new routines. The individual is presented with many changes that could cause distress and initiate challenging behaviours. Fortunately for the individual and their family, the LTCH homes not only have their internal supports in place, they have the support of the BSO LTC Mobile Team to ensure the transition is as smooth as possible.

**Wellington Park Care Center: A Transition Story**

(As told by Charlotte Nevills, Administrator of Wellington Park Care Center)

A 79-year-old gentleman, who was known to the BSO Community (Crisis) Outreach Team prior to admission to LTC, had a history of responsive behaviours including agitation, verbal and physical aggression, and resistance to care. He was previously living in a Retirement Home in the area and had been on CCAC placement for Long Term Care. Upon the family's acceptance of the bed, the Care Coordinator at CCAC initiated a referral for the BSO LTC Mobile Team to assist with the Transition.

This was Wellington Park Care Centre's first resident that had been identified by CCAC as requiring transition care, and we were very pleased to start this process to ensure a smooth transition. His CCAC case notes indicated that the client's wife (Power Of Attorney) and son would also be involved with the admission.

On the day of admission, all staff members were prepared for a challenge based on the history of this new resident, but the BSO Mobile Team was able to provide some much needed information and triggers for this gentleman. For example, they advised he has a keen sense of humour and one should try using humour with him when he first starts showing signs of distress. The staff also learned from BSO that should the resident say "no", not to push or try again, his no means no. It was also arranged that the staff of the Retirement Home, where he previously lived, would join this new resident on admission day so there would be familiar care givers when he first walked into his new room.

Action Plan Highlights

Single point of contact for individuals and caregivers to connect with multiple resources and services

Organization to support individuals and caregivers by taking a lead role in coordinating programs and services across multiple organizations

Mobile outreach teams to support individuals and caregivers in the community when in crisis

Mobile outreach teams to support individuals and caregivers in long-term care

Toolkit for primary care providers to help them assess and manage patients with responsive behaviours

BSO Flyers are now available to share!

Flyers for Clients/Caregivers:

BSO Connect Flyer

BSO Community Outreach Team (Crisis) Brochure

BSO Long-Term Care Mobile Team Flyer

Flyers for Health Care Providers:

BSO Connect Flyer

BSO Community Outreach Team (Crisis) Flyer

BSO Long-Term Care Mobile Team Flyer

Ontario

Alzheimer Society

Ontario

*From the moment of walking into Wellington Park Care Centre, he was handled smoothly acknowledging his resident-centred care needs. This was certainly not your average admission, but one that specifically met the needs of the resident based upon the history and assistance from the BSO Mobile Team.*

*Far too many times in the past there have been residents admitted to long-term care with the same story as this gentleman, but with the clear and very informative history for this resident, his needs were met. Thankfully it was a safe and smooth admission to Wellington Park Care Centre that I can say with certainty would not have been the success it was without the BSO Mobile Team.*

### Growing Interest for Support with Transitions

Over the past 24 months, the BSO LTC Mobile Team has developed collaborative working relationships with many of the 86 LTC Homes in Hamilton, Niagara, Haldimand, Norfolk, Brant and Burlington. There are six LTC homes that ask BSO to help with every new resident admitted with responsive behaviours, and four LTC homes request support for every new resident regardless of pre-existing behaviours. In addition, community partners, such as CCAC and Primary Care Practitioners, are growing referral sources for the LTC Mobile Team.

The quality of the support provided by the BSO LTC Mobile Team is important. Feedback on how BSO has supported both an individual's transition and the LTC home staff helps guide the Team's ongoing improvement. The BSO team asks long-term care home staff to complete a satisfaction survey following the most recent support for a transition or when a client is discharged. The results of these surveys identify areas for improvement, as well as recognize the team functions that effectively help the LTC home staff and their clients.

To learn more check out the HNHB LHIN BSO webpage.

---

# Hotel Dieu Shaver Receives Esteemed Designation, Clinic Can Serve More Patients

*The following was released by Hotel Dieu Shaver Health and Rehabilitation Centre March 11, 2014.*

Hotel Dieu Shaver Health and Rehabilitation Centre is proud to announce it has been successful in achieving the Ministry of Health and Long-Term Care Assistive Devices Program designation of Expanded Level Augmentative and Alternative Communication (AAC) Clinic. The AAC Clinic is a specialty clinic at Hotel Dieu Shaver that provides assistive technology and services for individuals in Niagara whose speech and/or writing does not meet their daily needs.

“Hotel Dieu Shaver recognized that there was a gap in services for adults in augmentative communication,” explains Jane Rufrano, CEO of Hotel Dieu Shaver Health and Rehabilitation Centre. “Our AAC Clinic staff and Leadership Team have been working tirelessly to ensure we can provide Niagara residents with the resources and care they need to reach their optimal level of independence and wellbeing.”

Designation under such an esteemed title permits augmentative communication clients who graduate from Niagara Children’s Centre at the age of 18, the opportunity to continue to receive service at Hotel Dieu Shaver. Additionally, adults with acquired conditions, such as Amyotrophic Lateral Sclerosis (ALS), Aphasia and congenital conditions, such as Cerebral Palsy, will have access to a local augmentative communication service, now that the Clinic is designated.

“An AAC Clinic as young as ours has never received expanded level designation under the Ministry of Health and Long-Term Care Assistive Devices Program,” continues Rufrano. “Achieving designation of Expanded Level AAC Clinic is incredibly unique, an accomplishment that sets us apart.”

Hotel Dieu Shaver Health and Rehabilitation Centre provides comfort, care and hope to thousands of Niagara residents through rehabilitation, complex care and geriatric programs. As a Centre of Excellence, Hotel Dieu Shaver prides itself on ensuring patients are the number one priority.

---

# NHS St. Catharines Site Celebrates Inaugural Year

*The following was released by Niagara Health System March 24, 2014.*

Today marks the first anniversary of the opening of the Niagara Health System St. Catharines Site and a year full of milestones and successes thanks to a new way of delivering care across Niagara.

"We are excited to celebrate this important milestone. In the 365 days since the St. Catharines Site opened, thousands of patients have benefited from new and expanded regional services that brought care closer to home in a state-of-the-art facility," says Susan Kwolek, Vice President, Patient Services, and Executive Lead, St. Catharines Site.

"It has been a remarkable and exciting time for healthcare in Niagara," says Angela Zangari, Interim President and Chief Financial Officer. "Our team has made a smooth transition and accomplished much of what we hoped for; providing the best possible patient care as we continue to build a better healthcare system. I want to thank everyone who made this year a success; those who were our fundraising champions, the hundreds of dedicated staff, physicians and volunteers across our NHS sites, and the community of Niagara for its support."

Over the past year, Niagara Health System has provided specialized healthcare services across the region. Here are some highlights from 2013/14:

- For the first time in Niagara, residents of the peninsula had access to a full spectrum of cancer care including radiation therapy through the hospital's Walker Family Cancer Centre. 7,600 radiation treatments were provided to 700 patients.
- Almost 1,300 cardiac care patients were able to receive diagnostic procedures at the Heart Investigation Unit (HIU). The opening of the HIU has meant access to cardiac catheterization for the first time in the region.
- Approximately 2,700 babies have been born at the St. Catharines Site new regional Women's and Babies' Unit. The patients and specialized team in this program have benefited from being in one location with the availability of concentrated expertise and training, and a multidisciplinary environment.
- The Mental Health and Addictions Program has started seven new programs, hired 105 new staff members, and recruited seven new psychiatrists with an additional four to join the team in 2014. The availability of new longer-term mental health care has meant that many patients and families no longer have to travel outside the region for care.
- The Kidney Care Program has expanded its care model to include a community-based satellite Kidney Care Centre in Niagara Falls; the first of its kind in the region. The Niagara Falls program has provided 15,400 treatments to 80 patients. NHS now provides dialysis across the region; in Welland, St. Catharines, and Niagara Falls.
- The NHS's Niagara District Stroke Centre at the Greater Niagara General Site continues to have the best "door-to-needle time" (the amount of time patients wait to receive life-saving t-PA) in the province at an average of 31 minutes.
- The Welland Site opened a Respirology Clinic and has been building a regional Comprehensive General Ambulatory Ophthalmology Program. The program has performed 5,600 cataract surgeries and had patient 2,200 visits.
- The Douglas Memorial, Niagara-on-the-Lake, and Fort Erie sites have focused on building improved specialized complex and palliative care services.

---

## ClinicalConnect Continues to Expand Reach Across Multiple LHINs

The Hamilton Niagara Haldimand Brant (HNHB) LHIN eHealth Office manages the advancement of regional eHealth initiatives and priorities. The HNHB LHIN eHealth Office also works in partnership with LHINs, HSPs, CCACs, eHealth Ontario, Connecting South West Ontario (cSWO), Health Links, providers and other partners to expand and leverage eHealth assets such as ClinicalConnect, Integrated Decision Support, Ontario Lab Information System, Resource Matching & Referral, Integrated Assessment Record and emerging Health Links care coordination tools.

The HNHB LHIN eHealth Office and Hamilton Health Sciences are solution providers in the context of cSWO and the HNHB LHIN eHealth is also a cSWO Delivery Partner for eHealth adoption and change management. At the centre of these solutions via cSWO is ClinicalConnect.

ClinicalConnect is a Regional Electronic Health Record (Provider Portal) that integrates data from 28

Hospitals plus Community Care Access Centres (CCACs) and Cancer Centres within the regions of HNHB and the Waterloo Wellington (WW) LHINs representing over 2.3 Million patients. ClinicalConnect is currently accessed by thousands of hospital and community physicians and healthcare professionals across the continuum of care. Today, physicians and other healthcare professionals across a broad region have secure, real time, anytime & anywhere access to their patients' electronically stored records via the internet. eHealth Ontario has funded the expansion of ClinicalConnect to South Western Ontario via the Erie St. Clair (ESC) and South West (SW) LHINs. Through the cSWO, ClinicalConnect will provide the Regional Clinical Viewer for 71 Hospitals, 3.6 million patients, over 46,000 healthcare users and 1800 healthcare organizations and providers across multiple sectors. This will provide an Electronic Health Record for 1/3 of the Province of Ontario. HNHB LHIN serves about 1,246 HSPs as follows: 21 hospital sites, 1,026 Primary Care providers, 194 Community Sector providers, and five Public Health Units.

ClinicalConnect has become a fundamental tool and framework to bridge the gap between acute care facilities and the community where access to patient information was often found in silos or was difficult to access in a timely manner. Health care professionals, such as family doctors and health care teams can gather essential information in seconds resulting in quicker diagnosis and treatment planning. This helps health care professionals make the best decisions when it comes to their patients' care and reduce the need for repeat lab and diagnostic tests and the time hospital staff spend sending patient information and test results to primary care providers. In the community, health care providers have access to patient medical information in one place, irrespective of where the patient was admitted or treated. Community physicians are integrating ClinicalConnect into their office workflow. They can also electronically transfer lab results and reports via the integrated hospital results manager process. This helps speed communication and ensures data accuracy since information is electronic.

The established infrastructure and integration is being further enhanced through additional data and by leveraging to support Health Links and patient care improvements. Options are being considered to develop a provider/clinician dashboard or virtual medical office environment to evolve the One Stop shop for medical information. This would provide personalized and additional contextual links to the wide array of information.

**Some of the other ClinicalConnect enhancements and future initiatives include:**

- **Community Care Access Centres (CCACs) Data:** CCAC data is integrated in ClinicalConnect from HNHB and WW LHINs and includes Nursing Services the patient is receiving at home, medical and supporting contacts and whether the patient is waiting for long term care placement. The information can assist with Family Physicians to suggest changes to patients at home services.
- **Diagnostic Imaging Repository:** Currently ClinicalConnect includes Diagnostic Imaging or Radiology Reports and in cases where there were performed at Hamilton Health Sciences the Image is available via a web-based image viewer. Access to the images performed at other regional hospitals will be provided through integration to the Diagnostic Imaging Repository, a provincial initiative where hospitals provide diagnostic images to a regional database.
- **Health Links defined Frequent ED Users:** In early 2014, an indicator in ClinicalConnect will be available for patients that are Health Links defined Frequent ED Users. From this indicator the care provider will be provided relevant information with the intent to contextually link to a shared care plan once available.
- **Care Plan virtual repository :** Similar to eConsult, Sharepoint environment could be utilized as an interim repository for a shared care plan. Services to design and configure the CCT would be required. Contextually passing information from ClinicalConnect is an option.

- **eNotifications:** Sending notifications leveraging the existing ClinicalConnect integration is being planned. If a patient has a hospital visit (ED, Inpatient, Outpatient) notifications can flow to community physicians or to the CCAC or via HRM as a report for distribution.
- **Wider scope:** Today the ClinicalConnect viewer has all reports including discharge summaries from hospitals across HNHB LHIN and WW LHIN. (Over the next 18 months it will be expanded to include ESC and SW LHINs as well). Discharge summaries along with other reports are contained in the Transcription Module of ClinicalConnect.
- Anticipated future integration may include additional Oncology data (to add to the existing progress and consult notes), Nursing and physician documentation.

To learn more about ClinicalConnect and the direction the eHealth Office is headed, read the full HNHB LHIN eHealth Office status report here.

---

## Join the HNHB Health System Transformation Team

The Hamilton Niagara Haldimand Brant LHIN consistently looks to team with hard working people that contribute to the HNHB LHIN's role in health system planning and integration, towards the improvement of access, quality and efficiency in the health care system.

Currently the HNHB LHIN is receiving applications for an Advisor, Health System Transformation.

The available role reports to the Director, Health System Transformation, and focuses on the planning and implementation of LHIN-wide clinical programs. Through this work a successful applicant will lead assigned clinical program planning processes, identifying population health needs, service gaps, and opportunities to integrate clinical service delivery. They will also be responsible for monitoring and ensuring the achievement of clinical program key performance indicators reflecting improvements in quality, integration and value.

To learn more about this opportunity and others in our LHIN visit the HNHB careers page.

---

## Call for Applications for Community-Based Specialty Clinics

When the Ministry of Health and Long-Term Care (MOHLTC) released Ontario's Action Plan for Health Care in January 2012 it identified non-profit Community-Based Specialty Clinics as a key component of Ontario's health care system.

These clinics play an important role in keeping Ontarians healthy, providing faster access and a stronger link to family health care, and ensuring Ontarians are receiving the right care, at the right time and in the right place.

Community-Based Specialty Clinics are non-profit health providers that will offer select low-risk procedures that are currently provided in acute-care
hospital settings. Specialty Clinics will focus
on providing high volume procedures, such

as routine cataract procedures, colonoscopies, and other procedures that do not require overnight stays in a hospital. These services are OHIP-insured and have no additional fees. Shifting these procedures to the clinics will improve patient access to high quality care at better value.

**Community-Based Specialty Clinics**

Community-Based Specialty Clinics are non-profit health providers that will offer select low-risk procedures that are currently provided in acute-care hospital settings. Specialty Clinics will focus on providing high volume procedures, such as routine cataract procedures, colonoscopies, and other procedures that do not require overnight stays in a hospital. Specialty Clinics will be subject to high quality standards, oversight and accountability. They will provide OHIP-insured services with no additional fees.

**Community-Based Specialty Clinic models fall into two categories :**

1. A public hospital operating in a new site (i.e., a satellite or ambulatory care centre) under the Public Hospitals Act (PHA); or
2. A non-profit Independent Health Facility (IHF) licensed under the Independent Health Facilities Act (IHFA).

- Why Community-Based Specialty Clinics?
- Initial Rollout of Specialty Clinics
- Cataract Specialty Clinic Applications
- Policy Guide
- Frequently Asked Questions
  - Community-Based Specialty Clinic Strategy
  - Improving Services For Patients
  - Process To Establish Community-Based Specialty Clinics

**Document download**

- Community-Based Specialty Clinics: Executive Summary - PDF
- A Policy Guide for Creating Community-Based Specialty Clinics - PDF
- 4910-85 - Public Hospital Guidelines and Forms
- 4911-85 - Independent Health Facility Guidelines and Forms

These clinic models fall into two categories:

1. A public hospital operating in a new site (i.e., a satellite or ambulatory care centre) under the Public Hospitals Act (PHA); or

2. A non-profit Independent Health Facility (IHF) licensed under the Independent Health Facilities Act (IHFA).

The MOHLTC, the LHINs and Cancer Care Ontario (CCO) are working together to rollout Specialty Clinics, which will initially focus on low-risk cataract and colonoscopy services. In the future, additional procedures that do not require overnight stays in a hospital will be eligible to be performed in Specialty Clinics.

The MOHLTC has launched the application process to create non-profit Community-Based Specialty Clinics for low-risk cataract procedures. Application materials and additional information about the Specialty Clinics can be found online at the main webpage or through requests sent to specialtyclinics@ontario.ca. The website also contains a FAQ document. Alternatively information will also be updated at the HNHB webpage.

Two important deadlines to keep in mind are the application and question submissions.

Questions about the applications process, the Application Guidelines, and/or the Application Form can be e-mailed to specialtyclinics@ontario.ca and must be received by March 31, 2014 at 11:59 PM (Eastern Standard Time), according to the time that the e-mail is received in the Ministry e-mail systems.

All applications must be submitted electronically, via email, to the Ministry at specialtyclinics@ontario.ca and the LHIN in which the Specialty Clinic would be located. All HNHB LHIN submissions should be sent to Ajay.Bhardwaj@LHINS.ON.CA. The deadline for submission of Applications is April 22, 2014 at 11:59 PM (Eastern Standard Time), according to the time that the e-mail is received in the Ministry and LHIN's e-mail systems.

---

# Upcoming Events

## Community Events and Board Meetings

**Wednesday, March 26, 2014**

Enhancing Cross-Cultural Dementia Care Workshop

Alzheimer Society of Hamilton and Halton

9:00 a.m.

1575 Upper Ottawa, Suite 700, Hamilton

**Wednesday, March 26, 2014**

HNHB LHIN Audit Committee Meeting

HNHB LHIN Office

2:30 p.m.

264 Main Street East, Grimsby

**Wednesday, March 26, 2014**

HNHB LHIN Board Business and Education Meeting

HNHB LHIN Office

4:00 p.m.

264 Main Street East, Grimsby

***For more community events, click here.***

## Health Service Provider Events

**Friday, March 28, 2014**

French Connection - 2nd Edition Forum

Old Mill Toronto

8:30 a.m.

21 Old Mill Road, Toronto

***For more HSP events, click here.***

---

# Feature Tweets

- Applications for 2014-15 Critical Care Nurse Training Fund now being accepted - more info here http://bit.ly/1kaRfwr Deadline is March 28
- Helping to spread the word -- Hamilton Food Share **@HFShare** is looking for a Community Development Coordinator http://bit.ly/1m0xdbc
- To ensure patient safety we check 2 patient identifiers **@HNHB_LHINgage** **@AccredCanIntl** **#Accreditation2014** pic.twitter.com/i2n2Q9qGDI
- Today marks the start of **#brainweek** find out more on the research Brain Canada is doing to help Canadians http://www.braincanada.ca
- RT **@SarahMcVanel** : Happy Social Work week from Discharge planning **@BCHSYS** colleagues! You provide awesome patient care...thank-you! pic.twitter.com/3haevXEjFb
- Expand your mind during #brainweek - learn more about the importance of brain tumor research http://bit.ly/1m4r3a6
- Nutrition is one of the most important factors in keeping good health - March is **#nutritionmonth** Learn more at http://bit.ly/1kdtKWb

**Follow @HNHB_LHINgage to stay informed of HNHB LHIN initiatives and activities.**

**We want to stay informed too - let us know if you're on Twitter!**


---

*LHINs are the only organizations in Ontario that bring together health care partners from the following sectors – hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care – to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario and HNHB LHIN communities. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health care system that delivers improved health care results and a better patient experience.*

**If you would like to be added to the distribution list, please subscribe using 'My Page.'**
**To provide story ideas and/or comments, please click here.**